PROJECT SAFE

SUBSTANCE ABUSE FREE ENVIRONMENT COMMUNITIES

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Des Moines, Iowa 50319

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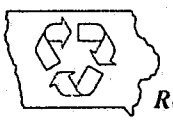

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PROJECT SAFE

STATEMENT OF PURPOSE

THE PURPOSE OF PROJECT SAFE IS TO FACILITATE THE EDUCATION AND INVOLVEMENT OF EVERY ENVIRONMENT IN IOWA'S COMMUNITIES SO THAT COMMUNITY SYSTEMS CAN TAKE RESPONSIBLITY FOR REDUCING THE INCIDENCE OF ALCOHOL AND OTHER DRUG ABUSE AND ASSOCIATED PROBLEMS.

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PROJECT SAFE

INTRODUCTION

The range of problems the use of alcohol and other drugs can create is vast. These substances hold the potential of causing great personal and economic suffering, including retarded emotional and intellectual performance, violence, crime, injury, and death.

Making these even more serious is the fact that many who suffer because of alcohol and other drug abuse may not even use, let alone abuse; they are the victims of someone else's involvement with these chemicals. In reality, everyone suffers to some degree in the form of higher government, medical, and insurance costs. While all of the problems mentioned above can occur for a number of reasons, a focused attempt must be made to reduce and ultimately eliminate those problems caused by alcohol and other drugs.

Across Iowa and the nation, people are learning that there is a solution to alcohol and other drug abuse. The solution is COMMUNITY PREVENTION.

The purpose of this manual is to provide communities with practical guidance for the planning and implementation of programs designed to prevent alcohol and other drug problems from occurring.

Prevention is complex and multifaceted. For lasting change, prevention efforts must focus on cooperative initiatives involving families, religious institutions, media, service organizations, private industry, labor, health care professionals, social service agencies, law enforcement, court systems, educational institutions, and substance abuse prevention and treatment professionals.

Communities that are mobilized to help their citizens work together have the potential of accomplishing prevention goals on a much broader scale than individuals working alone. Community prevention is at the heart of Project SAFE.

PROJECT SAFE

OVERVIEW

Project SAFE is a community mobilization program offered through a state-level coalition that includes the Governor's Office of Drug Policy and the Departments of Health, Education, Human Services, and Public Safety.

Project SAFE helps communities mobilize to reduce alcohol and other drug use by encouraging cooperation through coordination of organizations and activities that deal with alcohol and other drug problems. When all of the appropriate resources in a community are brought together the communities' efforts will make a difference in reducing these problems.

The centerpiece of Project SAFE is the Community Prevention Matrix. It was developed by the Department of Public Health's Division of Substance Abuse in collaboration with prevention and treatment professionals across the state and will be discussed at length later in this manual. The Matrix provides a conceptual overview of how to mobilize the human energy needed to address the social problems within a community. In this manual, the Matrix is utilized to deal with alcohol and other drug problems.

The Matrix is not just a theoretical model. It is a framework for human action. The Matrix draws in participation from every community sector and charts a course of progressive action for each component. No part of the community remains uninvolved or unaffected.

This is the strength of the Matrix and of Project SAFE - everyone working together to achieve a common good. A community free from alcohol and other drug problems is a SAFE community!

PUBLIC HEALTH MODEL

The Iowa Department of Public Health views alcohol and other drug abuse as a major public health problem. Therefore, the Department uses the "Public Health Model" as the conceptual foundation for its substance abuse efforts. The Model sees prevention as a three-pronged issue:

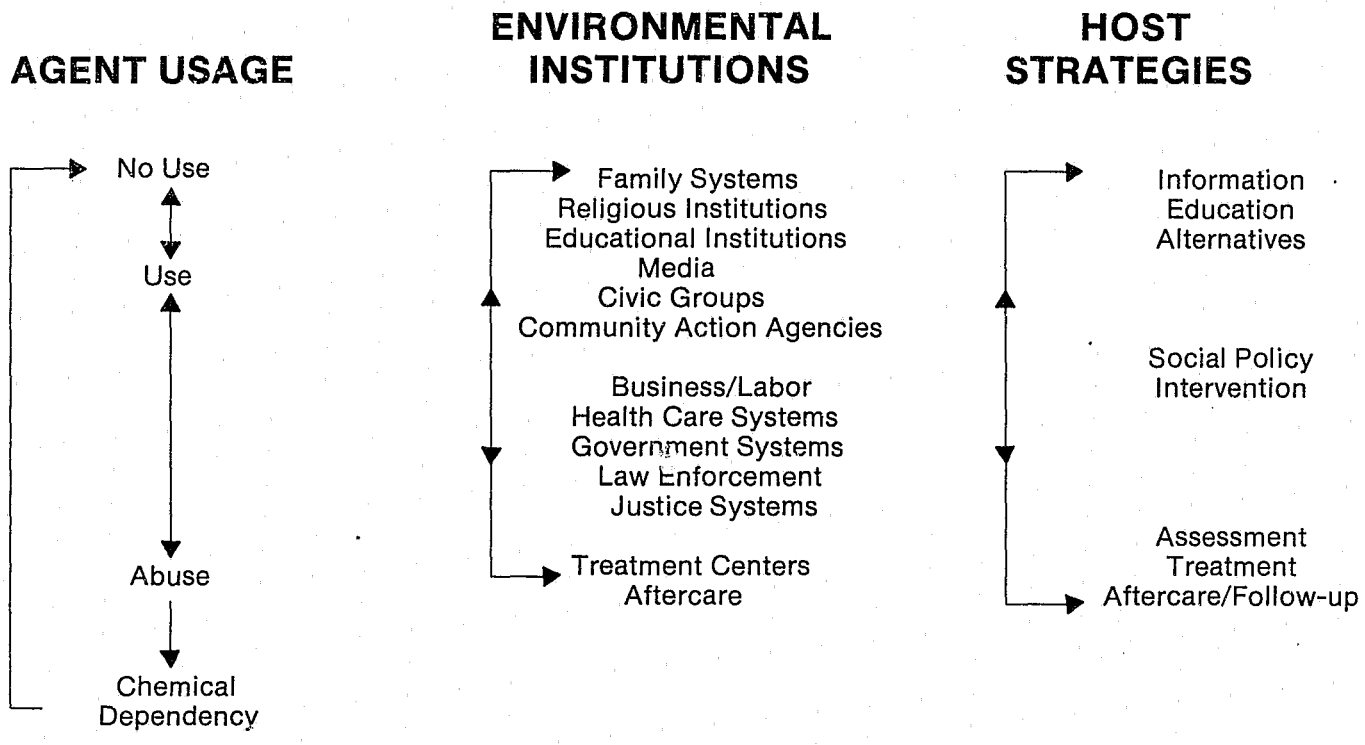
1. The AGENT, or the Alcohol and/or Other Drug(s)
2. The HOST, or the Individual
3. The ENVIRONMENT, or the Community

The AGENT is the chemical substance itself, the "what" of the substance abuse issue. Agents come in many forms and may be legal or illegal. In understanding agent usage, we look at the stages of chemical dependency: No Use, Use, Abuse, and Dependency.

The HOST is the individual, the "who" of this issue. Alcohol and other drug usage varies from host to host in terms of motivation, quantity, frequency, and consequences. The Department of Public Health views chemical dependency as a disease. Some hosts are predisposed to dependency because of their increased biological risk. Others may develop the disease by their frequency of use and the quantity consumed. Host strategies identified by the Department and used in the Community Prevention Matrix are Information, Education, Alternatives, Social Policy, Intervention, Assessment, Treatment, and Aftercare/Follow-Up. These strategies form the "Continuum of Care," and have been shown to be effective at impacting agent usage. No one strategy can be the "cure." A combination of the strategies used in a balanced approach is the key. The community will determine what combination of strategies is most effective.

The ENVIRONMENT is the community in its entirety, or the "where" of this issue. The environment includes sectors such as Family/Adult, Family/Youth, Religious Institutions, Educational Institutions, Media, Civic Groups, Community Action Agencies, Business/Labor, Health Care Systems, Government Systems, Law Enforcement, Justice Systems, Treatment Centers, and Aftercare Groups and Programs. The environment determines a community's standard of chemical health. It is important to impact policies and practices which influence alcohol and other drug availability, price, distribution and use. The aim is to minimize those factors that contribute to alcohol and drug problems and maximize the efforts that support healthier lifestyles.

This chart shows how agents, environmental institutions, and host strategies interact. Please note that these rules and interactions are general and do not necessarily apply in every case. Environmental institutions may, and often do, provide different services than the ones listed below.



COMMUNITY PREVENTION MATRIX

The Community Prevention Matrix is the interaction between the Host and the Environment from the Public Health Model discussed previously. An example of an empty Matrix appears on the following page with the host strategies comprising the "Continuum of Care" along the top and the community sectors comprising the environments down the left side.

The full Matrix was initially developed in 1987 through the collaboration of seventy prevention specialists from twenty-six state-funded programs. The goal of the collaboration was to provide a visual presentation of the "big picture" of an ideal community prevention effort. The strategies included across the top of the Matrix reflect the findings of current research on effective methodologies used in prevention and treatment. Furthermore, the Matrix illustrates that in any comprehensive prevention effort all sectors of the community need to participate.

On the following pages, each of the host strategies is defined in greater detail with examples to help you understand their practical application.

COMMUNITY PREVENTION MATRIX

	Information	Education	Alternatives	Social Policy	Intervention	Assessment	Treatment	Aftercare/ Follow-Up
Family Systems (Adult)								
Family Systems (Youth)								
Religious Institutions								
Educational Institutions								
Media								
Civic Groups								
Community Action Agencies								
Business and Labor								
Health Care Systems								
Government Systems								
Law Enforcement								
Justice Systems								
Treatment Centers								
Aftercare								

HOST STRATEGIES ALONG THE CONTINUUM OF CARE

1. INFORMATION

The Information strategy provides awareness and knowledge of the nature and extent of alcohol and other drug use, abuse, and dependency and the effects of use and abuse on individuals, families, and communities. It provides knowledge and awareness of available prevention and treatment programs and services. This strategy can be characterized by one-way communication from the source to the audience with limited contact between the two.

Examples:

- -Resource Directories
- -Media Campaigns
- -Brochures and Posters
- -Radio and Television Commercials and Public Service Announcements
- -Onetime Speaking Engagements
- -Health Fairs

2. EDUCATION

The Education strategy provides skill building through the use of structured learning processes. Critical life skills include decision making, coping with stress, problem solving, inter- and intrapersonal communication, systemic and judgmental abilities. This strategy can be characterized by increased interaction between facilitator and participants.

Examples:

- -Ongoing Classroom and/or Small Group Sessions
- -Parenting Classes
- -Project SAFE Community Mobilization Training
- -Peer Helper Programs

3. ALTERNATIVES

The Alternatives strategy provides participation in activities that exclude alcohol and other drugs. It is an opportunity for the individual to experience a renewed sense of personal accomplishment and pride.

Examples:

- -Drug-Free Dances and Parties
- -Peer Helper and Youth/Adult Leadership Retreats
- -"Fun Night" at Local Schools and Churches
- -Service Projects

4. **SOCIAL POLICY**

The Social Policy strategy establishes or changes written and unwritten community standards, codes, and attitudes and thereby influences alcohol and other drug use in the general population.

Examples.
- -Assisting the change of laws, regulations, and enforcement procedures
- -Assisting the change of taxation policies
- -Promoting the establishment or review of alcohol or drug policies in schools, businesses, and community organizations

5. **INTERVENTION**

The Intervention strategy is any activity designed to come between a substance user and their actions in order to modify behavior. This strategy includes a wide spectrum of activities that range from education to formal intervention with a substance abuse professional. From the educational standpoint the strategy helps individuals define their own alcohol and other drug problems and can refer them to appropriate resources.

Examples:
- -COA (Children of Alcoholics) Groups
- -Diversion Classes
- -Individual Referral Assistance
- -Employee Assistance Programs
- -Intervention Teams

As the strategy moves closer to assessment it may involve a loving confrontation by a family member, a friend, a teacher, a business associate, or a neighbor with a person who may be chemically dependent or is exhibiting substance abuse behavior. This intervention can be facilitated by professional guidance.

6. **ASSESSMENT**

The Assessment strategy clarifies an individual's level of use with alcohol and other drugs. Also clarified are an individual's need for treatment and problems and needs to be addressed during treatment.

Examples:
- -Determining that the use of alcohol and other drugs has caused family problems
- -Determining that the use of alcohol and other drugs has increased over time

-Identifying strengths and positive attributes to assist in treatment process

7. **TREATMENT**

The Treatment strategy includes specific therapeutic activities provided to individuals with alcohol and drug problems.

Examples:
-Outpatient, Intensive Outpatient, and Aftercare Treatment Services
-Inpatient, Residential, and Halfway House Treatment Services
-Individual/Group Counseling Activities
-Detoxification and Chemotherapy

8. **AFTERCARE/FOLLOW-UP**

The Aftercare strategy includes a component of services and activities provided to clients who have completed a primary treatment program designed to support and increase gains made in the treatment process.

Examples:
-Support Groups (AA, NA, ALANON, ACOA, ALATEEN, COA, etc.)
-In-School Support Groups
-Continuing Recovery Groups at Treatment Centers

GETTING STARTED

Community mobilization has proven to be the most effective means in addressing alcohol and other drug problems. While it seems that community efforts are never easy to initiate or perpetuate, they always bring effective, and often, dramatic results.

Your community may or may not be aware of the extent to which alcohol and other drugs are at the source of many community problems. The degree of alcohol and other drug abuse may be hidden from view because of apathy, ignorance, or a sense of hopelessness. The fact that the community may not be fully aware of the problems that exist is to be expected, but it cannot be accepted.

Community mobilization is first community awareness. Information and education are the critical first steps in bringing a community to a place of action. After a community becomes aware of its alcohol and other drug abuse problems and can visualize effective and realistic solutions to those problems, then community mobilization can proceed in earnest.

Recognizing the following community mobilization principles can help you understand how to generate interest in Project SAFE in your community.

COMMUNITY ORGANIZING PRINCIPLES

1. No change is possible unless people think there is a problem.
2. People need to see how a problem affects them.
3. People need to identify local resources available for dealing with the problem.
4. People need to identify meaningful alternatives for solving a problem.
5. People need to choose among alternatives with which they are comfortable.
6. Community leadership needs to be identified and become involved in implementing solutions.

STEP 1 - IDENTIFYING THE CORE GROUP LEADERSHIP

The Core Group is at the center of your mobilization efforts, and will consist of three or four individuals from your community who possess the time, energy, and leadership ability to see Project SAFE to its completion.

The Core Group members need to possess the ability to influence the opinions of others. They can either be recognized community leaders or individuals to whom the community leaders consult. Regardless of their station in life, Core Group members are people who can effectively impact their peers and their community.

The success of Project SAFE in your community will largely depend upon the quality of the Core Group membership. Therefore, be careful to consider the following qualifications for your Core Group members before you begin recruiting for these important positions.

CORE GROUP MEMBERSHIP QUALIFICATIONS

Core Group members will be individuals who:

1. Are known to be individuals who make firm commitments to long-term projects.
2. Have the time to devote to the project.
3. Have a cooperative spirit and a teachable heart.
4. Possess the energy and drive necessary for leadership.
5. Are like-minded and in agreement with the general scope of the project.
6. Possess creative abilities to bring innovative solutions to problems.
7. Are naturally enthusiastic and positive.
8. Can communicate goals and objectives effectively.

Remember that Core Group members do not need to be experts in the areas of alcohol and other drug abuse. They simply need to be willing to help you. They will become knowledgeable as they progress through the mobilization training discussed later in this manual.

STEP 2 - SELECTING A PROJECT CHAIRPERSON

The lead member of the Core Group will become the chairperson of the Central Committee that will be formed later. More than likely, this position will be the most important that you will have to fill. The Project chairperson sets the tempo and intensity of the entire community mobilization effort. In fact, the chairperson will become the focal point as Project SAFE is developed and launched in the community.

The Project chairperson needs to be chosen carefully. The following characteristics can guide your selection of this special community leader.

CHAIRPERSON QUALIFICATIONS

A good chairperson could be described as one who:

1. Clearly understands his/her own values and is willing to acknowledge those values to others.
2. Possesses good interpersonal skills, can develop trust, and is comfortable with people.
3. Can deal with others non-defensively and is willing to take risks.
4. Willingly gives up the ownership of ideas and allows others to take the credit; whose ego gratifications are internalized and do not depend upon group recognition.
5. Tolerates ambiguity and conflict and is not compulsive about following step-by-step procedures.
6. Willingly shares power with others and is aware of his/her own limitations in getting anything accomplished.
7. Does not fear change or the uncontrollable; is flexible and imaginative.
8. Listens well - even between the lines.
9. Recognizes the distinct dynamic of group behavior as rational and organized.
10. Easily works across institutions and respects different frames of reference without being hostile or adversarial.

Finally, and perhaps most importantly, a good chairperson is one who is seen in the community as a good role model, an example of leadership and integrity appropriate to the position of chairing Project SAFE.

STEP 3 - CONDUCTING THE COMMUNITY ASSESSMENT

The first task of the Core Group is to conduct an assessment of the extent of the alcohol and other drug problems in the community over the last three years. This is only an overview and not an exhaustive research project.

The community assessment is important because it gives the Core Group and the Central Committee a point of current reference for the level of alcohol and other drug abuse and the problems associated with it. The assessment will be completed through consultation with law enforcement officials, school representatives and health care and prevention/treatment professionals. Once it is completed, the assessment can be an effective tool to recruit others from the community to join the Central Committee or its many subcommittees.

A series of forms have been provided to help you gather and compile the information. These forms will be copied and sent to the Project SAFE Coordinator.

An important source of information for you will be the "Iowa Study of Alcohol and Drug Attitudes and Behaviors Among Youth" prepared tri-annually by the Iowa Department of Education. This study is a compilation of individual school district reports of student responses to selected survey items dealing with adolescent attitudes and behaviors relative to alcohol and other drug use. Nearly every school district in Iowa has compiled data in some form that pertains to adolescent attitudes and behaviors. Contact your local superintendent to determine what information is available for you to use. A copy of the full statewide report can be obtained from the Iowa Department of Education, Grimes State Office Building, Des Moines, Iowa 50319-0146.

Several other state agencies compile statistical data about the impact of alcohol and other drugs in Iowa. These agencies include the departments of Public Health, Public Safety, and Transportation. For more information contact the Project SAFE Coordinator who will direct you to the most appropriate state department to help you.

With the community assessment completed, you are ready to recruit others to join in the project. The assessment will be a valuable resource as you persuade other community leaders to make Project SAFE a community priority.

A Word of Encouragement

The community assessment forms may overwhelm you. They were designed to demonstrate the extent to which communities should compile detailed and comprehensive information. The forms allow a Core Group to gather information to whatever level of detail currently exists. The forms recognize that some communities may be able to fill in every box of every grid, while others may not be able to gather even half that amount of information. Remember that your responsibility is simply to report the data that already exists, regardless of how detailed or comprehensive.

The community assessment needs to be as thorough and complete as possible, recognizing, of course, your limited time, energy, and committee membership. Your assessment will be the basis of your project evaluation several months from now. The impact of your community prevention effort will be more easily discerned later if your initial assessment is accurate, detailed, and complete.

If your community has not been keeping records in a particular area as recommended by the assessment forms, you may want to include recordkeeping goals and activities in the community prevention matrix that will be developed later. Your community may not have a comprehensive substance abuse data base, but you can plan to change the data base for future community prevention projects.

The bottom line is simple: Don't Panic! Report the data that exists and encourage the various environments to begin recording the information that is recommended in the assessment.

STEP 4 - RECRUITING MEMBERS FOR THE CENTRAL COMMITTEE

The Central Committee is the formal group of community representatives who will develop and implement the community prevention matrix. Again, as in the selection of the project chairperson and the Core Group members, it is important to carefully recruit those who will be responsible for steering this project.

Central Committee members will be persons who have demonstrated leadership qualities, have the ability to positively influence others, and can organize a project and work independently. They need to be responsible, respectable, hard-working citizens of the community, and of course, they need to possess a sincere interest in solving the alcohol and other drug problems as they might exist.

The Central Committee needs to be limited to twenty people. A larger group may become unmanageable and unproductive. A small group maintains individual accountability, motivation, and participation.

Each member of the Central Committee will be expected to direct the subcommittee for the environment or sector that he or she represents. In other words, the representative from the religious environment or sector will be responsible for chairing the "religious institutions" subcommittee. Each member will also be responsible for recruiting his or her own subcommittee members - whomever and however many desired. When the community prevention matrix has been developed and the action plan is completed, the subcommittees will be responsible for implementing their portion of the action plan.

As Central Committee members are recruited, write their names, addresses and telephone numbers on the following pages.

ENVIRONMENT	NAME	ADDRESS	TELEPHONE
Family Systems (Adult)			
Family Systems (Youth)			
Religious Institutions			
Educational Institutions			
Media			
Civic Groups			
Community Action Agencies			

ENVIRONMENT	NAME	ADDRESS	TELEPHONE
Business/Labor			
Health Care Systems			
Government Systems			
Law Enforcement			
Justice Systems			
Treatment Centers			
Aftercare			

THE CENTRAL COMMITTEE

GOALS FOR THE FIRST MEETING

The first meeting of the Central Committee will set the tone of your entire project. A well-organized first step will inspire the committee members to continue in the program. The members need to be notified of the time and place of the meeting well in advance. A letter with a follow-up telephone call is a proven method of ensuring attendance.

