JUVENILE ALCOHOL ABUSE

HEARING

BEFORE THE

SUBCOMMITTEE TO INVESTIGATE JUVENILE DELINQUENCY

OF THE

COMMITTEE ON THE JUDICIARY

UNITED STATES SENATE

NINETY-FIFTH CONGRESS

SECOND SESSION

DES MOINES, IOWA
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APPENDIX

JUVENILE ALCOHOL ABUSE

SATURDAY, JANUARY 28, 1978

U.S. SENATE,
SUBCOMMITTEE TO INVESTIGATE
JUVENILE DELINQUENCY OF THE
COMMITTEE ON THE JUDICIARY,
Des Moines Iowa,

The subcommittee met, pursuant to notice, at 10:30 a.m., in the Polk County Courthouse, Des Moines, Iowa, Hon. John C. Culver (chairman of the subcommittee) presiding.

Present: Senator Culver.

Also present: Josephine Gittler, chief counsel and Howard Porter, associate counsel.

STATEMENT OF HON. JOHN C. CULVER, A U.S. SENATOR FROM IOWA

Senator CULVER. I now call to order this hearing of the U.S. Senate Subcommittee to Investigate Juvenile Delinquency to hear testimony concerning alcohol use and abuse by our children and youth.

A number of recent studies have found that drinking by juveniles has increased alarmingly in the past few years. In fact, the consensus of the experts is that the most rapid rate of increase of alcoholism is among young people and in recent years the age bracket has increasingly gone down to the very young. A recent survey by the National Institute of Alcoholism and Alcohol Abuse reported that 93 percent of boys and 87 percent of girls in their senior year of high school have been involved in some type of alcohol consumption.

This subcommittee has recognized from the beginning that juvenile deliquency can only be properly understood within the context of a wide range of social problems that contribute to it—broken homes, child abuse, emotional illness, learning deficiencies, and other such considerations.

Clearly, alcohol abuse has now become a major factor in disrupting and damaging the lives of children and youth throughout the country. The subcommittee is investigating the nature and extent of the problem and seeking to determine the services that are needed to deal with it and those that are presently available and operating. In addition to treatment and rehabilitation programs, the subcommittee has a vital interest in ways and means of prevention.

The prevention theme permeates throughout all of the activities of the subcommittee. Manifestly, I think prevention is the most sensible and desirable solution to the various juvenile problems, ranging from child abuse to chronic truancy, that have some relationship to delinquency. The point is particularly applicable to alcoholism and alcohol abuse.

The subcommittee recognizes that the development of effective alcoholism prevention programs targeted at children and youth poses an enormously difficult and subtle problem. Yet, if effective prevention programs can be devised, the gain to society in terms of conserving our most valuable resource—our children and youth—would be inestimable.

The subcommittee is aware that Federal effort can go only so far in combating such a problem as youth alcoholism. The Federal Government can provide leadership, guidelines, some funding, and it can focus national attention on what has become a major nationwide problem. But the ultimate responsibility in this area evolves on the State and particularly on the communities.

We have an impressive array of witnesses here today who can speak knowledgeably about the incidence of juvenile alcoholism and about programs of prevention, treatment, and rehabilitation.

I want to welcome all of you to the hearing this morning and to convey the subcommittee's sincere thanks for your participation. In the interest of time, I would like to ask the witnesses if they would be good enough to forego presenting their opening statements so that we may proceed directly to questions.

Naturally your written statements will be reproduced in full in the official record of the hearing and also in order to insure that your views are fully reflected, I will order the record to remain open for an additional 2 weeks so that each of you may submit supplemental material for inclusion in the official record if you so desire.

I wonder if our first panel would be good enough to come forward at this time? We have Mitchell Work, Dr. Stan Haugland, Dr. William Jackson and Bob M. All of these witnesses are connected with various alcoholism treatment centers here in the State of Iowa. The first member of the panel is Mitchell Work, the executive director of Alcoholism & Drug Abuse Services, Inc., and it is a pleasure to welcome you here.

Mr. WORK. Thank you.

Senator CULVER. I have gone through your statement and it appears to me that you have pulled together all the existing studies with respect to juvenile alcohol abuse. Your statement indicates that young people are drinking at an earlier age and are drinking more heavily. Your statement also indicates that there are almost no treatment or prevention services in Iowa specifically targeted to juvenile drug and alcohol abusers. Is that essentially a fair summary of your statement?

Mr. WORK. Yes, Senator, that would be accurate. There is especially a lack of juvenile alcoholism prevention and treatment programs in Iowa.

Senator CULVER. Now, for our record, what is the extent of alcohol use and abuse by adolescents within the State of Iowa?

STATEMENT OF MITCHELL R. WORK, EXECUTIVE DIRECTOR, ALCOHOLISM AND DRUG ABUSE SERVICES, INC., DES MOINES, IOWA [1]

Mr. WORK. Immediately I think we run into a problem of not having recent data to really reflect that. We go back to a statewide survey by Dr. Carl Chambers who did a statewide survey. His esti-

[1] See p. 39 for Mr. Work's prepared statement.

mates are that there are 17,000 juveniles between the age of 14 and 17 years of age who were heavy drinkers. This is a 1974 study, I believe.

I would just like to underscore the fact that there are 17,000 young people in Iowa who are on the verge of alcoholism. This to me constitutes a major health problem and if this were another disease I am certain that we would immediately have Federal aid and State aid to address the problem. The Chamber's study cited here is now several years old and there has not been much reaction to it. We've ignored the problem.

Senator CULVER. To what do you attribute this increase in the use of alcohol by young people?

Mr. WORK. Well, certainly the availability is a major factor. Alcohol is available even though we do have an established drinking age but it certainly is available to young people of any age. It is also cheap. I would point out that those young people we see in our program are continuing to use other drugs and frequently mixing them with alcohol. We call this polydrug usage.

Another reason why alcohol consumption is increasing is that more and more in the media—TV, radio—we hear messages that alcohol is not only OK for people to use but it is expected if you are to be successful and happy.

If you turn on the television tonight, I would suggest you probably will see several ads strongly encouraging the use of alcohol and other drugs. In addition, young kids especially have an opportunity to view their parents in a role modeling situation. Almost 100 percent of the adult population of this country is involved with some kind of alcohol usage. Through the media, through the home, the kids are getting the message that it's OK to go ahead and use and become involved in this dangerous substance.

Senator CULVER. You noted in your statement that Polk County Juvenile Probation contacted you and requested assistance in dealing with the adolescents involved in delinquent behavior who showed signs of having an alcohol problem. Could you elaborate on that?

Mr. WORK. Yes; I could. By the way, Mr. Gary Ventling is here from that office, and we were contacted by them about the possibility of providing outpatient services for juveniles who had come to the attention of the juvenile justice system and who were involved with drug or alcohol problems. The estimate that they gave to us was that over 400 kids per year could make use of these services and currently there are no services being offered in this particular area.

Senator CULVER. You say 400?

Mr. WORK. 470 was the figure that was given to me—kids needing some kind of service, whether it be early intervention outpatient services or assessment to see if there was an alcohol problem present.

Senator CULVER. What is the profile of the adolescent problem drinker that you encounter to the extent that there is a common denominator and background?

