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ABSTRACT

This booklet discusses obstacles to effective drug education programs and suggests components that should be included in order to ensure effective programs. The first section presents six questions to ask of one's drug education program, noting that a poorly conceived program can do more harm than good. The second section focuses on convincing students to delay beginning use of alcohol. Ten warning signs of drug and alcohol use are presented in the third section. These signs range from a drop in grades to a display of obvious behavior associated with intoxication or drug use. The fourth section discusses confronting social attitudes toward alcohol use. This section describes myths associated with alcohol use and the distorted messages which children receive from beer commercials. The fifth section provides the following suggestions for designing effective drug education programs: (1) articulate goals of the program; (2) focus on the gateway drugs; (3) start early; (4) plan a comprehensive program; (5) provide teacher inservice; (6) mobilize positive peer pressure; (7) involve parent networking; and (8) build evaluation into the program. An annotated bibliography of references and resources is included. (ABL)

FASTBACK

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# Developing Effective Drug Education Programs

Lowell Horton





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EDUCATIONAL FOUNDATION

**LOWELL HORTON**

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# Developing Effective Drug Education Programs

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# Introduction

School-based drug education can be effective when it is well planned, comprehensive, solidly reinforced by community values, and evaluated regularly. Factors working against an effective drug program are shared myths about drugs, especially alcohol; mixed messages students receive from their parents, teachers, and other adults; negative adolescent peer pressure; seductive messages received from the media; and erroneous, even dangerous, messages contained in some drug education materials. This fastback will discuss these obstacles to effective drug education programs and suggest components that should be included in order to ensure effective programs.

# What Message Is Your Drug Education Program Sending?

A poorly conceived drug education program can do more harm than good. Without careful planning and thoughtful reflection, the program can actually send dangerous messages to children and youth. Teachers, administrators, and parents should look carefully at the messages conveyed in the school drug program to see if they are really the intended message. Let us look at some of the common approaches to drug education and see what messages they are sending, messages that may be unintended but are nevertheless dangerous, even deadly.

1. Does your program attempt to teach the *responsible* use of alcohol? This is a common approach found in many earlier drug programs. This approach may have been acceptable at one time but is no longer, given what we now know about alcohol use among children and teenagers.

It is patent nonsense to suggest teaching the responsible use of an illegal substance. After all, drinking alcoholic beverages is illegal for adolescents in all states. If one accepts this approach, it would make just as much sense to teach the responsible use of cocaine or heroin. But alcohol holds a special status in our society; it is so commonplace in our homes and so widely advertised in the media that adults fail to accept it as an illegal substance for young users.

Adolescents have neither the physical maturity and judgment nor the social support structures to use alcohol (or any other drug) responsibly. To suggest otherwise is to put our youth at risk. Examine your

drug education materials and make certain that this tired old saw has been put to rest. Make certain that teachers, counselors, and other staff members involved in the drug education program understand that advocating the responsible use of any illegal drug, especially alcohol, by underage persons is not only nonsense but is illegal in most instances. Our goal must be a completely drug-free environment for all children and youth. No drug education program can be effective if this goal is compromised.

2. Does your program assume that experimenting with drugs, especially alcohol, is normal and to be expected of students? If you communicate that expectation, you can be sure that students will live up to it. It is neither necessary nor in any way desirable for children and youth to experiment with any drug. There is a direct correlation between experimenting and regular use. It should be obvious that if we can deter youth from experimenting, they are not likely to progress to occasional use and then to regular use. In fact, there is solid research to support delaying the use of alcohol until late adolescence or early adulthood. And let's not give any credence to the notion that the illicit use of alcohol, usually in the form of beer, is a rite of passage that young people need to go through as a normal part of growing up. This notion is as unfounded as it is dangerous. Drinking even one time can lead to tragic consequences, even death.

There is ample evidence to suggest that the younger one begins using alcohol and other drugs, the more likely one is to become addicted. Throughout the drug education program, students must be given the message that the use of drugs in any form is never necessary for anyone, regardless of age, and is always undesirable for those under the age for legal usage. It is impossible to have a drug-free school and community if we send implicit messages to students that we expect them to use alcohol. This message suggests not only a lack of faith in our students but also a lack of faith in our ability to educate.

3. Does your program lump all substances together as equally undesirable? Too many programs are cluttered with presentations on

the use of substances that, while not particularly healthy, are not likely to cause serious personal or societal problems. An example is caffeine. While the caffeine in coffee can be addictive and does contribute to poor health, in no way should it be equated with the use of alcohol and other drugs. Grouping the use of alcohol and other drugs with taking aspirin and other relatively harmless over-the-counter drugs trivializes our anti-drug message. We need to husband our resources and use them to attack only those substances that are likely to cause serious problems for adolescents and society. To cast about attacking every possible substance is to lose credibility with our students.

4. Does your program teach that only "bad" kids use and abuse drugs? In practice, this usually is taken to mean those who are disenfranchised from the school, the at-risk student, the dropout, those from broken homes, those from the other side of the tracks. The danger in this message, other than its obvious cultural bias, is that it is patently wrong. When we say that only bad kids have trouble with drugs, we are inadvertently sending the message that those who are school leaders, good scholars, talented athletes, and those from stable homes are immune to drug and alcohol problems. Good grades, membership in the honor society, participation in the student council, and playing on the varsity team do not protect students from drug problems. If sports participation prevents drug abuse, the National Football League should be the most drug-free institution in our society. A look at the sports page will quickly dispel that notion. The only way to guarantee that students will not have drug or alcohol problems is to convince them not to try drugs. There is no sure way to predict which kind of students will have drug problems; however, a good guide is to assume that there are two kinds: one kind is boys, the other is girls.