The goals for the first meeting should include:

1. An explanation of Project SAFE.
2. A brief overview of the community assessment completed by the Core Group.
3. A discussion of the responsibilities of the Central Committee members.
4. Identification of those environments of the community that are not represented at the meeting, and suggestions on how to recruit those sectors into the project.
5. An introduction of the Public Health Model and an orientation to the methodology of the Community Prevention Matrix.
6. A preliminary discussion of the budgetary needs of the project and the fundraising needs that may arise in the future.
7. The identification of individuals or businesses that can provide office space, xerox capability, and administrative support.
8. The date and location of the next meeting.

It is at this first meeting that Central Committee members will be introduced to the Public Health Model and the Community Prevention Matrix. These topics need to be facilitated by a local or regional substance abuse professional. If you are unable to locate a resource person for this responsibility, contact the Project SAFE Coordinator who will locate a suitable facilitator for you.

At this meeting Committee members should receive a copy of the full committee membership, including names, addresses, telephone numbers, and the environment represented by each member, their personal copies of the Project SAFE manual, any handouts pertaining to the Public Health Model or the Community Prevention Matrix prepared by the substance abuse professional, and a copy of the community assessment completed by the Core Group.

AN IDEA FOR COMMUNITY MOTIVATION

An excellent method of helping the Central Committee members comprehend the extent of the alcohol and drug problem in their community is to make a community alcohol and drug "site map."

Obtain a community map from your city administrator or clerk that is large enough to show every city street. On this map, place a small red dot at the street address of every individual arrested within the last three years on an alcohol or drug-related charge. You can obtain the arrest information from your local police or county sheriff's office. The names of the individual are not necessary, only their addresses.

Usually, the red dot will spread out across the entire community and will not be concentrated in any one locality. This illustration will help your committee members understand that the community's alcohol and drug problem is not isolated in any particular geographic, ethnic, social or economic sector of the community. In effect, the problem is community-wide.

AGENDA FOR THE FIRST MEETING (Suggested)

7:00 - 7:15 Introductions

7:15 - 7:45 Overview of Project SAFE and Community Assessment

7:45 - 8:45 Special Presentation: Public Health Model

8:45 - 9:00 Break

9:00 - 9:30 Special Presentation: Community Prevention Matrix

9:30 - 9:45 Discussion and Questions

9:45 - 10:00 Administration/Planning/Miscellaneous

Don't Forget:

1. To thank the committee members for attending.
2. To thank the substance abuse specialist(s) for his/her/their involvement.
3. To set the date, time, and location of the next meeting.
4. To assign tasks for the next meeting.
5. To bring refreshments.
6. To clean up.

The Tasks Ahead:

1. Recruitment of Subcommittee Members
2. Mobilization Training
3. Community Prevention Matrix Development

After the initial meeting there may be a natural "fall out" of members. Don't be discouraged. Some people may decide to send another representative from their group whom they know has a greater interest in this project. Some people may have a close friend or family member with an alcohol or drug problem and the committee participation may be too painful personally. On the other hand, this may be the very reason some commit to Project SAFE. In any case, it is important to remain sensitive to the many reasons people have for involvement or non-involvement in the project.

The following page describes why community task forces succeed and the phases that community action committees pass through.

NOTES

OVERVIEW OF PROJECT SAFE AND COMMUNITY ASSESSMENT

SPECIAL PRESENTATION: PUBLIC HEALTH MODEL

NOTES

SPECIAL PRESENTATION: COMMUNITY PREVENTION MATRIX

TASKS

POINTS TO PONDER

WHY COMMUNITY TASK FORCES SUCCEED	PHASES OF COMMUNITY ACTION
(1) They have clear, definite goals. (2) They define specific objectives that are: Meaningful (support goals) Realistic (accomplishable) Measurable (allow objective) (3) They are well organized and have strong leaders. (4) They make a commitment to planned action; each member takes responsibility for a small part of the master plan. (5) They establish programs that get visible results. (6) They evaluate each program and use the evaluation to make improvements. (7) Task force members regularly update their awareness and knowledge. They do their homework.	**Judgment Phase.** Some people naturally react to problems by blaming others. This can also happen in groups. The "blaming phase" hinders progress and identification of the real, underlying issues. Don't let your group get caught up in it. Some key words that clue you off to this phase: "Don't" and "Blame" and "There oughta be a law." **Information Phase.** As the group matures, members come to understand that they need information and facts to make informed decisions. **Intervention and Rehabilitation Phase.** The group wants to help the "casualties" of alcohol and other drug abuse. People in this phase are interested in providing better and earlier treatment and intervention services. **Alternative and Diversions Phase.** The group begins to see the value of alternative (more constructive) behavior patterns. The group senses that people need **What To Do** just as much as **What Not To Do.** **Constructive Social Action Phase.** During the phase, the group is concerned about the quality of life in the community. Members can clearly identify objectives and actions — planned prevention efforts that will benefit the whole community.

INTERLUDE

Between the first and second meetings of the Central Committee, each member will need to recruit others to join his/her environment subcommittee. These subcommittee members will attend the second Central Committee meeting, will be encouraged to participate in the mobilization training, will play an integral part in the development of the community prevention matrix, and will have key roles in the implementation of the action plan. Obviously, the subcommittee members are important, so use your best judgment in selecting them. Remember, they don't just fill a position - they do all the work ahead.

Central Committee members may first consider friends and close associates for subcommittee membership. Such a predisposition is only natural. However, it is good to remember that the community prevention matrix works best when it comprises the length and breadth of the community it represents. Therefore, don't be hesitant to cross the street and approach someone you do not know well or who is new to your community. The newcomer can probably give your subcommittee a perspective that your close friends and associates could never provide. A subcommittee made up of just friends can become a "closed system" and may not be as responsive to its specific environment as would be a subcommittee made up of diverse members.

Subcommittees can be of any size so long as they are manageable and productive. Aim for the best and forget about being the biggest.

CHARTING THE COURSE

CENTRAL COMMITTEE/SUBCOMMITTEES

The second meeting of the Central Committee takes place once the committee membership has been finalized. It is also the meeting where the subcommittee members are introduced to the Central Committee.

The goals for this meeting are few but very important. They include:

1. An introduction of the Central Committee members who have joined the committee since the first meeting.
2. An introduction of the subcommittee members.
3. A discussion of the first meeting and the topics covered.
4. Any residual administrative matters that need to be resolved.
5. The planning for the mobilization training, including:
    a. Date
    b. Location
    c. Number
    d. Frequency
    e. Notices by Mail and Telephone
    f. Substance Abuse Specialist Arrangements

DON'T FORGET:

1. To remind the Central Committee members that their participation in the mobilization training is required for community certification in Project SAFE.
2. To encourage the environment subcommittee members to attend the mobilization training.
3. To send to the Project SAFE Coordinator the following:
    a. Certification Form A
    b. A Copy of the Community Assessment
    c. The Dates of the Mobilization Training

MOBILIZATION TRAINING

The community mobilization training that has been developed for Project SAFE represents the most current substance abuse prevention education available to community leaders today. Much of the material that will be presented has been gleaned from the nation's leading prevention educators and has been used in other community mobilization efforts across the state of Iowa before Project SAFE was developed. The training is a proven and effective community awareness tool and has been prepared with the community layman in mind.

The mobilization training is required of the Central Committee members and is strongly recommended for the subcommittee members. The training is divided into 15 different agenda items, each requiring a different minimum amount of time. The local or regional substance abuse professional can facilitate these sessions and should be asked to do so by the committee chairperson. If you cannot locate a facilitator, contact the Project SAFE Coordinator who will arrange for a facilitator to come to your community.

Altogether, the 15 agenda items comprise approximately 11 hours of substance abuse education, prevention theory, and community mobilization strategies. The sessions should be presented in the order listed in the manual. While time limits have been designated for each item, a committee may decide to expand on these time limits. The timeframe of the training may be offered in any manner suitable to the committee. Some possible formats are:

1 1/2 Days (e.g., Friday evening and all day Saturday)

4 Three-Hour Meetings (e.g., One evening a week for a month)

3 Half-Days (e.g., Three Saturday afternoons in a row)

Whichever format you decide for your committee, remember that the training needs to be completed within a 60-day timeframe, i.e. it should be no longer than two months between the first and last sessions, regardless of the format that is chosen.

When the training is completed, fill out and send Certification Form B to the Project SAFE Coordinator along with the agendas that were prepared for each of the training meetings and the preliminary drafts of the community prevention matrix prepared by each Central Committee member in collaboration with his/her environment subcommittee.

Within 10 days of receipt of Certification Form B, the Project SAFE Coordinator will contact the chairperson in your community to give notification of when the outside substance abuse consultant will be able to attend your one-day community prevention matrix meeting.

INTERLUDE

Within 15 days of the end of the community mobilization training, each Central Committee member needs to return his/her subcommittee matrix draft to the committee chairperson. The drafts from all of the subcommittees will be reproduced on the forms provided and mailed to the Project SAFE Coordinator along with Certification Form B. It is important to keep in mind that your community Project SAFE cannot proceed until it has passed this critical hurdle.

The Project SAFE Coordinator will review your community assessment and your preliminary matrix draft before the outside substance abuse consultant is scheduled to visit your community. The consultant will be prepared to help the Central Committee finalize its Community Prevention Matrix and to assist in the development of a realistic, attainable action plan and timeline.

Please allow 45 days from the time the chairperson has submitted Certification Form B to the scheduling of your final matrix development meeting with the outside substance abuse consultant.

FINALIZING THE COURSE

DRAFTING THE COMMUNITY PREVENTION MATRIX

A one-day matrix development meeting will be held to finalize your Community Prevention Matrix and to develop your action plan. The meeting will be facilitated by the Project SAFE Coordinator and an outside substance abuse consultant arranged through the Project SAFE office.

Agenda:

1. Goals and Objectives
2. Matrix Development
3. Action Plan and Timeline

   --Identification of 3 to 4 Primary Themes
   --Identification of 1 Action Step for each Environment
4. Evaluation Mechanisms
5. Adjournment

IMPLEMENTATION

With the Community Prevention Matrix and Project SAFE Action Plan and Time Line completed, the Central Committee can concentrate on two important aspects of any successful community mobilization effort: Publicity and Evaluation.

The following materials on these subjects have been provided for you to ensure that your mobilization efforts begin well. It is also important for you and your community to properly evaluate your efforts to ensure that you have met your goals and objectives, that you have been effective, and that you can amend your project in the future to remove any problems or deficiencies that developed during implementation.

COUNTERPRODUCTIVE APPROACHES

MEDIA WARNING CAMPAIGNS. Local newspapers often search for a controversial story about teenage alcohol and other drug use. In an interview, a school or community person may tell a reporter that cocaine use among teenagers is epidemic and then explain where cocaine is purchased, how it is used and what effect it has on the body as a stimulant. The subsequent news story, instead of "warning" about cocaine, becomes free advertising for it. Teenagers learn where to get it, what to do with it and how it will make them feel. Well intentioned media campaigns about specific drugs have been linked to an increase in their use. Such pharmacological information makes much more sense on the third day of an awareness (campaign) when the students already know about chemical dependency and the effects of mood altering drugs. By themselves, media campaigns advertise the drug and increase its use.

FEAR. Scare tactics and sensationalism stimulate interest in alcohol and other drugs. In any school population, some students will be attracted to the excitement and danger linked to alcohol and other drug use. For students who are "at risk" for drug abuse, THE PERIL IS THE LURE. Scare tactics challenge the defiant students to try to prove that the authority figures are wrong. Scare tactics also alienate youth from adults. They usually represent adults' worst fears for their own children. Scare tactics are associated with many untruths, judgments and demands that are contrary to teenagers' experiences. Instead of opening communication between youth and adults, scare tactics trigger defensiveness among youth. Respecting the ability of youth to make rational decisions based on accurate information is better than trying to coerce them into behaving a certain way.

TESTIMONIALS OF EX-ADDICTS. Some nationally and regionally known speakers market themselves as "ex-addicts" who want "to tell the truth about drugs". The message they give is that anyone can overcome addiction and be cured. The theme of such testimonials is often that individuals conquered addiction by themselves. They perpetuate the myth that recovery from addiction is just a matter of willpower and as soon as use stops, the "problem" is solved. The reality is that addiction can be arrested but not cured, and recovery is a lifelong process.

"Ex-addict" testimonials are often characterized by horror stories that are intended to frighten those in the audience so they won't use drugs. However, the image that the speaker generally presents actually glamorizes that lifestyle and triggers a reaction among

youth of, "He gave it up....so could I." There is no lasting deterrent effect from these presentations.

There is a role for testimonials from recovering individuals in the context of on-going education about chemical dependency. These presentations focus on the dynamics of addiction and the process of recovery. Their intent is to educate the audience about the risks of use, the denial that characterizes addiction, and the struggle of recovering.

ONE NIGHT STANDS TO GIVE INFORMATION. Information about alcohol and other drug use can be easily misinterpreted. For some students, merely giving detailed information about specific drugs may arouse curiosity and stimulate experimentation. Drug displays, "hit 'em hard on drugs" assemblies, and "how to" lectures are classic activities which many adults believe will halt the problem. Research indicates that when the focus is on a single drug, the incidence of that drug's use increases. When information about alcohol and other drugs is given in isolation, it is often counterproductive.

Information needs to be presented in the context of an educational process that deals with the broad spectrum of issues related to alcohol and other drug use, abuse, and dependency. To be most effective, this process should address the needs of those who are using alcohol and other drugs, those with one or more family members who abuse or are dependent on alcohol or other drugs, and those who neither use nor have been exposed to the abuse of alcohol or other drugs.

EVALUATIONS

PROCESS EVALUATION assesses the process by which goals are attained, and whether objectives were achieved. Completed at the end of each group activity, it answers questions like: What did we do well? What do we need to improve? How do we improve?

Some examples: Ask media public service directors to evaluate the method and materials distributed as part of a public awareness campaign, asking how to improve next time. Ask Committee members who worked on the campaign how next time to make their jobs easier, or to make the campaign run smoother.

OUTCOME EVALUATION evaluates the outcome or the effect of a program or an activity. It answers questions like (depending on the project that is being evaluated): Did the target population show any measurable changes in behavior, attitude, knowledge or perception? How did the target population react to our materials or project? Did the project/campaign increase the target population's awareness of alcohol/other drug problems?

Outcome evaluations are hard to do correctly. They usually require "pre-" and "post" tests, so they need to be designed before the project begins. Unless someone in the group has expertise, get professional help before undertaking an outcome evaluation --- and before undertaking the project itself. Call the Project SAFE Office or a nearby university/college psychology department for assistance.

IMPACT EVALUATION measures the program's "impact" in the community, not just with the target group. It answers questions like (depending on the project that is being evaluated): Did the community show any measurable changes in behavior, attitude, knowledge or perception? How did the community react to our materials or project? Did the project/campaign increase the community's awareness of alcohol/other drug problems?

Again, impact evaluations are hard to do correctly. They usually require several years to complete. Call the Project SAFE Office or a nearby university/college psychology department for assistance.

IT IS FINISHED!

BUT YOU'VE ONLY JUST BEGUN

When fully certified, your community will be added to the "Iowa Registry of Safe Communities" to be published periodically by the Governor's Office of Drug Policy.

Your SAFE registration is effective for two years from the date of certification. Each member of the Central Committee will receive a certificate signifying his/her important role in the Project SAFE mobilization effort. Your community will also receive an IOWA SAFE COMMUNITY certificate that will be sent to your mayor's office.

RECERTIFICATION

TWO YEARS FROM NOW

Maintaining your "Iowa SAFE Community" designation will not be difficult. The Office of Drug Policy will be developing the standards and procedures for recertification in the months ahead. Each community that successfully completes Project SAFE will be sent the recertification information when it is available.

CERTIFICATION FORM A

Community _____ Date _____

Chairperson _____ Project SAFE Inauguration Date _____

CENTRAL COMMITTEE MEMBERSHIP

Environment	Name	Address
Family Systems (Adult)		
Family Systems (Youth)		
Religious Institutions		
Educational Institutions		
Media		
Civic Groups		
Community Action Agencies		
Business and Labor		
Health Care Systems		
Government Systems		
Law Enforcement		
Justice Systems		
Treatment Centers		
Aftercare		

A copy of your community assessment and the environment subcommittee membership lists must accompany this form.

State Office Use Only

_____ Membership _____

_____ Assessment _____

_____ Subcommittee Membership _____

Certified _____ Date _____

CERTIFICATION FORM B

Community _____ Date _____

Chairperson _____ Project SAFE Inauguration Date _____

I certify that the Project SAFE Central Committee has completed the community mobilization training as outlined in the Project SAFE manual.

_____, Chairperson

The Number of Training Meetings: (circle) 1 2 3 4 5 6

Dates of Each Meeting:	Facilitator(s) at Each Meeting:
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Have you included a copy of the agenda from each training meeting that was held? ____Yes ____ No

If no, why? _____

_____

Have you included the preliminary community prevention matrix segments as assigned to the subcommittees in session 15? _____Yes _____ No

If no, why? _____

_____

Please attach a list of attendees for each training meeting, and indicate whether they were 1) Central Committee Members, 2) Subcommittee Members, or 3) General Public.

Please list four possible dates in the next 45 days that would be feasible for the one-day matrix development meeting facilitated by the outside substance abuse consultant.

1 _____ 2 _____ 3 _____ 4 _____

State Office Use Only

_____ Meetings _____

_____ Agendas _____

_____ Matrices _____

_____ Attendees _____

Certified _____ Date _____

CERTIFICATION FORM C

Community _____ Date _____

Chairperson _____ Project SAFE Inauguration Date _____

I certify that the Project SAFE Central Committee has completed the final community prevention matrix development meeting with the outside substance abuse consultant.

_____, Chairperson

Have you included a copy of the final draft of the community prevention matrix? ____Yes ____ No

If no, why? _____

_____

Have you included a copy of the action plan and timeline? _____Yes _____ No

If no, why? _____

_____

Please attach a list of attendees for the final community prevention matrix development meeting, and indicate whether they were 1) Central Committee Members, 2) Subcommittee Members, or 3) General Public.

Please list four possible dates 60 days from today that would be feasible for Governor Branstad's visit to acknowledge your community as an Iowa SAFE Community.

1 _____ 2 _____ 3 _____ 4 _____

State Office Use Only

_____ Matrix Meeting _____

_____ Matrix Draft _____

_____ Attendees _____

_____ Action Plan/Timeline _____

Certified _____ Date _____

ALCOHOL AND OTHER DRUG-RELATED TREATMENT INCIDENTS

Please indicate the total number of alcohol and other drug-related treatment incidents. (If data is available, please specify the major drug involved.) If data is not available for a category, please mark "NA" in the appropriate box. If statistics are not kept for a category, please mark "NK" in the appropriate box.

	ALCOHOL RELATED			OTHER DRUG-RELATED*			*MAJOR DRUG INVOLVED (OPTIONAL)						
	ASSESSMENT	TREATMENT	AFTERCARE	ASSESSMENT	TREATMENT	AFTERCARE	OPIATES	COCAINE	CANNABIS	HALLU-CINOGENS	STIMU-LANTS	DEPRES-SANTS	OTHER
DEPENDENTS													
FAMILY MEMBERS OF DEPENDENTS													
OTHERS CONCERNED FOR DEPENDENTS													
TOTAL													

ALCOHOL AND OTHER DRUG-RELATED COUNSELING AND REFERRAL INCIDENTS

Please indicate the total number of counseling and referral incidents and the number that are alcohol and other drug-related. (If data is available, please specify the major drug involved.) If data is not available for a category, please mark "NA" in the appropriate box. If statistics are not kept for a category, please mark "NK" in the appropriate box.

ENVIRONMENT	TOTAL INCIDENTS	ALCOHOL RELATED	OTHER DRUG RELATED*	*MAJOR DRUG INVOLVED (OPTIONAL)						
				OPIATES	COCAINE	CANNABIS	HALLU-CINOGENS	STIMU-LANTS	DEPRES-SANTS	OTHER
RELIGIOUS INSTITUTIONS										
With Dependent										
With Family Members										
With Concerned Others										
EDUCATIONAL INSTITUTIONS										
With Dependent										
With Family Members										
With Concerned Others										
COMMUNITY ACTION AGENCIES										
With Dependent										
With Family Members										
With Concerned Others										
BUSINESS/LABOR (EAPs)										
With Dependent										
With Family Members										
With Concerned Others										
TOTAL										

Report Period _____

LOCAL DRUG REMOVALS

Please indicate the total amount of drugs removed from the market by local agencies during the report period. Report opiates and cocaine in kilograms, cannabis in pounds and other drugs in dosages. If data is not available for a category, please mark "NA" in the appropriate box. If statistics are not kept for a category, please mark "NK" in the appropriate box.

TYPE OF DRUG	METHOD OF REMOVAL	
	SEIZURE	PURCHASE
OPIATES		
Heroin		
Opium		
Morphine		
COCAINE		
Crack		
CANNABIS		
Marijuana		
Hashish		
Hash Oil		
DANGEROUS DRUGS		
Methamphetamines/Amphetamines		
Other Stimulants		
Barbituates		
Other Depressants		
PCP		
LSD		
Other Hallucinogens		
UNKNOWN/OTHER		

Report Period _____

LOCAL DRUG ERADICATION

Please indicate the amount of marijuana eradicated within the region through local efforts. The size of the plot and the means of destruction determine the common method of reporting the amount of drugs eradicated. Please report the number of plants destroyed or the number of acres of marijuana destroyed. Both methods may be used for different plots. If data is not available for a category, please mark "NA" in the appropriate box. If statistics are not kept for a category, please mark "NK" in the appropriate box.

TYPE OF MARIJUANA DESTROYED	AMOUNT OF MARIJUANA DESTROYED
Cultivated	
Wild (Ditchweed)	

Report Period _____

LOCAL ALCOHOL AND OTHER DRUG ARREST DISPOSITIONS

Please indicate the results, by defendant, of cases reaching disposition during the report period. If data is not available for a category, please mark "NA" in the appropriate box. If statistics are not kept for a category, please mark "NK" in the appropriate box.