Mr. WORK. Well, it is a very nondiscriminatory profile. Male and female, we are seeing juveniles of both sexes drinking heavily. Further, it does not seem to be isolated among economic groups. Young kids from middle class, upper middle, lower and lower middle class seem to be involved. It's a relatively cheap substance and its accessible in urban, suburban, and rural areas. Some of our programs at ADASI are delivered in very small towns where there is not even a liquor

store, yet they are having problems. I don't think juvenile alcoholism discriminates. We are seeing problems across the board.

Senator CULVER. Is there usually a disfunctional family or broken home associated with juvenile alcohol abuse?

Mr. WORK. My personal belief is that any alcoholism problem has roots in factors other than the substance itself. It can often be attributed to family problems. You visited the ADASI residence this morning and I think we indicated to you that many of our kids there experience problems that relate back to the family. Also, I think, it's a problem of self-identity and lacking a positive self-concept and in many severe cases we find a succession of failures that young people have had that makes the usage of alcohol very much of an attractive alternative or a temporary escape.

Senator CULVER. Now, of course, ADASI is providing the services that we discussed with you this morning for these young people?

Mr. WORK. Right, but only long term residential treatment to juvenile males with alcohol abuse problems.

Senator CULVER. Such comparable facilities are virtually nonexistent everywhere else, and there are none for women?

Mr. WORK. Not to my knowledge. There will be some people on the panel here who are involved with very fine services for juveniles on a limited scale.

Senator CULVER. Generally, in your view are there adequate treatment programs for juvenile alcohol abusers in our State?

Mr. WORK. No. I feel that there are not, given the data from the assessment from recent studies, given the contacts that we have had from the juvenile justice system, given the demand for services, I do not feel we are providing even minimal services to the juvenile alcoholic. Polk County has done a great deal towards supporting alcoholism and drug abuse programing but primarily we are doing all we can just to provide services for the adult alcohol problem.

Senator CULVER. What is needed in the way of programs here in Iowa for juvenile alcohol abusers? What specific kind of program do you see the most crying need for?

Mr. WORK. My first appeal is that we not utilize the bandaid approach. If we are going to address the problem, we should do it on a continuum of care bases. This should include prevention, assessment, detoxification, outpatient, residential, and aftercare services for juveniles.

I very much appreciate your earlier remarks about prevention. We are talking about a prevention need even at the preschool level. The earliest reported usage in Iowa is 6 years of age. We have to begin prevention even before kids get into school to address prevention in the family. We need detoxification program components for young kids who are picked up who are intoxicated and then we need an array of programs, outpatient, residential care, and some kind of followup and aftercare.

Further we need to investigate the need for special services for juvenile groups with unique problems. You have mentioned a very important area, the juvenile female alcoholic. We are finding that adolescent women have some unique needs and currently services for that population are not available here.

Senator CULVER. Gentlemen, I wonder if any of you would like to be heard? As I indicated, in the interest of time, we will have your

full statements inserted in the record but perhaps you would be kind enough to outline your key points.

STATEMENT OF DR. WILLIAM L. JACKSON, PRESIDENT OF THE BOARD AND MEDICAL DIRECTOR, GORDON CHEMICAL DEPENDENCY CENTER, SIOUX CITY, IOWA[1]

Dr. JACKSON. I am Dr. William Jackson. I would like to say that I think probably all of these studies are very conservative in their estimates. I think that the problem is a lot bigger than any of the studies show. I think Minnesota showed this very dramatically about 3 years ago when they passed legislation which guaranteed the right of the adolescent to get treatment and from a lot of beds available to kids there became none immediately and I think this shows that there are a lot more kids out there that need treatment than were getting treatment under the old programs.

Senator CULVER. You mentioned, I think, in your statement that there are over 2,000 estimated juveniles with alcoholic abuse problems in western Iowa.

Dr. JACKSON. This is an area for the Governor's area planning and these are strictly based on NIAAA studies of 1971 on incidents figures under the age of 21.

Senator CULVER. Dr. Jackson, you are, of course, president of the board and medical director of the Gordon Chemical Dependency Center in Sioux City?

Dr. JACKSON. Yes.

Senator CULVER. Could you describe your facility a little and the treatment approach that you use?

Dr. JACKSON. Certainly. We are almost a brandnew unit. We opened at the end of July 1977. We are a private, nonprofit organization funded privately through contributions in the community. We started our unit simply because there were inadequate facilities available for adolescents and we were seeing kids who needed treatment that we could not get into units anywhere. Primarily this was, we felt, due to the fact that most general treatment centers will accept little more than 10 percent of their clients in the adolescent age range.

It simply doesn't work if you get very many more in with adults. We were having kids that we would refer as far as 500 to 600 miles away to get them to treatment, and even using beds that far away, we couldn't get the kids in when we wanted to get them in. We have seen kids die and kids whose families were ready to help them not having a bed available. When there was a bed available, we couldn't get the kid.

That was the reason we did start. Our program is a 60-day inpatient treatment. That's a basically minimum 60-day treatment. It's for both male and female. We are an adolescent program only and we deal with both alcohol and drug addiction problems. Our service is basically one of confrontative group therapy which is what has proven to be the most successful in the most number of places with the disease of alcohol and drug abuse. We do use other modalities.

Our program encompasses an educational program provided by the Sioux City community school system, a lecture series, a series of lectures into the steps of the Alcoholics Anonymous program and two unique features that we have in our program are a very extended

[1] See p. 82 for Dr. Jackson's prepared statement.

aftercare program which is from 1 to 2 years after they finish inpatient treatment and a very strong family program. The family program we think is extremely vital to the success of our program.

If, indeed, one doesn't work with the families of these kids, then you are going to have a very high failure rate and this is currently one of the problems in virtually every facility available in the State of Iowa, except for a couple of inpatient treatment centers. There really isn't a strong family for these kids to go back home to. We have gone so far with some of our graduates to put them in foster homes because we felt that returning them to their natural home would be disastrous. They simply would not get support, in fact, they probably would get a lot of negative feedback for having been through treatment. Our family program involves having a family, or at least one family member, live in for a week with the client and go through everything except the school right with the client. They are even subjected to a lot of the same disciplines that the client is. In addition to that, they have 8 weeks that the client is an inpatient in the family program. They have individual one-to-one sessions with the counselors and a group session with other clients and families.

They will have a group of perhaps four families that will have group therapy together 1 night a week. Besides that, they are also included in the 1- to 2-year aftercare program. In other words, the client has 1 to 2 years of aftercare by himself, group, one-to-one, and family and the family has their own group plus their group with the client, so it's a very prolonged program. I don't know what else to tell you about the basics.

Senator CULVER. You mentioned you opened in July. How many juveniles have you treated during this time?

Dr. JACKSON. I think our total admissions are somewhere in the neighborhood of 35, perhaps up to 40 by now.

Senator CULVER. You probably haven't had time to really see the success or failure of your program?

Dr. JACKSON. We have had two juveniles that used alcohol again, one of them was in our unit from one of the reformatories and he went back to the reformatory. The other one tried drinking once, found out that it didn't work and since has stayed straight. The rest of our graduates have stayed straight. Now, we have had a fair number split and not complete the program and at the present time I can't give you any good statistics on how many of those are staying straight but we know several are.

