Adolescent substance abuse and handicapped students: antecedent or concomitant handicapping conditions and prevention programs: a review of literature

Patricia Brings

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ADOLESCENT SUBSTANCE ABUSE AND HANDICAPPED STUDENTS:
ANTECEDENT OR CONCOMITANT HANDICAPPING CONDITIONS
AND
PREVENTION PROGRAMS:
A REVIEW OF LITERATURE

by
Patricia Brings

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This research paper has been
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(Advisor)

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CHAPTER I

Introduction

Adolescent substance abuse is an issue of national concern (Spero, Leone, Walter & Wilson, 1989). The National Institute of Drug Abuse (NIDA) estimated in 1984 that the United States had the highest rate of teen alcohol and other drug (AOD) use of any industrialized nation in the world. Nearly two-thirds of all adolescents experiment with illicit drugs and 40 percent of all American youth use drugs other than marijuana before leaving high school. Data from the National Senior Survey shows that use of most drugs has decreased since the mid-1970s (Moore, 1987; National Commission of Drug Free Schools: a Final Report [NCDFS], 1990; Newcomb & Bentler, 1989; & Oetting & Beauvais, 1990). Other patterns are also important, especially increased use of inhalants among fourth to sixth grade students (Oetting & Beauvais, 1990), first use at an earlier age, and the availability of illegal drugs in almost every school district and college (NCDFS, 1990). There seems to be little differences in the use patterns of illicit drugs among various racial and socioeconomic groups (Thorne & DeBlassie, 1985). Alcohol continues to be the most widely used drug (Oetting & Beauvais, 1990). Tobacco, the only legal drug for adolescents, is second. Because of availability, experimental use of tobacco has the widest use during preadolescence (Newcomb & Bentler, 1989). Females report more use
of cigarettes than males (Oetting & Beauvais, 1990). Marijuana is the third most commonly used drug, even though rates of use have dropped since 1980 (Oetting & Beauvais, 1990). The overall decline in use may be overly optimistic when considering recent surveys do not include at-risk individuals who are not in school (Newcomb & Bentler, 1989).

In recent years a great deal of public and government attention has focused on the problem of alcohol and drug abuse (AODA). Yet very little information has been published regarding the incidence and prevalence of substance abuse in the handicapped population. The paucity of available data is critical when the study is narrowed to adolescence (Moore, 1987).

Among adolescents identified as "seriously emotionally disturbed" and enrolled in specialized treatment facilities, the use of controlled substances, such as cigarettes, alcohol, and marijuana, is higher than among adolescents enrolled in comprehensive high school programs (Caton, Gralnick, Bender & Simon, 1989; Safer, 1987; Spero et al, 1989). However, there are few data on specific correlations between substance abuse and specific adolescent psychiatric syndromes (Demilio, 1989). Studies have reported that children with attention deficit disorder with hyperactivity are at higher risk for the development of substance abuse and that approximately half of the patients with lasting depression acknowledged depressive symptoms that predated their substance
abuse (Demilio, 1989). A clearer understanding of pathways to substance abuse would contribute to improved prevention and treatment approaches for young people with serious mental illnesses (Caton et al, 1989).

Substance abuse is clearly a multidimensional phenomenon and any discussion of it should also include consideration of the conceptual models of chemical dependency, as they help define treatment guidelines, legal issues, and the potential inclusion of substance abuse as a handicapping condition in special education. Paul Spoor (1988), of the Lake Washington School District in Kirkland, Washington, stated that school districts could face the loss of federal funds unless they include youngsters who are addicted to drugs and alcohol in their count of handicapped students and give them the same special services. Attention must also be given to the role of predisposition in chemical dependency, be it genetic or social/environmental and to adolescence as a life stage, which involves risk-taking behaviors, self identity, separation from parents, and physical/emotional changes. Social acceptance is also an integral part of adolescence and, therefore, must include the role of peer pressure and peer relationships.

There is a complex relationship between alcohol and drugs and the myriad of problems which plague our youth today. Teen pregnancy, school drop-out rates, juvenile crime, unemployment, and violence
endanger the lives and futures of our young people. The societal costs of drug and alcohol abuse are enormous. This includes the economic and social costs of lost human potential. Recent reports estimate that alcohol and drug use costs the nation over $175 billion dollars a year (Spero et al, 1989). Alcohol-related highway deaths are the number one killer of 15 to 24 year olds. More than half of all adolescent suicides are alcohol and other drug related.

Educators must be aware of the AODA risk factors, characteristics, and treatment procedures needed to successfully educate the students of today. Districts now are spending thousands of dollars to provide basic AODA information to their faculty and staff members. It is time that all college preparation programs for educators contain such a course. Curriculum areas need to include basic AODA information on all grade levels. Information such as self-esteem training, decision-making skills, refusal skills, dealing with peer pressure, positive recreational skills and social competence. Parents and professionals not adequately trained in the dynamics of dependence and codependency usually assume they are to blame for the nervousness and irritability of the students.

The question is: How can schools best reduce this serious problem affecting our children and society? Introducing messages of ethical values and responsibility on a long-term basis in our curriculum is the best and most cost-effective. The incorporation of a Student
Assistance Programs (SAP) can also be effective. The SAP can help students communicate, understand, and cope with their pain. SAPs provide a network of caring adults who can identify and refer students to the appropriate services available to them. A well-trained faculty and an SAP will not solve the problem, but it will create an environment in which children in pain can be managed more effectively.

Purpose of the Study

The purpose of this paper was two fold. Primarily, it provided a review of literature on substance abuse in adolescence and antecedent or consequent concomitant handicapping conditions. The second purpose was to provide a prospective of the current prevention models and the SAP model most widely used in Wisconsin. This model includes roles for the parents, community, students, and educators in identification, intervention, and prevention/education procedures.

Scope and Limitations

The handicapped students discussed in this paper were diagnosed with Learning Disabilities, Attention Deficit Hyperactivity Disorder, Emotional Disturbance, or various personality disorder. It did not include physically handicapped or mentally disabled students. The statistics refer to adolescents, ages 12-19. This paper did not intend to deal with assessment or treatment issues. These should be done by an independent facility with qualified professional staff. Legal responsibility
and/or financial obligations for special education services are reviewed only to provide an indication of future services. This paper was intended to benefit special educators, but could be of value to regular educators as well.

Definitions

For ease of understanding, the following definitions were used:

**Abuse** - use of illegal drugs or drugs without a physician's prescription in spite of extreme disruption of physical well-being, psychological integrity or social functioning (Spero et al, 1989).

**Adolescent Behavioral Chemical Dependency Syndrome (ABCD-S)** - a disturbance of behavior that has its onset after the development of a chemical dependence disorder, and largely subsides two months after the onset of sobriety. The syndrome includes the following behaviors: belligerence toward home and parents, decline in achievement and expectations, drug and alcohol peer using group, decrease in recreations activities, decline in school achievement, trouble with school or police, denial, lying, increased risk-taking behavior, and lack of long-term goals (Ralph & Barr, 1989).

**Addiction** - an irresistible compulsion to use a drug at increasing dose and frequency even in the presence of serious physical and/or psychological side effects and the extreme disruption of the user's personal relationships and system of values (Chatlos, 1987).
Attention Deficit Hyperactivity Disorder (ADHD) - a disorder, described as that which includes inattention, impulsivity, and hyperactivity; begins before the age of seven (Kauffman, 1989).

Anxiety Disorders - disorders in which anxiety is the primary feature. Anxiety may focus on specific situations, or it may be generalized and pervasive (Kauffman, 1989). It may include phobic and obsessive compulsive disorders (Diagnostic and Statistical Manual of Mental Disorders ed. 3-Revised [DSM III-R], 1987).

AQDA - alcohol and other drug abuse

Behavior Disorders - disorders that are characterized by behavior that is socially disruptive and is often most distressing to others (ADHD, conduct disorder, and oppositional defiant disorder) (DSM III-R, 1987).


Chemical Dependency - a chronic, progressive, incurable, but treatable disease characterized by loss of control over alcohol and other drugs (DPI-AODA Program Resource and Planning Guide, 1991) which is indicated when physical or emotional discomfort or both result when the drug use is discontinued (Kerr, Nelson, & Lambert, 1987).

Depression - depressed mood or loss of interest or pleasure in all or almost all activities that represents a change and is persistent for at least
two weeks (symptoms include sleep and appetite disturbance, decreased energy, and thoughts of death and suicide). (DSM III-R, 1987).

**Dual-diagnosis** - refers to a person that is chemically dependent and has a concurrent psychiatric disorder (Chatlos, 1989).

**Emotional Disturbance (ED)** - a handicapping condition characterized by emotional, social, and behavioral functioning which significantly interferes with a student's educational program. Emotional disturbance is characterized by deviant behavior which is severe, chronic, or frequent and manifested in at least two of the student's primary environments (home, school or community) (Special Education Handbook for Principals, 1985).

**Fetal Alcohol Syndrome (FAS)** - physical and/or mental anomalies in a newborn child resulting from the mother's drinking of alcoholic beverages during pregnancy (Drug Free Schools).

**Handicapped Children** - mentally retarded, hard of hearing, deaf, speech impaired, visually handicapped, seriously emotionally disturbed, orthopedically impaired, and or other health impaired children (pregnancy), or children with specific learning disabilities, who by reason thereof require special education and related services (Osborne, 1988).

**Illicit Drugs** - drugs whose use, sale, or possession is prohibited by law (DPI, 1991).
**Learning Disabilities** - a handicapping condition in which students have learning problems which interfere with their ability to acquire, organize, and/or express information, which impairs their ability to read, write, spell, or calculate mathematically (Special Education Handbook for Principals, 1985).

**Mood Disorders** - disorders of emotion that color outlook on life. Usually characterized by either elation or depression. May be episodic or chronic, manic or depressive (Kauffman, 1989).

**Personality Disorders** - deeply ingrained, inflexible, maladaptive patterns of relating to, perceiving, and thinking about the environment and oneself that impair adaptive functioning or cause subject distress (Kauffman, 1989).

**Schizophrenia** - symptoms include delusions, hallucinations, or certain characteristic disturbances in affect and form of thought with a duration of at least six months (DSM III-R, 1987).

**Student Assistance Program (SAP)** - services designed to assist students in overcoming school performance problems. The program provides or arranges services for students which can include assessment, referral, counseling, education, and treatment. These services also provide the marketing of the program to the students (Drug Free Schools).
Special Education - specially designed instruction to meet the unique needs of handicapped students (Kerr et al, 1987).

Substance Abuse - used (rather than drug abuse) because not all abused chemicals are drugs (gasoline, cleaning fluid, glue, white out, etc.) In many cases in this paper, substance abuse is used in place of chemical dependency.

Support Groups - Concerned persons: a support group for students who are concerned and affected someone else's use of alcohol and other drugs; Recovery group: a support group for students who have participated in some form of AODA treatment; Use/Abuse group: a support group for students whose use of alcohol and other drugs has caused them some problems in their lives; Awareness group: a support group for students who are in need of AODA information to assist them in making wise choices about alcohol and other drugs (DPI, 1991).

Use - Experimental: short-term use of one or more drugs bolstered by peer pressure, does not occur on a daily basis or for the purpose of escaping or avoiding personal problems (1 to 5 times total); Social Use: 2 to 4 times per week; Habitual: multiple times per day depending on drug (Kerr et al, 1987).

Summary

Recent trends show the use of alcohol and drugs has generally declined in the last five years, yet substance abuse is still an issue of
national concern. When adolescents use substances at critical life stages, it is considered abuse because of the potential for interference with crucial growth and adjustment tasks (Newcomb & Bentler, 1989). When substance use substitutes for acquiring social competencies, social development is arrested and long-term problems ensue (National Clearing House of Drug Information [NCADI], 1987). Use generally occurs as a result of social influences, whereas abuse of drugs is more strongly tied to internal, psychological processes, to which genetic factors may be more of a contributor. Any focus on drug use and abuse must focus on all components of the general pattern or syndrome.