5. Does your drug education program claim to be "alue free, presenting only the facts so that students can make up their own minds about their behavior with regard to the use alcohol and other drugs?

This approach is an abdication of professional responsibility by those who do not have the courage to take a strong position to protect those in their charge. Teenagers have no business deciding for themselves if they will use illegal drugs. To even suggest to them that using drugs, including alcohol, is a reasonable option is bordering on criminal behavior. Granted, many areas of the curriculum can and should be treated with a value-free approach. This makes good sense in a democratic and pluralistic society. But educators cannot take a value-free approach where illegal and life-threatening behavior on the part of those entrusted to them is concerned. They must take a strong position that all illegal drug use is detrimental to the individual and to the social order. There can be no value-free education in the drug/alcohol curriculum. Examine your drug education curriculum. Does it suggest, even implicitly, that underage students have the maturity to decide for themselves if they will use alcohol and other drugs? If it does, get rid of it immediately before it does more harm.

6. Does your drug education program spend an inordinate amount of time analyzing *why* adolescents use alcohol and other drugs? Asking why usually is an unproductive question. There may be deep-seated personal reasons why some people drink alcohol and use drugs. But if there are, those problems and their solutions are beyond the scope of the classroom. We have drug counselors and rehab centers for these kinds of problems. Adolescents drink alcohol for most of the same reasons adults drink. *They like the feeling they get when they drink alcohol or use drugs.* They would rather drink than not drink. To delve too deeply into the "why" is to let users offer excuses for their drinking. Counselors who work with alcoholics and addicts of any age know that their clients become con artists who come up with dozens of excuses for their behavior. It is easier to find excuses than it is to accept responsibility for behavior. A favorite excuse of adolescents is that they come from a broken home. But what of the thousands of adolescents from broken homes who do not drink or use drugs?

Of course, if one is a trained therapist, it is certainly appropriate to look for underlying reasons as part of the treatment process. But public school personnel do not have the training, time, or resources for long-term therapy. The most effective educational approach is to deal with the behavior and leave the therapy to others. It is enough to take a strong stand against alcohol and drug use and to insist that students be responsible for their own behavior. Young people begin drinking and using drugs for a variety of reasons. The most common ones are satisfying curiosity, giving in to peer pressure, and feeling left out of the group. These are all reasons that can and should be dealt with in an effective drug education program.

# Convincing Students to Delay Beginning Use of Alcohol

There are many reasons why those under age 21 should not use alcohol or other drugs. Perhaps the most compelling is that it is illegal. But there are many other reasons more directly related to the developmental tasks of adolescence.

Adolescence is a period of emotional upheaval for many. It is a time for gaining understanding about one's self, about one's sexuality. How does one deal with budding sexuality? How do immature egos handle rejection by the opposite sex? Young males must learn what it means to be a man in this culture. Young females have an even more daunting task of learning what it means to be a woman in a time of changing sex role expectations. With increasing independence, adolescents must establish new kinds of relationships with parents and other family members.

Vocational and academic interests must become focused during adolescence. Decisions made at this stage of life are incredibly important for future career development. What skills will be needed for future vocational sufficiency? These issues may seem frightening or overpowering, but they must be faced during this period. To delay is to thwart development. That is exactly what happens when adolescents begin drinking alcohol and using other drugs. Their problems seem to vanish. Alcohol and drugs offer immediate relief from painful situations. Continued use leads to avoidance of the difficult, albeit necessary, life tasks of adolescence; and soon the individual is

on the way to becoming a developmentally deficient adult. This is a condition therapists recognize in many adult alcoholics and addicts who begin drinking and using drugs at a young age. Because drinking and drug use inhibit normal emotional and social development during adolescence, we can make a powerful case for delaying such use during this critical period of life.

There also are physiological reasons to delay the beginning of alcohol and drug use. Researchers believe that the hypothalamus is not fully developed until the late teens or early twenties. Alcohol or other drugs acting on the immature hypothalamus seem to have several detrimental effects not found in more mature users. This may account for the apparent ease with which younger users become addicted. The best evidence indicates that younger people tend to become alcoholic and drug dependent much sooner than do older people. Although alcohol is not as addictive as cocaine and nicotine, approximately one in ten or twelve adults who use alcohol become addicted. But the evidence suggests that as many as one in four of those who drink alcohol regularly during adolescence become addicted.

Not only does addiction occur sooner when one starts drinking at an earlier age, but the addiction progresses more rapidly. Adult alcohol drinkers often drink abusively for years before becoming addicted, whereas adolescents frequently become addicted within months of the onset of drinking alcohol. Clearly, addiction is a progressive disease. The younger one starts, the faster and more certain is the progression. Drug addiction does not go away with maturity. Chemically dependent kids become chemically dependent adults. There is good evidence that once a person is addicted, that person is always addicted. The analogy from drug treatment specialists is: "You can turn a cucumber into a pickle, but you can't turn a pickle back into a cucumber."

The long-term risk for young people using alcohol and other drugs is so great that educators must use every means possible to delay early use. *The first 20 years are crucial.*

Another reason to delay beginning alcohol use is that alcohol use tends to be situation specific. That is, people who drink tend to do it at a specific time, in a specific place, and with specific people. For example, you may drink a six pack of beer with your brother-in-law while watching the NFL football game on Sunday afternoon. Or you may stop with friends for a drink at a favorite tavern after work on Friday evenings. Teenage drinking is no less situation specific. The difference is that teenagers tend to drink on a weekend night, in an automobile with other teenagers, and with no adult supervision. The combination of inexperienced drivers and inexperienced drinkers is a potentially lethal one. We know that alcohol acts on the frontal lobe of the brain so that those things most recently learned are the first forgotten; hence the lessons recently learned in driver education are not heeded. It is noteworthy that raising the legal drinking age in all states has reduced the number of fatal automobile accidents involving teenage drivers.