Senator CULVER. Dr. Jackson, all your funding is private, is that correct?

Dr. JACKSON. At the present time. We have an application in for NIAAA for counselor salaries but we haven't heard anything on that.

Senator CULVER. Could you give us a breakdown of your funding sources?

Dr. JACKSON. We were able to raise approximately $60,000 from the the community through private contributions. We have borrowed the rest, simply the board has backed up the notes and that's where it stands right now. We are at the point right now where our referrals are coming in at least from the surrounding areas. We are not getting in a whole lot from Iowa itself.

Senator CULVER. What kind of communication do you have with other agencies and treatment programs? I know that there is a tremendous difference of opinion within the community, among individuals who have dedicated their lives, to this general problem as to the most effective approaches and means of treatment and prevention. I am curious as to what kind of formal communication you have established between your program and say Mr. Work with ADASI and the extent to which you have any kind of shared sessions as to what you think is working and what isn't working?

Dr. JACKSON. I haven't personally had any involvement with Mr. Work's group but with Dr. Haugland I have, and I have with the Omaha Alcoholic Treatment Center, with several other inpatient treatment centers in the Midwest. I think that just about everyone in the State of Iowa is attacking the problem from a different point of view and I think that ultimately we do have to get together and share our experiences and our ideas. At the present time I think that a lot of it is going to be pretty peripheral simply because we are all doing different things and trying to analyze it. We patterned our program after the AA model simply because I don't think that anyone can argue that that works best.

Senator CULVER. Dr. Jackson, what additional services are needed in the State for juvenile alcohol abusers? Do you have some thoughts on that?

Dr. JACKSON. Yes; I do. One would be that the Department of Social Services has to find ways of getting kids who do not have insurance policies into treatment programs. That's one of the areas that have been blocked for Iowa residents so far. There have been a few that have been able to come up with funding but not very many. I think we need to start outpatient programs that are basically treatment involved or treatment oriented but that are not inpatient groups but are daycare type centers.

I think we need to establish within the school systems some sort of groups for kids who have successfully become rehabilitated. They can have a support group within their school system. I have very negative feelings about anything that's been tried to date as being a preventative. I think that probably is obviously the ultimate goal to find some preventative treatment measure but at the present time nothing has worked nearly as well as treatment. Prevention is not nearly as strong as treatment.

I think we will find some tools eventually and I think perhaps getting encounter groups in schools would be one of the ways to start that.

Senator CULVER. But you agree that the prevention emphasis is one we have to address more seriously and imaginatively?

Dr. JACKSON. I don't think there is any question about that. In the first place it would cost you a pittance to prevent something as opposed to treating it.

Senator CULVER. You did mention you have an education program with the Sioux City school system. Could you briefly describe this program?

Dr. JACKSON. In our public high schools now each one of the schools has what's called a police liason officer and they have been able to set up in at least two of the schools groups where the administration of the school authorizes and promotes and provides space and time for these kids who have gone through treatment or otherwise gotten straight off of drugs to meet at least weekly for their own little group just like an AA meeting. They support each other. At times they go outside of their group and take a classmate who they see heading down the same road they went and say, "Hey, look, this is what I see you doing."

Senator CULVER. You don't find the more conventional educational presentations effective? You don't see the presentations where there is more of a medical approach to drug and alcohol abuse as being a very effective educational experience?

Dr. JACKSON. It can be but I think basically, as we use it, we use it much too late. We are putting it in junior high school now and we ought to have it in third and fourth grade at least and probably a lot younger than that. If it's going to work, it has to start very early.

Senator CULVER. That's not being done as far as you know currently?

Dr. JACKSON. It's not being done young enough.

Senator CULVER. Dr. Stan Haugland, is the medical director of Powell III, Iowa Methodist Medical Center. Powell III is located here in Des Moines. Dr. Haugland, would you be good enough to briefly describe your facility for us?

STATEMENT OF DR. STAN HAUGLAND, MEDICAL DIRECTOR, POWELL III, IOWA METHODIST MEDICAL CENTER, DES MOINES, IOWA [1]

Dr. HAUGLAND. We have several programs. We have a 40-bed inpatient treatment center. This was established about 5 years ago. Then we have a 16-couple outpatient treatment center wherein people live at home, come into treatment at night and then a strong aftercare program that lasts up to about 2 years. Our treatment approach, our staff is multidisciplinary in nature.

That is to say, we have people on the staff coming from many disciplines of life for the healing arts and we use much the same type program that Dr. Jackson has presented to you so I won't go over that a great deal.

We also are strongly AA oriented or the AA philosophy way of life is the backbone, I would say, of our treatment. That's a little capsule summary of the type of program we have.

Senator CULVER. In your statement I noticed you also, of course, pointed to this upward turn in juvenile admissions to your particular facility and I wondered if you could give us your views on this trend?

Dr. HAUGLAND. We have noticed an increasing demand for our services by the adolescent. I would say we noticed an upward swing at least 1½ years ago. Prior to 1½ years ago I would say our admissions approximated at about 4 percent in a year's time. Since that time it has doubled and we have had to put a stop order on admissions of adolescents in order to limit the numbers coming in. We try to keep the number of adolescents in our 40-bed inpatient unit to 5 at any given time.

[1] See p. 82 for Dr. Haugland's prepared statement.

I think that if we just let things go and not watch it, our place would be filled with adolescents because that's the big demand currently. Now, part of the reason for that seems like the adolescents, if you get too many of them at one time, you have a tendency to lose control. You just can't hire enough staff to keep the program structure and I don't feel that mixing them is the best idea either, adolescents with adults, but we have the only private treatment center in Des Moines and we simply felt we had to take them in and gain some experience as to what's going on.

We have had a waiting list for people trying to get in for 1½ years. We turn them away. I would say we must turn away at least 25 percent of all people that want to get in under the age of 20. Some of those we refer to Dr. Jackson's facility. I would say prior to that time we were sending many of our young people up to Minneapolis where they have a number of well established adolescent treatment centers.

Senator CULVER. Just what services do you feel are needed in the State if we are to more effectively address this problem? Do you just share what has been said about the prevention emphasis?

Dr. HAUGLAND. Yes; I do. I listened to Mitch's testimony and I don't believe more and more treatment centers is the answer. I know that we are going to have more adolescent treatment beds in centers, simply because the pleas of those that are sick are that powerful. In my opinion we can't build enough treatment beds to keep up with the increased demand. We simply cannot do that, so some massive preventative—educational preventative—measure is going to have to take place in my opinion to even start to break even, which I don't see is even possible within my lifetime, the magnitude of the problem is that great.

We need some research, of course, to look more at some of the causes but I think through education and prevention starting way down in the very earliest of years is where our main efforts should be directed.

Senator CULVER. This problem is growing and it appears to be increasingly a global problem. I had occasion to visit with some people from the Swedish Government who were involved in alcoholism treatment programs. They were extremely disturbed about what they had been experiencing within the last few years in Sweden where children with serious drinking problems are as young as 12 years old. When many children that young develop problems, the cost of treatment programs have been extremely high.