Caton et al, (1989) state that there is a coexistence between substance abuse and psychiatric disorders. Risk factors double for subsequent drug use disorders in young adults who have had an earlier depressive, anxiety, hyperactivity mixed with aggression and/or anger disorder (Christie, Berke, Regier, Rae, Boyd & Locke, 1988; Kramer & Loney, 1982; Siegel & Ehrlich, 1989; & Stattlin & Magnusson, 1989). Problems of the dual-diagnosed adolescent must also include their predispositions for abuse, family values and control, peer influences, and societal expectations.

No single prevention approach has been identified as most effective. For now a multifaceted community-wide approach seems warranted. The key elements of such a program should include the
individual (personality characteristics), the environment (availability of substances) and community norms. Clear consistent communicated alcohol policies by families, schools, and communities are vital to ensure an integrated and comprehensive approach (NCADI, 1987).

The two-fold purpose of this paper was to provide a review of literature of substance abuse in handicapped adolescents and to provide a model for prevention education and intervention procedures. The handicapped students discussed in this paper were diagnosed with LD, ED, ADHD, or various personality disorders. It did not include physically handicapped or mentally disabled students. The statistics refer to adolescents, ages 12 to 19. This paper did not intend to deal with assessment or treatment. Legal responsibility and/or financial obligations for special education services are reviewed only to provide an indication of future service. This paper was meant to assist special and regular educators in understanding the complex problem of a dual-diagnosed adolescent. For ease of understanding many related terms were defined in this paper.
CHAPTER II

Adolescent Substance Use/Abuse

Who uses what?

The University of Michigan's Institute for Social Research, funded by the National Institute on Drug Abuse, conducted an ongoing study of a representative sample of approximately 16,000 high school seniors from 130 public and private schools nationwide. The results of the 1989 survey indicated some positive signs. The use of cocaine dropped to 10.3%, down from 12.1% in 1988. The number of students who saw risk associated with cocaine use increased. Daily marijuana use which peaked at 10.7% in 1978 declined to 2.9% in 1989. On the negative side, results of the survey indicated that over half of high school seniors (51%) have tried an illicit drug at least once before they graduate from high school. Alcohol remains the most frequently used drug and no decline was shown. Ninety-one percent of high school seniors have used alcohol, two-thirds have used in the past month (National Clearinghouse for Alcohol and Drug Information, 1988). The most important limitation of the National Senior Survey is that it does not assess drug use of school dropouts, whose use is likely to be higher than the average senior (Oetting & Beauvais, 1990).

The National Household Survey of Drug Abuse conducted in 1988 reports that over 5 million (24.7%) young people aged 12-17 have tried
an illicit drug at least some time during their lives. Seventeen and four tenths percent have tried marijuana, with the highest rates represented in the West and North Central regions of the United States. By race/ethnicity, past month use was 4.4% for Black youth, 5.2% for Hispanics and 6.8% for White youth.

Oetting and Beauvais reported in 1990 that according to national surveys, although illicit drug use appears to be down among adolescents, alcohol continues to be the most widely used drug (Moore, 1987; Spero, et al, 1989), tobacco is the second, marijuana is third, and stimulant use is fourth. Marijuana and stimulant use have shown declines in the last 10 years, yet use of such drugs as inhalants has increased, especially among 4-6th grade students. Males report more use than females of all substances except cigarettes (Thorne & DeBlassie, 1985).

Rural youth are no longer isolated from drug problems. Drug use in rural areas seem to be essentially the same as those used by other youth. The most frequently used drugs are essentially the same for minorities as for White American youth. Use of most drugs is lower for Black American youth and about the same or lower for Mexican American youth. Native Americans, especially those on reservations, show the highest drug use rates. Asians or Black youth reported the lowest use rates but Mexican Americans and White Americans rates were higher.
The National Adolescent School Health Survey conducted in the Fall of 1987, included approximately 11,000 eighth and tenth grade students from public and private schools. Seventy-seven percent of the 8th grade students reported having tried alcohol (55% of these by 6th grade), 51% tried cigarettes, 15% tried marijuana, 21% tried inhalants, and 5% tried cocaine. Eighty-six percent of the students reported that it would be fairly easy for them to get cigarettes, 84% for alcohol, 57% for marijuana, and 27% for cocaine (NIDA, 1988) (See Figures I and 2).

How Does Wisconsin Compare?

In recent studies by the Wisconsin Cocaine and Drug Task Force, it was found that drug abuse impacts every area of the state, effects all age groups, alcohol abuse is higher in rural areas, drug abuse is higher in urban areas, males outnumber females nearly 7 to 3 in abusing alcohol and other drugs. Alcohol abuse continues to outweigh other drug problems in Wisconsin. Wisconsin ranks third in the nation in the per capita consumption of alcohol, with an estimated 336,000 users in the state. Wisconsin's dollar expenditures for alcohol prevention/intervention for the fiscal year 1989 amounted to $82,751,497. The total estimated cost was placed at $3.6 billion annually (Fact Sheet-The Wisconsin Drug Scene, 1990). AOD statistics for Wisconsin students as reported by the Department of Health and Social Services, 1988, indicate the percentage of Wisconsin adolescents who drink is 25% greater than the national
From: National Commission on Drug-Free Schools-Final Report
p. 8
From: National Commission on Drug-Free Schools-Final Report p. 9

FIGURE II  Grade of First Use

Grade of First Use of Drugs (in Percentages) as Reported by High School Seniors
average, 20% of Wisconsin students leave for school from a home containing at least 1 chemically dependent parent, 178,000 youth (ages 12-22) have alcohol or other drug problems each year, 46% of 12th grade students have, within the past year, driven a motor vehicle after drinking and 70% have ridden in a motor vehicle driven by someone who had been drinking.

Substance Use/Abuse and Handicapped Students

The National Institute for Alcoholism and Alcohol Abuse estimated that the number of individuals with multihandicapped disabilities (including work related injuries and other trauma) to be set at 2.8 million Americans (Moore, 1987). The prevalence of substance abuse among young adult chronic patients is on average at least three times greater than for high school seniors (Safer, 1987). For students enrolled in Special Education programs and labelled seriously emotionally disturbed, use of controlled substances (cigarettes, alcohol, marijuana) is higher than among adolescents enrolled in comprehensive high school programs (Ralph & Barr, 1989). The prevalence of alcohol abuse among mixed diagnostic groups of psychiatric inpatients ranges from 7% to 48%, when drugs other than alcohol are added the rates range from 18% to 50%, and the life time use of drugs and alcohol in young schizophrenic patients was five times greater than the representative community sample (Caton et al, 1989). The incidence of substance abuse among individuals with
disabilities may be no greater than it is among the general population, however, the impact...may be more debilitating...(Leone, Greenburg, Trickett, & Spero, 1989).

Additional drug-related research is required for the disabled of all ages, but it is the youth who have the greatest immediate need (Moore, 1987). This represents the time when individuals appear the most vulnerable to drug use and the age at which a person is at maximum risk for serious complications.

Adolescence

A Life Stage

Adolescence, beginning usually anywhere from the 10th to 12th postnatal year and concluding by the start of the third decade of life (Krasnegor, 1988), is the period of life in which an individual makes the transition from child to adult. This socio-developmental process includes the institutions of family, school, church, as well as peer relations. Moore (1987) states that adolescent drug use has been associated with a shift toward peer values, increased rebelliousness, lower school performance, lowered religiosity, decreased association with the family and possible psychological variables such as lowered self esteem, feelings of social inadequacy, confusion over sexuality and sexual behavior, and in some cases, incipient psychopathology. Adolescence is synonymous with upheaval and biobehavioral modifications which, if successfully
completed, transform the child into an adult (Krasnegor, 1988). These will be discussed in the following paragraphs.

According to William Braden as reported in Brown and Hendee (1989), adolescence did not really exist in earlier times when the population was centered in rural areas. Children were absorbed into adulthood by first observing and then assuming adult tasks. The child labor laws passed after the Industrial Revolution and the compulsory education laws made adolescence a social reality. With the current emphasis on education as a means of increasing upward mobility, adolescence has been prolonged. Psychologists suggest that the length of adolescence has been increasing about 1 year per decade, so that school now often extends into the middle 20's and beyond (Braden, 1989).

This is increasingly true for families of handicapped students who are unemployed or underemployed. Youths and adults with handicaps suffer major economic disadvantages in the labor market in comparison to the nondisabled population (Rusch & Phelps, 1987). Edgar (1987) reported that many handicapped students have low base-salary jobs or are employed only part time. Of major concern, is the number of handicapped students who drop out of high school (42% for handicapped versus 16% for all other students). Plata and Bone (1989) reported on a study of how adolescents with a handicapping condition
perceive work and occupations. Students with learning disabilities (LD) held in higher regard occupations that were classified as skilled, semi-skilled, or unskilled. More ethnic minorities than Anglos tended to give higher prestige ratings to technical, skilled, and unskilled occupations. They also reported that only 8% of occupations for fathers of students in the LD group were in the professional category, while for fathers of students in the non-LD group 25% of the occupations were in the professional category. Forty-nine percent of the students in the LD group reported retired, disabled, deceased, or unemployed fathers...The lack of role models in the home, problems related to ethnic minority status, plus problems caused by impulsivity, over-reactions, poor use of time, lack of motivation, and poor self-concept...no doubt contributed to these students perceptions of occupations (problems of LD adolescents may have caused them to modify their self-concept) (Plata & Bone, 1989). Few mildly handicapped students (and virtually no severely involved students) move from school to community jobs that allow for independent living (Edgar, 1989).

Physical Transition

Adolescence is a period of physical transition. Children become adults physically with the onset of puberty. It is the time when endocrine surges trigger menarche and breast development in girls and spermatogenesis, facial hair, and voice changes in boys. Rapid changes
often result in clumsiness and awkward movement and generalized self-consciousness. Factors such as hereditary, nutrition, and life-style result in differences in the timing of these maturational changes. According to Andersson and Magnusson (1990) early maturing boys show more advanced drinking habits in young adolescence (14-15) compared to normal maturing boys, but it did not indicate an increased risk for developing alcohol abuse in young adulthood (18-19). They also reported high frequency of early drinking habits in late developing boys. They hypothesized that it was based on their intense striving for participation in high-status activities. According to their results, early maturing girls reported more older friends, more working friends, and less negative reaction from their parents regarding their alcohol use.

**Psychological Transition**

Psychologically, adolescence is also an important stage of development. Miksic (1987) described adolescence as the final stabilization of hormonal secretion and final nervous system and brain function integration. During adolescence, formal operational thought appears where only concrete operational thought once existed. This ability to think abstractly allows the adolescent to make independent judgments and express opinions. The concept of choice is a key to the transition to adulthood (Mackenzie, 1987). Adolescents are capable of looking critically at the values and ethics embodied in adult society and in
some cases, rejecting them. Psychological development should also include a progressive accumulation of experiences that promote increased confidence, esteem, and wisdom. Trust, security, and self-esteem are essential ingredients in the development of a sense of identity and maturation to responsible independent functioning (Mackenzie, 1987). Siegel and Brown (1988) found that early adolescence appears to be a time of relatively greater vulnerability to stress, negative circumstances (as rated by the individuals), and later depression, particularly pronounced in girls.

During adolescence young people seek to form an identity separate from their parents. One of the earliest and most visible signs of transition to adulthood is a meaningful job. In an agrarian society, adolescents assumed adult work roles, without pay, yet they were contributing to the economy of the family and interacting with adults as adults. Today adolescents may never see firsthand what their parents do during the day (Nightingale, Hendee, & Sanders, 1989). With the transition from a manufacturing and industrial economy to a service and retail economy, job opportunities for adolescents have been restricted. Part-time jobs or jobs with no adult-type work role are all that are available to young people. The money that they earn is used for pleasure and leisure. They develop a distorted view of the real significance of a job. The full-time employment of both parents means
that many children grow up too fast. They are forced to accept more responsibility at an earlier age. Adolescents need to interact with adults and see them as consistent role models enforcing firm and consistent guidelines, yet providing guidance and feedback.