DISPOSITION	MAJOR DRUG INVOLVED								
	ALCOHOL	OPIATES	COCAINE	CANNABIS	HALLU-CINOGENS	STIMU-LANTS	DEPRES-SANTS	UNKNOWN/ OTHER	TOTAL
Convicted									
Acquitted									
Dismissed									
Declined									
Unknown									
Total									

Report Period _____

LOCAL ALCOHOL AND OTHER DRUG CONVICTIONS

Please indicate the total number of alcohol and other drug-related convictions within the community during the report period. If data is not available for a category, please mark "NA" in the appropriate box. If statistics are not kept for a category, please mark "NK" in the appropriate box.

OFFENSE	MAJOR DRUG INVOLVED								
	ALCOHOL	OPIATES	COCAINE	CANNABIS	HALLU-CINOGENS	STIMU-LANTS	DEPRES-SANTS	UNKNOWN/ OTHER	TOTAL
Using									
Purchasing									
Producing									
Distributing									
Possessing									
Transporting									
Other									
Total									

Report Period _____

ALCOHOL AND OTHER DRUG-RELATED HEALTH INCIDENTS

Please indicate the total number of health incidents and the number that are alcohol and other drug-related. (If data is available, please specify the major drug involved.) If data is not available for a category, please mark "NA" in the appropriate box. If statistics are not kept for a category, please mark "NK" in the appropriate box.

	TOTAL INCIDENTS	ALCOHOL RELATED	OTHER DRUG RELATED*	UNKNOWN OTHER	*MAJOR DRUG INVOLVED (OPTIONAL)						
					OPIATES	COCAINE	CANNABIS	HALLU-CINOGENS	STIMU-LANTS	DEPRES-SANTS	OTHER
Death											
Emergency Rm. Incident											
Fatal Traffic Accident											
Non-Fatal Traffic Accident											
Total											

Report Period _____

ALCOHOL AND OTHER DRUG-RELATED SCHOOL INCIDENTS

Please indicate the number of alcohol and other drug-related disciplinary actions reported by the schools. (If data is available, please specify the major drug involved.) If data is not available for a category, please mark "NA" in the appropriate box. If statistics are not kept for a category, please mark "NK" in the appropriate box.

ACTION	TOTAL INCIDENTS	ALCOHOL RELATED	OTHER DRUG RELATED*	UNKNOWN OTHER	*MAJOR DRUG INVOLVED (OPTIONAL)						
					OPIATES	COCAINE	CANNABIS	HALLU-CINOGENS	STIMU-LANTS	DEPRES-SANTS	OTHER
Disciplinary											
Suspension											
Expulsion											
Total											

Report Period _____

NON-DRUG ASSET SEIZURES AND FORFEITURES

Please indicate the number of non-drug assets seized or forfeited involving local agencies during the report period and the estimated dollar amount of the assets. Please provide the same information for seizures and forfeitures in which there was Federal assistance. If data is not available for a category, please mark "NA" in the appropriate box. If statistics are not kept for a category, please mark "NK" in the appropriate box.

STATE AND LOCAL AGENCIES	ASSET SEIZURES		ASSET FORFEITURES	
	NUMBER OF SEIZURES	DOLLAR AMOUNT	NUMBER OF FORFEITURES	DOLLAR AMOUNT
Vehicles				
Vessels				
Aircraft				
Currency				
Other Financial Instruments				
Real Property				
Weapons				
Other				
WITH FEDERAL ASSISTANCE				
Vehicles				
Vessels				
Aircraft				
Currency				
Other Financial Instruments				
Real Property				
Weapons				
Other				

MOBILIZATION TRAINING

COMMUNITY MOBILIZATION TRAINING

GOALS

The four goals of the community mobilization training for Project SAFE are:

1. Community participants will be able to identify the effects of alcohol and other drugs on the well-being of the individual and the community.

2. Community participants will be able to describe current prevention strategies and discern effective applications.

3. Community participants will be able to identify all local and regional substance abuse resources for help.

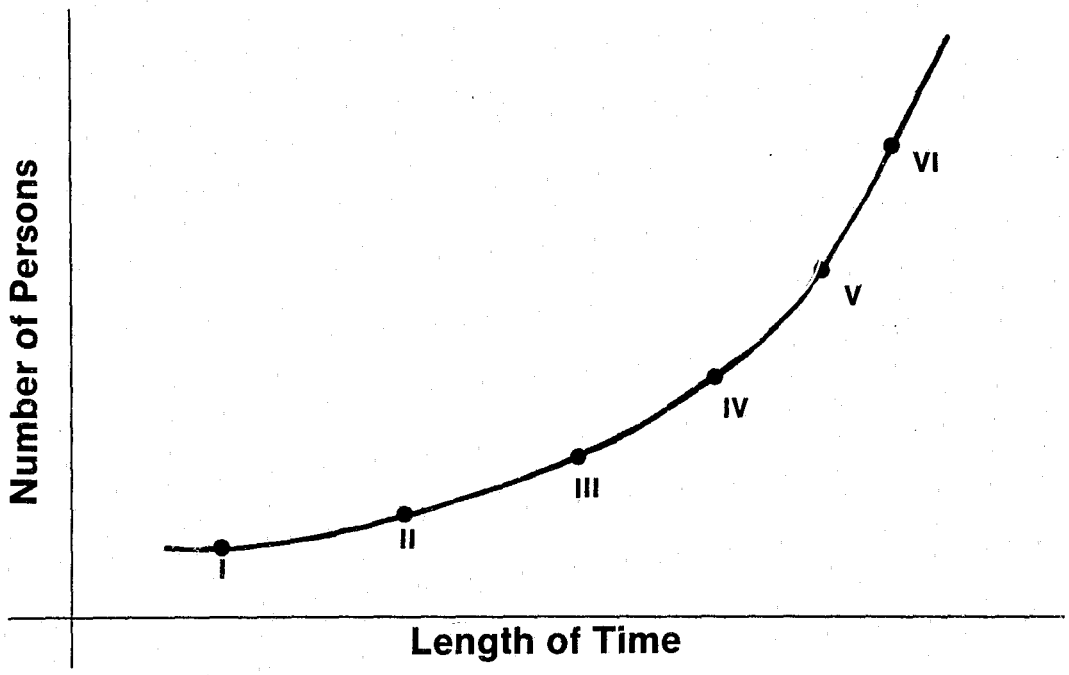
4. Community participants will accept ownership of their local alcohol and other drug problems and subsequent action plan in their community.

OVERVIEW

1. Introduction
2. Overview of Project SAFE
3. Overview of community mobilization training
4. Diffusion of innovation research
5. Exploring beliefs of the cause of alcoholism and other drug dependencies
6. Attitudes analyzer
7. History of prevention
8. Alcoholism and other drug dependencies
9. Family dynamics of alcoholism and other drug dependencies
10. The concept of enabling
11. Description of intervention, assessment, treatment, and aftercare
12. Social policy issues in prevention
13. Review of the community prevention matrix
14. Resource identification
15. Matrix sub-committee assignments

DIFFUSION OF INNOVATION RESEARCH

(15 Minutes)



DIFFUSION OF INNOVATION RESEARCH

The communities need to identify where on the diffusion graph their community would fit presently. Project SAFE is designed to help communities move through these phases.

This theory has been used to demonstrate how new concepts and new products are introduced into society, considered, and then acted upon.

Phase I	AWARENESS: The audience is learning about a new idea
Phase II	GETTING THE FACTS: The audience is learning about the problem, developing interest, and seeing possibilities for programs.
Phase III	PREPARING TO DECIDE: People are starting to analyze the situation and weigh the alternatives.
Phase IV	UNDERSTANDING THE SOCIAL IMPLICATIONS: The audience is understanding the social acceptability or social rejection of their decision; they are internalizing their choice.
Phase V	ADOPTING THE BEHAVIOR: The audience starts to adopt the innovative idea and acts upon it.
Phase VI	PRACTICING THE LONG-TERM COMMITMENT TO THE IDEA: The audience accepts the idea and makes long-term plans.

EXPLORING BELIEFS OF THE CAUSES OF ALCOHOLISM AND OTHER DRUG DEPENDENCIES

(30 Minutes)

This section of the training will help participants look at personality traits and emotional factors that have been commonly associated with the cause of alcoholism and other drug dependencies.

List of Causes:

There are three commonly held views about the cause and prevention of alcoholism and other drug dependencies.

1.

2.

3.

ATTITUDES ANALYZER

(30 Minutes)

Follow the directions given for the situations below. After completing the exercise individually, a physical representation of a line continuum will be used to process the exercise.

1. Give a rank of "10" to that situation with which you are LEAST comfortable.
2. Give a rank of "1" to that situation with which you are MOST comfortable.
3. Rank the other eight situations "2-9".

Situations

_____ A neighbor who offers you a few valium to help you through a personal crisis.

_____ A manufacturer of colorful, cleverly shaped vitamins, advertised to help children grow big and strong.

_____ A dentist who uses nitrous oxide with young children.

_____ A person who gives a cocktail party.

_____ The executive of a corporation who knowingly allows pollutants into the air we breathe.

_____ A grandparent who serves wine to everyone, young and old, at Thanksgiving dinner.

_____ Someone who offers marijuana to a friend.

_____ A person who continues to smoke at a meeting without asking non-smokers if it bothers them.

_____ A baby-sitter who gives children's aspirin to a cranky, tired child.

_____ A bartender who serves a regular customer who appears to be intoxicated.

Imagine that one wall of the room is marked "10" and the opposite wall is marked "1". The positions "2-9" form a straight line across the room. As the facilitator reads the given statement the participants will physically move to the position on the line continuum which corresponds with the number on their paper. Three or four persons will be asked what number they are on and for what reason they chose that number. When the process is completed and the participants have returned to their chairs, discuss the common criteria persons used to arrive at their decisions. The exercise will highlight the fact that we will not agree on our "10" and "1" but we can agree on common criteria to understand any alcohol or other drug situation in the community.

Criteria:

HISTORY OF PREVENTION

(30 Minutes)

In the evolution of substance abuse prevention many different theories have been the catalyst for prevention programming. Participants will understand where prevention has been, where it is now, and where it is going.

PREVENTION STRATEGIES
"What Research Studies Are Saying"

A. 1960's - "Inform and Scare" Theory

B. 1970's - "Values Clarification" and "Self-Esteem" Theories

C. 1980's - "Social Resistance Skills" Theory

D. TODAY - "Community Based Programs"

BASIC PREVENTION THEORIES

A. 1960's - "Inform and Scare" Theory

Programs focused on providing facts about "drugs" and the dangers of their use. It was believed that the more people knew about the drugs and their effects that they would be more likely to avoid them.

The impact of the theory suggests that:

1. People were not "scared."
2. The credibility of the "danger message" decreased as people observed drug use without observing the dangers associated with it.
3. Speeches by "ex-addicts" stimulated interest and made drug use seem adventurous.

B. 1970's - "Values Clarification" and "Self-Esteem" Theories

Programs focused on helping people develop and understand personal values that would influence their behavior when confronted with decisions about drug use. The facts about and consequences of drug use remained part of the programs, but a reference system was not taught by which people could make better decisions.

Values clarification was extended to the much broader and complex psychological concept of "self-esteem," with the belief that prevention could be successful if people learned to feel better about themselves and gained confidence in their ability to cope with problems.

These theories shifted prevention strategies away from external motivators such as fear of punishment or other injurious consequences to internal motivators that were seen to be the means of enabling people to "resist the temptation" of drug use.

The impact of these theories suggests that:

1. The deemphasis of factual presentations about drugs and their effects lessened the reliance upon up-to-date information which led to the misunderstanding that some drugs were less harmful than they were later proven to be.

2. The programs were not long enough to impact complex psychological concepts like values and esteem. Short-term sessions on increasing self-esteem proved to have little lasting effect.

3. Implicit in this approach was the belief that people with high self-esteem were "inoculated" against substance abuse. They would simply not be attracted to drugs. These theories tended to dismiss any other reasons for why people used drugs.

C. 1980's - "Social Resistance Skills" Theory

Programs focused on helping people develop the ability to cope with stresses in normal day-to-day life, as well as in peer relationships. One such coping strategy was to teach "social assertiveness" skills to instill a sense of increasing control over a person's environment.

An important factor in this approach was helping people understand that they are not isolated individuals making decisions not to use substances. Rather, they were taught that they often dramatically overestimated substance use among their peers and perceived themselves to be within a small minority of nonusers. When they realized that many of their peers were nonusers, their sense of belonging and peer acceptance was increased. Their choice not to use was thereby validated.

The impact of this theory suggests that:

1. Programs based in the "social resistance" theory have promise of reducing substance use by one-half among middle-school age children.

2. At least one-third of the "life skills" message must be specific to substance use issues. Otherwise, the skill may be learned but the relevance to drug use decisions may not transfer.

D. TODAY - "Community-Based Programs"

Prevention experts now recognize that substance abuse is far too deeply engrained in America's social fabric to warrant any unilateral or one-dimensional strategies. Such experts recommend multiple approaches and advocate community-wide efforts similar to Project SAFE.

In the following article, Bonnie Benard identifies the characteristics of effective prevention programs. Program comprehensiveness and intensity are major components of effective prevention programs, programs which are characterized as those that:

1. Address multiple systems (youth, families, schools, workplaces, community organizations, and media) and use multiple strategies (provide accurate information, develop life skills, create positive alternatives, train influential people, and change community policies and norms).

   Perhaps the most important conclusion we can draw from over a decade of prevention research is that because the causes of substance abuse are many (personality related, environmental, and behavioral) prevention efforts that focus on a single strategy probably will fail.

2. Involve the whole community in prevention efforts.

   In contrast to the ineffectiveness of most solely school-based prevention efforts, the research on comprehensive heart disease prevention programs that involved community-wide interventions has found significant reductions in the risk factors associated with the onset of negative health behaviors, the behaviors themselves, and related morbidity and mortality.

3. Address all youths, as opposed to only those identified as being at high risk.

   Although much research has focused on identifying youth at risk for substance abuse problems, researchers have cautioned against interventionist prevention programs. The latter view is supported by several points. First, adolescence is a high-risk time for everyone. Many adolescents experiment with health-compromising behaviors such as alcohol and other drug use. Second, labeling high-risk children and designing different programs for them tends to stigmatize them. This can have adverse social consequences and might make these children more likely to become involved with alcohol and other drugs. Third, many segments of the grassroots parent movement oppose the social and psychological testing and evaluation procedures necessary to identify youth at risk.

4. Make prevention programs part of a broader, generic prevention effort to promote health and success.

   Research indicates that health-compromising behaviors tend to be interconnected and have common antecedents. According to one study conducted in 1984, prevention efforts that focus on changing only one behavior (i.e., alcohol and other drug use) probably will not work.

5. Design programs of duration, with interventions, beginning early and continuing through life stages.

   Increasingly, the recommendations from research have been for earlier and earlier prevention programming. The protective factor research that has been conducted indicates that resilient children receive a great deal of attention in their first year of life, thereby giving them "a basic trust and a sense of coherence" in relating to their environment.

6. Provide a sufficient quantity of prevention (adequate time per intervention and an adequate number of interventions).

Since prevention activities are trying to change fundamental attitudes and behaviors, sufficient opportunities for these activities must exist. If we have learned anything from the last decade, it is that solitary prevention efforts do not work.

7. Integrate prevention activities into family, school, and community life.

   Although this remains more an ideal than a reality for many programs, the positive outcomes of several projects can be attributed in part to the emphasis they placed on integrating a prevention strategy into either the daily life of the classroom or the total school and home environments.

8. Build a supportive environment that encourages participation and responsibility.

   Much research has focused on identifying positive family and school environments. From a brief literature review, it can be inferred that environments in which children are given both opportunities to participate and responsibilities produce positive behavioral outcomes.

The impact of this theory on your community will be determined by your degree of commitment to developing your own comprehensive community prevention matrix and implementing an intensive long-range action plan.

ALCOHOLISM AND OTHER DRUG DEPENDENCIES

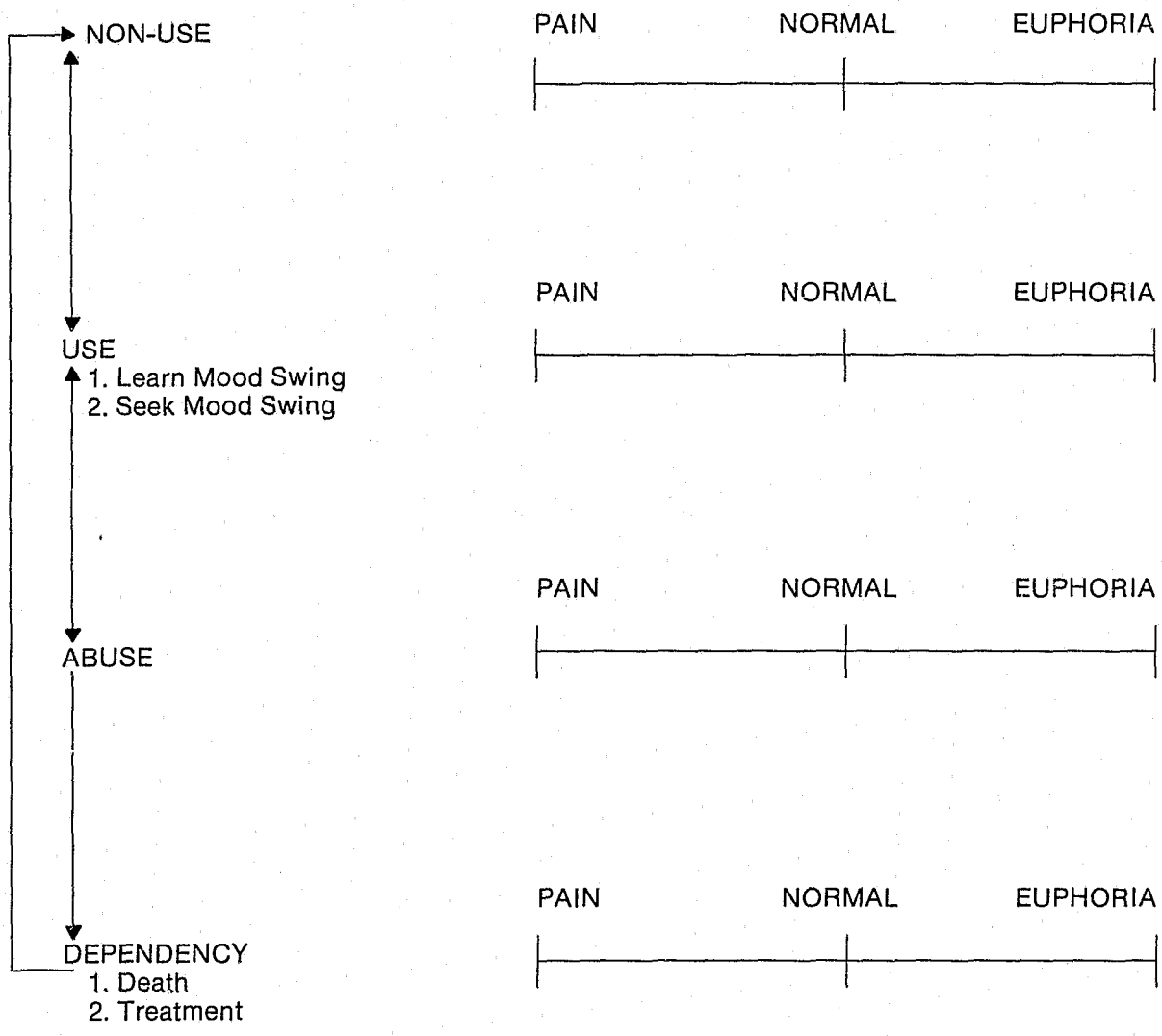
(90 Minutes)

It is crucial that participants gain an understanding of the disease of alcoholism and other drug dependencies. Detailed descriptions of the stages of alcoholism and other drug dependencies will be presented. Along with the stages, the Johnson Institute's "Feeling Chart" will be used.

Major Points:

1. Family History
2. Age of First Use
3. Quantity of Use
4. Frequency of Use
5. Primary Disease
6. Progressive Disease
7. Permanent Disease
8. Terminal Disease
9. Biological Factors - Liver, Brain, Gonads
10. Psychological and Social Factors

A FEELING CHART OF SUBSTANCE USE



Stages of Adolescent Dependency:

1. "Everybodies Doing It"
2. "Let's Party"
3. "Live to Use"
4. "Use to Live"

THE JOHNSON INSTITUTE

PHILOSOPHY OF ALCOHOLISM AND DRUG ABUSE

NATURE OF THE DISEASE

We believe that alcoholism and related chemical dependencies are primary, progressive, chronic and fatal diseases which, by their nature, and particularly in their later stages, render the victims incapable of the spontaneous insight required to offer themselves to remedial care. In these later stages, these persons are progressively locked away from their perception of the reality and the severity of their symptoms by the defensive life styles which have risen unconsciously to meet the growing and free floating mass of negative feelings about self which have resulted from the increasingly dependent and bizarre behavior which occurs around the use of alcohol and other mood changing chemicals. We believe that, in due time, chemically dependent people are victimized not only by the destructive drinking or using pattern alone, but also by these very defensive life styles, which are unconsciously successful to the point where these people are sincerely deluded. Moreover, we believe that the memory systems of these victims become so thoroughly distorted through blackouts, repression and euphoric recall that they are incapable of using human resources for any valid self-evaluation and are out of touch with reality. Massive impairment of judgment or mental mismanagement results from these successful self-deceptions. Progressive deterioration occurs in all phases of life, emotionally, spiritually and physically. We believe that, in these later stages, these persons are more and more immobilized by these self-deceiving factors and that unless intervention with these factors takes place from the outside, premature death is inevitable.