The concept of social drinking is foreign to most alcoholics. When they drink, they get drunk. Unfortunately, adolescents drink the way that adult alcoholics drink. Studies of adolescent drinking patterns reveal that they are very similar to adult alcoholics. *Kids set out to get drunk.* They do not talk about social drinking; they say they are going to get "shit faced" or use equally graphic expressions to indicate that they intend to get intoxicated. While there may be some teenagers who can drink socially, the risk is so great and the stakes so high that the sensible approach in any drug education program is to make a compelling case for delaying drinking alcohol until one is of a legal age.

Alcohol, most often in the form of beer, is the drug of choice of teenagers. In second place is marijuana. Adolescents often mix these two drugs, resulting in deadly consequences. Few adults die of alcohol poisoning. In fact, it is difficult to drink yourself to death in a single binge, because your body will reject an overdose of alcohol by vomiting. However, when marijuana and alcohol are mixed, a

different reaction occurs. The THC in marijuana inhibits nausea and the vomiting reflex, allowing a drinker to ingest enough alcohol to bring on a coma or death. Most older alcoholics are addicted to only alcohol, but younger addicts often are addicted to more than one substance. The combination can be lethal.

Adolescents are vulnerable to peer pressures and to a constant barrage of media commercials for beer and other alcoholic beverages. A drug education program must meet these forces head on with accurate information and with specific skills for coping with these pressures. If students can be convinced to delay alcohol use until they reach legal drinking age, then we will have reached a major goal of an effective drug education program.

## Warning Signs of Drug and Alcohol Use

Drug and alcohol use begins at a much earlier age than most teachers or parents realize. The average age for beginning use of alcohol is approximately 12½, with boys beginning a little earlier than girls. Typically, teachers and parents are not aware of this until more than two years after the onset of regular use.

Alcohol/drug use may be associated with the onset of any unusual behavior or academic problem. Following is a list of behaviors that are recognized as possible indicators of beginning alcohol/drug use. If any of these behaviors occur, educators should at least consider alcohol/drug use as a source of the problem.

1. A drop in grades. The student's academic performance and motivation declines over a relatively short time, say six months to a year.

2. Switching friends. An abrupt change of social groups may indicate that a student is moving into a new group whose members are experimenting with alcohol/drugs. If alcohol/drug use intensifies, the student may change social groups again in order to be with peers who use drugs as much as he does. This phenomenon commonly occurs with adult alcoholics who seek out drinking companions from the ranks of those who are similarly addicted.

3. Emotional highs and lows. Mood swings are common in adolescence; but when a student who previously was emotionally stable suddenly becomes upset easily and has abrupt mood changes, then alcohol/drug use may be indicated.

4. Defiance of rules and regulations. Adolescents who are using alcohol/drugs frequently resent authority. They will push the limits by refusing to obey even minor regulations.

5. Becoming more secretive. Alcohol/drug users are suspicious of authority figures. They refuse to share personal problems, or if they do they are guarded about the amount and type of information they share. They find it increasingly difficult to relate to their teachers and parents, who are perceived as the enemy.

6. Loss of energy. Alcohol/drug use saps students' energy and drive. Since more of their physical energy goes into finding and using drugs, they have less to devote to worthwhile pursuits.

7. Withdrawal from school functions. Preoccupation with alcohol/drugs leaves little time and energy for, or interest in, participating in school functions.

8. Change in physical hygiene. Alcohol/drug users sometimes neglect personal grooming. This may be because they lose interest in their personal appearance or because they choose to be openly defiant of conventional standards.

9. Often late or absent. When students frequently are late and come to school looking tired or sick, it may be an indication of alcohol/drug use. Frequent absences, especially on Mondays and Fridays, are a further indication.

10. Display obvious behavior associated with intoxication or drug use. Obvious signs include slurred speech, an unsteady walk, the smell of alcohol on breath and body, falling asleep in class, or becoming unusually agitated in class.

Teachers who ignore any of the above warning signs are not doing the student a favor. It takes courage to confront the problem. In serious cases, intervention may mean referral to appropriate social agencies. But by being alert to these warning signs, courageous teachers and administrators can prevent young lives from being destroyed by substance abuse.

# Confronting Social Attitudes Toward Alcohol Use

No school program operates apart from its social milieu. This is especially true of drug education. For a drug education program to be effective, educators must carefully consider the social context in which that program is embedded. Alcohol use should be the primary focus in drug programs, first because it is the illegal drug most commonly used by adolescents, and second because it has a unique role in our society. If alcohol had just been discovered, it would most certainly be on the list of controlled substances along with other illegal drugs. But because alcohol has been around at least since the beginning of recorded history and because its use has widespread acceptance, it creates special problems for educators.

Society is replete with contradictions and myths about alcohol use. In the United States there are laws proscribing the sale and use of alcoholic beverages in every state, and they vary widely from state to state and from community to community. Nearly one-third of U.S. adults are abstainers, a statistic that is difficult to accept if one looks to movies and television for models of contemporary adult behavior. Approximately 60% of U.S. adults drink alcoholic beverages on occasion. About 10% of our drinkers account for about 50% of the alcohol consumed. Further, we have regional differences. Adults on the western and eastern coasts drink more than do people in the Midwest, while those in the southern part of the nation drink least of all. There are different drinking patterns according to religious affilia-

tion, gender, ethnic origin, and size of community, with those in cities drinking more than those in rural areas or small towns. In some subcultures, it is acceptable and even expected that the male adolescent will drink to intoxication on occasion but not acceptable for his female sibling to drink at all.