Consequences of Adolescent Use/Abuse

The consequences of substance abuse during adolescence are extremely serious. Adolescent drug use while seen as a behavior of independence, may well require the parents to become more involved and less trusting (Rugg & Jaynes, 1983). As adolescents progress through the stages of addiction, they become more controlled by dependence (psychologically and economically) and delinquent peer cultures (Ralph & Barr, 1989). To adolescents whose transitional skills are in a developmental stage, chemicals provide a vehicle to meet these needs, albeit a dysfunctional one (Rugg & Jaynes, 1983). There is increased clinical evidence to the effect that one's emotional growth ceases with the advent of drug use. There is also evidence to suggest that the earlier a person begins drinking or using drugs, the more likely that he/she will develop an addictive problem (Newcomb & Bentler, 1989; Svobodny, 1982). Users avoid the challenges and experiences needed to develop these skills. The adolescent who turns to chemicals becomes less and less able to develop mature adult relationships, due to the constant fear of rejection, a rejection that is never resolved. Adolescents
have not been drinking long enough to suffer the physiological damage characteristic of adults who drink heavily over a long period of time (liver and/or brain damage), but they do suffer the consequences of alcohol-impaired driving. Alcohol is also related to producing and justifying uninhibited behavior which could result in unwanted pregnancy, injury, or sexually transmitted diseases. In severe cases, substance abuse can impair the reproductive organs of developing adolescents (Rosiak, 1987). Substance abuse usually has a negative effect on school performance, attendance, and future goals. When alcohol is substituted for social competencies, social development is arrested and long-term problems ensue (Alcohol Fact Sheet, 1987). As a result, teenage drug users enter adult roles of marriage and work prematurely and without adequate socioemotional growth and often experience greater failure in these adult roles (Newcomb & Bentler, 1989).

Pathways to Substance Use/Abuse

Great research efforts have been devoted to understanding the etiology and antecedents of drug use during adolescence. Several researchers have suggested that there are probably many diverse paths to drug use and that looking for the definite path or cause is doomed to failure since this may very well not exist (Dishion, Patterson, & Reid, 1988; Newcomb, Maddahian & Bentler, 1986).
**Family Life**

Family life is a major contributing factor in an adolescent's alcohol misuse. Research has reported that an adolescent's misuse of alcohol corresponds to the alcohol use of their parents (Robertson, 1989). Teens seem to be influenced by the example of older family members. According to Thorne and DeBlassie (1985) children learn general orientations toward or away from substance use in accordance with the mother's substance use and that of older brothers and sisters, whereas the father's substance use does not appear related to sons' or daughters' use. Svobodny (1982) reported that last or later-born children (who tended to rely on others more than other sibling positions) had a higher incidence of substance abuse. Some types of alcohol abuse appear to have a genetic component, yet no evidence exists that can separate genetic and family environmental contributions (Newcomb & Bentler, 1989). Sexual addiction is commonly seen in association with other addictions (also having a genetic component), and is only recently being recognized and understood (Chatlos, 1989). Dishion et al. (1988) report that heavy alcohol or drug use by a parent could influence the child's initial exploration of drugs. The child models the parent behavior and the parent's use makes the drugs readily available.

Children of alcoholics (COA) are considered at high risk for developing alcohol-related problems (Bingham & Bargar, 1985). Life in
an alcoholic family is neither consistent nor predictable. Trust, affection, and sharing are scarce and emotions are often repressed. COAs experience significant gaps in growth and development that occurs as a result of a chaotic imbalance on conditions in an impoverished environment with inadequate gratification of esteem needs. Depression may manifest itself in adulthood. COAs are treated in therapy groups that educate the children about the disease and provide a vehicle for the exploration of feelings.

Family system dynamics is clearly posited in any relationship between adolescents and substance abuse (Bartle & Sabatelli, 1989). Families with substance abusing adolescents have been described as overprotective, rigid, and ineffectual at conflict resolution. Bartle and Sabatelli (1989) reported that a child has a better sense of identity when the opposite sex parent-child reciprocal relationship is perceived as promoting a balance between individuality and intimacy. Teenagers with stronger social bonds to home and school are not as likely to be substance users as those with weaker bonds (Thorne & DeBlassie, 1985). Nubel and Solomon (1988) reported that girl drug addicts were less favorable toward their mothers and less likely to be living in a family situation with two parents and a number of siblings. The findings indicated that an adolescent girl with a perception of a poor relationship with her single mother may be at risk for drug addiction.
The effect of parental presence in the home and the gender of the parent and adolescent is also reported to be linked to substance abuse. Parent's divorce, marriage, and remarriage were specific for different age groups and varied by gender (Needle, Su, & Doherty, 1990). Children whose parents divorced during adolescence seemed to be more likely to be involved in substance use and to report more negative consequences. Divorce during adolescence had a significant effect on boys in terms of overall drug use and consequences, but not on girls. The absence of a father figure is highly associated with alcohol and marijuana use and sexual acting out, especially for males (Miksic, 1987; Stern, Northman, & Van Slyck, 1984). Remarriage had more adverse effects on girls and more positive effects on boys. Robertson (1989) reported that the presence of a mother in the home was significantly associated with whether an adolescent misused alcohol. Homes without the presence of a mother were twice as likely to generate a problem user. Flewelling & Bauman (1990) found that there was a higher impact of marital disruption on white than nonwhite adolescents. They also report that the underlying dysfunctional characteristics (diminished quality of parent-child interactions) of some families influence the greater likelihood of both marital disruption and adolescent problem behavior.

Parental rejection or family conflict has also found to be strongly associated with alcohol misuse for adolescents (Miksic, 1987; Robertson,
Interestingly, Brown (1989) found that adolescents in families with only one generation of abuse (nonabusing adolescents with substance-abusing parents and the abusing adolescents with non-substance-abusing parents) reported more stress and conflict than in second generation abusing families. Family bonds are more important to decreasing the possibility of drug use in daughters than in sons (Miksic, 1987; Robertson, 1989). Family conflict may be caused by family alcoholic or substance abusing parents (Brown, 1989). These parents exhibit harsh discipline, lack of warmth, inconsistency and poor management skills. The greater the restrictiveness of the home setting, the greater the rebellion reaction is likely to be. Many problem drinkers come from homes where alcohol is forbidden (Miksic, 1987). Homes filled with conflict or parent abuse are more likely to be linked to drug abuse.

In clinical populations, youth (more female) who have been sexually abused may be at higher risk for substance abuse (Robertson, 1989; Singer, Petchers, & Hussey, 1989). According to Robertson (1989) half of the adolescent females in treatment for substance abuse report they are survivors of incest. Singer et al. (1989) reported that significantly more sexually abused youth were found to make regular use of cocaine and stimulants than their control group counterparts. Victimized youth can often have difficulty making close relationships and trusting others.
Therefore, using part of the drug culture, the sexually abused adolescent may have a peer group by virtue of mutual chemical affiliation, yet successfully avoid interpersonal closeness.

Generally neglected in the study of etiology has been the relation of specific parenting practices to the child's development of addictive behaviors (Dishion et al, 1988). The level of parent monitoring has a direct and/or indirect effect on adolescent drug use. Poor monitoring is likely to increase the possibility that an adolescent will associate with a deviant peer group. Monitoring practices are extremely important during preadolescence, when the influence of parents on social development may be more important than peers' influence (Dishion et al, 1988). Heavy parent substance abusers are more likely to practice poor monitoring skills.

American society today fails to provide consistent, responsible, moral guidelines for adolescents to use as a basis for their emerging moral freedom. Since the 1960s, the focus has been on the individual, freedom of choice, and fulfillment, as long as it didn't harm anyone. Parents who use illicit drugs or who have multiple sexual relationships present confusing and inconsistent role models for their children (Comerci, DuRant, & Besinger, 1989). These attitudes and values have weakened parental authority and the disciplinary bonds between parents and children. Television also adds to this problem. Children watch a
great deal of television. In one year a child could see 1000 ads for alcohol, most associated with sex symbols, sports heroes, and power symbols. Adolescents can spot hypocrisy a mile away. Why should they say no when society says yes?

**Peer Relationships**

During adolescence children begin to separate from their families and increase the importance of peer relationships. The values and attitudes of the peer group may be the same or different from those of the family and the struggle to reconcile those differences has a profound influence on the drug-use habits of the adolescent (Miksic, 1987). Peer influences (modeling use, provision of substances, and encouraging use) are the most consistent and strongest of factors in initial involvement in substance use (Newcomb & Bentler, 1989). Kandel and Davies (1982) reported that adolescents who are more likely to rely on their peers rather than their parents are more depressed than those who rely on both equally. Stronger peer bonds seem to enhance use (Thorne & DeBlassie, 1985). Most use of drugs occurs as a result of social influences, whereas abuse of drugs is more strongly tied to internal, psychological processes (self medication) (Newcomb & Bentler, 1989). Opportunity is an important factor in the process of beginning illicit drug use by adolescents. A typical first time user does not seek out the experience, but rather the acquaintance with a user precedes the first
experience (Thorne & DeBlassie, 1985).

Swain, Oetting, Edwards, and Beauvais (1989) introduced the peer cluster theory as a variable in the path to substance use/abuse. Their research identified several variable domains: social, psychological, values/attitudes, and behaviors that when linked to peer clusters may relate to adolescent substance use. They describe a peer cluster as a tightly knit and cohesive subset of the peer group such as best-friends dyads, small groups, or couples. They state that the peer cluster can operate to inoculate the adolescent against drug use or to set the stage for use through influences that encourage or discourage peer drug associations. They do not exclude emotional distress as an antecedent factor (self medication), but only to the extent that it increases the possibility that a youth will more likely find friends who have a potential for drug involvement. The peer cluster theory suggests that youths within a peer cluster will use essentially the same drugs and to the same extent, when they are together.

Personality Factors

Mayer (1980) reported that the following items did not influence alcohol use/misuse: gender, family size, position in family, religion, social class, or maturity level, but personality factors do. These personality factors were hostility, dependency, poor impulse control, depression, aggression, low self esteem, anger, and incipient
psychopathology. Shedler and Block (1990) reported on the relation between psychological characteristics and drug use in subjects studied longitudinally, from preschool through age 18. They indicated that drug use cannot be understood unless you understand the individual's personality structure and developmental history. They concluded that there is a difference in the personalities of abstainers (subjects who had never tried marijuana or any other drug), experimenters (subjects who has used once or twice and who had tried no more than one drug other than marijuana) and frequent users (subjects who used once a week or more and who had tried at least one more drug other than marijuana).

Experimenters, the largest portion of their research sample (36 of 101), were psychologically the healthiest. Some experimentation with marijuana cannot be considered deviant behavior and some drug experimentation apparently does not have psychologically catastrophic implications for high school seniors in this culture at this time (Newcomb & Bentler, 1989; Shedler & Block, 1990).

Abstainers were described as anxious, inhibited, morose as children, with poor maternal parenting. Their mothers were observed as cold, critical, pressuring, and unresponsive to the needs of the child. Fathers were stern, authoritarian, domineering, and unresponsive to the needs of their children. The children were viewed as narrow, controlled, not gregarious, not liked, alienated from peers, fearful, not responsive to
humor, avoiding risky behavior, not curious, and immobilized under stress. Their abstinence was viewed as an omission not commission.