Dr. HAUGLAND. I would quote Richardson when he was Secretary of HEW, and that's going back a few years, even back at that time he said alcoholism was our No. 1 health problem, and really, I don't think that too much was done about it but even back that far, Norm Pawlewski in the State, he had information from the World Health Organization and he said that all of the developing nations felt it was their No. 1 health problem, the undeveloped or underdeveloped simply we have no statistics or demographic data, so I think it is our No. 1 health problem, in my opinion, no question about it.

People don't get too alarmed about it. Everybody is doing some drinking. We live in an era where we are looking for the easy, quick solution. There is a pill to go to sleep, a pill to wake up, rather than

work through some of those problems. It's simpler to take a chemical to solve problems.

Senator CULVER. I remember this kind of cynical indifference to the problem. I, as a student, had occasion to be traveling in Europe and at that time you may remember Pierre Mendes-Frances, the Prime Minister of France, was making a very serious effort to take on the problem of alcoholism in France. He said it was their biggest problem and this was 1954. He put signs up that said, "Beware, wine kills slowly," and I remember one person wrote beneath that, "That's OK, I'm in no hurry."

That was the kind of response in terms of cynicism that the prevention program got. Now admittedly, he took on about the toughest ground he could find in trying to talk about prevention. I think one of the most constructive things that has been suggested here is to make sure that we get the educational program down to the lowest possible level very early on when peer group pressures haven't yet started to assert themselves as much as they do later.

The last member of the panel is Bob M., a recovered alcoholic and member of Alcoholics Anonymous. I wonder, Bob, if you would briefly describe the Alcoholic Anonymous treatment approach?

STATEMENT OF BOB M., A RECOVERED ALCOHOLIC[1]

Bob M. I would like to clarify one thing to start off with, Senator. I do not in any manner, shape or form represent AA. I do work for ADASI and Mr. Work happens to be my boss and if I didn't know better, I would think all four of us read each other's resume on this prevention deal. My feeling is we should start in the fifth grade. If we should ever learn anything from Germany and Russia, start here. You don't start up here, you start down here. You don't build a house with a lath, you start with cement blocks.

Senator CULVER. Russia has one of the biggest problems.

Bob M. Especially with milkmaids. Did you read that? They are not producing milk because there is too many drunks. We in AA have 12 steps and 12 traditions and this is why AA works is because we stick with them. Our program is built basically on tradition 11 which reads, "Our public relations policy is based on attraction rather than promotion." It's just that simple. Now, the first treatment centers were started, the first detoxification centers were started, when Senator Hughes got involved in it. They were basically formed to treat the alcoholic. Alcoholics Anonymous is an organization which, to my notion, is the finest aftercare group, if you will, going in the United States.

I would also like to state that it has been through the treatment center such as ADASI which I happen to think is the best in the country, Alcoholics Anonymous has grown. It has doubled. We are at the present well over a million members. As to the juvenile program, there was a study done in 1976 and this is fascinating. They came up with the figure that 12 percent; 12 percent of all the students from the 9th through the 12th grades either had a serious alcoholic problem or were in fact alcoholics.

That's the way it always went with our programs. We get statistics. We get figures. We get all these grandious policies and procedures.

[1] See p. 90 for Bob M.'s prepared statement.

Then we sit here and do nothing about it. As my learned colleagues have already brought out, there are four areas that have not been examined that directly deal with the juvenile, No. 1 is the parents, educational system, the schools, and the court systems.

I would like to explain that statement. We identify these problem drinkers, problem abusers and we shuffle them off to Buffalo and that's where they stay because of the trouble they got into, not what caused the trouble. We do not address the alcoholism part. We do not address what's happening in the home. We do not address what's happening in the schools. These people aren't referring them to us. This is where we are having our problem, I feel, as treatment centers because people are not referring them to us.

We are not going to grab you off the bar stool but we are very willing to cooperate and work with any service center any place to help solve this problem. It is also interesting to note that there was a nationwide survey done where 50 percent of the high school individuals were interviewed and this is one figure that really interested me was that 40 percent of the problem drinkers and abusers, the chemical abusers, are women, young women, and I'm talking about from the age of 12 to 20. This has been a very, very neglected area along with the juveniles.

By the way, I do not like the word "juveniles." They are human beings. That's another thing. We have never listened to them. We have always said, you know, shut up, go about your business, we'll handle it, and that's not the way it works. I have had the privilege of working with quite a few juveniles and, believe me, they are not quite as dumb as they appear to be. I think it's time not only for the prevention but I think it's time to sit down and listen to what these young people have to say with us and to cooperate with them and work with them.

Senator CULVER. In that regard, Bob, does AA have any programs that are directed specifically at young alcoholics?

Bob M. We do not, Senator. We do have a group that is called Aloteen but this is for the children of the alcoholic. As for the children themselves, no.

Senator CULVER. What have been the barriers to establishing such programs?

Bob M. The barriers is what I mentioned previously is that we do not go out and solicit business. All ours is on referral basis. The parents will not refer them. The educational systems will not refer them to the treatment centers. Therefore, the treatment centers cannot refer them to us. The courts do not refer them to us so we end up with the old problem.

Senator CULVER. I would suggest here that the program Jackson described of having people who have reformed as far as drinking problems are concerned go to the schools might be utilized.

Bob M. That's why in my first remarks we read each others reports because this is one thing I do have in my report that I think it is very necessary that the juvenile abuser not only be identified in the schools but we should use them and they want to be used and they want to be heard. I think this is where the success actually lies. It doesn't lie with us guys. We can give them the treatment.

Senator CULVER. I want to thank each and every one of you for your appearances here today. It has been extremely helpful and I want to assure you that we look forward to working with you in our

subcommittee work as we try to develop the proper approach of the role of the Federal Government that reflects more directly some of the concerns that you noted here and directions you have pointed out for us.

Our next witness is Mary M. Mary, I am very happy to welcome you here this morning. We appreciate your coming before our subcommittee. Mary is a young person who has had some previous problems with alcohol and she has been kind enough to agree to testify before the subcommittee because of her concerns about young people like herself who find they have had an alcohol problem. I have assured her that the press and television camera persons would not write stories or take pictures which would reveal her identity.

Photographs and film shots may be taken from behind the witness table and I ask that you respect and honor this request. I would like to ask Josephine Gittler, our legal counsel, to ask you a few questions, Mary, if it's all right.

Ms. GITTLER [Chief counsel]. Mary, how old are you now?

STATEMENT OF MARY M., A FORMER JUVENILE ALCOHOLIC

Mary M. Twenty-one.

Ms. GITTLER. I understand that as a teenager you became an alcoholic; is that right?

Mary M. Yes.

Ms. GITTLER. How old were you when you started drinking?

Mary M. Fifteen.

Ms. GITTLER. What did you drink when you started drinking?

Mary M. Hard stuff, hard liquor.

Ms. GITTLER. Did you drink alone or did you drink with classmates?

MARY M. With classmates.

Ms. GITTLER. Where did you obtain the liquor that you and your classmates drank?

MARY M. From older people.

Ms. GITTLER. People that were above the legal age?

MARY M. That were legal age.

Ms. GITTLER. Why do you think you started drinking?

MARY M. Experimentation, I wanted to see what it would feel like to be drunk.

Ms. GITTLER. Did you drink heavily during your sophomore year in high school?

MARY M. No.

Ms. GITTLER. Mary, when you went into your junior year in high school, did you begin to drink more heavily?