Alcohol is the only drug with these vast differences in usage and in levels of acceptance. When we teach about cocaine, heroin, or marijuana use in our drug education programs, we get fairly consistent attitudes about their undesirability. However, no such consistency exists with alcohol. Alcohol use is so common that neither adolescents nor their parents acknowledge the potential damage it can do. Moreover, failure to understand the disparity of drinking patterns leads to misconceptions. When researchers have asked about personal drinking patterns, most people believe their drinking is about the norm for the country. In other words, most drinkers believe that they drink about the same as everyone else does. Adolescents tend to respond in the same way. If young people are led to believe that drinking is the norm, they feel comfortable in their own alcohol use. On the other hand, if students realize that many people never use alcohol and that most of those who do use alcohol use it in moderation or infrequently, they will learn that it is always acceptable to refuse to drink alcohol and it is never necessary to drink it. The implication for drug education is clear: not everybody drinks, and you don't have to either.

## Myths, Alcohol, and Kids

Children and many adults are short on facts and long on myths when it comes to alcohol use. Many males believe that being able to drink a lot and not become intoxicated is an indication of virility, thus the myth that "a real man can hold his liquor." This myth is perpetuated by men who brag that they can "drink their buddies under the table." The truth is, far from being a mark of masculinity, a high tolerance for alcohol is a warning sign that one may be on the road to becom-

ing alcoholic. Alcoholics often have a higher tolerance for alcohol than do other drinkers – at least in the early stages of alcoholism.

The alcohol industry, through television commercials, perpetuates dangerous myths to young people. We are all familiar with televised NCAA sports events during which a former star athlete urges teenagers not to use drugs. This so-called public service announcement is followed by beer commercials that sponsor the event. The clear message here is that beer is not a drug but a harmless recreational drink. Beer commercials fail to reveal that the alcohol in beer is no different than the alcohol in hard liquor. There is about the same amount of alcohol in a 12-ounce can of beer as is in one mixed drink – approximately one-half ounce.

Televised college athletic events sponsored by breweries are a vehicle for promoting their products to underage drinkers. By definition, most college students and college athletes are under the legal drinking age. If breweries are interested in reaching only mature drinkers, as they claim, why spend valuable advertising resources on a market audience comprised of a large number of people under the legal drinking age?

It is no secret that the alcohol beverage industry needs to develop new markets because the traditional market is saturated. That new market is women and young people who are just beginning to drink. The problem the industry has is that most new drinkers do not like the taste of alcoholic beverages. Many who taste alcoholic beverages for the first time spit them out. What drinkers do like is the *feeling* they get from drinking. This is why non-alcoholic beer accounts for less than 1% of beer sales. For beer that does not provide the "buzz," the market is exceedingly small.

Drinking alcoholic beverages is an acquired taste. The problem for marketers of alcoholic beverages is how to influence women and younger people to acquire the taste for alcohol. Their answer is a marketing masterpiece – the wine cooler. Adult male drinkers do not belly up to the bar and order wine coolers. They are drunk primarily

by beginning women drinkers and by adolescents, especially adolescent girls. Wine coolers are designed as a "transitional drink," something between fruit juice and hard liquor. They are intended as a drink for beginning users – until they acquire a taste for alcohol.

Our language reveals our ambiguity about alcohol use. We speak of "partying" when we mean drinking heavily. We talk about "happy hour" or "attitude adjustment hour" instead of saying that we are going to consume a mind-altering drug in order to relax at the end of the day. When teaching about alcohol and other drugs, educators must use terminology that describes their effects clearly and accurately. For example, instead of using the term "drunk driving," it would be more accurate to talk about "alcohol-impaired driving," thus conveying the message that one does not need to be legally intoxicated to be impaired. Even a small amount of alcohol can impair driving. Such a phrase as "recreational use of drugs" is inaccurate, since no drug use is recreational. When speaking to teenagers, we should talk in terms of preventing "drug use," not "drug abuse," since the aim is to prevent any use. We should not speak of "mood-altering drugs" but of "mind-altering drugs," which more accurately describes their effect.

There are frequent jokes on television about drinking to excess. Johnny Carson jokes about Ed McMahon's excessive drinking as though it were a harmless, even endearing, personality quirk. The old Andy Griffith shows often portrayed Otis, the town drunk, as harmless and happy. Dudley Moore portrayed an irresponsible but lovable alcoholic in the movie, *Arthur*. Alcoholics are not happy people. Alcoholism is a serious and deadly disease affecting thousands of men, women, and adolescents. It costs billions of dollars in lost productivity and social services. It is a tragedy for those who are addicted as well as for their families and associates. While society has become more enlightened about alcoholism in recent years, far too many of these dangerous myths persist.

## Distorted Messages from Beer Commercials

Researchers estimate that children see more than 6,000 hours of television before entering school and about 23,000 hours before graduating from high school. This is nearly twice as much time as they spend in school and more time than they will spend with both parents combined. Children see five hours of commercials a week – about 1,000 commercials. We know that very young children pay more attention to the commercials than they do to the programs. The fast pace, catchy music, and smiling faces in commercials are especially attractive to young children. Between the ages of two and 18, young viewers might see 100,000 beer commercials, which are laden with blatant and distorted messages pushing their product on immature audiences.

Beer commercials portray beer drinking in a setting of cultural rites that are particularly attractive to adolescent males. They portray sex role models in which, to be a man in a man's world, beer is always a part of the message. Drinking the right beer is essential in order to be a real man, to be respected by other men, to enjoy good friends, and to be attractive to women.