Robertson (1989) described frequent users/abusers as unconventional, nonconforming, more socially precocious, defiant of social norms, and possessing different coping skills. Their use was based on some unresolved issue of adolescent development, usually an inconsistent and conflicting behavior and value standard. Mayer (1980) portrayed frequent users as socially immature, unambitious, vengeful, explosive, self-centered, stubborn, not tolerating responsibility, with negative self feelings such as depression and anxiety, ostentatious, exhibitionists, lacking trust, and very pessimistic about the future. Freidman and Utada (1989) described frequent users as having more psychological symptoms such as anxiety, emotional disturbance, obsessive-compulsive, hostility reactions, agitation, and violent reactions. They viewed them in laymen's terms as lacking motivation, disassociated from adults, involved in more gang activity, having more school problems, and as spending more time watching TV or "hanging out" with peers. Shedler and Block (1990) describe the frequent user as insecure, unable to form healthy relationships, emotionally distressed, and with poor maternal parenting. They feel alienated, inadequate, and unable to invest in, or derive pleasure from, meaningful personal relationships. Feeling troubled and inadequate becomes a vicious cycle. With no future
goals or connectiveness, they give in to their immediate impulses to make them feel better.

Thus it seems that parental history (including genetic and environmental factors), family dynamics, peer influences, and personality characteristics have a profound effect on adolescent substance use/abuse. Newcomb et al. (1986) reported that based on adolescent substance abuse research, no single causal or etiological implication could be drawn, but that the number of risk factors (not the risk factors themselves) were linearly associated with increased percentage of drug use, frequency of use, and heavy use. They restate that substance abuse is not a simple problem with a simple solution, but that there were multiple pathways to drug use.

The Dual-Diagnosed Adolescent

A dual-diagnosed adolescent is one in which substance abuse and a psychiatric disorder coexist. Handicapped students (L.D., E.D., ADHD, depressed, hyperactive, aggressive, or schizophrenic) have heightened risk factors for substance abuse because of their low school performance, sensitivity to peer acceptance, greater tolerance for deviance, low self-esteem, social inadequacy, and sexual confusion (Moore, 1987). Miksic (1987) reported that special education students may be experiencing difficulties with self-image, resulting in a high vulnerability to peer pressure. Add to this the difficulty these students
have finding a job (short term or long term) and this increases the likelihood that these problems will continue into adulthood. Those handicapped students at greatest risk are those most like the normal population. The coexistence of substance abuse and psychiatric disorders is associated with a more severe course of illness (Chatlos, 1989). The combination of drug use and mental illness is tenacious, as mental illness potentiates drug use, and reciprocally, drug use exacerbates poor mental health...thus the prognosis for recovery from drug problems decreases exponentially when mental illness is dually diagnosed (Moore, 1987). The dependency can also impede the identification of the clinical condition. In many cases substance use/abuse may precipitate psychosis, in other cases substance abuse is not initiated until after a psychotic episode (Caton et al, 1988; Christie et al, 1988; Levy & Wells, 1987). Shedler and Block (1990) emphasize that data indicates that use and abstinence have psychological antecedents that predate drug use and can not be adequately explained in terms of peer influence. Siegel and Ehrlich (1989) cited evidence that personality problems and deviant behavior precede rather than follow excessive drug use. Patients raised in a nontraditional family had higher rates of concurrent substance abuse and psychiatric disorders than patients raised by two biological parents. The substance abuse usually occurred after the onset of the psychiatric disorder, most commonly depression,
Several handicapping conditions were reviewed for this paper in relation to substance abuse. They are Attention Deficit Hyperactivity Disorder (ADHD), aggression, depression, hyperactivity, schizophrenia, Learning Disabilities (LD), Adolescent Behavioral Chemical Dependency-Syndrome (ABCD-S), and Emotional Disturbance (ED).

Attention Deficit Hyperactivity Disorder

Attention deficit hyperactivity (ADHD) is characterized by inattention, impulsiveness and hyperactivity. ADHD children describe themselves as restless, overactive, and impulsive. Three percent of children have this disorder and boys are diagnosed six to nine times more than girls (Ralph & Barr, 1989). Hechtman, Weiss, and Perlman (1984) studied young adults who were diagnosed as hyperactive as children. They reported that many children diagnosed with hyperactivity continue to have emotional problems in everyday living into adulthood. A greater percentage of the hyperactive subjects had used nonmedical drugs at some time, but there was no difference in the type or severity between the hyperactive subjects and the control subjects. Hechtman et al. (1984) did not find that prolonged stimulant treatment for hyperactivity predisposed the patients for general drug use and possible abuse. Ralph and Barr (1989) reported that when aggression is also present with ADHD, the prognosis is worse. These patients have limited ego skills...
and resources for coping with significant life stresses and are at risk for being labeled as "out of control" under severe stress. Using a general linear model with age, sex, and time as covariates, children with a history of ADHD and special education placement had an average of 12% drug use, while those without a special education placement had an average of 1% drug use.

**Aggression**

An early childhood diagnosis of aggression (fighting and breaking rules) taken in first grade was predictive of drug and alcohol use 10 years later for boys but considerably less for girls (Stattin & Magnusson, 1989). The lower rate for girls was expected considering the difference in the ways they express aggression. The early aggressive subjects were described as socially maladjusted, with low school motivation, underachievers, and tended to have poor peer relations.

**Depression**

Depression is occurring at earlier ages in more recent generations and the risk of substance abuse is doubled with early depressive (or anxiety) disorder (Christie et al, 1988). Ralph and Barr (1989) emphasize the need to differentiate between primary or secondary (withdrawal or negative family feedback to the chemical dependency) depression in chemically dependent adolescents. DeMilio (1989) reported that over half of the chemically dependent adolescents admitted for his study were
seriously depressed and that 35% of them continued to be depressed three weeks after sobriety.

Maag and Behrens (1989b) reported that more girls than boys exhibit categories of severe depressive symptomatology (regardless of handicap) and more junior high than senior high age students experience severe depression. Depression, a form of internalized disorder, reflects problems with self, whereas externalized disorders are characteristic of conflict with others. Girls are more likely to internalize than boys (Worchel, Nolan, & Willson, 1987). The study found that females were more likely to feel sad, alone, and tired. Males were more likely to report getting into fights and having to push to do schoolwork. Males show depression with more active types of behavior, while it appears females display feelings and worries. It is unsettling that many depressed students with learning and behavior problems fail to receive special education services until their condition is identified by outside agencies (Maag & Behrens, 1989a). That depression has only recently become a concern to special educators probably reflects research indicating that externalizers (aggression, disobedience, hyperactivity) have been more likely to receive special education services than internalizers (withdrawal, depression, anxiety) (Maag & Behrens, 1989b). Murray & Whittenberger (1983) stated that while the behavioral disordered (BD) class includes withdrawn as well as acting-out children, typically the latter receive the
most attention and find their way into the BD class. Ostrander, Colegrove, and Schwartz (1988) reported that states operating under behavioral disordered terminology and definition tended to classify significantly higher numbers of children (classified as acting out, conduct disordered, and hyperactive)...and less inclined to classify depressed children. They also reported that depression symptomatology has been identified as a characteristic of the seriously emotionally disturbed (SED), learning disabled, and educable mentally retarded. Two to forty-nine percent of SED and LD students exhibit moderate to severe depressive symptomatology. When viewed in relation to the number of substance abusers who reported depressive disorders prior to their abuse, these statistics have significant implications for special education teachers.

Hyperactivity

Hyperactivity, often associated with school problems, occurs in 4-10% of the general population, mostly boys (Kramer & Loney, 1989). Hyperactivity is characterized by overactivity, short attention span, and impulsivity, low self-esteem, learning difficulties, and aggression. Kramer and Loney (1982) view hyperactive children as social isolates, having few friends, and therefore, would not have the availability or peer influence posited in drug use/abuse. They state that hyperactive youngsters might not be especially vulnerable to substance use. Few data exist that support a direct connection between substance use and overactivity.
There is data to suggest a link between low self-esteem, poor scholastic functioning, aggression, and substance use that may not be relevant for hyperactive children. This would seem to be supported by Hechtman et al. (1989) who reported that hyperactive children's inappropriate behavior generates strong societal responses and that their social immaturity is a result of less social and personal experiences.

Post Molestation

Ralph and Barr (1989) indicated that anxiety and panic disorders as well as post molestation syndromes, are also conditions that might lead to hyperactivity and distractibility. The post molestation concept is important to consider in the course of treatment for substance abusing adolescents.

Fetal Alcohol Syndrome

As Gold and Sherry (1984) reported hyperactivity, attention deficit disorder, learning disabilities, and behavioral problems have been linked to fetal alcohol syndrome (FAS). Studies found that fetal exposure to alcohol in utero may be the primary source for mental impairment associated with FAS. This impairment usually occurs in conjunction with central nervous system impairment ranging from aberrant and delayed fine motor control to poor attention spans, to hyperdistractibility, and to hyperactivity. Gold and Sherry (1984) reported on a study done by Shaywitz, Cohen and Shaywitz in 1980 that investigated 87 children
known to have been exposed to alcohol prenatally. Of the 15 children exposed to heavy maternal drinking during pregnancy, all were recommended for special education services by the third grade. These children had intelligence levels in the average range, yet experienced persistent academic failure, especially when asked to utilize higher cognitive processes to meet academic demands in a classroom. Gold and Sherry (1984) suggested that children at risk due to maternal drinking should be followed closely for signs of learning disabilities and that children who experience learning or behavioral problems be evaluated for exposure to alcohol during the prenatal period. Rhodes and Jasinski (1990) postulated that inherited neuropsychological deficits would most likely be functionally manifested as learning disabilities that would persist into adulthood, precede alcohol use, and be associated with family histories of alcoholism. This study demonstrated that some type of relationship between alcoholism and learning disabilities may well exist. Van Dyke and Fox (1990) expressed concern with the lack of information available on polydrug users, particularly those women who use multiple drugs and alcohol during pregnancy. Los Angeles is reporting 10 to 15 new referrals per month to regional centers for developmental evaluations. The American educational system needs to anticipate providing services to the significant number of children with these learning and behavioral problems.
Schizophrenia

The relationship between substance abuse and schizophrenia is complex and confusing (Bogdaniak, 1989). Research studies point out that significant numbers of individuals diagnosed schizophrenic abuse alcohol, yet the uncovering of the process may occur after withdrawal and detoxification from the abused substance. The withdrawal may even intensify the psychopathological symptoms and subsequent suicide attempt rates are high. Caton et al. (1989) reported that the most common psychiatric diagnosis (among dual-diagnosed adolescents in treatment) was depression, followed by schizophrenia and when the psychosis followed drug or alcohol abuse, it is most frequently attributed to an organic cause. They also reported on a comparison study between young adult schizophrenic patients and a representative community sample on lifetime use of drugs and alcohol. Schizophrenic patients' use sedatives five times more, stimulants eight times more, narcotics five times more, and psychedelics two times more than the representative community sample.

Learning Disabilities

In addition to the emotional disturbances listed above, learning disabilities are also related to adolescent substance abuse, but studies remain to be carried out. Ralph and Barr (1989) could not identify any research that studied this relationship specifically. Learning disabilities
refer to arithmetic, expressive writing, reading, articulation, expressive language, receptive language or coordination disorders. These disorders interfere significantly with the ability to function academically, representing a discrepancy between the person's intellectual capacity and academic performance. Current figures cite an LD rate of 2-8% of children in the general population, while boys substantially outnumber girls. There has long been a noted association between LD and ADHD, and the terms have often been used interchangeably. The only difference seems to be that ADHD symptoms often persist into adulthood, while the persistence of LD symptoms are far fewer (Ralph & Barr, 1989). The impact of substance abuse may be far more serious on individuals with disabilities than on students without serious academic and social skill deficits.