MARY M. Yes; on weekends, every Friday and Saturday night.

Ms. GITTLER. To the point where you would get drunk?

MARY M. Yes.

Ms. GITTLER. What happened to your drinking patterns in your senior year?

MARY M. They progressed to drinking during the week plus the weekends and getting drunk every time I drank.

Ms. GITTLER. Did your mother realize you were drinking this heavily?

MARY M. No.

Ms. GITTLER. Did your teachers in your school?

MARY M. A few of them knew I had a problem.

Ms. GITTLER. Did any of your teachers try to assist you with that problem?

MARY M. Yes; one of them. They made an appointment with the regional alcoholism center.

Ms. GITTLER. Did you go there?

MARY M. Yes.

Ms. GITTLER. What happened as a result of your going there?

MARY M. Nothing. I didn't want the help at that time.

Ms. GITTLER. What effect did all this drinking during the week as well as on weekends have on you?

MARY M. I became very depressed.

Ms. GITTLER. So then during your senior year in high school you were actually hospitalized, were you not?

MARY M. Yes.

Ms. GITTLER. What precipitated that hospitalization?

MARY M. I went out on a weekend drunk.

Ms. GITTLER. And got so drunk that——

MARY M. And got so drunk that I was hospitalized.

Ms. GITTLER. What kind of treatment did you receive in the hospital where you were taken?

MARY M. Alcoholism wasn't even touched on. They gave me pills to keep me happy and I left there with two prescriptions for a year but as to the alcoholism, it wasn't even touched on.

Ms. GITTLER. After you got out of the hospital, did you go to a shelter house?

MARY M. Yes, I stayed at a shelter house for a week and there again the alcoholism wasn't touched on. They thought my main problem was a conflict between my mother and me and if we got that worked out the alcohol would disappear.

Ms. GITTLER. After you graduated from high school, did you continue to drink this heavily?

MARY M. Yes.

Ms. GITTLER. Eventually you were admitted to Powell III that we have heard testimony about?

MARY M. Yes.

Ms. GITTLER. What precipitated your admission there?

MARY M. I went out one night and got drunk and hit my bottom, my low point, and decided I didn't like myself and so I attempted suicide and I was admitted to Powell III on the advice of my sister.

Ms. GITTLER. How old were you then?

MARY M. Twenty-one.

Ms. GITTLER. What kind of treatment did you receive at Powell III?

MARY M. They made me take an honest look at myself and made me realize that I am an alcoholic and that I am powerless over alcohol.

Ms. GITTLER. How long ago did you leave Powell III?

MARY M. Last April.

Ms. GITTLER. Since then have you had any kind of drinking problem?

MARY M. No.

Ms. GITTLER. You haven't been drinking since then?

MARY M. No.

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Ms. GITTLER. Looking back on it, what do you think were the causes of your problem?

MARY M. I think it's hereditary. I came from an alcoholic family. My father is an alcoholic and I have three alcoholic brothers and an alcoholic sister.

Ms. GITTLER. One of the things that strikes me is that this problem really started when you were 15 and very few people seemed to have realized how much of a problem it was. How do you explain that?

MARY M. I managed to cover it up pretty good. I managed to go to school every day and to work almost every day. It was just toward the last that I started missing work more frequently.

Ms. GITTLER. How typical is your case? For example, in your high school class, can you give us any estimates of how many of your fellow students drank heavily?

MARY M. Out of a class of 85, I would say about a third of them were heavy drinkers.

Ms. GITTLER. Where is the town where this was all taking place? Is it an urban area?

MARY M. Small town, 2,800.

Ms. GITTLER. So this isn't just a problem that occurs in large urban areas?

MARY M. No.

Ms. GITTLER. Now, the other thing that I think is striking about your testimony is that you weren't really able to get too much in the way of assistance with your problem until you went to Powell III and I wonder what your feelings are about what kind of services exist in the State for juvenile alcohol abusers and what we need?

MARY M. There aren't very many. I think there need to be more treatment centers and more like halfway houses for aftercare. Juveniles are released from treatment centers and are sent back to the same playgrounds and the same playmates and they are soon back to drinking.

Ms. GITTLER. Do you have any other thoughts about what we could do to cope more effectively with the problem of teenage drinking?

MARY M. Better educate people and, I think, if you changed the legal age back to 21 it wouldn't be so available and it would be harder for the teenagers to get ahold of.

Ms. GITTLER. Mary, what are you doing now?

MARY M. I'm working and this March I'm going to go to nursing school.

Ms. GITTLER. Thank you very much.

Senator CULVER. Mary, I certainly want to thank you very much for cooperating with us and helping us here with this hearing. I wondered, you heard perhaps some of the others talk about the need, to give more attention to prevention and you mentioned that one way may be educational programs in the schools. Do you have any more specific thoughts on that? Everyone thinks about a movie and bringing a doctor in and having a lecture. Does anyone else have any better ideas? We are anxious to have them flood the witness stand with imaginative, creative proposals. I wonder what you had in mind?

MARY M. A course in high school and junior high.

Senator CULVER. You mean we should have health courses dealing with hygiene, sex education, and nutrition which specifically goes into the affects upon the body of excessive drinking?

MARY M. Yes.

Senator CULVER. I wondered if I understood you correctly when you described what happens when people leave the residential centers. As you properly point out, even when they are quite successful in straightening people out they return to an environment that really is so unhealthy and gives rise to a lot of their unhappiness and frustration which leads to their looking for relief and escape in alcohol and drugs.

When they leave a residential center, obviously there are independent living opportunities that could be subsidized in some way, but how would you suggesting that we avoid the problem of sending them back into an unhealthy environment?

MARY M. Send them to halfway houses where there is a somewhat structured system and where there are other teenagers.

Senator CULVER. For like 6 months or more extended periods, too?

MARY M. Yes, 6 months to 1 year.

Senator CULVER. Would you suggest one where everyone of the residents has this kind of problem in common or, do you think perhaps it would be better to have a mix, or do you think that makes very little difference.

MARY M. I think a halfway house that was just mainly connected with alcohol and drug abuse.

Senator CULVER. And the people really essentially at the same stage of rehabilitation or reform?

MARY M. Yes.

Senator CULVER. Well, I want to thank you very much again, Mary, for helping us and the best of luck to you.

MARY M. Thank you.

Senator CULVER. I want to compliment you very much, too, and commend you for your own personal character and being on top of this problem. It's an inspiration to many people.

Next we have a panel. If those on that second panel would be good enough to come to the witness table, Dr. Benton accompanied by, Mary Hayes and David Wright and John Tapscott. This panel, of course, consists of individuals who have some expertise with respect to the prevention of juvenile alcoholism as opposed to its treatment and, as you have observed and as you have heard earlier this morning, this has been a very strong theme.

The first member of the panel is Robert Benton who is the State superintendent of the Iowa Department of Public Instruction. I understand, Dr. Benton, that with you today are Mary Hayes and David Wright, who are alcohol and drug specialists within your department?

Dr. BENTON. That's right.

Senator CULVER. In your statement, Dr. Benton, you stressed the need for prevention and education programs. What is your feeling for our record as to why this approach should be emphasized?