FAMILY

We believe that those living with harmfully dependent persons, on the job, but more particularly in the home, become emotionally involved and distressed to the point where they display similar symptoms, and need remedial care as well, as they become progressively immobilized by their distress. Typically, they misunderstand the nature of the illness and, as they wait for the chemically dependent person "to hit bottom" and "come to his senses" in some spontaneous fashion, or as they manipulate the environment to make the situation "go away," the failures of these approaches cause them even greater distress. This pathology parallels, and in some cases, even exceeds that of the chemically dependent

person. In short, we believe that these persons are not only inadvertent "enablers" of the disease process--they are a part of the process itself.

SOCIETY

Likewise, we believe that the misunderstanding of the nature of harmful chemical dependency by the general public is contributing not only to the incidence of the disease, but is consistently enabling the disease to progress to its later and more dangerous stages even before it is recognized. Moreover, after recognition does occur, we believe this misunderstanding blocks effective intervention while society, too, waits for "the bottom" and spontaneous insight, or while society unsuccessfully manipulates the environment through social or legal sanctions in order to make this health problem "go away."

INTERVENTION

We believe that intervention with these conditions can and does occur at two levels. First, intervention takes place through a general educational process aimed at replacing misunderstandings of the nature of the illness with more useful insights. We believe that a general climate of understanding can be created where intervention is viewed as not only necessary, but possible, and where intervention becomes the expected "norm of approach" to victims in the later stages of the disease. Second, at the individual level we believe that those immediately around the suffering chemically dependent person can be taught specific and useful methods for successful intervention. We believe that replacing misunderstandings of the nature of the illness has the added benefit of causing those persons in the earlier stages (i.e., before loss of control appears) to reduce usage of these chemicals spontaneously or to alter their dependent relationship to them significantly and thus to avoid the illness.

We believe that the progressive nature of the disease requires that intervention be applied at the earliest possible time for two reasons, namely: (1) the suffering is limited to both time and degree and (2) the likelihood of successful recovery is enhanced.

Finally, we believe that the illness is treatable, and that, while numbers of treatment models are effective, the most useful clinical model is that which is designed to reduce simultaneously the major symptoms of mental mismanagement and emotional distress while any physical complications are receiving care.

CHEMICAL DEPENDENCY - A DISEASE

Dependence on alcohol and/or other drugs used to be thought of as a moral problem. The alcoholic was looked upon as a weak-willed individual. He was thought not to care about other people, or even himself. A common attitude was "all he has to do is control his drinking or, better yet, quit altogether."

Today, of course, medical doctors, clergymen and other professionals have come to realize that alcoholism is a disease, and that it responds to properly designed treatment.

The chemically dependent person himself is often the last to accept the disease concept. But family members and other persons close to the victim also continue to be very slow in identifying the disorder as an illness. This is because they are simply too involved emotionally with the sick person.

The American Medical Association has given formal recognition to the disease concept since 1956. Recognizing alcoholism and other drug abuse as an illness means several things.

1. The illness can be described.
2. The course of the illness is predictable and progressive.
3. The disease is primary, i.e., it is not just a symptom of some underlying problem.
4. It is permanent.
5. It is terminal - if left untreated, it inevitably results in premature death.

THE ILLNESS CAN BE DESCRIBED. The alcoholic's compulsion to drink is manifested in drinking habits that are inappropriate, unpredictable, excessive, and constant. His behavior changes to extremes, so that people around him are confused and bewildered. He might be good at hiding the compulsion, but it is always there. He might say, "Compulsion means that you just have to have a drink. I'm obviously not like that. I always decide whether or not I'm going to drink or use, so I can't possibly be chemically dependent." However, to an objective outside observer, it becomes obvious that sooner or later, the "decision" is always the same - to drink or use.

THE COURSE OF THE ILLNESS IS PREDICTABLE AND PROGRESSIVE. It will get worse; it's as simple as that. Sometimes there are plateaus where the drinking behavior seems to remain constant for months or even years. Occasionally, some event will trigger

what seems to be spontaneous improvement. But, over a period of time, the course of the disease is inevitably towards greater and more serious deterioration. This deterioration can be physical, mental and spiritual.

THE DISEASE IS PRIMARY. For a long time, most medical and psychiatric professionals started from a false premise - they treated alcoholism as though it were only a symptom of emotional or psychological disorders. The method of treatment was "let's find out what's really wrong with you and then you will no longer have the need to drink." It didn't work. Now these people have come to realize that alcoholism is a primary disease. It causes mental, emotional, and physical problems. Other problems which the victim may have cannot be treated effectively until the alcoholism is treated first.

THE DISEASE IS PERMANENT. Once you have it, you have it. Trying to learn to "drink like a gentleman or lady," just won't work. The only solution is to seek help to permanently arrest the disease - the earlier the better. It used to be thought that alcoholism could not be treated effectively until the victim had "hit bottom." Now we know that this is not so. The chances for successful treatment are much better in the earlier stages of the disease.

THE DISEASE IS TERMINAL. If you have this disease, and you do not successfully arrest it, you will die from it. Death certificates use many different terms for alcoholism, but the result is the same - the victim is dead. Whether the chemical complicated a heart condition, high blood pressure, a liver problem, a bleeding ulcer or precipitated a suicide, it is still the agent that caused the death.

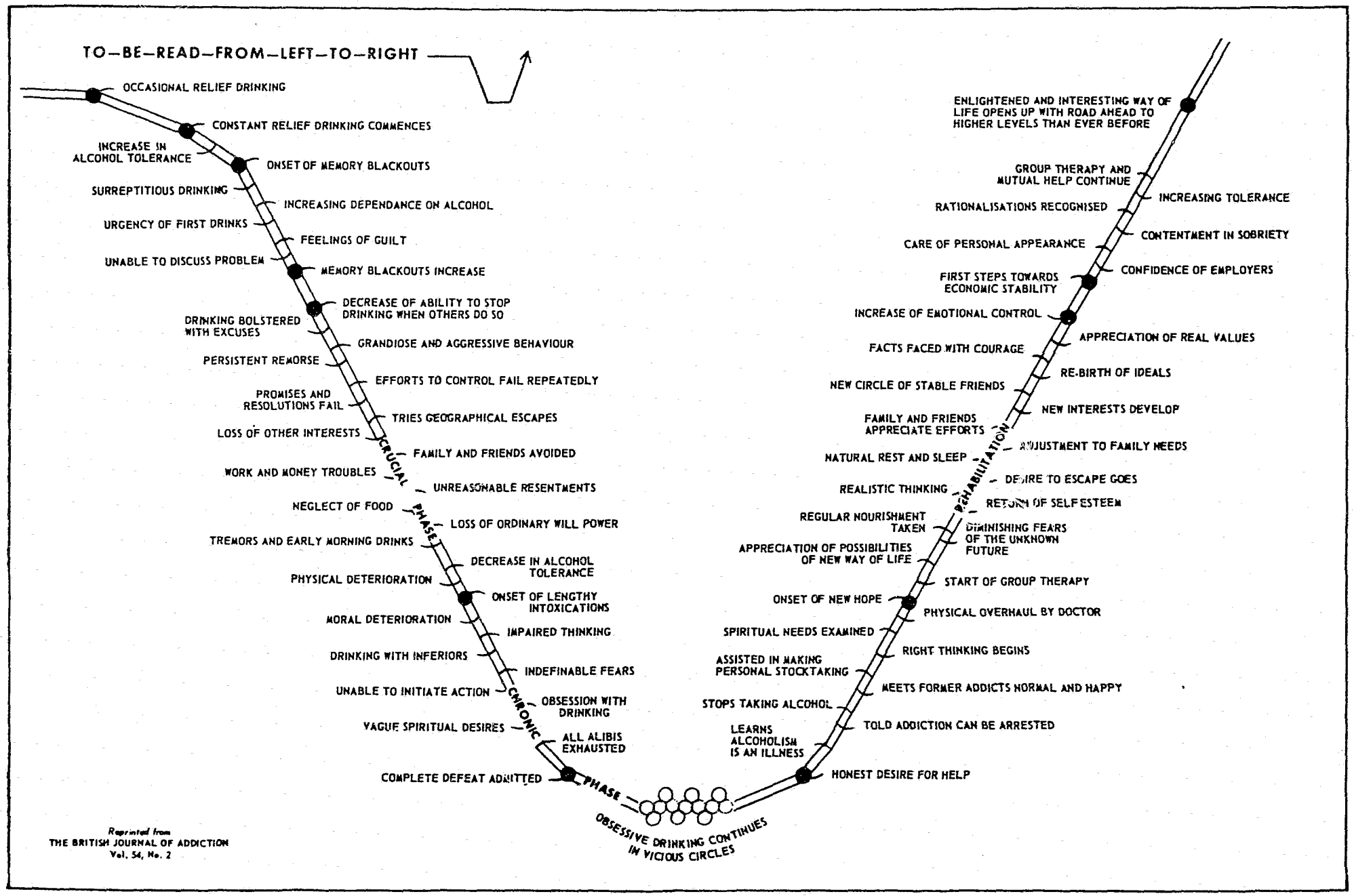
There are many definitions of chemical dependency. One of the most useful ones is this:

> If the use of alcohol and other chemicals is causing any continuing disruption in the individual's personal, social, spiritual or economic life, and the individual does not terminate use of the chemical, that constitutes harmful dependence.

The nonalcoholic might have one brush with the law. He might have one reprimand from his employer. He might have family problems over one drinking episode. But one such event would be enough to make him say to himself, "Wow, if I'm going to have that kind of trouble, I'm going to cut this stuff out!" And he will!

The alcoholic, on the other hand, will continue to use the chemical even though it causes continuing problems in any or all of the relationships that are important to him. He is saying by his actions, "Family, friends and job are important to me, but my dependence on this chemical is so great that I must continue using it even though it interferes with these relationships." This is attaching an emotional importance to an inert substance, a chemical. It is obviously abnormal. This is one of the surest symptoms of harmful dependency.

A CHART OF ALCOHOL ADDICTION AND RECOVERY



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FAMILY DYNAMICS OF ALCOHOLISM AND OTHER DRUG DEPENDENCIES

(90 Minutes)

When an individual is chemically dependent, people who are close to them (family, friends, co-workers) respond in ways that can be detrimental to themselves and to others. Participants will learn the "roles" that family members develop in order to cope with the effects of the chemical dependency. Discussion will center on what rules exist in chemically dependent families and how those rules affect the members' ability to have intimate relationships.

ROLES:

1. Dependent

2. Chief Enabler

3. Family Hero

4. Scapegoat

5. Lost Child

6. Mascot

RULES:

1. Don't Talk

2. Don't Trust

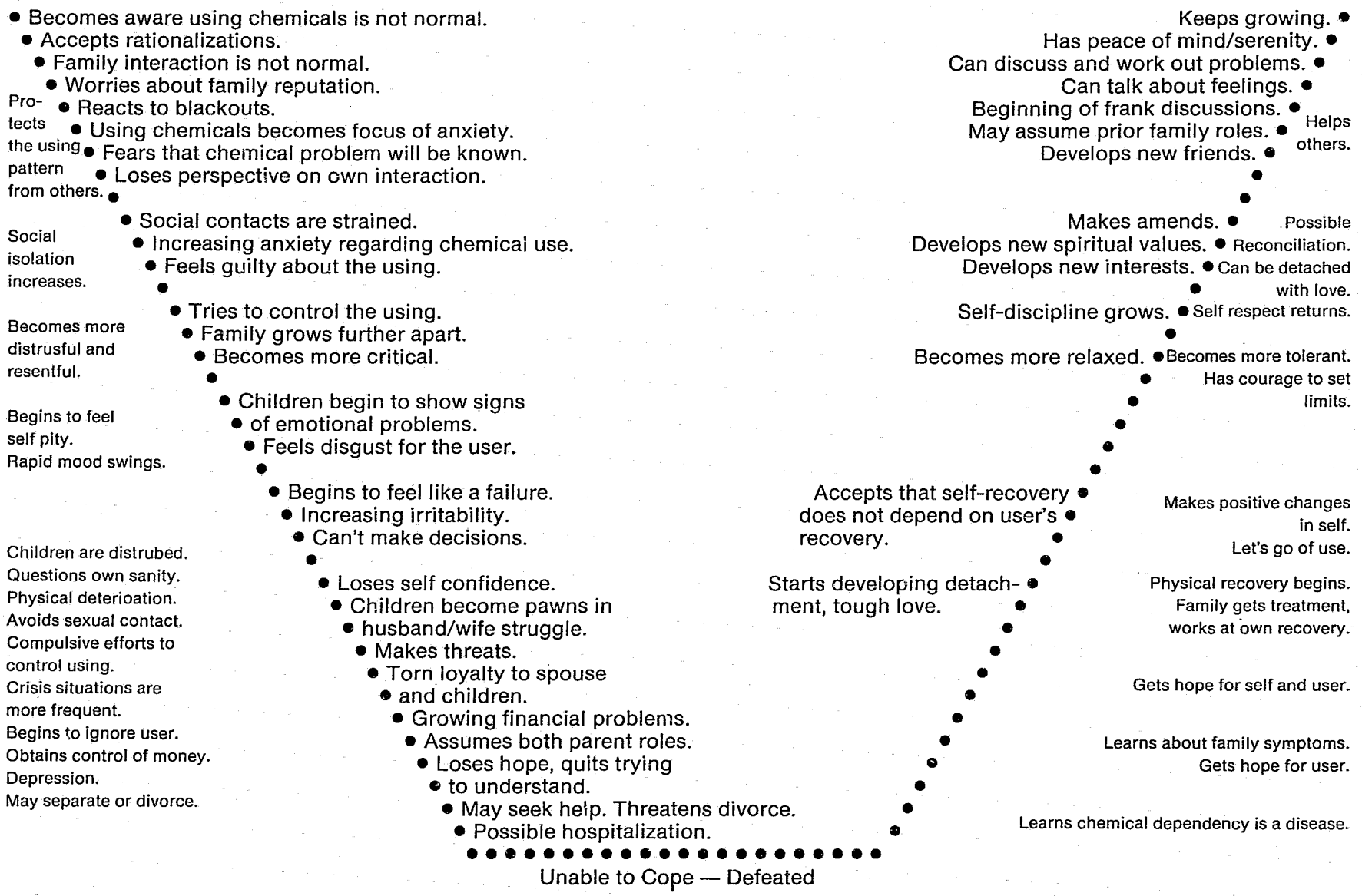
3. Don't Feel

THE EFFECT OF ALCOHOLISM ON THE FAMILY

ROLE	VISIBLE QUALITIES	INNER FEELINGS	REPRESENTS TO FAMILY (Payoff)	CHARACTERISTICS	POSSIBLE FUTURE CHARACTERISTICS	
					Without Help	With Help
DEPENDENT	Alcohol/drug use Lying Attempts to control use Preoccupation with using	Shame Fear Self-pity Worthlessness Out of control Helpless	A focus	Denial Regid Blames others Demanding Controlling Charming Selfish	Addiction Health Problems Death Rejection by family	Stability Recovery Serenity Accepts responsibility Contact with emotions
CHIEF ENABLER	Powerlessness Martyrdom Seriousness Fragility Mood swings Tolerance breaks	Anger Self-doubt Hurt Despair Guilt Tired Afraid	Responsibility Importance Self-righteous Self-worth Power Control	Hypochondriac Manipulative Blames self Denies problem Preoccupied with alcoholic/addict Over-responsibility	Stress-related illnesses Depression Numbness Emotional illness Isolation	Detachment Self-esteem Health Focus on self Serenity
FAMILY HERO	Successful Does what's right All-together Perfectionism Over-responsible Self-control	Inadequate Feels responsible Loneliness Numb Frustration Guilty Hurt	Family pride Good image An example Proof that all is well	Overachievement Independent Self-sacrificing Driven	Workaholic Compulsive Marries alcoholic Chronic stress Bitterness Emptiness	Accepts failures Good leaders Playful Intimacy Leans on others
SCAPEGOAT	Hostility Defiance Chemical use Rebellion Prefers peers	Angry Rejected Unloved Self-hate Shame Hurt	Takes focus off alcoholic "The Problem" Expresses feelings for the family	Withdrawn Sullen Self-destructive "In-trouble" Anti-social Runs from problems	Chemical dependency Pregnancy Prison Self-destructive behaviors Premature death	Accepts responsibility Good counselors Courageous Sees reality Wisdom of experience
LOST CHILD	Withdrawn Loner Intense Aloof	Lonely Unimportant Confused Inadequate Sad Afraid	Relief Escape One child not to worry about	"Invisible" No friends Lives in fantasy world Materialistic Demands nothing	Isolation Depression Victimization Suicide Mental illness	Creative Talented Independent Imaginative Accepts attention Self-actualized
MASCOT	Sensitive Fragile Immature Cute Funny Hyperactive	Afraid Anxious Insecure Feels crazy Confused Panicky	Comic relief Distraction Fun Release of tension	Placates Learning problems Charming Manipulative Tense Wiry Small	Ulcers Marries "hero" Never grows up Compulsive clown Lonely	Able to be serious Fun to be with Self-esteem Maturity

Information taken from *Another Chance: Hope & Health for the Alcoholic Family,* Sharon Wegscheider, 1981.

SYMPTOMS OF THE FAMILY — CHEMICAL DEPENDENCY



THE CONCEPT OF ENABLING

(30 Minutes)

The concept of enabling for health or illness will be defined and examples will be cited. The role of the chief enabler was described in the previous section. However, individuals, families, businesses, and entire communities can enable on different levels. Enabling may cause a dependent person to not experience the consequences of his/her choices. Participants need to examine how they and the institutions of which they are a part help shape lifestyles in the community.

HOW DO I ENABLE?

I. Negative Mode

SELF	FAMILY	OCCUPATION
1.	1.	1.
2.	2.	2.
3.	3.	3.
4.	4.	4.

II. Positive Mode

SELF	FAMILY	OCCUPATION
1.	1.	1.
2.	2.	2.
3.	3.	3.
4.	4.	4.

DESCRIPTION OF INTERVENTION, ASSESSMENT, TREATMENT AND AFTERCARE/FOLLOW-UP

(90 Minutes)

1. Intervention

   A. Formal

   B. Informal

2. Assessment

   A. Formal

   B. Informal

3. Treatment

A. Inpatient

B. Residential

C. Outpatient

4. Aftercare/Follow-Up

A. Self-Help Groups

B. Treatment-Center Based

SOCIAL POLICY ISSUES IN PREVENTION

(30 Minutes)

Every community has written and unwritten rules about the issue of substance use. These rules are often in conflict, sending mixed messages to the members of the community. A discussion of what rules exist in your community will be facilitated after each participant answers the following questions.

1. What substances are legitimate to use?

2. Has the community established rules regarding substance use?

    A. Where is it legitimate to use?

    B. When is it legitimate to use?

    C. Why is it legitimate to use?

    D. What behavior should we tolerate from individuals who use substances?

3. Has the community established a method to communicate the rules mentioned above?

4. Has the community developed a sense of accountability for those who break the rules?

5. Do culturally specific tools to cope with stress exist in the community?

6. Do culturally specific "rites of passage" exist in the community?

REVIEW OF COMMUNITY PREVENTION MATRIX

(30 Minutes)

At this point in the training, it would be beneficial to review the Public Health Model and the descriptions of the prevention strategies. A clear understanding of these will be necessary to proceed to the first application of the Matrix.

IDENTIFICATION OF PREVENTION ACTIVITIES AND SERVICES

(60 Minutes)

Using the Community Prevention Matrix, the Central Committee will identify the activities and services available to the community across the continuum of care (i.e. from Information through Aftercare/Follow-up). The purpose here is to write down the activity or service specific to content and target population.

MATRIX SUB-COMMITTEE ASSIGNMENTS

(30 Minutes)

Following the identification of the prevention activities and services on the Matrix, time needs to be allotted to clarify the subcommittee work that will take place after the training and before the one-day Matrix development meeting facilitated by the outside substance abuse consultant. Each Central Committee member will meet with his/her subcommittee members to add any other existing activities and services to the Matrix and to verify the accuracy of the activities and services identified at the training.