Beer commercials frequently play on the theme of male bonding, blatantly exploiting this early adolescent phase of development. They frequently feature groups of men doing something together (usually fishing or camping), from which females are excluded or assigned a secondary role. The activity is like the one pre-adolescent males engage in when they form secret clubs that exclude girls. The message to young males is that this is the way real men behave. And to behave as a real man, it is necessary to drink the correct brand of beer.

In some cases beer commercials link beer drinking with physical speed – a deadly combination – in the form of galloping horses, speeding boats, or sleek automobiles speeding along a rain-slick city street at night. Other commercials combine beer drinking and risk-taking behaviors. In one commercial, a group of men are using block and tackle to lift a piano into an upper-floor apartment; the rope breaks, and the piano crashes to the street. The men's reaction is to laugh

about their mishap over a beer. In another commercial for the same beer, the men are loading hay on a wagon when the load slips and falls from the wagon. Both of these cases present a dangerous situation in a flippant fashion, conveying the message that real men don't take dangerous situations seriously; they laugh them off over a beer. Such behavior is not lost on the underage viewer. Men get together, do dangerous things, and drink beer. Therefore, if boys want to act like men, the thing to do is drink beer.

Women, when included in beer commercials, are assigned primarily to one of two roles. They either are relegated to the background as waitresses or girlfriends with no part in the action, or they are portrayed as passive women waiting to be seduced by the male who drinks the right beer. In this latter role, women are nearly always seated while the dominant male is standing. An example is the Colt 45 commercial featuring Billy Dee Williams. The standing male claims he can read the seated female's mind. He knows what she likes. She remains passive throughout but is obviously waiting to be seduced by the right man. The male character refers back to the product: "The power of Colt 45. . . . It works every time." This sexist commercial is clearly aimed at sexually insecure males. Beer becomes the aphrodisiac – a message not lost on sexually insecure adolescent males.

Taverns in beer commercials are pictured as clean, well-lighted, congenial places where everyone is friendly. They play up the theme of belonging to the in-group, a powerful need of adolescents. Outsiders are welcomed to the in-group when they decide to order the correct beer (Bud Light commercials). Nobody in these taverns ever gives any indication that he has had too much to drink. Nobody ever vomits. Nobody ever gets loud and abusive, provoking an altercation with other bar patrons. There is no indication of how patrons got to the bar or, more important, how they intend to get home. Is anyone a designated driver? That seems unlikely since everyone is drinking. Do they take public transportation? That's not the American way. They surely will not all walk home. These commercials con-

sistently present a glamorized picture of beer drinking and assiduously avoid any suggestion of problems connected with alcohol use.

Beer commercials often depict scenes where offering a beer to others is the way "real men" show their emotions. In one commercial, a young man has learned that his father worked overtime some years ago to buy the son a baseball glove. As a way of showing his affection and appreciation, the son offers the father a beer. Men are not supposed to show real feelings through touch or words. The giving and accepting of beer is substituted for demonstrating real emotions. Beer commercials send the message that beer drinking is associated with good friends, good times, and social and sexual acceptance. These are powerful messages for immature audiences.

Beer commercials are not the only ones that convey distorted messages to youngsters. Alka Seltzer commercials have regularly pictured a person who abuses his body by overeating spicy and heavy foods and then finds relief by using the product. "Plop, plop, fizz, fizz. Oh, what a relief it is." The obvious message here is that it is O.K. to abuse your body by overindulgence. We do not need to be responsible for our behavior. We can just use some pill or chemical and everything will be fine.

Television commercials are a continuing source of distorted and dangerous messages. But they also can serve as an excellent instructional tool when teachers and students analyze them to discover the distorted values they promote.

## Designing Effective Drug Education Programs

School drug education programs can have a positive impact if they are thoughtfully planned, carefully implemented, and continuously evaluated. Too frequently, school districts start drug education programs following this scenario: someone, usually the superintendent or other central office personnel, as a result of attending a conference or because federal or state money is available, decides that the district should have a drug education program. The next step is establishing a committee of teachers, administrators, and perhaps some representatives from the community to review commercially prepared materials and to recommend one of the available programs. A program is selected; teachers are given a few inservice sessions to familiarize them with the materials; then the drug education program is officially implemented.

The above scenario has the advantage of being fast and easy. Unfortunately, complex problems do no lend themselves to fast and easy answers. Drug education programs, in particular, must not be implemented by using short cuts or hurry-up methods. Commercially published programs may not be appropriate for local needs; and if used, they nearly always need to be adapted to local needs. In any case, purchasing commercially published materials should not be the initial concern in designing an effective drug education program.

Designing an effective drug education program involves several components that, if attended to in the proper sequence, will help to

ensure that the program achieves its goals. These components are identified and discussed below.

*Community Involvement*. At the outset, there must be broad community involvement in developing a drug education program. This must occur long before any decision is made about purchasing materials. Initially, educators should devote their energies to galvanizing the community in a commitment to a drug-free environment for children and youth. Without total community commitment, the anti-drug message from the schools could easily be negated by contradictory messages from the community.

Teachers and administrators should use their organizational skills and credibility in the community to take their message to civic groups, churches, news media, social agencies, police departments, local, state, and national politicians, and yes, even your local retail liquor dealers – a group often overlooked but who nevertheless have a large stake in community efforts to curtail alcohol use by underage drinkers. Representatives from these groups and other interested citizens can form task forces to discuss the problem, to assess the needs of the local community, and to design an ongoing plan of action. There is no one organizational scheme that will work for every community. What is important is to have a strategy that unites the community in promoting an environment that is not only anti-drug but also pro-education. Such an organization can help create communities that are good places for children and adolescents to live and grow.