STATEMENT OF DR. ROBERT D. BENTON, SUPERINTENDENT, IOWA DEPARTMENT OF PUBLIC INSTRUCTION, DES MOINES, IOWA [1]

Dr. BENTON. It seems to me there are several things that have happened in our society in recent years that kind of puts this thing

[1] See p. 92 for Dr. Benton's prepared statement.

into proper focus. You can do all kinds of things in society but people still drink. You can tell them that cigaret smoking is extremely dangerous to them and yet I'm told that the actual number of people who smoke in this country has increased, so you are really kind of faced with a dilemma here. Do you inundate people with a lot of scientific information and knowledge? I think the information is, you can do that but it's not overly effective.

It's only when people are really willing to understand the problem and then make those kinds of decisions that are going to have an impact on their lives, either positive or negative, that you probably have some type of response that's productive. I think from the standpoint of education particularly, it is important that they do have the knowledge and understanding. Probably you have got to go beyond that in terms of helping young people particularly, build some type of a concept or perspective in this whole area of decisionmaking and these types of things.

How do they react to peer pressures? How do they react to the other society pressures? How do we as adults if we go to a cocktail party react to these things? These are all thoughts I have had on the thing but we have gone into it in a preventative way. We have tried to go into it in a preventative way. We don't contend that in this particular point in time that everything tried in the educational system has been successful. It obviously hasn't been.

We have only been able to scratch the surface in the educational areas. I would like to respond to another aspect of this particular question. I don't think it's either a preventative program or a treatment program. I think the point has to be made that regardless of how successful your preventative programs may be, how successful your treatment programs may be, we are still going to have those two needs in our society. It seems to me that that's kind of an important concept so I don't want to put preventative programs versus treatment programs or treatment versus preventative programs. I think that's not very productive as we take a look at these problems.

We need to try to do the best job we can in the preventative way and educational way and hope that there will be less people for treatment. No matter how much you stress the treatment program, how successful you might be, there is going to be the need for the preventative program because it does fall into a continuum.

Senator CULVER. Now, I notice that in your statement you mentioned that you think the Federal Government can perhaps be helpful in making available some funds to try to get this kind of educational effort introduced at an earlier level, elementary school. Is your current program pretty much aimed at the high schools? What age group does this prevention education program aim at?

Dr. BENTON. Mary, would you want to comment on that and Dave? Actually, they deal with it more.

Ms. HAYES. I would be happy to respond to that.

Senator CULVER. Why don't you just describe the comprehensive program that you developed within the Iowa Department?

STATEMENT OF MARY HAYES, ALCOHOL AND DRUG SPECIALIST, IOWA DEPARTMENT OF PUBLIC INSTRUCTION, DES MOINES, IOWA

Ms. HAYES. A direct answer, it's a K through 12 program. But first of all I would like to say that we believe that there are things that schools and communities can do which will reduce the abusive use. We believe that we can do some preventing in terms of the number of people that have problems with alcohol abuse. We believe that schools and communities can provide students with knowledge and skills to enable them to make responsible decisions about their own alcohol use and whatever lifestyle they choose.

Our program specifically recommends that alcohol programs help students understand human behavior in general, especially regarding substance abuse and nonuse. We also recommend that schools help students develop personal skills for making responsible decisions. Schools can help students make factual information relevant to their lives. We think we have given kids factual information for many years but that somehow or another it really doesn't transfer.

What do I do when I'm with a bunch of kids and somebody has a joint or a six-pack? We believe that schools can help them develop interpersonal skills for carrying out the things they want to do. For instance, we want them to know how to make friends, how to talk to other people, but more than that, how to say to their peers, "Hey, in my life I would rather not do this right now," and we think that we need to reinforce the individual's right to control their own life.

Fourth, that schools will provide for young people's needs for mental and emotional health. In transferring this into what happens in a school program, there are four areas. We think there has to be classroom experiences; teachers presenting factual information and students learning to apply decisionmaking skills. The second area in the school has to be services, what kinds of things do schools do to intervene and how do they refer kids to help and what kind of followup do they do when they come back into school.

I think one of the earlier persons mentioned how schools and people treat young people when they come back. The third part we think is equally important and that is the school environment, what kinds of things do the schools, the teachers, the grading system, the scheduling do which enhances students' self concepts and feelings of usefulness, acceptance, and power.

The fourth part, includes school administrative support for alcohol education, such as helping teachers get inservice training, developing some positive school policies, and working with the community in some cooperative programs. We have to present to you as part of the material a curriculum guide called alcohol and other drugs which Dave and I have worked on for the last couple of years. This guide is K through 12. (See page 127 for text of guide.)

It's based on six major outcomes: human behavior, scientific facts, consequences, prevention, alternatives, and decisionmaking. That doesn't mean just what do I do if I have too much to drink, that's talking about family and social, prevention, that's not that it's somebody else's job, it's my role, too, to do something about that and a very important part is alternative and decisionmaking.

Our program is divided into four grade-level sections and for each of these we have specific outcomes which relate to the developmental level of those students. We deal with kindergartners on the kinds of things they understand, dealing with feelings, moral reasoning and the same then for junior high or senior high.

Senator CULVER. Mary, are these programs that are now actively being conducted?

Ms. HAYES. We distributed these guides to all superintendents and all principals this last fall and during October and November conducted workshops to introduce schools to this. We contacted 700 teachers. The concern is, however, that we simply introduced them to this idea, the idea that is beyond factual information. It was very, very well received and as we may bring up later on, the problem is they do not feel that they have the skills to carry it out. That's where we need some funding and some assistance.

Senator CULVER. In terms of just counselors?

Ms. HAYES. No; classroom teachers. You see, we are talking about putting factual information together and helping kids relate that to their lives and that has to be done throughout the school day. That has to be all teachers helping kids use these kinds of skills.

Senator CULVER. And the State department doesn't really have any power to require this to be adopted in the curriculum, is that right?

Ms. HAYES. That's right. It's in our State code.

Mr. WRIGHT. We don't have the power to mandate that that curriculum be implemented. What it is is it's a resource guide that we are suggesting as a model program for alcohol and drug abuse prevention.

Senator CULVER. How would this work? Take the kindergarten year, would you equip the kindergarten teacher or would a separate instruction person come in and how often?

Ms. HAYES. Yes. At the kindergarten level it would be the classroom teacher.

Senator CULVER. The one they see every day?

Ms. HAYES. The one they see every day because part of the message is factual information which at a primary level deals with poisons, safety rules relating to health people and also, how do I deal with my feelings, my behavior and how do I solve situations, what do I do when I want to beat up on somebody else, and the classroom teacher needs the methods for helping kids learn these kinds of skills. It's the same all the way through senior high. However, at high school levels you could find these kinds of programs in related subject areas but we think the science teacher needs to know how to do this as well as the math or health teacher.

Senator CULVER. Is it my understanding that you are trying to raise the consciousness level in all the disciplines and all the instructors?

Ms. HAYES. Excuse me. It has to be this way. I mentioned the school environment. If you have one classroom teacher presenting these things and helping students make decisions and being in control of their life and all of the rest of the teachers being very restrictive, then we aren't getting very far.

Senator CULVER. It has been said that the experience with many drug education programs in the schools has been somewhat negative. I mean, arguably it has aroused interest and pressure toward experimentation rather than discouraging drug use. Would you care to comment on that?