Adolescent Behavioral Chemical Dependency Syndrome

Ralph and Barr (1989) address the relationship between ADHD, LD, and substance abuse. They describe an additional adolescent syndrome called Adolescent Behavioral Chemical Dependency Syndrome (ABCD-S), which also describes the behavioral symptoms associated with adolescent substance abuse. The authors define ABCD-S as a disturbance of behavior that has its onset after the development of a chemical dependency disorder, and largely subsides two months after the onset of sobriety. The syndrome includes the following: home behavior problems (parental alienation), decline in values and
expectations, identification with delinquent peer group, decrease in previous social groups, decline in school achievement, increased trouble with the law, increased denial, increase risk-taking behavior, sexual acting out, and lack of long-range planning. Ralph and Barr (1989) believe the symptoms disappear with the development of sobriety and that depression, etc. show a dramatic decrease within the first two weeks of successful abstinence. This seems to be the link between antecedent and consequent psychiatric disorders. Extensive medical and psychological evaluations need to be done to determine if the dual diagnosis (psychiatric disorder) is a primary or secondary condition. A diagnosis of conduct disorder or oppositional defiant disorder is not justified unless the behaviors significantly precede the onset of the chemical dependency and/or persist more than two months after sobriety. This is also an important concept for the treatment process and prognosis.

Emotional Disturbance

The category of emotional disturbance includes all handicapping conditions mentioned in this paper with the possible exceptions of specific learning disabilities and hyperactivity. Emotional disturbance was recognized as a special education problem as early as 1931, but it was not defined until 1961. Eligibility criteria are determined through a comprehensive study of a child, ages 0-20, by a M-Team. The category
of emotional disturbance is characterized by emotional, social, and behavioral functions that significantly interferes with the child's social systems (school, home, or community). The following behaviors may be indicative of an emotional disturbance: deviant behavior, unexplained inability to learn, interference with social interactions, inability to develop and maintain interpersonal relationships, general depression, inappropriate affective response, phobias, autistic-like behaviors, withdrawal, aggression, and lack of age appropriate behaviors. The majority of risk factors mentioned as indicators or predictive of adolescent substance abuse apply to the emotional disturbed population. This places a severe burden on special educators to educate, identify, and manage dual-diagnosed adolescents.

Suicide Risk

Both mental illness and substance abuse diagnoses carry with them a powerful societal stigma, a potential suicide/violence risk, a high relapse rate, and severe impairment of family and social relationships (Mckelvy, Kane, & Kellison, 1987). Substance abuse may be an important additional symptom contributing to suicidal risk. In a depressed adolescent, substance abuse appears to both increase the risk of multiple attempts and to add to the risk of a medically serious attempt (Robbins & Alessi, 1985).
Whose Responsibility is it?

Regular or Special Education?

Schools are not currently required to provide specialized educational services to students who abuse drugs. Pressure from parents and the federal government may necessitate addressing the issue beyond that of a disciplinary action. Substance abuse, perceived in terms of the medical model (as an illness), may require substance-abusing adolescents to be placed in special education classes. Two federal laws: Section 504 of the Rehabilitation Act of 1973, essentially a civil rights act, and P.L. 94-142, The Education for All Handicapped Children Act of 1975 (EHA), which defines special education classifications, are not overlapping. A student may meet the definition in one and not the other. Section 504 defines a handicapped person as anyone with a mental or physical impairment that substantially impairs or restricts one or more major life activities. Alcoholism and drug addiction fit into this definition and are considered handicapping conditions under Section 504. The U.S. Office of Education states that under EHA, chemically dependent youths are not handicapped. Federal law, specifically Section 504, mandates that public schools have the responsibility to evaluate alcoholic or chemically dependent students and provide appropriate educational services (Williams, 1990). Williams (1990) reported the responses of state special education directors who
answered questionnaires regarding the status of chemical dependency as a handicapping condition. Thirty-six states responded. None of the states include chemical dependency as a distinct classification, eight states said it could be certified under existing classifications as emotionally disturbed, and only three states said that no services were available for chemically dependent students. Eighty-three percent of the schools have school-wide prevention programs and 25% paid for outpatient treatment services. Five states pay for inpatient treatment. Three of these list this service as part of a special education program. The major difference between the states is whether of not chemical dependency is a primary condition (a disease occurring before the onset of a psychiatric disorder) eligible for special education services of a symptom of an underlying emotional, psychiatric, or moral problem. Only two states view chemical dependency as a disease, Louisiana and Texas (See Appendix A). The Wisconsin Department of Public Instruction (Fredlund, 1990) states in the SAP Operational Components that an AODA specific problem does not provide reason to suspect and refer a child for exceptional education needs under the EHA or Chapter 115 of the Wisconsin Statutes unless characteristics of a handicapping condition also exist, but that it may be reason under Section 504 of the Rehabilitation Act of 1973. They also state that drug addiction and alcoholism are included if a person’s impairment substantially limits one
or more major life activities, including learning. Schools are not expressly authorized to provide AODA assessment, referral or treatment services, only to cooperate in the dissemination of information about available services and the development of procedures for referral to appropriate agencies (Contrucci, 1991).

The Office of Civil Rights in the U.S. Department of Education recently ruled that the Lake Washington School District violated the law when it failed to evaluate students with alcohol and/or drug addictions to determine their individual education needs. They stated that a school district is required to provide an appropriate education to each qualified handicapped person in its jurisdiction regardless of the nature or severity of the person's handicap (Shannon, 1986). The regulation fails to make clear what "appropriate" means. According to Paul Spoor (1988) this ruling suggests the school is responsible for referring addicted students for assessment, placing them in specialized classes or programs, and developing individualized education programs for them. Schools are not required to provide medical treatment, but based on this ruling, schools could be required to pay for medical and psychological evaluations for addicted students, and if the results are positive, to provide appropriate educational programs.

The perceived conceptual model of substance abuse (chemical dependence) is very important in terms of assessment, treatment
(services provided), and prevention. The traditional model viewed substance abuse as an immorality or sin and, as during Prohibition, it could be legislated away. The legal model is a modern version of the moral model. It is a crime to use illicit drugs. The medical model views substance abuse as a chronic illness in which the user/abuser must be treated. This model implies that the user is not responsible and is totally helpless. All three of these models view substance abusers as dysfunctional members of society, as the locus of the problem (either immoral, criminal, or sick), and remove them from society for treatment (Spero et al, 1989). The social learning model examines the social and environmental factors that influence the individual. This model views substance abuse as a learned series of reinforced behavior. In order to treat the individual these maladaptive behaviors must be replaced with appropriate behaviors. Society must also examine and change its response, attitudes and media presentation of substance abuse. This perceptual model implies that schools cannot solve this problem alone. All members of the community, mass media, and government must work together to solve the problem.

Drug Prevention Program

What has been tried?

Schools have not created the drug problem, but they do see the dramatic consequences everyday. A school's primary responsibility is to
create an environment in which learning can best take place. Schools provide an important site for substance abuse prevention. They provide adolescents with a social environment and are staffed by personnel with requisite skills to implement the program. Based on the conceptual models of the causes of substance abuse, there are three basic programs currently in use. These are (a) informational/education programs, (b) social resistance interventions, and (c) personal and social coping skills training programs.

Information/Education Programs

The information/education programs are based on the assumption that knowledge of the health effects of substance abuse will deter use and prevent abuse. This type of program has not been effective with adolescents and some researchers have found that it may actually increase substance use (Chatlos, 1989; Forman & Linney, 1988; Newcomb & Bentler, 1989; & Shedler & Block, 1990). Their failure may be explained by the exclusion of all environmental factors (Newcomb & Bentler, 1989). Despite its lack of efficacy, education is the most widely used approach in substance abuse prevention.

Peer Resistance Programs

Peer pressure has been cited as a significant cause of substance use. The second model focuses on teaching adolescents the necessary social skills to resist peer pressure and more effectively handle social
situations in which substances may be a problem. Peer programs had the strongest effect on the average teenager. By enhancing social skills and assertiveness, drug use was reduced or initiation of drug use was prevented. The problem is that abuse of drugs occurs for different reasons, thus peer programs have less impact on abuse of drugs (Newcomb & Bentler, 1989). Resistance interventions have been most commonly implemented with middle school aged students (Forman & Linney, 1988). It would be misleading to bask in the success of some peer programs who has reduced the number of youngsters who experiment with drugs and ignore the tougher problems of those youngsters who are at risk for drug abuse as well as other serious problems (Newcomb & Bentler, 1989).

**Personal and Social Coping Skill**

A third model addresses a broad spectrum training in personal and social coping skills, utilizing didactic instructional methods, group discussion, and role play. This method recognizes multiple reasons for substance use and includes skill training and practice sessions. The strongest effects have been found when the intervention is implemented at the middle school by high school student leaders. Booster sessions are used to enhance maintenance.

Schinke and Gilchrist (1985) reported that health education programs did affect children's knowledge and attitudes about drugs, but
had little impact on substance use. They divide intervention/prevention programs into three categories: agent interventions (focus on abused substances), environmental interventions (focus on settings where use originates), and host interventions (focus on the user). Agent interventions include licensing, minimum-age laws, and penalties for noncompliance. These efforts are affected by the tobacco and alcohol industries that generate a large government tax revenue. Environmental interventions include schools (peer resistance programs), home (television messages), and the community (alternative recreation programs). Host interventions help build cognitive and behavioral abilities to avoid substance use. They report effective techniques have been developed in each of the three interventions and together they form a framework for a comprehensive substance use prevention approach.

*Just Say No*

Current policy seems to follow the assumption that peer influence leads to experimentation which in turn leads to abuse. The "just say no" concept is aimed at discouraging experimentation, which was reported in and of itself does not seem to be personally or societally destructive. As long as problem drug use is construed primarily in terms of lack of education, the real issues the psychological triad of alienation, impulsivity, and distress go unaddressed. The "just say no" approach is oblivious to the serious problem of psychological causes. Efforts should be aimed at
encouraging sensitive and empathic parenting, at building childhood self-esteem, at fostering sound interpersonal relationships, and at promoting involvement and commitment to meaningful goals (Forman & Linney, 1988). These programs may not be as popular and easy to sell to the general population, but may have a greater individual and societal payoff.

Drug Prevention Program Components

A drug prevention effort must bring together several elements: a strong, effective policy, a comprehensive drug education curriculum, a student assistance program, and the community. Kumpher (1987) stated that in junior high and high school, peer counseling and student assistance programs could offer help, support, and referrals for high-risk children of substance abusers.

A wide variety of issues need to be considered when planning implementation of prevention programs in the school setting. One major issue is approval and commitment from the administration and/or school board. A well-developed presentation detailing specific program components, costs, needs assessment, benefits, consequences of opposition, and promotion will help. Administrative approval is necessary to obtain program materials, release time for training, substitute teachers, student schedule adjustments, allocation of space, and positive sanctions for building staff participation. Another major issue is opposition from
parents and staff members. Parents want to end substance abuse in their community, but may be concerned that their own substance use behavior will come under scrutiny (Foreman & Linney, 1988). Many teachers see any new program as negative and fear the increased paper work. Their opposition may also be fear of their own use behavior.

**Policy**

The National Commission of Drug-Free Schools describe a policy as the foundation for a disciplined, safe school environment. The best policies are clear, direct, firmly and consistently applied, and perceived as fair and appropriate by students and staff. It is the mission of the school to teach the dangers of drug use, but also to instill in students a sense of responsibility for their actions and a respect for the laws of society. The elements of a comprehensive policy should include the school's philosophy, descriptions of drug offenses, definitions of related terms, the rules and regulations, responses to violations, procedures to communicate the policy, steps in implementation and enforcement, and an evaluation procedure (See Appendix B.).

Dogologg (1990) formulated several steps to take in developing a drug policy: (1) assess local needs including school attendance, test scores, and student and faculty satisfaction with school life, (2) train members of the staff to understand chemical dependency in order to identify suspected users and encourage prevention, (3) determine
direction of policy, including consequences of such behavior, (4) review all present policies in light of present goals, (5) assess staff requirements, (6) add specifics to policy and implement, and (7) evaluate and update the policy regularly.