One important activity of this organization should be lobbying political groups at the local, state, and national levels to secure funds for education and other community efforts to promote a drug-free environment for children and youth. Another activity is letter-writing campaigns to sports heroes and entertainers who promote positive role models. For example, Reggie White of the Philadelphia Eagles refused an Outstanding Player Award from the Miller Brewing Company because he realized he was a role model for young people and did not want his name associated with alcohol. How many parents

and teacher groups wrote to Reggie White or the Eagles commending his action? Letters of condemnation are in order, too, when NFL or NBA players are arrested on charges on drunk driving or drug use, which then are glossed over by team owners.

*Articulating Goals of the Program.* Engaging groups in assessing the needs of the school and community will lead to setting goals for the drug education program. It will then be up to school personnel to design the curriculum to achieve those goals. From the start, it is essential that the goals be clearly articulated. For example, a basic goal should be that the school and community will take a strong anti-drug stance. Having taken that stance, the school clearly articulates its position to students and parents. Expectations for student behavior are defined and agreed on by educators and parents, and sanctions for violating these expectations are clearly stated and consistently enforced. Likewise, other program goals should be expressed in concise and unambiguous language and be widely disseminated throughout the school and community.

*Focus on the Gateway Drugs.* There is nothing wrong with teaching about heroin, cocaine, and other hard drugs; but when resources and time are limited, it makes sense to focus on those substances that are most widely used. These are alcohol, marijuana, and tobacco, the so-called gateway drugs, which lead to abuse of hard drugs. Actually, the incidence of heroin use is very low among school-age children; and cocaine use is down and never was widely used by youth. When these hard drugs are used, almost invariably there has been a history of earlier use of the gateway drugs. If adolescents do not use alcohol or marijuana, it is highly unlikely they will progress to using hard drugs. The substance that requires the most attention in drug education programs is *beer*. Because it is so readily available and so widely accepted in society, it is the most commonly used and abused by adolescents. If youngsters can graduate from high school without beginning beer drinking, it is unlikely they will ever use hard drugs.

*Start Early.* Effective drug education must start in the early elementary school years and continue in the ensuing years. The program must build sequentially on children's previous learning. Information and skills for resisting negative peer and societal pressure introduced at a young age must be refined and modified as children mature. Surveys of drug use indicate that initial use increasingly is occurring at the elementary school level. And drug counselors report that the earlier their patients began experimenting with drugs, the more likely they were to expand their repertoire of drug use. Drug education that waits until secondary school or even middle school is too late. It is never too early to begin teaching the facts, attitudes, and skills required to enable children to live a healthful, productive life, one in which they can face each new developmental task with confidence.

*Plan a Comprehensive Program.* A comprehensive drug education program progresses from the early grades through late adolescence. The program is sequential, building on previous learnings in both the cognitive and affective domains. In addition to teaching information about the negative influence of drugs on healthful living, students must develop positive attitudes regarding respect for their bodies and leading productive and satisfying lives.

A comprehensive program uses a variety of teaching methods that are appropriate for different age levels and for different learning objectives. In addition to traditional lecture and discussion approaches, other methods need to be used. For example, counselors from alcohol treatment centers often are willing to talk with school groups; police departments frequently provide personnel for school presentations; local and state politicians often are willing to meet with classes to discuss impending legislation affecting alcohol and drugs; recovering alcoholics are appropriate for selected student groups. Field trips to police labs, treatment centers, and to open Alcoholics Anonymous meetings are options for more mature students. Reviewing and reporting on recent research or conducting original survey research in the community are appropriate projects for students who are sufficiently

interested. Any of these methods offer interesting approaches for gaining information and for developing healthful attitudes.

*Teacher Inservice Is a Must*. Teachers must be adequately prepared to implement the drug education program. A few after-school inservice sessions are not adequate. Teacher preparation must be in-depth and ongoing. This is not to say that a teacher needs to become a specialist in alcohol and drug therapy; but they do need enough training to grasp the scope of the problem, to design innovative lessons, to be able to evaluate instructional materials, and to recognize serious drug-related problems and refer them to appropriate sources for help. In large schools or in smaller districts, there should be one teacher or counselor with more specialized training who coordinates and supervises the program and plans the evaluation.

*Mobilizing Positive Peer Pressure*. The term, "peer pressure," when used in the context of drug use, usually connotes a negative influence. And there is no question that involvement with drugs is highly correlated with association with others who use drugs. However, peer pressure can be positive as well as negative. It has been clearly established that peer support groups and peer counseling are effective means for preventing drug use and for helping addicts recover from drugs.

The challenge for educators is how to mobilize peer pressure for positive ends. Some models of peer support groups used in effective drug education programs include: Student Assistance Programs (SAP), an organization encouraging student support groups, parent/community involvement, integration with athletic programs, and other methods of dealing with student substance abuse; Ala-Teen, a support group for children from alcoholic families; and Students Against Drunk Driving (SADD), a group dedicated to raising the awareness level of teenagers about the danger of mixing alcohol and driving. Alcoholics Anonymous (AA) groups are being formed on some high school and college campuses. Peer counseling is another model. Students who receive training in the techniques of one-on-

one counseling often can be helpful with problem cases that are not too severe. Part of their training is learning how to recognize when additional help is needed. With all these peer groups (AA is an exception), informed and caring adults need to be involved in the training of students and as sponsors. But the real value of peer support groups stems from the student-to-student relationships. Use of positive peer support should be a key strategy in your drug education program.