PRELIMINARY MATRIX DRAFT

	FAMILY SYSTEMS (ADULT)
INFORMATION	
EDUCATION	
ALTERNATIVES	
SOCIAL POLICY	
INTERVENTION	
ASSESSMENT	
TREATMENT	
AFTERCARE/ FOLLOW-UP	

PRELIMINARY MATRIX DRAFT

	FAMILY SYSTEMS (YOUTH)
INFORMATION	
EDUCATION	
ALTERNATIVES	
SOCIAL POLICY	
INTERVENTION	
ASSESSMENT	
TREATMENT	
AFTERCARE/ FOLLOW-UP	

PRELIMINARY MATRIX DRAFT

	RELIGIOUS INSTITUTIONS
INFORMATION	
EDUCATION	
ALTERNATIVES	
SOCIAL POLICY	
INTERVENTION	
ASSESSMENT	
TREATMENT	
AFTERCARE/ FOLLOW-UP	

PRELIMINARY MATRIX DRAFT

	EDUCATIONAL INSTITUTIONS
INFORMATION	
EDUCATION	
ALTERNATIVES	
SOCIAL POLICY	
INTERVENTION	
ASSESSMENT	
TREATMENT	
AFTERCARE/ FOLLOW-UP	

PRELIMINARY MATRIX DRAFT

	MEDIA
INFORMATION	
EDUCATION	
ALTERNATIVES	
SOCIAL POLICY	
INTERVENTION	
ASSESSMENT	
TREATMENT	
AFTERCARE/ FOLLOW-UP	

PRELIMINARY MATRIX DRAFT

	CIVIC GROUPS
INFORMATION	
EDUCATION	
ALTERNATIVES	
SOCIAL POLICY	
INTERVENTION	
ASSESSMENT	
TREATMENT	
AFTERCARE/ FOLLOW-UP	

PRELIMINARY MATRIX DRAFT

	COMMUNITY ACTION AGENCIES
INFORMATION	
EDUCATION	
ALTERNATIVES	
SOCIAL POLICY	
INTERVENTION	
ASSESSMENT	
TREATMENT	
AFTERCARE/ FOLLOW-UP	

PRELIMINARY MATRIX DRAFT

	BUSINESS AND LABOR
INFORMATION	
EDUCATION	
ALTERNATIVES	
SOCIAL POLICY	
INTERVENTION	
ASSESSMENT	
TREATMENT	
AFTERCARE/ FOLLOW-UP	

PRELIMINARY MATRIX DRAFT

	HEALTH CARE SYSTEMS
INFORMATION	
EDUCATION	
ALTERNATIVES	
SOCIAL POLICY	
INTERVENTION	
ASSESSMENT	
TREATMENT	
AFTERCARE/ FOLLOW-UP	

PRELIMINARY MATRIX DRAFT

	GOVERNMENT SYSTEMS
INFORMATION	
EDUCATION	
ALTERNATIVES	
SOCIAL POLICY	
INTERVENTION	
ASSESSMENT	
TREATMENT	
AFTERCARE/ FOLLOW-UP	

PRELIMINARY MATRIX DRAFT

	LAW ENFORCEMENT
INFORMATION	
EDUCATION	
ALTERNATIVES	
SOCIAL POLICY	
INTERVENTION	
ASSESSMENT	
TREATMENT	
AFTERCARE/ FOLLOW-UP	

PRELIMINARY MATRIX DRAFT

	JUSTICE SYSTEMS
INFORMATION	
EDUCATION	
ALTERNATIVES	
SOCIAL POLICY	
INTERVENTION	
ASSESSMENT	
TREATMENT	
AFTERCARE/ FOLLOW-UP	

PRELIMINARY MATRIX DRAFT

	TREATMENT CENTERS
INFORMATION	
EDUCATION	
ALTERNATIVES	
SOCIAL POLICY	
INTERVENTION	
ASSESSMENT	
TREATMENT	
AFTERCARE/ FOLLOW-UP	

PRELIMINARY MATRIX DRAFT

	AFTERCARE
INFORMATION	
EDUCATION	
ALTERNATIVES	
SOCIAL POLICY	
INTERVENTION	
ASSESSMENT	
TREATMENT	
AFTERCARE/ FOLLOW-UP	

ADDENDUM/NOTES

SOME THINGS YOU SHOULD KNOW ABOUT ALCOHOLISM

Kenneth Blum, Ph.D. and Michael C. Trachtenberg, Ph.D.

BRAIN NUTRITIONAL DEFICITS

Historically, people believed that alcoholism was caused by lack of willpower; that any "straight thinking" person could control his/her drinking habit and that failure to do so was a sign of a weak character.

Now, as a result of scientific studies over the past 20 years, we know that these beliefs are wrong. There are at least three factors that appear to cause alcoholism - genetics, stress and chronic alcohol abuse. These factors produce a deficiency that results in a disturbance in brain chemical signals. This causes well known physical and mental symptoms. These symptoms commonly include a craving - often irresistible craving - for alcohol.

To understand this present view of alcoholism you have to understand something of how the brain regulates behavior. If the body signals the brain that a need exists, the brain responds by releasing chemical signals (messengers or transmitters) which cause an action to fill that need. Two such chemicals the brain normally produces are called "endorphins" and "enkephalins". These two chemicals seek out and attach to mating "receptors" in the brain. The receptors accept only those chemicals whose molecules have the right (mating) shape. It is like a key (the chemical messenger) fitting into a lock (the receptor).

If a sufficient number of the receptors are "filled" with endorphins and enkephalins, you feel a sense of well-being. This is a natural sequence: the production of endorphins and enkephalins and the filling of the receptors, followed by a feeling of well-being. As long as those receptors are filled by endorphins and enkephalins you feel well.

But, if for some reason endorphin and enkephalin availability is reduced, and too few receptors are filled, the deficiency causes you to feel a sense of urgency and irritation. Similarly, if production is too high and an excessive number of receptors are filled you feel a sense of euphoria that may be followed by a letdown. This, too, is natural, and is a major cause of the "ups and downs" of everyday life for most people.

If you consume a drug such as morphine or heroin, these drugs take the place of endorphins and enkephalins at the receptors and, if taken in quantity, activate a large number of receptors and thereby create an unnatural euphoria. You feel "great" for a time, but the drug has a serious side effect: it causes the body to shut down production of natural endorphins and enkephalins. Then, as the drug wears off, your feeling of need becomes greater than ever. If drug consumption continues over a long period of time, the ability of the body to produce endorphins and enkephalins is reduced, and you become increasingly dependent upon the drug.

Alcoholism is not a single disease. Scientists believe that the deficits that result in changes in brain chemical transmitters may be arrived at by three pathways: 1) alcohol toxicity, alcohol induced or intensified alcoholism, where too much social drinking causes alcoholism; 2) stress, occupational or situational alcoholism; and 3) genetic predisposition, i.e. familial alcoholism.

Alcohol has recently been found to cause production of chemicals called tetrahydroisoquinolines (TIQ's), which have effects that resemble morphine and heroin. That is, they fill enkephalin receptors, produce an unnatural euphoria, and reduce the output of the natural endorphins and enkephalins. Because of this third effect, long-term use of large amounts of alcohol produces a permanent, urgent need for alcohol - the craving familiar to every alcoholic. As output of natural endorphins and enkephalins is reduced, the craving over comes willpower and becomes the dominant force in the person's life.

The most recent animal research indicates that genetic factors are a major predisposing element in alcohol craving. It is thought that in genetically predisposed humans, from birth, the production of endorphins and

enkephalins in the brain is abnormally low, and the resultant feelings of need and lack of fulfillment make such people susceptible to the illusory "highs" of drinking. Once the drinking habit is formed, the already low level of endorphins and enkephalins falls lower and lower, and dependence on alcohol becomes intense.

Stress leads to a reduction of enkephalins and endorphins. Alcohol, by producing TIQ's can lead to stress reduction. Frequent exposure to highly stressful circumstances can facilitate a habit and in conjunction with chronic alcohol use result in a physical need.

Social drinking can get out of hand if a too-great or too-frequent intake of alcohol results in too many receptors being filled by TIQ's for extended periods, and the normal output of endorphins and enkephalins is curtailed. In this case a simple habit generates a physical need - which strengthens the habit - and worsens the need, and so on.

Another group which exhibits certain dysfunctional behaviors, which may have a genetic basis, is the Adult Children of Alcoholics (ACA's). It is estimated that there are 28 million ACA's in the U.S. Scientists believe that this high risk population has distinct differences in their ability to metabolize alcohol, and in responsivity to alcohol. Many ACA's clinically have difficulties which include a high degree of stress and anger; insomnia; depression; and, compulsivity.

SOME THINGS YOU SHOULD KNOW ABOUT COCAINE

Kenneth Blum, Ph.D., Michael C. Trachtenberg, Ph.D., and Laurel A. Loeblich, Ph.D.

INTRODUCTION

Scientists test the benefits and/or destructive consequences of humans taking certain drugs by giving these drugs to animals with similar tissues, chemistry, etc. The results of many such experiments reveal that cocaine is more addicting than heroin and more lethal. The ultimate consequence of unlimited cocaine access in animals is always DEATH! In experimental animals allowed to self-administer the drug no more often than every 50 seconds, all die within 30 days. Monkeys allowed to self-administer every 10 seconds die within 5 days.

The recent popularity of cocaine abuse might thus seem surprising. However, public awareness of scientific studies is slow and the profits from the sale of cocaine are so large that nearly any sales technique is tried. In the end it all boils down to the cocaine dealer's promise to his prospective customers, "It feels great, AND you can use it occasionally - it really isn't addictive unless you're one of those idiots who allow themselves to get hooked on it." With this statement he is setting his trap. The very first "hit" causes changes that lead to physical addiction as we will see below. And, of course, he never mentions the problems that usually develop, often after minimal usage of the drug. Common among these are:

- Sleeplessness
- Reduction in feeling pleasure from everyday experiences
- Increased number of accidents
- Poor appetite
- Depression
- Fatigue
- Suicidal thoughts
- Paranoia
- Reduced sexual performance
- Brain hemorrhages
- Lung hemorrhages
- Seizures
- Degenerated value system
- Loss of self esteem

Cocaine use is very dangerous. It can, and often does, cause heart attacks, seizures, and/or convulsions. Increasing the amount, using more frequently, and smoking and/or injecting instead of snorting all dramatically increase risk; these serious consequences can occur with even first time use. Cocaine is potentially lethal.

The deadliness of cocaine has radically increased during the last decade as more pure and therefore stronger cocaine has become available. This has been coupled with the increased effect obtained by new methods of administration, such as shooting (intravenous injection), freebasing (smoking crack), etc. While some people can "snort a line" of cocaine occasionally in a "recreational" manner, many are unable to stop there. The occasional lines become the weekly lines, which become the daily lines. All too often this leads to smoking or shooting cocaine in an effort to achieve a faster, bigger "high". The highly predictable end result has been well demonstrated in a large series of studies. It is virtually impossible to stop - often after only one such "fast track" use. Inevitably the cocaine ends up in control of the person, instead of the person being in control of the use of the drug. Even worse, less than one-third of those who are addicted can stop even with the aid of standard drug abuse treatment. New developments have given hope to most of the remaining two-thirds. To understand how these work, we must first understand how cocaine acts on the brain.

THE CHEMISTRY OF COCAINE

Cocaine is a naturally occurring stimulant derived from the leaves of the coca plant. The leaves contain only one-half of one percent pure cocaine. Unlike pure cocaine, coca leaves contain a variety of minerals and vitamins. These nutrients are believed to chemically reduce the toxic effects of the cocaine contained in the leaf. When a leaf is chewed, a relatively modest amount of cocaine is released. Only a small quantity of that released is absorbed by the digestive system, and the digestion of it is very slow. For these reasons, the South American habit of chewing coca leaves has never become the serious public health problem associated with more potent forms and more efficient routes of administration.

In contrast the situation is dramatically changed when pure cocaine is used. If the substance is injected or smoked, the stimulating effects and feelings of euphoria are greatly magnified. Using cocaine in this way delivers significant amounts of the substance to the brain in seconds!

Once in the brain, cocaine acts upon the "reward/punishment" (r/p) systems. The normal function of these systems is to encourage the individual to do, or not to do, specific things. For example, if the body requires a particular nutrient, a specific brain chemical will be put into "short supply", causing the individual to feel ill at ease or have an urgent sense that something must be done. On the other hand, if the individual has just done something that was good for the body, release of certain brain chemicals will give the individual a sense of euphoria or elation. For example: the runner's high becomes encouragement to do further exercise. It also eases the muscle pain of hard work.

The mechanism by which the above takes place involves brain chemicals, called neurotransmitters. Cocaine's extraordinary release of one such chemical, dopamine, causes us to focus on this action.

The brain usually stores just enough dopamine to meet normal demands. For most people this supply needs to be rebuilt slowly with small quantities of dopamine. Not much is needed as release of even small amounts for short periods of time causes a strong effect. For instance, during the sexual climax a small dopamine release over a fraction of a second gives a very powerful reward feeling. Cocaine causes a much larger release over a longer period of time. This "feels so good" that one can become "hooked" after the first use. This is especially true of the first use of crack or shooting up. With repeated use of cocaine, the dopamine supply becomes depleted because it cannot be replenished quickly enough.

An analogy is helpful. The dopamine releases discussed above might be thought of as coming from a dam holding back a lake of dopamine. Normal use is rather like an occasional hole, the size of a toothpick, punched into the dam. The puncture releases a small amount of dopamine and then seals itself shut. The supply thus lost is replaced by a small trickle of dopamine coming from the cells which produce it. These cells could produce much more except that the "raw materials" (precursors) they use are just sufficient for the need.

Snorting cocaine is analogous to firing a bullet through the dam with a pistol. It releases a much larger amount than the toothpick and the feeling of euphoria is very desirable. However, the system is now depleted and rebuilding the supply to normal levels can take days from just one such use.

Smoking or shooting cocaine is analogous to firing a cannon through the dam. A great hole is breached causing profound euphoria. This feeling is so "incredibly good" that almost no one can do it just once; in short, a person can become addicted after the first use. Needless to say, the dopamine supply after such use is greatly diminished and after many such uses no amount of cocaine will produce the good feeling.

It should be noted that too much cocaine can be fatal. Thus, if the first time user takes the large dosage required by the longer term user, his first use can be his last!

The cocaine abuser experiences three stages of drug effects:

1. The first is acute intoxication (whether from snorting, injecting, or smoking). For a short time there is less anxiety, more self-confidence and alertness, a perception of clearer vision and understanding, and increased sexual appetite. However, the experience may be marred by sexual indiscretions, irresponsible spending, and accidents attributable to reckless behavior.

2. Next the "crash" replaces euphoria with longer term feelings of anxiety, fatigue, agitation, irritability, and depression. Perhaps worse, suicidal thoughts often increase during this stage. The abuser now faces three choices: 1) suffer through this time, 2) take more cocaine to alleviate the "crash", or 3) take another euphoriant drug which is less expensive, such as alcohol, marijuana, amphetamines, heroin, etc. This is how many cocaine abusers develop dependencies on other drugs. Most often alcohol is chosen as it is inexpensive, legal and often has been used before the cocaine addiction. Use of alcohol frequently leads to the cocaine abuser also becoming or intensifying his/her alcoholism.

3. Then the withdrawal stage follows--a lengthy period of limited ability to derive pleasure from normal activities. In long term cases, the abuser may permanently lose this ability. At the same time a craving develops for the euphoric effects of cocaine. The cravings are usually satisfied by using the drug again; and thus, the addiction develops.

THE DEVELOPMENT OF COCAINE ADDICTION

If cocaine use is repeated often, the resultant large and continuing dopamine releases cause a depletion of the dopamine supply. It also places a strain on the dopamine producing cells and abuses the dopamine release system. This is why many cocaine users report that "The first hit is by far the best." As further use is made of cocaine, the individual needs more and more just to get a desirable effect. Ultimately, the dopamine supply may become so small that cocaine, "just doesn't give an acceptable hit."

At this point, the cocaine abuser will often decide to seek treatment. If so, he has made a fortunate decision. If he does not seek treatment he will then typically turn to other drugs to try to get the relief he needs. Often the new drug of choice is alcohol. As it produces artificial euphoriants, there is no dependence on naturally produced neurotransmitters. Consequently, the high can be easily obtained whenever it is desired and for as long as desired.

Unfortunately, the continual use of alcohol reduces the body's ability to produce the natural opioid. It is a process rather like muscle atrophy; any muscle which goes unused for long periods of time deteriorates and ultimately ceases to function. If the brain is no longer called upon to make the natural euphoriants (enkephalins and endorphins [opioids]) because substitutes are being supplied in the form of drugs, its ability to make the opioids deteriorates. When the cocaine abuser switches to alcohol or some other drug, his dopamine supply is given a chance to rebuild. Once it is rebuilt the addict sooner or later learns that cocaine will work again. Perhaps not as well as before, but at least acceptably. The cycle is then repeated. Each time, new damage is done to the body, especially the brain, and the likelihood of return of full mental and physical capacity is reduced even further. Again, the frequent result is that the cocaine abuser also becomes an alcoholic or intensifies his/her alcoholism.

SOME THINGS YOU SHOULD KNOW ABOUT ALCOHOLISM

Kenneth Blum, Ph.D. and Michael C. Trachtenberg, Ph.D.

BRAIN NUTRITIONAL DEFICITS

Historically, people believed that alcoholism was caused by lack of willpower; that any "straight thinking" person could control his/her drinking habit and that failure to do so was a sign of a weak character.

Now, as a result of scientific studies over the past 20 years, we know that these beliefs are wrong. There are at least three factors that appear to cause alcoholism - genetics, stress and chronic alcohol abuse. These factors produce a deficiency that results in a disturbance in brain chemical signals. This causes well known physical and mental symptoms. These symptoms commonly include a craving - often irresistible craving - for alcohol.

To understand this present view of alcoholism you have to understand something of how the brain regulates behavior. If the body signals the brain that a need exists, the brain responds by releasing chemical signals (messengers or transmitters) which cause an action to fill that need. Two such chemicals the brain normally produces are called "endorphins" and "enkephalins". These two chemicals seek out and attach to mating "receptors" in the brain. The receptors accept only those chemicals whose molecules have the right (mating) shape. It is like a key (the chemical messenger) fitting into a lock (the receptor).

If a sufficient number of the receptors are "filled" with endorphins and enkephalins, you feel a sense of well-being. This is a natural sequence: the production of endorphins and enkephalins and the filling of the receptors, followed by a feeling of well-being. As long as those receptors are filled by endorphins and enkephalins you feel well.

But, if for some reason endorphin and enkephalin availability is reduced, and too few receptors are filled, the deficiency causes you to feel a sense of urgency and irritation. Similarly, if production is too high and an excessive number of receptors are filled you feel a sense of euphoria that may be followed by a letdown. This, too, is natural, and is a major cause of the "ups and downs" of everyday life for most people.

If you consume a drug such as morphine or heroin, these drugs take the place of endorphins and enkephalins at the receptors and, if taken in quantity, activate a large number of receptors and thereby create an unnatural euphoria. You feel "great" for a time, but the drug has a serious side effect: it causes the body to shut down production of natural endorphins and enkephalins. Then, as the drug wears off, your feeling of need becomes greater than ever. If drug consumption continues over a long period of time, the ability of the body to produce endorphins and enkephalins is reduced, and you become increasingly dependent upon the drug.

Alcoholism is not a single disease. Scientists believe that the deficits that result in changes in brain chemical transmitters may be arrived at by three pathways: 1) alcohol toxicity, alcohol induced or intensified alcoholism, where too much social drinking causes alcoholism; 2) stress, occupational or situational alcoholism; and 3) genetic predisposition, i.e. familial alcoholism.

Alcohol has recently been found to cause production of chemicals called tetrahydroisoquinolines (TIQ's), which have effects that resemble morphine and heroin. That is, they fill enkephalin receptors, produce an unnatural euphoria, and reduce the output of the natural endorphins and enkephalins. Because of this third effect, long-term use of large amounts of alcohol produces a permanent, urgent need for alcohol - the craving familiar to every alcoholic. As output of natural endorphins and enkephalins is reduced, the craving over comes willpower and becomes the dominant force in the person's life.

The most recent animal research indicates that genetic factors are a major predisposing element in alcohol craving. It is thought that in genetically predisposed humans, from birth, the production of endorphins and

enkephalins in the brain is abnormally low, and the resultant feelings of need and lack of fulfillment make such people susceptible to the illusory "highs" of drinking. Once the drinking habit is formed, the already low level of endorphins and enkephalins falls lower and lower, and dependence on alcohol becomes intense.

Stress leads to a reduction of enkephalins and endorphins. Alcohol, by producing TIQ's can lead to stress reduction. Frequent exposure to highly stressful circumstances can facilitate a habit and in conjunction with chronic alcohol use result in a physical need.

Social drinking can get out of hand if a too-great or too-frequent intake of alcohol results in too many receptors being filled by TIQ's for extended periods, and the normal output of endorphins and enkephalins is curtailed. In this case a simple habit generates a physical need - which strengthens the habit - and worsens the need, and so on.

Another group which exhibits certain dysfunctional behaviors, which may have a genetic basis, is the Adult Children of Alcoholics (ACA's). It is estimated that there are 28 million ACA's in the U.S. Scientists believe that this high risk population has distinct differences in their ability to metabolize alcohol, and in responsivity to alcohol. Many ACA's clinically have difficulties which include a high degree of stress and anger; insomnia; depression; and, compulsivity.

SOME THINGS YOU SHOULD KNOW ABOUT COCAINE

Kenneth Blum, Ph.D., Michael C. Trachtenberg, Ph.D., and Laurel A. Loeblich, Ph.D.

INTRODUCTION

Scientists test the benefits and/or destructive consequences of humans taking certain drugs by giving these drugs to animals with similar tissues, chemistry, etc. The results of many such experiments reveal that cocaine is more addicting than heroin and more lethal. The ultimate consequence of unlimited cocaine access in animals is always DEATH! In experimental animals allowed to self-administer the drug no more often than every 50 seconds, all die within 30 days. Monkeys allowed to self-administer every 10 seconds die within 5 days.

The recent popularity of cocaine abuse might thus seem surprising. However, public awareness of scientific studies is slow and the profits from the sale of cocaine are so large that nearly any sales technique is tried. In the end it all boils down to the cocaine dealer's promise to his prospective customers, "It feels great, AND you can use it occasionally - it really isn't addictive unless you're one of those idiots who allow themselves to get hooked on it." With this statement he is setting his trap. The very first "hit" causes changes that lead to physical addiction as we will see below. And, of course, he never mentions the problems that usually develop, often after minimal usage of the drug. Common among these are:

- Sleeplessness
- Reduction in feeling pleasure from everyday experiences
- Increased number of accidents
- Poor appetite
- Depression
- Fatigue
- Suicidal thoughts
- Paranoia
- Reduced sexual performance
- Brain hemorrhages
- Lung hemorrhages
- Seizures
- Degenerated value system
- Loss of self esteem

Cocaine use is very dangerous. It can, and often does, cause heart attacks, seizures, and/or convulsions. Increasing the amount, using more frequently, and smoking and/or injecting instead of snorting all dramatically increase risk; these serious consequences can occur with even first time use. Cocaine is potentially lethal.