Dr. BENTON. Well, there is that argument. That's what the sex education opponents were saying, that really, we were going to try to teach sex. I have a feeling that teenagers, and I remember my own teen years and I think most here do, they are years of uncertainty and wanting to experiment. You have to kind of come back to this issue of the individual kind of being in charge of his own will and willing to do these things.

Senator CULVER. How are you evaluating? How confident are you of qualitative evaluation?

STATEMENT OF DAVID WRIGHT, ALCOHOL AND DRUG SPECIALIST, IOWA DEPARTMENT OF PUBLIC INSTRUCTION, DES MOINES, IOWA

Mr. WRIGHT. I would like to express some facts, some data about that issue. One thing that we have learned in Iowa is that when we surveyed schools in Iowa, less than 10 percent of the school districts have attempted to do any type of evaluation of alcohol and drug education programs. Now, that's not a bad reflection on the schools particularly because they really aren't required to do a curricular evaluation of alcohol and drug education. It takes a lot of time and a lot of money for them to try to do their evaluation.

Senator CULVER. Are they required to do evaluations in the other disciplines? How can you be a good teacher and not do it?

Mr. WRIGHT. It's really in our system in the State that it is a local board responsibility to make that request of curriculum in the districts. That's how it operates. We are having a difficult time establishing the program, the alcohol and/or alcohol and drug education model we are advocating. It becomes even more of a super sales job to sell the school district on evaluating on a short-term basis or long-term basis on what they are doing with that program. Now, that's the condition. We are moving into some evaluation stuff here in Iowa with our program.

I want to talk, though, directly at some of the things that have been shown and demonstrated through drug education programs. Now, there is a whole resource packet that is available to the Federal Government. It has been published by the Project Pyramid. It's called Primary Prevention Research Preliminary Review of Program Impact Studies.

In that report what they are looking at is the direct relationship between program efforts and impact on students. What was in that report and some of the other reports and studies that I have come across in the last few years, is that 40 of the studies that they reviewed had some impact measures, some measure of specific substance be-

havior. Of those 40 studies, the programs that had a prevention education approach like we are advocating were fairly effective. However, over 75 percent of the programs that use this new approach to substance abuse prevention showed positive impacts on one or more of the specific behaviors.

They also reflect that 29 percent of them did not show positive but had negative results on impact measures, but it's a 75 to 25 relationship. Seventy-five percent positive, 25 percent negative. A lot of those studies had some methodology problems, so there are some questions still there, but when they looked at the programs that were pretty much the traditional school program of information presentation, a teacher-centered classroom, the effects were 46 percent positive and 46 percent negative with a remainder undetermined.

It's hard to determine whether it was positive or negative. The overall pattern of those studies, though, indicates that a multidimensional program like we are advocating that does the job with blending the affective development with the cognitive development of the kids can be effective in preventing alcohol and drug abuse. Regardless of whether we talk about alcohol or drug abuse, those programing things that are effectively oriented have a tremendous effect and documented effect on facilitating the affective growth of kids.

In other words, their mental and social health. It also had a tremendous effect on improving the kids' school performance and also in reducing dysfunctional behaviors of other types: juvenile delinquency, dropouts, this type of problem. The issue for me is really not whether the program is one that reduces significantly some measure of alcohol or drug abuse but what it does pay off in terms of an overall effect on young people's mental, emotional, and social health.

We are stuck in a bind because we have the critics you just mentioned that pick out a few studies here and there that show negative effects and say that is the fault of substance programs. That is the traditional programs. There really are programs that are having good effects but the really difficult thing for us is that we have to prove to the critics that something bad didn't happen because of our programs and to match those programs with treatment effects; that the school efforts influenced substance behaviors either at the end of 1 week or at the end of 10 years. This evaluation is going to cost some money and prevention programs are not funded to do evaluation or research.

They are funded to provide a service and consequently we need to have some more money, need to have some more staff time, and we need to have some time to live in our society and we need some time to demonstrate program effects.

Senator CULVER. I understand that this program was introduced last fall for the first time, that some 60 percent of the school districts have voluntarily tried to implement it in part; is that correct?

Ms. HAYES. These are people who were interested, who attended the workshop. We do not know whether they implemented programs. We are in the process of preparing some kind of evaluation in April to determine this and we also propose—in the following year, next school year—to work in some field test sites and directly implement them.

Senator CULVER. How about the other States? How progressive and far advanced do you think that this type of initiative is from a national perspective? Are there many States that are further along

than this? It sounds to me as if you have a very creative concept here, at least you want to implement one.

Dr. BENTON. Frankly, I'm not sure I know and I don't know whether these two do either. I know that most of the States—I meet with the chiefs of the other State departments periodically. I know that this is an area of real concern and my guess would be that they are struggling as we have struggled. It hasn't been just an educational struggle.

Senator CULVER. But this isn't broiler plate off of somebody else's model or anything and I wondered how many other States are using it.

Ms. HAYES. We think we have an unusual model and we think it's a workable model for preventing substance abuse. There are some States that have some well developed educational programs, comprehensive health programs, that are no doubt in some of these documents. We feel that our model addresses the total educational system because, regardless of the subject matter area, whether it's alcohol or environment or whatever, students still need these process skills to act toward substances as citizens.

Dr. BENTON. You may be interested, Senator, to know that as an outcome of this, and I didn't go for it this time, the staff did recommend that we get involved in the total comprehensive health education area and that's one of the areas that we do plan to move into. You are familiar with the Federal legislation on nutrition education. I was in Washington consulting with some of the rules on that nutrition education thing and we have established a task force here in Iowa to deal with that.

That's where I'm coming from in a general way; we could piecemeal these things. That's all very fine but I would like to go the next step in trying to address the next issue of comprehensive health education problems in the schools of Iowa. These are very important bits and pieces and parts. They are more than bits and pieces. They are very important parts, but the whole comprehensive health education has not been addressed adequately in this State and that is one of the initiatives we plan to get going.

You asked earlier or posed the question, what can the Federal Government do. I guess being a States' person I always feel the Federal Government is a bit too prescriptive but I must admit that the Federal Government in the various educational programs at least can provide some kind of incentives, seed money, whatever you want to call it, getting these programs off the ground.

We do sometimes have trouble translating that to State support. This brings me to the concept really that if the Federal Government wants to make a comprehensive move in this area, make it, but don't get in and get out. It's a long-range circumstance and I think the Federal Government has a role to play, if not the dominant role, at least a role, but I hope that if they get into it that they are willing to stick in the ballgame because it isn't a problem that's going to be solved in 1 or 2 years.

Senator CULVER. You mentioned in your statement specifically making funding available from the Federal Government for training of school personnel, elementary school counseling, and early interven-

tion programs. Is that your list of specifics? What is the current availability of either State or Federal funding for such programs?

Mr. WRIGHT. Just pick them up one by one. We have no Federal dollars in our program in substance education. We train teachers on a shoestring, and that's basically our predicament. We will operate training on the State level on a very tight budget. However, we are talking about a larger, very much larger, training or retraining kind of process with all the teachers in the State to deal with the effective growth of children and how to foster that in the classroom.

That's going to cost a lot of money and we can use incentives as Dr. Benton said. The Federal Government would be very well off to do that.