*Parent Networking*. One of the most effective strategies in preventing and curtailing adolescent drug use is parent networking. It should be a key component in planning a comprehensive drug education program. By involving parents in planning and implementing a drug education program, the goals of the program will be reinforced by the home. To encourage networking, parents can be organized into support groups. They can meet together to share expectations about student behavior and to agree on a set of rules for their children's behavior. They can agree to support a policy of no tolerance for alcohol or other drugs. They can agree that they will not permit unchaperoned parties in their homes. They can agree that no student can leave a party at their home and return later. They can agree not to allow "open invitation" parties in their homes. They can agree on places that are off limits to teenagers. They can agree on reasonable curfews. Helping teenagers stay out of trouble with drugs, especially alcohol, is easier when rules are consistent and uniformly enforced.

Parent networks can lobby their local, state, and national officials for legislation aimed at protecting children and adolescents from alcohol and other drug use. They can demand strict enforcement of laws prohibiting selling alcohol to minors. And they can support the school drug education program through volunteer work and through securing additional funding for the program. The development of parent networks is central to the success of school drug education programs.

*Evaluation Must Be Built into the Program*. Evaluation is a missing element in too many drug education programs. A recent study

at the University of Michigan found that most of 126 programs studied did not follow up to see if students' attitudes and behavior had changed as a result of the program. Evaluation must be designed during the initial planning, when the goals for the program are established. Those planning the evaluation first must determine what goals can reasonably be accomplished in a school setting. Baseline data might include students' knowledge of, attitudes about, and behaviors with alcohol and other drugs prior to participating in the program. The evaluation instruments should be designed to answer these questions: Do students know more about alcohol and other drugs and their effects on the body? Do they have a healthful attitude about drugs? Are their behaviors in line with their knowledge and attitudes? Have they refrained from drug use, at least until they are of a legal age?

The components of an effective drug education program discussed in this chapter cannot be implemented with the wave of a wand. They require careful planning and organization. But the results will be worth the effort.

## Summary

An effective school drug education program must be firmly rooted in a total community effort committed to a drug-free environment. Educators must organize parent and community support so that the goals of the drug education program are reinforced by the total community. What is required is a concerted effort by educators, parents, and others who care about children and the quality of their lives.

# Annotated Bibliography of References and Resources

## Books

Bell, Catherine S., and Battles, Robert, eds. *Prevention Research: Deterring Drug Abuse Among Children and Adolescents*. Rockville, Md.: National Institute on Drug Abuse, 1987.
Reports research on school-based strategies of social skills and social inoculation as drug prevention measures.

Chandler, Mitzi. *Whiskey's Song: An Explicit Story of Surviving in an Alcoholic Home*. Pompano Beach, Fla.: Health Communications, 1987.
In more than 50 lyric poems, the author reveals the pain, confusion, and ultimate survival in a family disrupted by alcohol abuse. The poems portray parental alcoholism from the perspective of childhood, adolescence, and adulthood. The author's insight into a dysfunctional family is offered without bitterness or resentment.

Economaki, George. *Alcohol, Drugs and You: A Guide for Young People*. Johnson, Iowa: 7-E Publishers, 1987.
This easy-to-read book, intended for both parents and children, deals with family problems that may cause children to start experimenting with alcohol and other drugs as well as problems for youngsters resulting from regular use of drugs. The book is designed to curtail alcohol and other drug use among children by encouraging them to talk about it.

Jaynes, Judith H., and Rugg, Cheryl A. *Adolescents, Alcohol and Drugs*. Springfield, Ill.: Charles C. Thomas, 1988.
Provides both research and practical experience to help adults, especially teachers, recognize symptoms of alcohol and drug abuse in students. In-

cludes suggestions for locating help and making referrals. An extensive appendix provides checklists for identifying problems.

Johnson, Lloyd D.; O'Malley, Patrick M.; and Bachman, Jerald G. *Drug Use Among American High School Students, College Students and Other Young Adults*. Rockville, Md.: National Institute on Drug Abuse, 1986.
Updates ongoing research by the Institute of Social Research at the University of Michigan on national trends in drug use. Provides comparative data from previous years.

League, V.C., and Pump, Stephanie Soares. *A Policy Development Manual for Drug-Free Schools*. Oakland, Calif.: Vincente Associates, 1988.
Offers guidance on formulating school policies for alcohol and other drugs. Contains material on policy language, the policy development process, and legal issues. An extensive appendix includes sample school policies and examples of forms.

Milgram, Gail Gleason. *What, When and How to Talk to Students About Alcohol and Other Drugs: A Guide for Teachers*. Center City, Minn.: Hazelden Educational Materials, 1986.
Provides teachers with guidelines on how to help students make responsible decisions about alcohol and drug use. Includes communication techniques and discussion exercises.

Office of the California Attorney General. *Schools and Drugs: A Guide to Drug and Alcohol Abuse Prevention Curricula and Programs*. Sacramento, Calif.: Crime Prevention Center, 1987.
Developed to help educators establish drug-free schools, this guide provides descriptions of 19 curricula, six programs, and three projects on drug and alcohol prevention. Also includes a list of resources: classroom materials, background reading, and referral agencies and services.

Postman, Neil, et al. *Myths, Men and Beer*. Falls Church, Va.: AAA Foundation for Traffic Safety, 1987.
Examines the cultural myths in television beer commercials and analyzes the relationships among beer, masculinity, and driving and how they influence children's attitudes toward beer drinking and driving.

Ray, Barbara A., ed. *Learning Factors in Substance Abuse*. Rockville, Md.: National Institute on Drug Abuse, 1988.
Presents a technical review of the range of learning factors influencing the onset of drug abuse and its treatment.