The deadliness of cocaine has radically increased during the last decade as more pure and therefore stronger cocaine has become available. This has been coupled with the increased effect obtained by new methods of administration, such as shooting (intravenous injection), freebasing (smoking crack), etc. While some people can "snort a line" of cocaine occasionally in a "recreational" manner, many are unable to stop there. The occasional lines become the weekly lines, which become the daily lines. All too often this leads to smoking or shooting cocaine in an effort to achieve a faster, bigger "high". The highly predictable end result has been well demonstrated in a large series of studies. It is virtually impossible to stop - often after only one such "fast track" use. Inevitably the cocaine ends up in control of the person, instead of the person being in control of the use of the drug. Even worse, less than one-third of those who are addicted can stop even with the aid of standard drug abuse treatment. New developments have given hope to most of the remaining two-thirds. To understand how these work, we must first understand how cocaine acts on the brain.

THE CHEMISTRY OF COCAINE

Cocaine is a naturally occurring stimulant derived from the leaves of the coca plant. The leaves contain only one-half of one percent pure cocaine. Unlike pure cocaine, coca leaves contain a variety of minerals and vitamins. These nutrients are believed to chemically reduce the toxic effects of the cocaine contained in the leaf. When a leaf is chewed, a relatively modest amount of cocaine is released. Only a small quantity of that released is absorbed by the digestive system, and the digestion of it is very slow. For these reasons, the South American habit of chewing coca leaves has never become the serious public health problem associated with more potent forms and more efficient routes of administration.

In contrast the situation is dramatically changed when pure cocaine is used. If the substance is injected or smoked, the stimulating effects and feelings of euphoria are greatly magnified. Using cocaine in this way delivers significant amounts of the substance to the brain in seconds!

Once in the brain, cocaine acts upon the "reward/punishment" (r/p) systems. The normal function of these systems is to encourage the individual to do, or not to do, specific things. For example, if the body requires a particular nutrient, a specific brain chemical will be put into "short supply", causing the individual to feel ill at ease or have an urgent sense that something must be done. On the other hand, if the individual has just done something that was good for the body, release of certain brain chemicals will give the individual a sense of euphoria or elation. For example: the runner's high becomes encouragement to do further exercise. It also eases the muscle pain of hard work.

The mechanism by which the above takes place involves brain chemicals, called neurotransmitters. Cocaine's extraordinary release of one such chemical, dopamine, causes us to focus on this action.

The brain usually stores just enough dopamine to meet normal demands. For most people this supply needs to be rebuilt slowly with small quantities of dopamine. Not much is needed as release of even small amounts for short periods of time causes a strong effect. For instance, during the sexual climax a small dopamine release over a fraction of a second gives a very powerful reward feeling. Cocaine causes a much larger release over a longer period of time. This "feels so good" that one can become "hooked" after the first use. This is especially true of the first use of crack or shooting up. With repeated use of cocaine, the dopamine supply becomes depleted because it cannot be replenished quickly enough.

An analogy is helpful. The dopamine releases discussed above might be thought of as coming from a dam holding back a lake of dopamine. Normal use is rather like an occasional hole, the size of a toothpick, punched into the dam. The puncture releases a small amount of dopamine and then seals itself shut. The supply thus lost is replaced by a small trickle of dopamine coming from the cells which produce it. These cells could produce much more except that the "raw materials" (precursors) they use are just sufficient for the need.

Snorting cocaine is analogous to firing a bullet through the dam with a pistol. It releases a much larger amount than the toothpick and the feeling of euphoria is very desirable. However, the system is now depleted and rebuilding the supply to normal levels can take days from just one such use.

Smoking or shooting cocaine is analogous to firing a cannon through the dam. A great hole is breached causing profound euphoria. This feeling is so "incredibly good" that almost no one can do it just once; in short, a person can become addicted after the first use. Needless to say, the dopamine supply after such use is greatly diminished and after many such uses no amount of cocaine will produce the good feeling.

It should be noted that too much cocaine can be fatal. Thus, if the first time user takes the large dosage required by the longer term user, his first use can be his last!

The cocaine abuser experiences three stages of drug effects:

1. The first is acute intoxication (whether from snorting, injecting, or smoking). For a short time there is less anxiety, more self-confidence and alertness, a perception of clearer vision and understanding, and increased sexual appetite. However, the experience may be marred by sexual indiscretions, irresponsible spending, and accidents attributable to reckless behavior.

2. Next the "crash" replaces euphoria with longer term feelings of anxiety, fatigue, agitation, irritability, and depression. Perhaps worse, suicidal thoughts often increase during this stage. The abuser now faces three choices: 1) suffer through this time, 2) take more cocaine to alleviate the "crash", or 3) take another euphoriant drug which is less expensive, such as alcohol, marijuana, amphetamines, heroin, etc. This is how many cocaine abusers develop dependencies on other drugs. Most often alcohol is chosen as it is inexpensive, legal and often has been used before the cocaine addiction. Use of alcohol frequently leads to the cocaine abuser also becoming or intensifying his/her alcoholism.

3. Then the withdrawal stage follows--a lengthy period of limited ability to derive pleasure from normal activities. In long term cases, the abuser may permanently lose this ability. At the same time a craving develops for the euphoric effects of cocaine. The cravings are usually satisfied by using the drug again; and thus, the addiction develops.

THE DEVELOPMENT OF COCAINE ADDICTION

If cocaine use is repeated often, the resultant large and continuing dopamine releases cause a depletion of the dopamine supply. It also places a strain on the dopamine producing cells and abuses the dopamine release system. This is why many cocaine users report that "The first hit is by far the best." As further use is made of cocaine, the individual needs more and more just to get a desirable effect. Ultimately, the dopamine supply may become so small that cocaine, "just doesn't give an acceptable hit."

At this point, the cocaine abuser will often decide to seek treatment. If so, he has made a fortunate decision. If he does not seek treatment he will then typically turn to other drugs to try to get the relief he needs. Often the new drug of choice is alcohol. As it produces artificial euphoriants, there is no dependence on naturally produced neurotransmitters. Consequently, the high can be easily obtained whenever it is desired and for as long as desired.

Unfortunately, the continual use of alcohol reduces the body's ability to produce the natural opioid. It is a process rather like muscle atrophy; any muscle which goes unused for long periods of time deteriorates and ultimately ceases to function. If the brain is no longer called upon to make the natural euphoriants (enkephalins and endorphins [opioids]) because substitutes are being supplied in the form of drugs, its ability to make the opioids deteriorates. When the cocaine abuser switches to alcohol or some other drug, his dopamine supply is given a chance to rebuild. Once it is rebuilt the addict sooner or later learns that cocaine will work again. Perhaps not as well as before, but at least acceptably. The cycle is then repeated. Each time, new damage is done to the body, especially the brain, and the likelihood of return of full mental and physical capacity is reduced even further. Again, the frequent result is that the cocaine abuser also becomes an alcoholic or intensifies his/her alcoholism.

CHEMICAL DEPENDENCY -- A SYSTEM ILLNESS

Sharon Wegscheider

As I look back over the past 13 years which I have spent in the field of alcoholism counseling and training, it seems that the issue of alcoholism has become more complex as more has been discovered. For example, although alcoholism has existed since ancient times, it has been considered a disease in the United States only since the mid-1950's. Prior to the American Medical Association's re-definition of alcoholism form a condition to a disease at that time, treatment was somewhat punitive and certainly did not take suffering family members into consideration.

Now we know that alcoholism is a disease of biochemical origin; and this opens us to the wide-ranging controversy that almost always attends issues of health and medical treatment. So, the more we know, the more problematic the issue becomes.

And yet, if I could make just one statement that I felt should be the cornerstone to all types of alcoholism treatment, it would be: Alcoholism is a system disease. This notion is virtually impossible to overstate, so endemic is it to understanding and treatment.

Think of the system as a mobile. A tug on one of the suspended objects of this mobile will set the other objects swinging wildly as they scramble to regain equilibrium. This constant balance-seeking movement is the dynamic on which all systems operate. Now, think of the emergence of alcoholic behavior within a family as that tug on one of the objects of the mobile. The other family members must react quickly and automatically to restore order to their system.

The point of departure between a family system and a mobile is that for a family, these movements, i.e., balance-seeking behaviors that counter one member's alcoholic behavior, can become habituated. And if the family members' habituated behaviors militate to protect or "enable" the alcoholic, we have to look at a "system disease," as opposed to an individual one.

Alcoholism is essentially a test to the system in which it exists. The system can and will enable the alcoholic if its members are passive or choose to avoid the issue (which also indicates a bit of self-delusion: "If I ignore it this time, it will go away."). Or the system can mobilize, confront the alcoholic, and give him the tough love required to break the downward spiral on which he is moving.

An unhealthy system exists prior to alcoholism: it is simply this disease that illuminates the system's illness. An unhealthy system fears change; and it accommodates alcoholism because alcoholism is there. The underlying attitude is that change cannot occur without pain, stress, and temporary imbalance to the system -- and this must be avoided at all costs. In an unhealthy family system, for example, The Chief Enabler (spouse), with foot-stomping (impotent) rage, produces a temporary cessation of alcoholic behavior, which gives the Enabler time to restore herself to the delusional "Everything is all right now" state.

In any discussion of the effect of alcoholism on children, the primary concern should be an understanding of the disruption that inevitably occurs in the home and family when one or both parents are alcoholic. Although it is true that during the school years a child gradually becomes less bound to the home, the influences of the parents during this period remain profound. It is within the context of the home that rules, ideas, mores and values are established by which the child comes to measure life, and those who share his or her life space. Within the home are found climates of love, affection, indifference, and hostility created by those persons who make that home, and these climates have extremely powerful influences on the growth and development of the child. The forces that shape personality are found in the milieu of the home, and these forces also contribute to those affects that will ultimately determine the quantity and quality of the relationships a child will form with his peer group and, later, with his adult companions.

To appreciate the impact of parental alcoholism on children we must first understand which parental functions are of specific relevance to the child's normal personality development, and how these operate. It is useful, in this context, to consider the formation of the ego and superego in the child, where the influence of parental attitudes is of critical importance.

The ego, that part of the psychic apparatus necessary for adapting to reality, is continually being molded by statements such as "That is not the proper way it is done;" "That will get you into trouble;" "That is not the proper way to do it;" "You'll get hurt if you do that;" "Stop," etc. This learning of self-identification and self-protection is absolutely fundamental for equipping a child to live in a particular environment. If the chid knows in what psychological and physical situations he is safe and comfortable, and if he develops a competency in conducting himself in such situations, he will develop a strong, well integrated and intact ego.

When the child learns from adults, usually parents, concepts such as "That is right," "That is wrong," he is in the process of developing a superego, which is a major sector of the psyche that is only partly conscious, and aids in character formation by reflecting parental conscience and the rules of society. The growing child must ultimately internalize both safe and dangerous modes of behavior, and he must also internalize those things considered acceptable and appropriate in his social group.

If good personal adjustment is to occur in children there is evidence to suggest that the overall climate in the home should be warm, permissive, but with understood limits and accepting of the individuality of the child. Children should be permitted opportunities for democratic participation in the home, and given confidence and support by the parents.

People working in the field of alcoholism are painfully aware that the climate found in most alcoholic homes is extremely unsatisfactory, and the antithesis of that just described. Although there may be relatively harmonious periods, the organization of the alcoholic family unit is usually found to be disrupted, with confusion of roles, constant stresses and tensions in various stages of eruption, and a multitude of problems directly and indirectly related to the alcohol abuse. There is little doubt that this climate is the resultant of a complex of factors. The alcohol dependency in itself is often generated and perpetuated by intrafamilial conflict. Personality traits such as low frustration tolerance, irresponsibility, impulsiveness, egocentricity and need to escape from reality are frequently seen in alcoholics, making them very inadequate family members. Wives of alcoholics undoubtedly have an unenviable task in coping with a disturbed husband, but not infrequently they too have personality problems which, in turn, contribute to the husband's alcoholism, and the family chaos. When to this is added the unpredictable and dysfunctional behavior produced by the action of a disinhibiting drug, such as alcohol, and the response by the family members to this behavior, a vicious circle is established which makes the alcoholic family a veritable arena of potential disaster of the worse kind.

Remembering the importance of family climate in determining healthy development of the ego and superego, it is not difficult to understand why children growing up in homes with such disturbed climates should have defects in these two most important components of the psychic mechanism. It must be remembered, however, that alcoholism is not a simple condition, and persons and families suffering from it are extremely diverse and heterogeneous. There is no such thing as a "typical" alcoholic family, any more than there is a "typical" schizophrenic or diabetic family. Sweeping generalizations about alcoholic families are therefore, likely to be inaccurate and misleading, and each family unit is, to a great extent, a unique entity. The turbulent conditions in most alcoholic homes contribute to a great variety of maladaptive behavior patterns in the children.

Children from alcoholic homes show generally more disturbed behavior than those from non-alcoholic homes, and most studies agree that trouble in school, poor school records and conflict with the law often characterize children with alcoholic parents. The specific symptoms include school truancy, running away from home, staying out late, theft, incorrigibility, impulsiveness, and pathological lying. The implications of such antisocial symptomatology for the future development of the child are uncertain, but should be noted

that not a single individual student has developed an antisocial personality as an adult in the absence of antisocial symptoms in childhood. Also, the clinical relationship between alcoholism and antisocial personality is a striking one, and there is often difficulty in differentiating the two syndromes. Behavior with regard to arrests, imprisonment, marital difficulties, lying and rationalization is common in both; approximately 75% of patients with a diagnosis of antisocial personality as adults also have alcoholism. This would suggest the possibility of at least some common etiological factors, and it is reasonable to assume that a proportion of children raised in alcoholic homes will ultimately develop antisocial personalities in adulthood.

A study I and my colleagues recently completed in Philadelphia demonstrated very clearly that for children eight to twelve years, those with parental alcoholism were significantly more disturbed than normal children. In all other areas they were significantly different than normal children, and always in the direction of greater pathology.

Compared with normal children, those in a family with parental alcoholism are less able to maintain attention, less responsive to environmental stimulation and much more prone to emotional upset. They tend to be anxious, fearful individuals who have great difficulty in containing or regulating their excitement or mood. They are subject to aggressive behavior, and show evidence of deficient learning of certain moral codes of conduct. They are also socially isolated and preoccupied with inner thoughts rather than concern for what is going on around them.

Further indication of the detrimental effects of parental alcoholism can be found in the greater frequency of symptoms such as stuttering, unreasonable fears, bed-wetting after age six, isolation and temper tantrums in children of alcoholics. There is little doubt that in the majority of cases these symptoms are related to the effect of parental alcoholism on the functioning of the family unit.

There are probably no better examples of parentally rejected children than those youngsters in many alcoholic homes. This is often associated with a pervasive sense of shame which children feel from a parent who is frequently intoxicated. The phenomenon of rejection itself has received attention by researchers, who have shown that rejected children are emotionally unstable, restless, overactive, given to troublemaking, resentful of authority, given to troublemaking, resentful of authority, more inclined to steal and quarrelsome. These characteristics are frequently seen in children from alcoholic backgrounds where, inevitably, the rejection is accompanied by other undesirable forms of parental behavior.

One of the most important elements lacking in homes of alcoholics is something so basic that is often not taken into account. The role of love, as it affects human development, often eludes the researcher because it cannot be seen or measured. Yet all of us know it exists and is probably one of the most real forces in our lives. There is considerable evidence that love is the most important force in shaping the relationships of adults with children, and without it the child never develops a sense of basic security, and finds difficulty in identifying with his peers. Being loved and loving allows the child to adjust to situations that involve strong and unpleasant emotions, while terror to the unloved child is unfaceable and overwhelming. If parents love each other, they indirectly tell the child it is safe to love one's self and others. Love is perhaps one of the earliest, and most significant, components lost in relationships involving an alcoholic, and should always be taken into consideration when trying to understand behavior of children involved in such relationships.

In considering the impact of the parental attitude on the child, it is important to also consider the child's perception of the parents. For example, excessive daydreaming occurs when children "see" their relationship with their mother as being of poor quality. The power wielded by a husband and wife is perceived by a child, and will influence his identification choices. The division of labor between husband and wife determine in large part the child's understanding of what male and female roles are, and the degree of marital tension will affect the child's sense of security. The alcoholic family is a classic situation of role changes, especially where the husband is the alcoholic. A common example is where the wife is forced to take over all financial responsibilities because of the husband's neglect, and eventually he

relinquishes all decisions about finance to his wife. It is common to hear wives of alcoholics complain that, as the disorder progresses, the husband gradually becomes increasingly dependent, and assumes a child-like role in the family. Under this circumstance, a child can become extremely confused as to how he should relate to his parents, and, not infrequently, a child will be forced to become "the man of the house" when he is ill-prepared to do so. A most serious form of behavior often manifested in alcoholic households is overt violence. Children are sometimes the victims of such violence, and many of the most serious cases of the battered child syndrome are found to be associated with serious alcohol abuse. Similar dramatic events such as infanticide, gross malnutrition, sexual assault and severe burns are seen more often in children from homes where alcoholism is part of the life-style.

It is quite obvious then the children growing up in homes where one, and occasionally both of the parents are alcoholics, have an extremely difficult task in avoiding serious damage to their personalities, and, on occasions, to their physical health or even their lives. The great frequency of psychiatric symptomatology, of varying degrees of severity, found in these children indicates an urgent need for more attention to be given to the off-spring of alcoholics. Alcoholism is very given to the off-spring of alcoholics. Alcoholism is very much a family illness, and treatment applied only to the alcoholic spouse is not sufficient. Unfortunately, in too many cases the patient presents himself for treatment after his marriage and home have been permanently disrupted. With increasing emphasis on early detection of alcoholism, more and more cases are being seen at a stage where opportunities exist for involvement of the total family in treatment. This should be done whenever possible, and could result in not only a better prognosis for the alcoholic, but in skilled diagnosis and care being available to the unfortunate children in that family.

Another compelling reason for more attention being paid to children with parental alcoholism is the very high risk these children run of themselves becoming alcoholics. Although there is evidence to suggest that some of the most severe forms of alcoholism are hereditary, the climate of the alcoholic home clearly plays an important role in determining the types of personality damage, or maladaptive learning processes, that lead in many cases to alcohol addiction. Working with children of alcoholics may be one of the more tangible ways of preventing cases of alcoholism developing in the future.

RISK FACTORS FOR TEENAGE DRUG ABUSE:
THE KEYS TO PREVENTION

Just as medical researchers have found risk factors for heart attacks such as a diet high in fats, lack of exercise, and smoking, our research has defined a set of risk factors for teenage drug abuse. We know that the more risk factors for heart disease present, the greater the likelihood a person will suffer a heart attack. This is true with risk factors for adolescent drug abuse as well. The more risk factors present, the greater the chances that a young person will develop a drug problem.

What are the risk factors for teenage drug abuse?

1. **Family History of Alcoholism**

When children are born to or raised by an alcoholic parent, their risk of abusing drugs is increased. For boys, this increased risk is a result of both genetic and environmental factors. Sons of alcoholic fathers are up to four times more likely to abuse alcohol than boys without an alcoholic father, even if not raised by that father. For both boys and girls, alcoholic parents provide a powerful role model for drinking that influences children's behavior.

2. **Family Management Problems**

Poor family management practices increase the risk that children will abuse drugs. Research has shown that in families where expectations are unclear or inconsistent, where there is poor monitoring of children's whereabouts and behavior, where children are seldom praised for doing well, and where punishment is inconsistent or excessive, there is greater risk that children will develop drug abuse problems.

Children who grow up in homes where rules are not clearly stated and enforced have difficulty knowing what is expected of them. If they are not consistently recognized for their positive efforts and for doing well, then children fail to learn that their good behavior makes a difference. Similarly, if they are not consistently and appropriately disciplined for breaking family rules, then they don't experience the security of knowing right from wrong and are less likely to develop their own good judgment.

Bonding to families and attachment to parents have been shown to be negatively related to drug use. In order to make good decisions about their behavior, children need clear guidelines for acceptable and unacceptable behavior from their family. They need to be taught basic skills, and they need to be provided with consistent support and recognition for acceptable behaviors as well as consistent but appropriate punishment for unacceptable behaviors. They also need to know that their parents care enough to monitor their behavior so that rewards and consequences are applied fairly.

3. **Early Antisocial Behavior**

A relationship has been found between male aggressiveness in kindergarten through second grade and delinquency and teenage drug abuse. The risk is especially significant when this aggressiveness is coupled with shyness and withdrawal. About 40% of boys with serious aggressive behavior problems in early elementary grades will develop delinquency and drug problems as teenagers.

4. **Parental Drug Use and Positive Attitudes Toward Use**

If family members use illegal drugs around children, if there is heavy recreational drinking in the home, or if adults in the family involve their children in their drinking or other drug use, such as asking a child to get a beer or light a cigarette, the children have an increased risk of developing problems with alcohol and other drugs.

5. **Academic Failure**

Children who do poorly in school, beginning in approximately the fourth grade, have an increased risk of abusing drugs. Children who fail in school for whatever reason -- boredom, lack of ability, a mismatch with a poorly skilled teacher -- are more likely to experiment early with drugs and to become regular users of drugs in adolescence.

6. **Little Commitment to School**

Children who are not bonded to school for whatever reason are more likely to engage in drug use. The annual surveys of high school seniors by Johnston, Bachman and O'Malley show that the use of strong drugs like cocaine, stimulants, and hallucinogens remains significantly lower among high school students who expect to go to college. Drug users are more likely than non-users to be absent from school, to cut classes, and to perform poorly. Factors such as how much students like school, time spent on homework, and perception of the relevance of course work are also related to levels of drug use.