Schwartz (1984) suggested that school systems individualize their disciplinary responses to drug use. Schools continue to take a punitive approach to disciplining youth involved with drugs... Schwartz contends that schools should review their drug policies and consider the following actions: (a) alternative discipline programs, (b) viewing alcohol as dangerous, (c) individualizing sanctions, (d) recognizing voluntary admission of drug use as constructive, and (e) understand the legal rights of students and the limitations of the school.

Curriculum

A drug education prevention curriculum should include all grade levels K-12. The course can be part of a comprehensive health curriculum, a separate course, or be infused in other subject areas. The curriculum should include information about drugs, attitudes for change, the legal and health consequences of use, resistance training and skills, and values clarification. Community resources such as the police department, treatment centers and service agencies should be used as resources in the program. See Appendix C for elements of the Drug-Free Schools curriculum by grade levels.
Mainstreamed special education students present unique challenges. Many special education students do not go to some classes (health, science, math) where essential elements of an integrated prevention curriculum may be taught. Gaps may exist in their prevention education knowledge. Considering their vulnerability to exploitation, need for acceptance, and lack of understanding regarding risk factors, it is incumbent upon school authorities to teach them prevention strategies. The delivery of the curriculum may take special arrangements, a more direct approach, adapted reading materials, and even sign language. Their individual education plan could be drawn up to include monitoring to ensure their full share of appropriate prevention education.

**Student Assistance Program**

The Student Assistance Program (SAP) is based in the employee assistance program used in industry. The SAP offers assistance to students who are dealing with a personal alcohol/drug problem or are living in an alcoholic home and are being negatively affected by the situation. The SAP has six basic functions: early identification, assessment, referral, intervention, support, and case management (Milgram, 1989). Many schools do not have the qualified staff to include assessment or treatment. In the Wisconsin Model assessment, therapy and treatment take place outside the school setting. This procedure is written into the school policy and is usually conducted at the expense of
the parents. Thus it is important to establish a working relationship with community resources. Many schools hire an SAP Coordinator to implement the program. Teachers and nonmedical staff are advised and trained to identify students who are experiencing problems that interfere with their functioning at school. Appendix D details the procedures of the SAP in the Wisconsin Model which includes promotion of the program, referral, referral consequences, services, and follow-up procedures.

Support groups are the heart of any SAP. Students find them safe places to discuss problems and express feelings. The major goal of the group is education, focusing on enhancing personal growth, increasing self-esteem, and developing interpersonal relationships. They are beneficial to a wide variety of students. The Wisconsin Model recognized the broad range of student support groups, not just those related to AODA problems. Groups are led by facilitators trained in AODA issues and group facilitation skills. Groups usually contain from 8 to 12 students and meet for 10-12 weeks each semester during the school day.

Each SAP designs their own support groups based on available resources and individual needs, but the general descriptions that follow are typical. The Nonuse Group is for students who have chosen to remain drug free. Their goal is to promote nonuse, have fun, and serve as positive role models. The Concerned Persons Group is for students who are concerned about and affected by someone else's alcohol and
other drug use. The goal of this group is to provide support, teach coping skills, and to encourage the participant to share feelings and concerns. The well-being of the student is the main concern. The Awareness Group is for students who need AODA information to assist them in making responsibility choices regarding their drug use. The Use/Abuse Group is for students whose own alcohol and other drug use has caused some problems. The goal is to encourage participants to make healthier lifestyle choices. The Recovery Group is for students who have participated in some form of treatment. Their goal is to remain drug free by making new friends, increasing their physical activity, and becoming aware of their personal relapse symptoms.

The referral component is the process by which the person is placed in the system for a needs assessment. The referral may come from a classroom teacher, counselor, support staff, family member, friend, community member, or from the student. There are two basic reasons for referral. The first is the overt violation or emergency health and safety of the student. The second reason is for behaviors of concern that usually represent a teacher's "gut level" feelings (See Appendix E.). After the referral, the information gathering begins including grades, attendance records, and additional teacher contacts. A screening interview (See Appendix F.) is conducted to meet the student and gather information, not to diagnose an AODA problem. After these
components have been completed, a decision must be made regarding a need for services. Recommendations may be made for no services, in-school services (support groups), or outside services (treatment centers).

The two final components of the prevention program include the parents and the community. Programs for parents include using them as the means of enhancing generalization of skills taught in school and the other provides family management skill training. Trained parents are used to train other parents. They form a network to maintain positive communication between parent and child and other parents. Hopefully, they become an active force in providing drug-free activities and positive role models.

The goal of an SAP is for students to care about themselves, take care of themselves in positive ways and develop a reliable support system. Schools without Drugs (1989) detailed a list of things that students, parents, communities and schools can do to build drug-free schools (See Appendix G.). Positive, healthy adults working with students can do much to encourage students in positive lifestyles (Contrucci & Holloway, 1991). Community members and business people must be included in the planning and advisory levels of the prevention program. If students are provided with alternative activities and experiences they will have less time to spend "hanging around" local places of business causing disruption to customers.
The real question for the future is where should the finite amount of energy and money be directed: toward general use of drugs or toward the abuse of drugs?
Chapter III
Summary

National surveys indicate that although illicit drug use appears to be down among adolescents, alcohol continues to be widely used. Alcohol and cigarettes are still the most dangerous drugs, because they are readily available and considered "safe" by most people. Ninety-one percent of high school seniors have tried alcohol. In Wisconsin the problem is even greater. The percentage of adolescents who drink is 25% higher than the national average. Twenty percent of the children go to school from homes with at least one alcoholic parent. In the handicapped population, substance use/abuse is three times greater than among comprehensive high school students.

Adolescence is the life stage in which a person makes the transition from child to adult. Child labor and compulsory education laws made adolescence a social reality. During adolescence young people seek to form an identity separate from their parents, while developing physically and psychologically. The consequences of substance use/abuse during adolescence are numerous. Substance abuse causes physical damage, psychological delays, emotional dysfunction, and uninhibited behavior. The inadequate socioemotional growth often results in problems with adult roles and responsibilities.
There are many diverse and interrelated pathways to substance abuse. Family life is a major factor. Drug use by a parent or older sibling influences the child's initial use. Family system dynamics including conflict resolution, reciprocal relationships, social bonds, the presence of parents in the home, divorce for boys, remarriage for girls, parental rejection, parenting practices, parent monitoring, lack of positive role models, and inconsistent values have a significant affect on the substance use/abuse of adolescents.

Most use of drugs occurs as a result of a social influence, whereas most abuse is tied to psychological processes. When linked to a cluster of peers, adolescents essentially use the same drugs and to the same extent when they are together. The peer cluster can act to inoculate the adolescent or set the stage for use. Stronger peer bonds (compared to parental bonds) seem to enhance use of drugs.

An individual's personality structure, psychological development, and family history influence alcohol use/abuse. In a comparison of abstainers, experimenters, and regular users, experimenters were psychologically the healthiest. Abstainers were described as anxious, inhibited, morose, alienated from peers, not responsive to humor, not curious, and immobilized under stress. Frequent users were socially immature, vengeful, explosive, stubborn, with negative self feelings. They are insecure and are unable to invest in, or derive pleasure from,
meaningful personal relationships. The abstainers and the frequent users lack effective parenting.

Parental history (including any genetic predisposition), family dynamics, peer influences, and personality factors have a profound effect on adolescent substance use/abuse. A dual-diagnosed adolescent has heightened risk factors for substance abuse. Handicapped adolescents experience difficulties with self-image, school performance, that can result in a high vulnerability to peer pressure. The dual-diagnosed adolescent faces a more severe course of illness and a depressing prognosis. There is increasing evidence that personality problems and deviant behavior precede excessive drug use.

Several handicapping conditions were reviewed for this paper. Attention deficit disorder with hyperactivity, usually treated with stimulants, does not predispose a child to future abuse of drugs. Children with hyperactivity and a special education placement had an average of 12% drug use, while those without a special education placement has a 1% drug use rate. Hyperactivity, alone, did not prove to be an indicator of later substance abuse, but hyperactivity with early aggression did predict later drug abuse.

Depression, anxiety disorders, and mood disorders also increase the risk of substance abuse. Girls, especially those in junior high, exhibit more severe depressive symptomatology. Girls tend to internalize their
depression, whereas boys tend to externalize their depression, with acts of aggression (fighting and pushing). As many as 49% of those students enrolled in special education and learning disabled classes are severely depressed. Schizophrenia may occur more often after the withdrawal from drugs and alcohol, and in that case is attributed to an organic cause.

Maternal consumption of alcohol and drugs during pregnancy have been linked to central nervous system impairment, delayed fine motor control, hyperactivity, and poor attention spans in children exposed to alcohol and drugs in utero.

Who is responsible for educating handicapped students with substance abuse problems? Is substance abuse a handicapping condition? Section 504 of the Rehabilitation Act of 1973 says yes and the EHA, P.l. 94-142 says no. The Wisconsin Department of Public Instruction says that if one or more life activities, such as learning, is affected by the use/abuse, then appropriate educational services need to be provided. States disagree on who should currently pay for this identification, assessment, and treatment. Only two states view chemical dependency as a disease. Based on the medical model of substance abuse (as an illness), special education programs may be forced to provide services to substance abusers.
The perceived conceptual model of substance abuse is very important in terms of assessment, treatment, and prevention. The medical model views substance abuse as a chronic illness requiring treatment. The emerging model is the social learning theory that views substance abuse as a learned series of reinforced behavior that is influenced by social and environmental factors.

Drug prevention efforts have focused on educating adolescents about the adverse affects of drug use/abuse hoping to deter use and prevent abuse. This type of program has not been effective with adolescents. The "just say no" campaign is oblivious to the serious problems of psychological, environmental, constitutional factors involved in substance abuse. Social resistance programs focused on teaching peer refusal skills and assertiveness in social situations where drugs are present. Personal and social skill training has also been tried. This model recognizes multiple reasons for substance abuse. It has been most effective in middle schools when presented by high school students using multiple sessions.

Successful drug prevention programs contain the following components. A strong, effective policy which clearly defines the school's philosophy and rules regarding substance abuse. A comprehensive K-12 curriculum integrated in several aspects of education, including special education classes with appropriate materials. The program should
include community resources and parental support and involvement. The incorporation of an SAP is also encouraged. The SAP identifies, screens, and makes referrals to appropriate agencies outside of school or to support groups in school. The support groups consist of students who share common concerns meeting on a regular basis to develop coping skills and support systems of caring individuals.

Conclusions

Unfortunately, tightening budgets and renewed interest in basic curricula may delay widespread launching of substance abuse prevention programs. Mandates from the federal and state governments regarding what should or should not be taught in schools, are placing stress on the taxpayers. Historically, schools have been asked to solve the social injustices of the nation. Rather than pass laws to regulate fair housing, we transported children miles from home for many hours a day at huge expense to the taxpayers. And now rather than provide adequate employment, education, and opportunity for all citizens, we treat a symptom and ignore the cause. People with little hope of a better future, trained to accept welfare assistance, and basically deserted by their government, cannot be faulted for turning to substances to ease their pain.

Based on the reading for this paper, it is clear that substance abuse is a multi-symptomatic problem that encompasses economic
turmoil, parental neglect, abuse, poor role models, mixed mass-media messages, and a need for adolescents to feel adult and independent. It is a problem with multiple perspectives that no single solution can change. It is not a black/white, rich/poor, or male/female issue, but one of nurturing parents (from birth) who act as sensitive role models and provide consistent, just rules and monitoring at the most impressionable time of life, adolescence. The question is, how do we resolve that issue in school?