United States Department of Education. *What Works: Schools Without Drugs*. Washington, D.C.: Department of Education Information Office, 1986.
Contains a list of 12 recommendations for achieving drug-free schools and communities. Focus is on prevention. Advocates a hard-line policy of no tolerance for drug use.

United States Department of Health and Human Services. *Adolescent Peer Pressure: Theory, Correlates, and Program Implications for Drug Abuse Prevention*. Rockville, Md.: Office for Substance Abuse Prevention, 1988.
Focuses on constructive ways of channeling positive peer pressure to communicate the message that drug use is not appropriate and often harmful.

## Pamphlets

Horton, Lowell. *Adolescent Alcohol Abuse*. Fastback 217. Bloomington, Ind.: Phi Delta Kappa Educational Foundation, 1985.
Examines the problem of adolescent alcohol use and abuse and suggests ways that educators, parents, and communities can take preventive action.

Johnson, Jeanette, and Bennett, Linda A. *School-Aged Children of Alcoholics: Theory and Research*. New Brunswick, N.J.: Alcohol Research Documentation, Center on Alcohol Studies, Rutgers University, 1988.
Reviews theory and research in studies comparing school-aged children of alcoholic and non-alcoholic parents. Presents some guidelines for interpreting published research. Includes a bibliography and list of resources.

Minnesota School District 281 Chemical Awareness Advisory Committee. *Never Too Early, Never Too Late*. Center City, Minn.: Hazelden Educational Materials, 1983.
Developed by a community action group concerned with adolescent drug and alcohol problems, this pamphlet addresses how parents can work in the schools and community to ensure a drug-free environment.

Milgram, Gail Gleason. *What Is Alcohol and Why Do People Drink It?* New Brunswick, N.J.: Alcohol Research Documentation, Center on Alcohol Studies, Rutgers University, 1988.
Provides basic information about alcohol: what it is, why people drink it, how it is metabolized, and what its effects are. Contains suggestions for dealing with problems related to alcohol and a section on laws and legal liabilities pertaining to alcohol. Includes a list of resources and additional readings.

## Periodicals

Beard, Bonnie; Fafoglia, Barbara; and Perone, Jan. "Knowing What to Do and Not to Do Reinvigorates Drug Education." *ASCD Curriculum Update* (February 1987). Alexandria, Va.: Association for Supervision and Curriculum Development.
Discusses problems with existing school-based drug prevention programs and provides guidelines for necessary improvements. Includes a resource section on available programs by grade level.

Horton, Lowell. "The Education of Most Worth: Preventing Drug and Alcohol Abuse." *Educational Leadership* 45, no. 6 (1988): 4-9.
Suggests that schools can make a difference if they design innovative programs and seek support from parents and the community.

McCord, Joan. "Identifying Developmental Paradigms Leading to Alcoholism." *Journal of Studies on Alcohol* 49, no. 4 (1988): 357-62.
Reports a study of adult alcoholic males who had been in juvenile delinquency prevention programs as adolescents. Findings were that children who demonstrated "shy-aggressive" behaviors in elementary school were at elevated risks for both alcoholism and criminal behavior; also sons of alcoholic fathers were found to be more likely to become alcoholic.

Walker, Betty; Jaskinska, Marda D.; and Carnes, Earl F. "Adolescent Alcohol Abuse: A Review of the Literature." *Journal of Alcohol and Drug Education* 23, no. 3 (1978): 51-65.
Examines research on adolescent drinking patterns and investigates such variables as psychological characteristics, religious influences, family dynamics, and peer pressure as factors contributing to adolescent drinking behaviors.

Zwedben, Joan Ellen, and O'Connell, Kathleen. "Strategies for Breaking Marijuana Dependence." *Journal of Psychoactive Drugs* 20, no. 1 (1988): 121-27.
Provides guidance to those who want to help others break their marijuana dependence.

## Sources for Additional Information

Alcoholics Anonymous World Services, Inc.
P.O. Box 459
Grand Central Station
New York, NY 10017

Al-Anon Family Group Headquarters
P.O. Box 182
Madison Square Station
New York, NY 10159

Addiction Research Foundation
33 Russell Street
Toronto, Ontario, Canada M5S 2S1

Alcohol Drug & Problems Assn. of North America
Suite 181
444 North Capitol Street, N.W.
Washington, DC 20001

American Council for Drug Education
5820 Hubbard Drive
Rockville, MD 20852

American Medical Association
535 North Dearborn Street
Chicago, IL 60610

Families for Action National Information Center
Suite 300
3845 North Druid Hills Road
Decatur, GA 30033

Hazelden Educational Materials
P.O. Box 176
Pleasant Valley Road
Center City, MN 55012

Just Say No Foundation
1777 North California Blvd.
Walnut Creek, CA 94596

National Clearinghouse for Alcohol Information
Dept. 10
P.O. Box 2345
Rockville, MD 20852

National Congress of Parents & Teachers
700 North Rush Street
Chicago, IL 60611

National Council on Alcoholism
14th Floor
733 Third Avenue
New York, NY 10017

National Federation of Parents for Drug-Free Youth
Suite 200
8730 Georgia Avenue
Silver Springs, MD 20910

National Institute on Alcohol Abuse & Alcoholism
5600 Fishers Lane
Rockville, MD 20852

National Institute on Drug Abuse
11400 Rockville Pike
Rockville, MD 20852

Parents' Resource Institute for Drug Education
Suite 1002
100 Edgewood Avenue
Atlanta, GA 30303

North Conway Institute
14 Beacon Street
Boston, MA 02108

Rutgers Center on Alcohol Studies
P.O. Box 969
Piscataway, NJ 08854

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Suite 103
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