7. **Alienation, Rebelliousness, Lack of Social Bonding**

In middle or junior high school, those students who rebel against authority, particularly their parents and school officials, and who do not attend church tend to be at higher risk for drug abuse than those who are bonded to the primary social groups of family, school, church, and community.

8. **Antisocial Behavior in Early Adolescence**

This risk factor includes a wide variety of antisocial behaviors including school misbehavior and a low sense of social responsibility. Fighting, skipping school and general aggressiveness have been shown to be related to drug abuse.

9. **Friends Who Use Drugs**

Association with drug-using friends during adolescence is among the strongest predictors of adolescent drug use. The evidence is clear that initiation into drug use happens most frequently through the influence of close friends rather than through drug offers from strangers. This means that even children who grow up without other risk factors, but who associate with children who use drugs, are at increased risk for drug use and for developing problems with drugs. This risk factor underscores the power of peer influence on teenagers.

10. **Favorable Attitudes Towards Drug Use**

Children in late elementary school often have very strong negative feelings against drugs. Yet by the time these children enter junior high school, they may begin associating with peers who use drugs, and their attitude can quickly change. This shift in attitude often comes just before children begin to experiment with alcohol or other drugs.

11. Early First Use

Early onset of drug use predicts subsequent misuse of drugs. The earlier the onset of any drug use, the greater involvement in other drug use, the greater the frequency of use and the probability of involvement in deviant activities such as crime and selling drugs. Children who begin to use drugs before age 15 are twice as likely to develop problems with drugs as children who wait until they are older. Waiting until age 19 to try alcohol or other drugs dramatically decreases the risk of drug problems.

12. Economic and Social Deprivation

Children from families who experience social isolation, extreme poverty, and poor living conditions are at elevated risk of chronic drug abuse.

13. Low Neighborhood Attachment and Community Disorganization

Neighborhoods with a high population density, high rates of crime and lack of natural surveillance of public places have high rates of juvenile delinquency as well. Research has also found that attachment to neighborhood is a factor in inhibiting crime.

Studies have shown that neighborhood disorganization is a factor in the breakdown of the ability of traditional social units, such as families, to provide pro-social values to youth. When this occurs there is an increase in delinquency and recidivism in these communities.

It is likely that disorganized communities have less ability to limit drug use among adolescents as well.

14. Transitions and Mobility

Transitions, such as those between elementary and middle or junior high school, and residential moves, are associated with increased rates of antisocial adolescent behavior, including rates of drug initiation and frequency of use.

15. Community Laws and Norms Favorable Toward Drug Use

Communities with laws favorable to drug use, such as low drinking ages and low taxes on alcohol, have higher rates of alcohol-related traffic fatalities and deaths due to cirrhosis of the liver. The availability of alcohol and illegal drugs is associated with use. Research has shown that greater drug availability in schools increases the use of drugs beyond other risk characteristics of individuals. Community attitudes favorable toward teenage drug use increase the risk of drug abuse.

Knowing these risk factors can help us to prevent drug abuse before it occurs. By addressing factors associated with higher risk and increasing factors associated with lower risk, we can decrease the chances that our children will develop problems with drugs.

These factors are summarized from the following research articles written by members of the Social Development Research Group at the University of Washington School of Social Work, JH-30, 4101 15th Avenue N.W., Seattle, WA 98195:

Hawkins, J.D., Lishner, D.M., Catalano, R.F., & Howard, M.O. (1986). Childhood predictors of adolescent substance abuse: Toward an empirically grounded theory. Journal of Children in Contemporary Society, 8;, 11-48.

Hawkins, J.D., Jenson, J.M., Catalano, R.F., & Lishner, D.M. (1988). Delinquency and drug abuse: Implications for social services. Social Service Review, 62, 258-284.

PERCEIVED SOURCES OF INFLUENCE AMONG YOUTH IN IOWA

To Not Use Alcohol	To Not Use Tobacco	To Not Use Marijuana	To Not Use Other Drugs
1. Parents	1. Parents	1. Parents	1. Parents
2. Friends	2. Health Teacher	2. Friends	2. Friends
3. Health Teacher	3. Friends	3. Health Teacher	3. Health Teacher
4. Treatment Counselor	4. Brother/Sister	4. Brother/Sister	4. Treatment Counselor
5. School Nurse Counselor	5. School Nurse Counselor	5. School Nurse Counselor	5. School Nurse Counselor
6. Police Officer	6. Treatment Counselor 6. Police Officer 6. Clergy	6. Police Officer	6. Police Officer 6. Clergy
7. Clergy		7. Clergy	

Source: Iowa Department of Education 1987-88 Iowa Study of Alcohol and Drug Attitudes and Behaviors Among Youth.

PERCEIVED SOURCES OF INFORMATION AMONG YOUTH IN IOWA

6th Grade	8th Grade	10th Grade	12th Grade
1. Parents (22)	1. School Counselor (18)	1. Friends (13)	1. Friends (14)
2. School Counselor (18)	2. Parents (15)	2. Parents (12) (13) 2. School Counselor (12) 2. Books/Magazines (12) 2. TV/Radio (12)	2. School Counselor
3. TV/Radio (16)	3. TV/Radio (14)	3. Classroom Teacher (12)	3. Books/Magazines
4. Classroom/School Teacher (12)	4. Classroom Teacher (12) 4. Books/Magazines	4. Addict 4. Personal Experience	4. Personal Experience 4. TV/Radio (11)
5. Books/Magazines	5. Friends	5. Brother/Sister 5. Treatment Counselor	5. Parents (10)
6. Friends	6. School Assembly	6. School Assembly	6. Classroom Teacher 6. Addict
7. School Assembly 7. Police	7. Addict 7. Brother/Sister	7. Police	7. Brother/Sister 7. Treatment Counselor 7. School Assembly
8. Brother/Sister 8. Treatment Counselor	8. Personal Experience		8. Police
9. Addict	9. Police		
10. Personal Experience			

Source: Iowa Department of Education 1987-88 Iowa Study of Alcohol and Drug Attitudes and Behaviors Among Youth.

PERCEIVED SOURCES OF HELP AMONG YOUTH IN IOWA

6th Grade	8th Grade	10th Grade	12th Grade
1. Close Friend (32)	1. Close Friend (45)	1. Close Friend (49)	1. Close Friend (57)
2. Parent (30)	2. Parent (18)	2. Parent (12)	2. Parent (11)
3. Don't Know (12)	3. Don't Know (11)	3. Don't Know (11)	3. Don't Know (9)
4. Treatment Center 4. School Teacher/ Counselor	4. Treatment Center 4. Brother/Sister	4. Brother/Sister	4. Brother/Sister
5. Brother/Sister	5. Brother/Sister	5. Trusted Adult	5. Treatment Center 5. Trusted Adult
6. Trusted Adult 6. Clergy	6. Trusted Adult	6. Treatment Center	6. School Teacher/Counselor
7. Family Doctor	7. Clergy	7. School Teacher/ Counselor	7. Clergy
8. Family Doctor	8. Family Doctor	8. Family Doctor	

Source: Iowa Department of Education 1987-88 Iowa Study of Alcohol and Drug Attitudes and Behaviors Among Youth.

NON-USING IOWA ADOLESCENTS

In 1985, non-using Iowa adolescents were characterized as being:

- most "anti" in their attitudes toward marijuana, alcohol, tobacco, and other drug behaviors.
- least likely to have friends who used alcohol, tobacco, marijuana, or other drugs.
- least likely to have friends who would approve of alcohol, tobacco, marijuana, or other illegal drug use.
- least likely to be involved in the problems behaviors of selling/distributing drugs, truancy, vandalism, or theft.
- least likely to be involved in drinking and driving.
- most likely to be involved in church activities and extracurricular activities at school.
- most likely to live with both parents/to have a father present in the home.
- most likely to spend free time at home, school, or church.
- most likely to turn to their parents for help with personal substance use problems.
- most likely to communicate with their parents about personal interests, problems and plans for the future.
- most likely to experience shared affection between themselves and their parents.
- least likely to have fathers who smoked tobacco or drank alcoholic beverages.
- least likely to have mothers who smoked tobacco or drank alcoholic beverages.
- most likely to experience firmer/more consistent parental guidelines regarding alcohol, tobacco and marijuana behaviors.
- most likely to have positive attitudes toward their school experiences and least likely to consider "dropping out" of school.
- least likely to have tried alcohol, tobacco, marijuana, or other drugs by 16 years of age.
- least likely to project their own use (intentionally) of alcohol, tobacco, or marijuana at age 21.
- least likely to report themselves to be tobacco smokers or users of smokeless tobacco.

Forty-seven percent (47%) of non-users were males and 53% were females.

Source: Iowa Department of Education 1984-85 Iowa Study of Alcohol and Drug Attitudes and Behaviors Among Youth.

TOP RATED DISCIPLINE PROBLEMS IN PUBLIC SCHOOLS, 1940 AND 1982

1940	1982
1. Talking	1. Drug abuse
2. Chewing gum	2. Alcohol abuse
3. Making noise	3. Pregnancy
4. Running in the halls	4. Suicide
5. Getting out of turn in line	5. Rape
6. Wearing proper clothing	6. Robbery
7. Not putting paper in wastebaskets	7. Assault

Source: California Department of Education

HELPFUL DO'S FOR PARENTS

1. DO wait to confront your child about his or her drinking until he or she is not under the influence.

2. DO keep in mind that you are not responsible for your child's behavior but to him or her. Making excuses isn't necessary.

3. DO allow your child to take on the responsibility for his or her drinking behavior.

4. DO provide consequences for drunken behavior that causes havoc in family life or destroy the home.

5. DO talk to your child about his or her drinking.

6. DO allow your child to be responsible for his or her own messes and predicaments.

7. DO allow your behavior to be of your own choosing and not a result of being brought down by your child's drinking behavior.

8. DO view your child as being out of control rather than lacking backbone or willpower.

9. DO remember that the way your child acts when drinking isn't an indicator of the lack of love.

10. DO be patient with your child.

11. DO maintain consistent consequences for drinking behavior.

12. DO respect the privacy of your child. Watch their behavior and use this as an indicator instead of snooping.

13. DO give your child a minimal allowance.

14. DO present consequences that you are willing and able to back up.

15. DO attempt to become involved and communicate with your child.

16. DO seek out information and support from outside resources for your own growth and understanding.

DON'TS FOR PARENTS

1. DON'T confront your child about drinking while he or she is under the influence.
2. DON'T make excuses to your spouse, family, friends or school authorities for your child's drinking.
3. DON'T take responsibility for your child's drinking problem.
4. DON'T accept as normal behavior a drunken son or daughter who comes home and destroys the house or creates havoc within the family.
5. DON'T nag or scream at an adolescent about drinking.
6. DON'T clean up your alcohol-abusing child's messes and predicaments.
7. DON'T let yourself be so ruled by the kid's alcohol behavior that you let it pull your own behavior down, too.
8. DON'T view your child as lacking backbone or will power.
9. DON'T assume your child doesn't love you because of the way he or she acts when drinking.
10. DON'T be angry with your alcoholic child, if you can help it.
11. DON'T be patronizing or indulgent.
12. DON'T play amateur detective. Following your offspring around the town to see what he or she is doing is a waste of your time and strength.
13. DON'T give an alcohol-abusing son or daughter any money, except for a minimal allowance.
14. DON'T make threats you're not prepared to back up.
15. DON'T ignore changes in your child's behavior, grades, or personality.
16. DON'T attribute unacceptable behavior to "growing up" or "just being a kid".
17. DON'T blame your spouse for your child's problems.
18. DON'T believe your child's stories that the drugs or paraphernalia you found in his or her room belong to a friend.
19. DON'T blame yourself for your child's problems because you're not at home, you work long hours, or have to be on the road frequently.
20. DON'T blame divorce or the absence of one parent in the home for your child's behavior.

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SIGNS OF CHEMICAL DEPENDENCY IN AN EMPLOYEE

It is important for supervisors to recognize the subtle signs that suggest possible patterns of chemical dependency. Individually, signs may seem harmless enough, yet taken together they present a startling picture.

One pitfall a supervisor must avoid is to ignore some of the beginning indicators. By failing to document them, it is likely that the supervisor will end up later with only vague recollections of when the problem began and what was observed.

The following are important signs of chemical dependency. Place a check mark in front of those signs you are sure are *not* evident among your employees. Place an "X" in front of those you have noticed and want to review more carefully.

_____ 1. Swings in an employee's pace of work, individual productivity, reliability and/or attendance. Peaks and valleys that progressively become more serious and closer together.

_____ 2. Deadlines that are missed; or an overall decrease in efficiency.

_____ 3. A gradual decline in work quality and/or quantity.

_____ 4. Unreasonable excuses for not getting the job done properly.

_____ 5. Attendance problems that begin on an infrequent basis and gradually get worse.

_____ 6. Tardiness, lengthy lunches and/or frequent breaks through the day. Early departures from work.

_____ 7. Accidents causing minor injuries to self and others, and or damage to equipment.

_____ 8. An increase in physical complaints and medical ailments that cause lost time.

_____ 9. Complaints from other workers, customers and/or public about work output, quality, timeliness or attitude.

_____ 10. Emotional changes which produce tension, conflict and morale problems among co-workers.

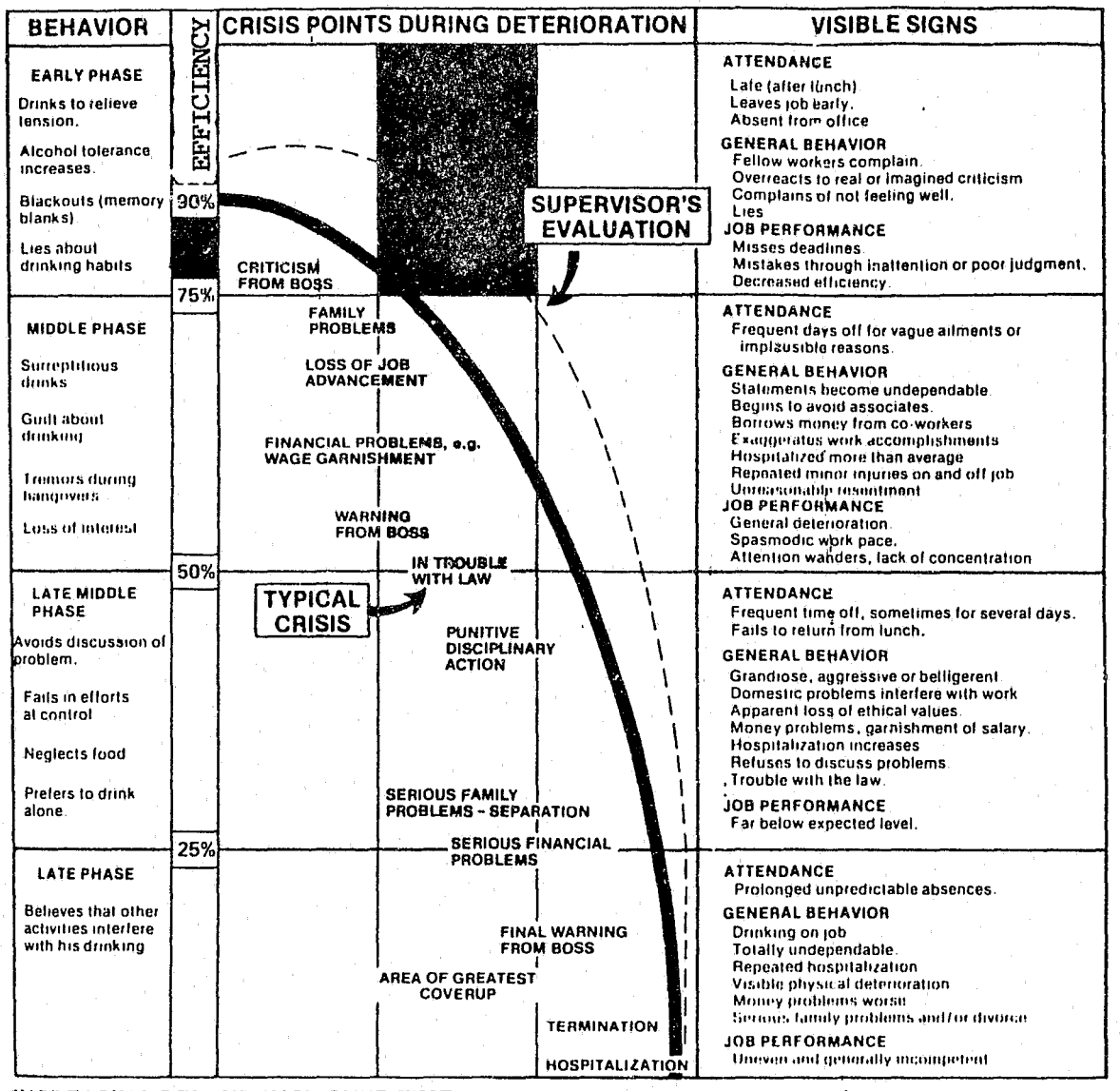
_____ 11. Lack of attention to detail, and/or an inability to concentrate on the task at hand.

_____ 12. A promise to improve behavior (which may happen for awhile) but then gets worse.

DO YOU WATCH FOR THE SIGNS?

From the book *Job Performance and Chemical Dependency* by Robert Maddux and Lynda Voorhees

HOW AN ALCOHOLIC EMPLOYEE BEHAVES



THE TWELVE STEPS OF A.A.

1. We admitted we were powerless over alcohol - that our lives had become unmanageable.

2. We came to believe that a Power greater than ourselves could restore us to sanity.

3. We made a decision to turn our will and our lives over to the care of God as we understood Him.

4. We made a searching and fearless moral inventory of ourselves.

5. We admitted to God, to ourselves, and to another human being the exact nature of our wrongs.

6. We were entirely ready to have God remove all these defects of character.

7. We humbly asked Him to remove our shortcomings.

8. We made a list of all persons we had harmed and became willing to make amends to them all.

9. We made direct amends to such people whenever possible, except when doing so would injure them or others.

10. We continued to take personal inventory and when we were wrong promptly admitted it.

11. We sought through prayer and meditation to improve our conscious contact with God as we understood Him, praying only for knowledge of His will for us and the power to carry that out.

12. Having had a spiritual awakening as the result of these steps, we tried to carry this message to alcoholics and practice these principles in all our affairs.

THE FACTS ABOUT ALCOHOL AND OTHER DRUGS

ALCOHOL

Alcohol, a natural substance formed by the fermentation that occurs when sugar reacts with yeast, is the major ingredient in wine, beer, and distilled spirits. Although there are many kinds of alcohol, the kind found in alcoholic beverages is ethyl alcohol (ethanol). Whether one drinks a 12-ounce can of beer, a shot of distilled spirits, or a 5-ounce glass of wine, the amount of pure alcohol per drink is about the same - one-half ounce. Ethyl alcohol can produce feelings of well-being, sedation, intoxication, or unconsciousness, depending on the amount and the manner in which it is consumed. Ethanol is water soluble and therefore an ounce can be metabolized by your system in one hour. If the consumer of this substance is an adolescent, additional risks exist due to incomplete body growth.

Alcohol is a "psychoactive" or mind-altering drug, as are heroin and tranquilizers. It can alter moods, cause changes in the body, and become habit forming. Alcohol is called a "downer" because it depresses the central nervous system. That's why drinking too much causes slowed reactions, slurred speech, and sometimes even unconsciousness (passing out). Alcohol works first on the part of the brain that controls inhibitions. As people lose their inhibitions, they may talk more, get rowdy, and do foolish things. After several drinks they may feel "high," but their nervous systems actually are slowing down. Once again, an adolescent is at a distinct disadvantage because of his immature body development. Everything from hormone spurts to relaxed brain inhibitors act against a youth consuming alcohol. A person does not have to be an alcoholic to have problems with alcohol. Every year, for example, many young people lose their lives in alcohol-related automobile accidents, drownings, and suicides. Serious health problems can and do occur before drinkers reach the stage of addiction or chronic use. Don't be fooled, though. Adolescents can become alcoholics and addiction takes place much faster in youths; sometimes in as little time as 6 months.

In some studies more than 25 percent of hospital admissions were alcohol-related. Some of the serious diseases associated with chronic alcohol use include alcoholism and cancers of the liver, stomach, colon, larynx, esophagus, and breast. Alcohol abuse also can lead to such serious physical problems as:

- -Damage to the brain, pancreas, and kidneys
- -High blood pressure, heart attacks, and strokes
- -Alcoholic hepatitis and cirrhosis of the liver
- -Stomach and duodenal ulcers, colitis, and irritable colon
- -Impotence and infertility
- -Birth defects and Fetal Alcohol Syndrome, which causes retardation, low birth weight, small head size, and limb abnormalities
- -Premature aging
- -A host of other disorders, such as diminished immunity to disease, sleep disturbances, muscle cramps and edema

Alcohol is the most widely used drug in America. It is illegal for use under the age of 21 in the state of Iowa.

ANABOLIC-ANDROGENIC STEROIDS

Anabolic-androgenic steroids are a synthetic version of the male hormone testosterone. Steroids, in one form or another, have been in existence for over 50 years. It has been within the last 15 years that their use has become more widespread than just among elite athletes. Estimates today tell us that between 7-18% of male high school students have used steroids at some time during their high school career. If we use a rather conservative 10%, that would mean that approximately 7,000 high school males in the state of Iowa have used or are using steroids.

Steroids have few legitimate medical uses. They are used for the treatment of impotence in males, asthma, severe burns, some bone diseases, breast cancer, and a few other rare diseases. There is no good evidence

that steroids will help a person recover from an injury, as some athletes and doctors have claimed. Steroids can, in fact, increase your chance of injury. Your bones and tendons do not keep up as your muscles get bigger and stronger, increasing the risk of tendon and ligament injury. This can also lead to bone injuries.