Youthful experimentation coupled with the popularity of licit and illicit drugs, predict little natural abatement of substance abuse (Schinke & Gilchrist, 1985). Donovan and Jessor (1985) believe that prevention programs should broaden their focus beyond individual problem behaviors and focus on the larger syndrome. Prevention of use may be appropriate for the developmental stage of preadolescence, hoping to prolong the initiation of use. Prevention and intervention must focus on the misuse, abuse and heavy use of drugs. It is also important to determine the amount of use/abuse an individual is engaging in when they are screened. Substance abuse progresses in a predictable order. Caton et al. (1989) stated there is a relationship between upbringing, family constellations, and family problems. Environments filled with conflict and parental abuse are particularly traumatic and are more likely to be linked to drug abuse (Miksic, 1987). Newcomb and Bentler (1989)
state that for students at high-risk for substance abuse, alternative programs including alternative activities, building confidence and social competence, and providing broadening experiences was the most effective. This would seem to indicate that in their case, constitutional or environmental factors (prior to any peer influence) were the cause of their substance abuse. Svobodny (1982) states that adolescents need successful experiences and warm accepting relationships with one or more adults to move to adulthood uneventfully. Based on this theory there needs to be more information and research regarding the self-medication theory of substance abuse (Caton et al, 1989; Swain et al, 1989). More research is needed on successful methods to integrate schools, families, and media approaches to prevention programs. Support groups can help students cope, but when nothing changes at home, how long will this coping strategy be effective?

Kauffman (1989) states that not all substance abuse is preventable and we should, therefore, focus on substances that cause the most damage and consequences for the greatest number, alcohol and tobacco. The important prevention issue is to focus on decreasing the number of adolescents who make the transition from experimentation to regular use and often to abuse (Goldstein & Engwall, 1989; Newcomb & Bentler, 1989).
Recommendations

Specific Treatment

Based on the research that indicated the correlation between family problems and becoming a regular user, it is imperative to conduct prevention programs that involve families and are consistent with their cultural traditions. Siegel and Erhlich (1989) report that treatment procedures may need to be as different as the socioeconomic status (SES), ethnic background, and reasons for using. Their research did not support the self-medication theory of substance abuse. They contend that high SES leads to more unconscious motivation (psychological orientations) and low SES to a behavioral orientation. Both levels of SES had family members who used drugs, had poor communication with family members, and had a readily available source of drugs. Intervention programs must encourage males to find ways to experience closeness and autonomy from family and peers without the use of alcohol and a family component is an essential treatment component for females. When parents enter treatment centers, their children should also be targeted for counseling services or therapy. More studies need to be conducted on the healthy children of substance abusers (from dysfunctional families) to determine what kept them healthy. Numerous studies are conducted on the unhealthy children, the reverse is also necessary.
At-Risk Children

Children are at an increased risk for substance abuse if their parents abuse substances, favor use (not likely to limit exposure), and physically or sexually abused them. Research indicated that as early as kindergarten, antisocial behavior (aggression) preceded drug use and was predictive of substance use/abuse in later years (Hawkins, Lishner, Jenson, & Catalano, 1987; Kumpfer, 1987). Assuming at least one half of these students will become drug abusers, it is imperative to target severe conduct disordered students with substance abusing parents as early as possible (Kumpfer, 1987). Thorough assessments should be conducted on all students entering the school system as Kindergarten students or as transfers. A "child find" program for students at risk for substance abuse may help break the vicious cycle of addiction.

The research indicated that the period of greatest concern for adolescents is that time around puberty, when peer influence seems stronger than family influence. Those students who mature early are also at greater risk for substance abuse and need to be targeted early.

Teacher Preparation Programs

Educators, counselors, and social workers deal with and listen to children in pain everyday. Parents and professionals not adequately trained in the dynamics of dependence and codependency usually assume they are to blame for the nervousness and irritability of the
students. Districts are now spending thousands of dollars to provide basic AODA information to their faculty and staff members. The burden of training teachers and other administrators falls exclusively on the school districts. Few states require training in drug prevention for certification of teachers and other professionals who work with youth. Most colleges do not include drug education in their education curricula. Drug prevention training should be incorporated in required or elective teacher certification courses, such as classroom management and/or courses that teach how to work with high-risk students. Based on the implications of the readings, teachers need to be knowledgeable in sexual and substance abuse prevention and intervention.

Prevention Programs

Prevention programs should provide appropriate consequences for both abstinence and substance abuse as an important feature of management. We provide consequences for abusers, what do we do for the abstainers? Based on the reading for this paper, it is clear that abstainers may have as many personality problems as abusers. They need to have positive experiences, alternative activities, and possibly more physical exercise in social situations. The goal of any program must be to build personal and social coping skills that will provide positive side effects on all non-substance use behavior. Prevention programs need to involve the parents and community members. Parents
of students disciplined for substance abuse violations should also be required to attend counseling, parent training workshops, and accept responsibility for their actions or inactions. Parents might have to fulfill contingency contracts to keep their children in school. Participation in alternative activities, training workshops, and school volunteer programs are possible components of the contract. If the social learning theory model of substance abuse is viable, these children learned this behavior from their parents, siblings, or media messages. Therefore, these people are as responsible as the children themselves.

**Special Education**

Special education programs need to shift their focus from cognitive dominated programs to more preparation in personality and behavioral areas (Bender, 1987), especially in high school. Teachers of special education students must be aware of any prescribed medication dosages and their side effects. Teachers and school personnel can be the first defense against abuse and need to know the signs, usually moodiness associated with a change in grades, school performance, and a loss of interest in usual friends and activities. They must also become active participants in drug prevention programs, taking into account the ability of the individual to process and utilize relevant information. The curriculum's cognitive demands should be examined, avoiding any unnecessary complex language and illustrations. The resource room
may be the primary location for alcohol prevention/education instruction geared to special education students. The psychological assessment of a dual-diagnosed student is critical to successful treatment. Most school based approaches have been inadequate to alter basic personality characteristics. Programs that address modifiable predictors of drug use are superior to information-only programs... (Hansen, 1988). Extended therapy outside of the building (as well as in the building) may be a necessary part of the detoxification process.

**An Effective Program**

An effective prevention program needs to offer a range of techniques and services to help those at different levels of involvement with drugs. A professional psychological and medical assessment for the individual student is imperative to the success of any intervention program. Prevention/intervention programs have to target those students at risk (isn't everyone) as early as possible and begin treating the entire family. Prevention efforts should focus not only on discouraging initial use, but more importantly at stopping the transition from experimental to regular use.

**Final Note**

It often seems that the United States experiences social and cultural changes before other parts of the world (the woman's liberation movement, student unrest, jeans, etc.). If this is true, there is hope in the
implication that we will also be the first to come up with the correct method of treating and resolving the substance abuse problem. That theory seems to be the only conclusion the author can derive from the reported depressing statistics, trends, and cyclical spiraling network of related substance abuse problems.
Appendixes

A Special Education Services: State Comparisons
B Elements of a Comprehensive Antidrug Policy
C Drug Free Curriculum by Grade Level
D Wisconsin SAP Model
E SAP Referral Form
F Screening Device
G A Plan for Achieving Schools Without Drugs
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36 States Reproduced by Regular Ed. Reproduced by Special Ed

From: Adolescent Chemical Dependency as a Handicapping Condition: An Analysis of State Regulations pp. 76-77
Elements of a Comprehensive AntiDrug Policy for Schools

All drug prevention policies should state that the possession, use, promotion, distribution, or sale of all drugs, including alcohol and tobacco will not be tolerated. Policies should apply to students, school staff, and anyone attending school functions. Responses to policy violations by students and staff should reflect a range of appropriate punitive and rehabilitative measures, and every violation, regardless of how minor, should receive a response. Policies should specify at least the following items:

- The philosophy of the school board and the schools' goals for drug education and prevention.
- A definition of what constitutes a drug offense.
- A description of key terms, specification of times and places that policies apply, and the responsibilities of people who implement the policy.

- Rules and regulations:
  - strict no-use of drugs;
  - sanctions reflecting the seriousness of the violation, with lesser or more serious offenses subject to increasingly harsher measures;
  - documentation of all drug violations to be used in due process procedures and in drug suspension; required reporting of all violations of law to police;
  - procedures and conditions for locker searches;
  - procedures and conditions for drug testing; (see page 71)
  - due process guidelines on reasonable suspicion of drug use, search and seizure, confidentiality, and procedures for suspension and expulsion;
  - guidelines for notifying parents; and
  - guidelines for drug intervention and referral for treatment, including at the elementary level.

- Responses to violations:
  - mandatory participation of a parent in deliberations over student violations (elementary and secondary levels);
  - referral to counseling and/or treatment;
  - mandatory participation in drug education and prevention classes;
  - participation in Alcoholics Anonymous, Narcotics Anonymous, or other support groups;
  - community service;
  - before- or after-school detention;
  - in-school or out-of-school suspension;
  - placement in an alternative education program;
  - expulsion of students; and
  - termination of school employees.

- Procedures for communicating policy to students, staff, and parents.
- Steps to implement and enforce policy.
- Steps to evaluate success in meeting goals and to update policy.

From: National Commission on Drug-Free Schools-Final Report p. 9
Part II
Kindergarten Through Grade 3

GENERAL OBJECTIVES:

- To know the difference between medicines and illegal drugs;
- To know from whom it is appropriate to take medicines;
- To know that children face problems and it is acceptable to seek help for these problems;
- To know that most people do not use illegal drugs.

LESSON PLANS:

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<th>Objective</th>
<th>Curriculum Area</th>
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<td>1. To identify good things about oneself</td>
<td>1. Art/Music</td>
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<td>2. To distinguish between medicines and illegal drugs</td>
<td>2. Science</td>
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<td>3. To develop the social skill of helping others</td>
<td>3. Health/Phys Ed.</td>
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<tr>
<td>4. To learn about friendship</td>
<td>4. Social Studies</td>
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<tr>
<td>5. To identify feelings and know how they affect behaviors</td>
<td>5. Language Arts</td>
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<tr>
<td>6. To identify individuals from whom it is safe to take medicines</td>
<td>6. Science</td>
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<td>7. To assume responsibility for personal care</td>
<td>7. Language Arts</td>
</tr>
<tr>
<td>8. To know people have problems and it is OK to ask for help</td>
<td>8. Health/Phys Ed.</td>
</tr>
</tbody>
</table>

From: Learning to Live Drug Free
Part III
Grades 4–6

GENERAL OBJECTIVES:

- To know the names of illegal substances;
- To have information about illegal drugs and their effects;
- To have peer refusal skills;
- To understand friendship;
- To understand the importance of helping others;
- To learn to deal effectively with peers and the pressures they exert;
- To develop a future orientation especially regarding friendship and continuing education;
- To develop coping strategies for dealing with rejection, frustration, disappointment, and failure.

LESSON PLANS:

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</thead>
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<td>1. To learn to say no to peers</td>
<td>1. Language Arts</td>
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<td>2. To learn the names of drugs and how they are sold</td>
<td>2. Science</td>
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<tr>
<td>3. To understand how we influence laws and how laws protect us</td>
<td>3. Social Studies</td>
</tr>
<tr>
<td>4. To know how to assess the credibility of sources of information and requests</td>
<td>4. Language Arts</td>
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<td>5. To understand the cost of drug use to the society</td>
<td>5. Mathematics</td>
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<tr>
<td>6. To know how to retain individuality and still belong to a group of peers</td>
<td>6. Social Studies</td>
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<td>7. To understand the importance of helping others</td>
<td>7. Language Arts</td>
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<td>8. To use scientific reasoning for arriving at a decision</td>
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<td>9. To critically assess movies, television, and music as sources of information</td>
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<tr>
<td>10. To understand short- and long-term consequences in making decisions</td>
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<td>11. To know the elements of healthy friendships</td>
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<tr>
<td>12. To develop strategies and skills for coping with stress</td>
<td>12. Health/Phys Ed.</td>
</tr>
</tbody>
</table>
Part IV
Grades 7–8

OBJECTIVES:

• To know how drugs affect the body and its systems;
• To know the consequences of illegal drug use;
• To enhance peer refusal skills;
• To understand the relationship of decisions made now and future outcomes;
• To develop a positive sense of personal identity;
• To understand the importance of continuing one's education;
• To know sources of help for problems.