Steroids do nothing in terms of "building muscle" unless they are combined with several other training principles. The person using steroids must have been in an intensive weight training program before steroid use and must continue to keep up this intensive training regimen in order to get the maximum benefit. Proper diet and adequate rest also need to be included. Steroid use does nothing to improve the cardiovascular fitness level of a person. Steroids will not improve a person's endurance.

Recently, the Food and Drug Administration released the following lists of established and other possible side effects or adverse reactions from steroid use.

*Established Side Effects or Adverse Reactions

- -Acne
- -Cancer
- -Cholesterol increase
- -Clitoris enlargement
- -Death
- -Edema (water retention)
- -Fetal damage
- -Frequent or continued erections
- -HDL (good cholesterol) decrease
- -Heart disease
- -Hirsutism (irreversible hairiness in women)
- -Increased risk or coronary artery disease
- -Jaundice
- -Liver tumor
- -Liver disease
- -Male Pattern Baldness (irreversible on women)
- -Oily skin (females only)
- -Peliosis hepatitis
- -Prostate enlargement
- -Shrunken testicles
- -Sterility (reversible)
- -Stunted growth
- -Swelling of feet or lower legs
- -Yellowing of the eyes or skin

*Other Possible Side Effects or Adverse Reactions

- -Aggressive combative behavior ("Roid Rage")
- -Anaphylactic shock (from injections)
- -Abdominal or stomach pains
- -Black tarry or light colored stools
- -Bone pain
- -Breast development (soreness/swelling in males)
- -Chills
- -Diarrhea
- -Dark colored urine
- -Depression
- -Fever
- -Fatigue
- -Feeling of discomfort (continuing)
- -Frequent urge to urinate (mature males)

-Feeling of abdominal or stomach fullness
-Gallstones
-Hives
-Headache (continuing)
-Hypercalcemia
-High blood pressure
-Impotence
-Increased chance of injury to muscles, tendons, and ligaments
-Insomnia
-Kidney disease
-Kidney stones (from hypercalcemia)
-Listlessness
-Muscle cramps
-Menstrual irregularities
-Nausea or vomiting
-Purple or red colored spots inside mouth or nose
-Rash
-Septic shock (blood poisoning from injections)
-Sexual problems
-Sore tongue
-Unexplained darkening of skin
-Unexplained weight loss
-Unnatural hair growth
-Unpleasant mouth odor (continuing)
-Unusual bleeding
-Unusual weight gain
-Urination problems
-Vomiting of blood

Ceasing to take anabolic-androgenic steroids can cause strong withdrawals, which may sometimes lead to abusing other drugs. Steroids are legal only by prescription by a licensed medical doctor.

COCAINE

Cocaine is one of the most powerfully addictive of the drugs of abuse and it is a drug that can kill. No individual can predict whether he or she will become addicted or whether the next dose of coke will prove fatal. Cocaine is a powerful, mind-altering stimulant. As a powder it absorbs through the mucous membranes - mouth, nose, vagina or rectum. It is snorted through the nose. It can also be smoked or injected. Injecting cocaine, or any drug, carries the added risk of contracting Acquired Immune Deficiency (AIDS) if the user shares a needle with a person already infected with Human Immunodeficiency Virus (HIV), the AIDS virus.

Cocaine is a very strong stimulant to the central nervous system, including the brain. This drug produces an accelerated heart rate while at the same time constricts the blood vessels, which are trying to handle the additional flow of blood. Pupils dilate and temperature and blood pressure rise. These physical changes may be accompanied by seizures, cardiac arrest, respiratory arrest, or stroke.

Nasal problems, including congestion and a runny nose, occur with the use of cocaine. With prolonged use, the mucous membrane of the nose may disintegrate. Heavy cocaine use can sufficiently damage the nasal septum to cause it to collapse.

Research has shown that cocaine acts directly on what have been called the "pleasure centers" in the brain. These "pleasure centers" are the brain's survival mechanisms (thirst, hunger, fight or flight, and sex) that, when stimulated, produce an intense desire to experience the pleasure effects again and again. This causes changes

in brain activity and, by allowing a brain chemical called dopamine to remain active longer than normal, triggers an intense craving for more of the drug.

Users often report feelings of restlessness, irritability, anxiety, and paranoia. Users also report being depressed when they are not using the drug and often resume use to alleviate further depression. In addition, cocaine users frequently find that they need more and more cocaine more often to generate the same level of stimulation. Therefore, any use can lead to addiction.

"Freebase" is a form of cocaine that is smoked. "Freebase" is produced by a chemical process whereby "street cocaine" (cocaine hydrochloride) is converted to a pure base by removing the hydrochloride salt and some of the "cutting" agents. The end product is not water soluble, and so the only way to get it into the system is to smoke it. "Freebasing" is extremely dangerous. The cocaine reaches the brain within seconds, resulting in a sudden and intense high. However, the euphoria quickly disappears, leaving the user with an enormous craving to freebase again and again. The user usually increases the dose and the frequency to satisfy this craving, resulting in addiction and physical debilitation.

Cocaine is illegal.

CRACK

"Crack" is the street name given to one form of freebase cocaine that comes in the form of small lumps or shavings. The term "crack" refers to the crackling sound made when the mixture is smoked (heated). Crack has become a major problem in many American cities because it is cheap - selling for between $3 and $10 for one or two doses - and easily transportable - sold in small vials, folding paper, or tinfoil.

Crack is illegal.

DESIGNER DRUGS

By modifying the chemical structure of certain drugs, underground chemists have been able to create substances called "designer drugs" - a label that incorrectly glamorizes them. They are, in fact, analogs of illegal substances. Frequently, these drugs can be much more potent than the original substances, and they can therefore produce much more toxic effects. Health officials are increasingly concerned about "ecstasy" - a drug in the amphetamine family that, according to some users, produces an initial state of disorientation followed by a rush and then a mellow, sociable feeling. We now know, however, that it also kills certain kinds of brain cells. These "designer drugs" are extremely dangerous.

These drugs (methamphetamines) are literally cooked in inexpensive laboratory settings. Thus the term "meth labs" seen so frequently in the press. The fumes from cooking these chemicals are so highly toxic that the houses and rooms in which it has taken place are unsalvageable. They must be condemned. Often the cars in which the chemists have ridden are unusable. The odor from these labs is similar to that of extremely condensed cat urine. Even short, recurrent exposure to these fumes can be hazardous to your health.

Designer drugs are illegal in the state of Iowa.

HEROIN

Heroin is an opiate drug. Its addictive properties are manifested by the need for persistent, repeated use of the drug (craving) and by the fact that attempts to stop using the drug lead to significant and painful physical withdrawal symptoms. Use of heroin causes physical and psychological problems such as shallow breathing, nausea, panic, insomnia, and a need for increasingly higher doses of the drug to get the same effect.

Heroin exerts its primary addictive effect by activating many regions of the brain; the brain regions affected are responsible for producing both the pleasurable sensation of "reward" and physical dependence. Together, these actions account for the user's loss of control and the drug's habit forming action.

Heroin is a drug that is primarily taken by injection with a needle in the vein. This form of use is called intravenous injection (IV). This means of drug entry can have grave consequences. Uncertain dosage levels (due to differences in purity of the drug), the use of unsterile equipment, contamination of heroin with cutting agents, or the use of heroin in combination with such other drugs as alcohol or cocaine can cause serious health problems such as serum hepatitis, skin abscesses, inflammation of the veins, and cardiac disease. Of great importance, however, is the fact the user never knows whether the next dose will be unusually potent, leading to overdose, coma, and possible death. Of all illegal drugs, heroin is responsible for the greatest number of deaths.

Needle sharing by IV drug users is fast becoming the leading cause of new AIDS cases. It is conservatively estimated one in six persons with AIDS probably acquired the virus through needle sharing. The AIDS virus is carried in contaminated blood left in the needle, syringe, or other drug-related implements and is injected into the new victim when he or she uses this equipment to inject heroin or other drugs. There is no cure for AIDS and no proven vaccine to prevent it.

Heroin use during pregnancy is associated with stillbirths and miscarriages. Babies born addicted to heroin must undergo withdrawal after birth (just as an adult would) and these babies show a number of developmental problems.

The signs and symptoms of heroin use include euphoria, drowsiness, respiratory depression (which can progress until breathing stops), constricted pupils, and nausea. Withdrawal symptoms include watery eyes, runny nose, yawning, loss of appetite, tremors, panic, chills, sweating, nausea, muscle cramps, and insomnia. Elevations in blood pressure, pulse, respiratory rate, and temperature occur as withdrawal progresses.

Symptoms of a heroin overdose include shallow breathing, pinpoint pupils, clammy skin, convulsions, and coma.

Heroin is illegal.

MARIJUANA

Marijuana is a harmful drug; especially since the potency of the marijuana now available has increased more than 275 percent over the last decade. For those who smoke marijuana now, the dangers are much more serious than they were in the 1960s.

Preliminary studies have shown chronic lung disease in some marijuana users. There are more known cancer-causing agents in marijuana smoke than in cigarette smoke. In fact, because marijuana smokers try to hold the smoke in their lungs as long as possible, one marijuana cigarette can be as damaging to the lungs as four tobacco cigarettes.

New studies using animals also show that marijuana interferes with the body's immune response to various infections and diseases. The body becomes more open to various herpes viruses. This finding may have special implications for those infected with the AIDS virus, HIV. Although not everyone infected with the virus gets the disease, those who use immune-weakening drugs such as marijuana may increase their risk for developing full-blown AIDS.

Even small doses of marijuana can impair memory function, distort perception, hamper judgment, and diminish motor skills. Because the cannaboids in marijuana remain in the fatty tissues of the body for weeks, after

repeated use they build up and cause serious problems. Chronic marijuana use can cause brain damage and changes in the brain similar to those that occur during aging. Health effects also include accelerated heartbeat and, in some persons, increased blood pressure. These changes pose particular health risks for anyone, but particularly for people with abnormal heart and circulatory conditions, such as high blood pressure and hardening of the arteries.

Marijuana can also have a serious effect on reproduction. Female users' reproductive organ tissue may atrophy. Menstruation may be altered. Some studies have shown that women who smoke marijuana during pregnancy may give birth to babies with defects similar to those seen in infants born with Fetal Alcohol Syndrome, e.g., low body weight and small heads. No one yet knows the effect of marijuana on the female ova, which are completely present at birth. Males can experience a testosterone (male hormone) drop. Continued use can lead to a lowered sperm count. Recent studies have shown that male animals exposed to continued marijuana use genetically pass their negative physical gains to second and third generation males in their families.

More importantly, there is increasing concern about how marijuana use by children and adolescents affects both their short- and long-term development. Mood changes occur with the first use. Observers in clinical settings have noted increased apathy, loss of ambition, loss of effectiveness, diminished ability to carry out long-term plans, difficulty in concentrating, and a decline in school or work performance. Teenage boys having used heavily may not physically develop into adult manhood. Many teenagers who end up in drug treatment programs started using marijuana at an early age.

Driving under the influence of marijuana is especially dangerous. Marijuana impairs driving skills for at least 4 to 6 hours after smoking a single cigarette. When marijuana is used in combination with alcohol, driving skills become even more impaired.

Marijuana is illegal.

PCP

PCP (Phencyclidine) is a hallucinogenic drug, i.e., a drug which alters sensation, mood and consciousness and may distort hearing, touch, smell or taste, as well as visual sensation. It is legitimately used as an anesthetic for animals. When used by humans, PCP induces a profound departure from reality, which leaves the user capable of bizarre behavior and severe disorientation. Because of its anesthetic qualities, it produces an inability to feel pain. These PCP-induced effects may lead to serious injuries or death to the user while under the influence of the drug. Reports also state users may commit homicides while under its influence.

PCP produces feelings of mental depression in some individuals. When PCP is used regularly, memory, perception functions, concentration, and judgment are often disturbed. Used chronically, PCP may lead to permanent changes in cognitive ability (thinking), memory, and fine motor function. PCP can induce a psychotic state in many ways indistinguishable from schizophrenia.

Mothers using PCP during pregnancy often deliver babies who have visual, auditory, and motor disturbances. These babies may also have sudden outbursts of agitation and other rapid changes in awareness similar to the responses in adults intoxicated with PCP.

PCP is illegal.

TOBACCO

Tobacco is addictive (due to nicotine) and kills 350,000 Americans prematurely each year. It is a major contributor to lung and heart disease.

Over 70% of the compounds inhaled through the smoker's mouth are retained in the lungs. Of the thousands of chemicals in cigarette smoke, tar, nicotine, and carbon monoxide are among the most seriously damaging. For example, cigarette smoke causes the following:

-Blood vessels constrict, making the heart pump harder
-Oxygen is displaced in the red blood cells
-Blood flow is slower than normal
-Blood pressure is increased
-A brown, sticky tar substance forms on delicate lung tissue
-Skin temperature is lowered on body extremities

These factors are multiplied for smokers if they:

-Inhale numerous times in one minute
-Pull the smoke deeply into the lungs
-Hold the smoke for a lengthy period of time
-Smoke the cigarette down to its extreme
-Cover the holes near some brand's filter systems

Although cigar and pipe smokers have a lower death rate than cigarette smokers, the rates are higher than that for non-smokers. Cigar smokers' rates are higher than pipe smokers'rates. However, pipe smokers are at increased risk of getting lip cancer. Both have higher risks than cigarette smokers of dying from cancer of the mouth, throat, and larynx.

Ironically, smoking hurts the non-smoker, too. "Second-hand smoke", the smoke that remains in the air of a room where someone is smoking, is hazardous in its own right. Cigarette smoke is bad enough, but the air pollution from cigar and pipe smoke is worse.

"Second-hand smoke" comes in two forms. One from the burning of the tobacco product and the other from exhaled smoke. The "sidestream smoke", smoke from the burning end, has even higher levels of compounds than the exhaled smoke. Therefore, non-smokers in close proximity to people smoking actually reap twice the negative benefits.

These ideas may seem important to know only when thinking about the workplace or public places. However, it is true at home as well. Since youngsters breathe more rapidly than adults, they inhale more of the polluted air, and its effect is multiplied because of the increased ratio to their total body weight. There is a much higher incidence of lung disease in children whose parents choose to smoke.

Smokeless tobacco, chew and snuff, can lead to nicotine addiction. Because of the damage they do by resting continuously against the wall of the mouth and draining down the throat, we can attribute various gum diseases, oral cancers, heart disease and stroke to them.

Tobacco is legal to purchase for those over the age of 18.

Source: Washington State Substance Abuse Coalition Commmunity Task Force Handbook. Information on steroids was provided by Alan Beste, Iowa High School Athletic Association.

GUIDELINES FOR EVALUATING PREVENTION MATERIAL

1. **Check date of publication.** If printed in the late 1960's or early 1970's, the publication is probably out of date (unless it has been revised). However, be aware that a recent publication or copyright date does not necessarily mean that the material is accurate and up-to-date.

2. **Research the author's affiliations.** Authors who are acknowledged to be board members or active in NORML, The National Organization for the Reform of Marijuana Laws - a pro-marijuana lobby - may be expected to be prejudiced in their attitude toward marijuana and actually promote marijuana and other drug use as well as the legalization of marijuana and/or other drugs.

3. **Make certain that current, accurate information concerning the effects of drugs on the mind and body are adequately described.** Facts that should be included are:
-The higher potency of marijuana on the market today makes it more harmful than ever.
-Cocaine is addictive.
-Alcohol is a drug.

4. **Be alert for contradictory messages.** Often the author:
-Gives a pro-drug message by discussing how to use drugs.
-Glamorizes wonderful feelings associated with drug use while minimizing harmful effects.
-Creates confusion of issues. For example, the pro-drug statement that "legalization of drugs will reduce crime" appeals to the desire to stop violence but does not address national addiction, new black market products, targeted exploitation of children, etc.

5. **The message must be clear and unequivocal:** NO UNLAWFUL USE OF ALCOHOL AND OTHER DRUGS.

6. **Material should promote positive standards of behavior, especially for children.** The message must:
-Expect that people can say "no" to drugs.
-Provide information to reinforce the person's courage to stay drug-free.
-Teach people, especially youth, to make decisions for which they are responsible and accountable.

7. **Material should concentrate on reasons people should not use drugs and stay away from reasons for using drugs.**

8. **Watch out for WARNING FLAG phrases,** like:

"Experimental Use" - Drug users do not experiment with drugs as a scientist experiments with substances in the laboratory.

"Recreational Use" - The word "recreational" means doing something healthy. Using drugs is NOT an acceptable form of recreation.

"Social Use" - Drugs are anti-social and destroy families, friendships and social interactions.

"Soft drugs" - No illegal drug is "soft" on the body. This adjective implies harmlessness.

"Mood-altering" - The implication is that only temporary feelings are involved when, in fact, what causes these moods are biological changes in the brain. The term used should be "mind-altering."

"Use/Abuse" - This implies that USE is okay but ABUSE should be avoided. Any use of illegal drugs is ABUSE.

"Controlled Use" - There is no quality control in the contents of illegal drugs. Their addictive qualities lead to uncontrolled use.

"Lumping Together Unlike Substances" - A common ploy of the drug culture is comparing medications, aspirin, caffeine, or chocolate with illegal mind-altering drugs. There is a vast difference, and this approach minimizes the difference between legal and illegal substances and gives a message that dangerous drugs have a benign quality.

"There Are No Good Or Bad Drugs, Just Improper Use" -This expression is often found in pro-drug literature which serves to confuse the reader and minimize the very distinct chemical differences among substances.

"It's Your Decision" - Or, "Now that you know the facts, it's your choice whether or not to use illegal drugs." In what other area do we teach our children, "It's your choice to break the law."? Decisions that break the law are unacceptable.

"Scare Tactics" - Scientific research results are NOT scare tactics. Facts are facts. Carefully interpret statistics. Commonly used percentages can be misleading, e.g., 50% of 2 is vastly different from 50% of 1000. Check author, date and number of people tested or surveyed.

"Individual Rights" - Legal rights do NOT pertain to ILLEGAL activity.

"What Little We Know" or "Little Is Known" - These phrases are used to minimize or ignore factual data that is unfavorable to a pro-drug statement. For example, since 1965, over 9,500 scientific research papers on marijuana have been published and are listed in An Annotated Bibliography of Marijuana, Volumes I and II and Supplements. All reports state that marijuana is harmful to health.

"Responsible Use" - The use of illegal drugs is irresponsible, harmful to health and NEVER responsible. Judgments and perceptions are impaired when using any psychoactive drug. After using a psychoactive substance, one cannot make a "responsible" decision.

Source: Drug Prevention Resources Committees of Correspondence, Danvers, MA 01923

THE LIMITATIONS OF SCHOOL-BASED DRUG EDUCATION

Bruce Richards

Bainbridge Island is an affluent, upscale community located in Washington State's Pugent Sound. The island's school system is ranked among the best in the state, its students consistently scoring well above the national average on standardized achievement tests. The school dropout rate is practically nil, and 80% of the island's high school graduates go on to college.

In response to the growing concern about alcohol and other drug use by youth, the Bainbridge Island school system implemented a comprehensive, sequential drug prevention curriculum in 1977. The chosen curriculum covered all grades, kindergarten through 12th grade, and had been developed in accordance with the most current research findings at that time concerning the necessary social skills to resist experimentation with these substances. The curriculum which was chosen is highly regarded in the prevention field; some observers believe that this curriculum is one of the best available.

One might expect, then, that Bainbridge Island would experience enormous success with its school-based drug prevention program, and that Bainbridge students would display a significantly lower incidence of alcohol consumption and other drug usage. Such a positive outcome has not been the case, however. In fact, the November 10, 1989, issue of the *Wall Street Journal* documents the failure of the program to stem teenage alcohol and drug use on Bainbridge Island. The article describes a survey of Bainbridge students which revealed that as many as 70% use alcohol or other drugs weekly. One student is quoted as saying that "drugs are as plentiful as potato chips" at various parties hosted by teens. An honors student, who admits to drinking and taking drugs on weekends, refers to the drug prevention curriculum as "a joke."

Results such as these are, at the least, disheartening to a school system which has made such a diligent, long-term commitment to provide its students with state-of-the-art drug education. One might ask, "Where did the Bainbridge Island school district go wrong? Should school systems abandon their drug prevention programs altogether, given the meager results which these programs produce? How can a curriculum which is so well-grounded in research, and is so carefully and comprehensively implemented in the classroom, yield such a poor outcome?"

The problem does not lie with school-based prevention programs in themselves, but arises instead from the fact that **these programs, by themselves, are only one necessary component of a larger, more comprehensive prevention effort. This larger effort must target not only students in a classroom setting, but all other segments of the community, particularly parents.** There must also be participation from the local health care community, local government, the church, the media, law enforcement, and the business community. The members of these various elements of the community must first become better informed about issues related to substance abuse, and they must form a community-wide prevention network, working cooperatively and collaboratively to address the prevention needs of that community. In a drug-oriented culture such as ours, any prevention efforts which do not seek to impact the health of the **entire** community are bound to fail. In an article in the Journal of Alcohol Studies, Washington State University Armand Mauss notes that "society is permeated with messages about alcohol and drugs that range from tolerance to glamorization. In such an environment, any effort to teach youngsters abstinence from such substances is a little like trying to promote chastity in a brothel."

In short, **we will not have drug-free youth and drug-free schools until we have achieved the larger objective of drug-free communities.** We will not realize this objective as long as our prevention efforts are limited to school-based drug prevention curricula and programs.

Source: Jacksonville-South Jacksonville Prevention Task Force.

CREDITS

Public Health Model Diagram - Alvera Stearn, Illinois Department of Alcoholism and Substance Abuse.

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