LESSON PLANS:

Objectives                                      Curriculum Area
1. To recognize the importance of family and family ties  1. Social Studies
2. To identify and assess messages in media, such as music, artifacts
   videos, movies, television, and advertisements
3. To know the effects of drug use on crime and the economy
4. To learn how to establish goals for the future
5. To assess the credibility of persons as the source of information
6. To know the effects of drugs on the human body
7. To know the importance of physical activity in a healthy life
8. To identify ways to cope with peer pressure to use drugs
9. To encourage youth to help other people
10. To understand how decisions made now can have long-term implications
11. To learn how to use the scientific method in making decisions
12. To learn the policies and laws regarding drug use

1. Social Studies
2. Art/Music
3. Mathematics
4. Social Studies
5. Art/Music
6. Science
7. Health/Phys Ed.
8. Language Arts
9. Social Studies
10. Language Arts
11. Science
12. Social Studies
OBJECTIVES:

• To know the dangers of drug use;
• To know the impact of drug use on future education, jobs, health, and offspring;
• To have peer refusal skills and know why they are saying "No";
• To critically assess persons who influence them and are models for them;
• To understand their own moral, ethical systems;
• To understand the importance of their own responsible behavior to the larger society;
• To develop healthy coping strategies;
• To develop a positive sense of self-worthiness.

LESSON PLANS:

Objectives
1. To understand the legal consequences of illegal drug use
2. To know how certain illegal drugs affect the human body
3. To understand that growing up takes time
4. To understand the harmful effects of alcohol and other drugs on unborn children
5. To understand myths and stereotypes which seem to encourage drug use
6. To identify ways to cope with peer and social pressures to use drugs
7. To know how steroid use affects the body physically and mentally
8. To understand how drug use affects personal financial resources

Curriculum Area
1. Social Studies
2. Science
3. Language Arts
4. Health/Phys Ed.
5. Language Arts
6. Art/Music
7. Health/Phys Ed.
8. Mathematics
Appendix D

Student Assistance Program

Promotion
- Student Body Awareness
- Student Staff Awareness

Referral
- Self-Referral
- School Referral
- Peers
- School Staff

Initial Action/Consequences
- Screening Process
- Administrative Action
- School Discipline

Services
- Monitoring
- Other School Services
- Individual and Group AODA-Related Services

Follow-Up
- Monitoring
- Ongoing Support
- Re-Referral

From: Alcohol and other Drug Abuse Programs p. 32
Appendix E

Student Assistance Program Referral Form

This form is to be used by the teacher or other school staff member wishing to refer a student, in confidence, to the Student Assistance Program. The signs and symptoms listed here are merely indicators, and the list is not all-inclusive. Furthermore, most apply to students who use alcohol and other drugs; not many apply to those who might become involved in an SAP because of a family member's use or abuse of alcohol or other drugs. Schools are urged to tailor such lists to their own particular needs.

Instructions for Referral

Complete this student referral form and give it to your Student Assistance Program contact person, or place it in his/her mailbox in an envelope marked "confidential." Referrals should be based on behavior you have actually observed. Check those signs below that apply.

Behavior Assessment

Student ___________________________ Grade _____ Date __________

Referred by __________________________

Class Performance

___ Drop in grades
___ Change in class participation
___ Inconsistent daily work
___ Inconsistent test grades
___ Failure to complete homework

School Attendance

___ Change in classroom attendance
___ Pattern of early morning tardiness
___ In-school nonattendance
___ Classroom tardiness
___ Frequenting nurse's office
___ Frequenting counselor's office
___ Truancy

Extraschool Activities

___ Loss of eligibility in sports
___ Increasing noninvolvement in any activity
___ Dropping out
___ Not fulfilling responsibilities

Physical Symptoms

___ Staggering or stumbling
___ Smelling of alcohol or marijuana
___ Vomiting
___ Glassy, bloodshot eyes; dark glasses
___ Poor coordination
___ Slurred speech
___ Changes in appearance, weight
___ Sleeping in class

From: Alcohol and other Drug Abuse Programs pp. 68-70
<table>
<thead>
<tr>
<th>Physical injuries</th>
<th>Behavior—Criminal/Illlegal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Frequent physical complaints</td>
<td>Selling drugs; exchanges of money</td>
</tr>
<tr>
<td>Frequent bruises, bandages</td>
<td>Possession of alcohol or other drugs</td>
</tr>
<tr>
<td></td>
<td>Involvement in thefts and assaults</td>
</tr>
<tr>
<td>Social Problems</td>
<td>Talking about involvement in illegal activities</td>
</tr>
<tr>
<td></td>
<td>Vandalism</td>
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<tr>
<td>Family problems</td>
<td>Use of alcohol and other drugs</td>
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<tr>
<td>Runaway</td>
<td>Behavior—Atypical</td>
</tr>
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<td>Job problems</td>
<td>Talking freely about drug use</td>
</tr>
<tr>
<td>Peer problems</td>
<td>Erratic behavior change as viewed on a day-to-day basis</td>
</tr>
<tr>
<td></td>
<td>Dramatic change of friends—usually negative</td>
</tr>
<tr>
<td>Difficulties with boyfriends and girlfriends</td>
<td>Member of other-age social group</td>
</tr>
<tr>
<td>Parental resistance or lack of follow-through</td>
<td>Hypersensitivity</td>
</tr>
<tr>
<td></td>
<td>Time disorientation</td>
</tr>
<tr>
<td></td>
<td>Inappropriate responses</td>
</tr>
<tr>
<td></td>
<td>Depression</td>
</tr>
<tr>
<td></td>
<td>Seeking adult advice without a specific problem</td>
</tr>
<tr>
<td></td>
<td>Defensive attitude</td>
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<tr>
<td></td>
<td>Withdrawn, secluded</td>
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<tr>
<td></td>
<td>Change in student/teacher rapport</td>
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<tr>
<td></td>
<td>Suicide attempt</td>
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<td></td>
<td>Accidental overdose of drugs</td>
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<tr>
<td></td>
<td>Unexplained attitude change</td>
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Additional Information

I have spoken to the student regarding my concern.

____ Yes ____ No

I feel this student should be seen for a screening.

____ Yes ____ No

I would be willing to be involved in the screening.

____ Yes ____ No

You may share information on this form with the student.

____ Yes ____ No

I would like feedback from the counselor.

____ Yes ____ No

Comments

Please use the front and, if necessary, the back of this sheet for comments, including descriptions of any specific incidents.
Sample Screening Device

This device may be used by teachers, administrators, or counselors for preliminary interview of adolescents with suspected problems relating to alcohol and other drugs.

The present contains suggested questions for gathering useful data and is meant to act as a guide—not as a format—for interviewing. Much of this information will be revealed if the interviewer asks students to list their problem areas or "biggest worries." From there, the following questions can be used to clarify.

General Questions

1. How do you feel about being here?
2. Do you have a job?
3. How do you get your spending money?
4. What do you want to be doing five years from now?
5. Where do you want to be five years from now?
6. In what way would you like to be different?
7. What would you like to have done differently in your life so far?
8. What do you like most about yourself?
9. What do you like least about yourself?
10. Do you have any serious health problems? Are you on any medication now?
11. Has anyone ever been upset or concerned with your alcohol or other drug use?
12. Are you concerned about the alcohol and other drug use of anyone in your family?
13. What have you been like to live with for the past six months? How do you feel about this?
14. What do you do for fun? What did you like to do two years ago?
15. What do you do that makes you feel good?
16. How do you get along with your peers? Have you changed peer groups in the past two years? (To provide a self-evaluation of peer relationships.)
17. Describe a person who has an alcohol or other drug abuse problem. What are they like?
18. Tell me about your friends. What kinds of things do you and your friends do? Are these the same friends you had two years ago?
19. When did you first use alcohol and other drugs? How old were you?
20. Have you ever smoked marijuana (or taken it in any other form)?
21. What over-the-counter drugs have you used, how much and for what reasons?
22. Have you ever used any drugs other than alcohol or marijuana?

From: Alcohol and other Drug Abuse Programs pp. 71-72
23. When and how often do you use new?
24. Has the amount and frequency of your use changed from the time you first started? What would you consider normal use for someone your age?
25. Are you using more alcohol or other drugs now than you were, say, six months ago?
26. What are your reasons for using alcohol or other drugs?
27. Do you ever skip classes? (Check background information and confront it if necessary.)
28. Have you ever attended classes after using alcohol or other drugs? How often?
29. After consuming alcohol or other drugs, do you ever have periods of time that you cannot remember later? (To establish possibility of blackouts.)
30. Have you ever encountered difficulties as a result of your use? (To expose harmful consequences of use.)
   a. Have you ever had trouble with the police? If so, did you use just prior to the incident?
   b. Do you feel that your personality or behavior has changed? Have you ever participated in acts of violence?
   c. Have you had any trouble at home because of your use?
   d. Have you ever thought of just giving up? Have you ever thought of hurting yourself? (To explore possibility of feelings of guilt or depression.)
31. Have you ever thought about taking your own life?
32. Have you ever felt bad about your drinking or other drug-related behavior?
33. Does your personality change when you are under the influence of alcohol or other drugs? How would you describe yourself when you are using alcohol or other drugs?
34. Have you had any accidents or dangerous incidents involving yourself or others while you were high?
35. Have you ever attempted to stop using? If so, how many times, for how long?
36. Have you ever talked to anyone about these problems?

**School Performance**

The interviewer should get as much background information as possible about changes over the years in the following areas of the student's life.

- Grades
- Attendance
- Extracurricular activities
- General behavior
- Status within the school
- Self-evaluation of school performance
A Plan for Achieving Schools Without Drugs

PARENTS:
1. Teach standards of right and wrong, and demonstrate these standards through personal example.
2. Help children to resist peer pressure to use alcohol and other drugs by supervising their activities, knowing who their friends are, and talking with them about their interests and problems.
3. Be knowledgeable about drugs and signs of drug use. When symptoms are observed, respond promptly.

SCHOOLS:
4. Determine the extent and character of alcohol and other drug use and monitor that use regularly.
5. Establish clear and specific rules regarding alcohol and other drug use that include strong corrective actions.
6. Enforce established policies against drug use fairly and consistently. Ensure adequate security measures to eliminate drugs from school premises and school functions.
7. Implement a comprehensive drug prevention curriculum for kindergarten through grade 12, teaching that drug use is wrong and harmful, and supporting and strengthening resistance to drugs.
8. Reach out to the community for support and assistance in making the school’s anti-drug policy and program work. Develop collaborative arrangements in which school personnel, parents, school boards, law enforcement officers, treatment organizations, and private groups can work together to provide necessary resources.

STUDENTS:
9. Learn about the effects of alcohol and other drug use, the reasons why drugs are harmful, and ways to resist pressures to try drugs.
10. Use an understanding of the danger posed by alcohol and other drugs to help other students avoid them. Encourage other students to resist drugs, persuade those using drugs to seek help, and report those selling drugs to parents and the school principal.

COMMUNITIES:
11. Help schools fight drugs by providing them with the expertise and financial resources of community groups and agencies.
12. Involve local law enforcement agencies in all aspects of drug prevention: assessment, enforcement, and education. The police and courts should have well-established relationships with the schools.

From: Schools Without Drugs p. vii
References


Maag, John W., & Behrens, John T. (1989b). Epidemiologic data on seriously emotionally disturbed and learning disabled adolescents:


Rugg, Cheryl, M.S.W., & Jaynes, Judith, PhD. (1983). The role of chemical abuse during adolescence. Focus on Alcohol and Drug Issues, 6(3), 16-17, 27.