Dr. BENTON. I have the feeling that the Federal dollars, and they are always limited, the Federal dollars channeled into that area might be as productive as anything. That is one of the issues. I think it needs to be pointed out here that very frankly, the dollars we have used haven't come from my budget as much as they have come from the State Division of Alcoholism.

Senator CULVER. You have received money from the Department of Substance Abuse?

Dr. BENTON. Not in our agency but there has been some State money here. The point being that the alcohol and substance abuse State agency has been very cooperative and we have worked very cooperatively with them. We have had interagency subcontracts in this area; that's basically where our dollars have come from. My State carries Dave's salary but that's all the State has been willing to put in the end of it. Mary has been with my staff through a subcontract. I'm not totally familiar with everything that's going on. You have a witness later on here, I think, who will be able to give you some information on the new lists of the statewide basis. The Governor has had a task force working and that was one of the issues that came out with the recommendation of about $200,000 in our agency. That, very frankly, is in the political arena and I'm not very sure where it's going to go. The point I'm trying to make is it hasn't been a segmented effort in other agencies and our agency has been trying to work with other agencies on this issue.

Mr. WRIGHT. I would like to go ahead with that elementary counselor business. Very few of our schools in the State of Iowa have elementary counselors and that's one of the positions that's cut out when school dollars start going down, when the total school budget for a district goes down. Elementary school counselors, if they are given the opportunity to counsel the elementary age youngsters, are very effective in early intervention in problems with kids before they further digress down the road to other more significant or overt dysfunctional behaviors and I don't think that's an unwise investment.

Senator CULVER. Your statement as well as others that we have had today indicates that one significant cause of juvenile alcohol problems is a general cultural tolerance of drinking. Of what value do you think these educational prevention programs are in the schools when children are surrounded by a society which so readily accepts and uses alcohol often in abusive ways? I guess that the only hope is to get a new generation that has different attitudes and value systems and perhaps they can work effectively on their parents in this area as they have in other areas of public policy.

Ms. HAYES. There are two aspects of our program that deal with that. One is the skill to make some educated decisions and to reinforce students for looking at their social environment and for analyzing features of that environment which influence their decisions.

The second emphasis in our program is alternatives. That is to very clearly help students develop leisure time skills, job skills, and other ways of meeting needs. There is statistical evidence that young people who have considered alternatives are less likely to choose situations where alcohol and drugs are used. I think those are two very powerful parts that will counter what you have mentioned.

Mr. WRIGHT. I think there is another thing we are trying to do with the school districts that we work with. We say to the school and community that the school is one institution in that community, that it can help deal with some of the problems but the community has to own some of those problems. What we are suggesting, and it's backed up by parent data, is that parents want and need parent education to deal with alcohol and drugs and the rest of the shopping list of youth and social problems.

They want help in helping their kids deal with developmental problems and that's something we are saying when we go into a school district. We say "Look, we will help set up a school program. We have a package here that you can work with but please also address the needs of the parents."

Dr. BENTON. The National PTA, as you are probably well aware, has a real thrust in parenting. That's a broad, general term but it's the thrust. Instead of PTA trying to zero in on the kid, it's finally seeing that parent-teacher type of thing. The parent does have some problems and responsibilities here and it's kind of a major thrust. It's one that I am told, I haven't been that close to it, is starting to have some productive results.

Senator CULVER. I didn't mean to neglect you, Mr. Tapscott. We have another member of our panel, John Tapscott, the executive director of the Des Moines National Council on Alcoholism. John, I understand that the council has received a grant to formulate an alcohol abuse prevention program to be located in selected Des Moines schools. Could you briefly describe this program for us?

STATEMENT OF JOHN TAPSCOTT, EXECUTIVE DIRECTOR, NATIONAL COUNCIL ON ALCOHOLISM, DES MOINES AREA, DES MOINES, IOWA [1]

Mr. TAPSCOTT. Well, because of the limited resources we have asked the board of supervisors, and since the board of supervisors do fund part of our employee assistance program that deals with 51,000 employees in this community, we asked for an additional grant beginning in school year 1978–79 to do a pilot project in three community schools from kindergarten through 6. The model that would be used, of course, is a similar model that the Department of Public Instruction has given our inschool educator.

We have an educator who spends most of her time in schools with teachers, nurses, and counselors and giving school presentations, PTA presentations, et cetera. The kindergarten through 6 model that we will be using will be identifying the students of chemically dependent

[1] See p. 278 for Mr. Tapscott's prepared statement.

parents. There are criteria that the National Council on Alcoholism devised to use for teachers who are trained, to qualify in the area particularly of alcoholism and drug abuse, in identifying the child from a chemically substance abused home, particularly alcohol, because of the behavior and emotional problems that the child brings with him/her.

Specifically speaking to alcoholism being a family disease, many times we see the juvenile referred to us by the school as the dysfunctional family member. In reality, 90 percent of all alcohol and other drug-related cases show a marked deterioration in family relationships and that not one but all of the family members are dysfunctional.

This is a pilot project in conjunction with the program that we already have, a project called the student assistance program.

Senator CULVER. Could you explain the student assistance program?

Mr. TAPSCOTT. We also have a student assistance program at one of the private schools here for a pilot project that we are looking at and that is in its infancy. It's only 2 months old. We are getting those students referred to us who have been suspended from school for behavioral problems and we are finding that 77 percent of those are chemically related. Eighty-four percent are females, of which 80 percent have chemical dependencies. That's a frightening number.

It's early. The program is only 2 months into existence but nevertheless we are also finding that those individuals who are coming, who have behavioral problems have an alcoholic parent or parents in the home and, if I might, just one of the things that disturbs us, Senator, is in the area of prevention specifically versus treatment.

We certainly would not want to see and we don't advocate transferring or shifting money from treatment to prevention but I think when we look at the overall figures of the National Institute of Alcohol and Alcohol Abuse last year funding $52 million for treatment and $3 million for prevention, or when you take all of the alcoholism programs in the United States, $237 million for treatment and $12 million for prevention in the 50 States.

Senator CULVER. Excuse me. What were those figures again?

Mr. TAPSCOTT. $237 million for treatment, $12 million for prevention.

Senator CULVER. Is that total expenditures on all levels of government, private and public?

Mr. TAPSCOTT. Private and public, all levels of expenditures relative to alcoholism, use, abuse, treatment, and prevention, and when we consider that in a State like Iowa we had $350 million of alcohol sales in one form or another, that we just simply do not and are not dealing with the problem. I think one of the things, and I came here specifically today hoping that we might get some recommendations as we have in our written testimony, but I think many of the things we have talked about today would be redundant. I would like to specifically go away today with some feeling that maybe we do address some issues and it was touched on briefly this morning, and that's the issue of the advertisement of alcoholic beverages on television.

These are prime time commercials and they reflect, first of all, stereotypes but they unrealistically distort the truth by equating the alcohol consumption with friendship, with fun, with popularity, and positive other good feelings that have nothing to do with alcohol use. I think that's something that hopefully your committee would address itself to because I think that's a starting place.

I frankly believe that commercials are written for the young minds, for the preschoolers and the kindergarten through 6. I hope that they don't write them for me. I hope that I don't, as an adult, look at a television commercial and believe that if I'm not feeling black velvet or if I'm not a man of gusto, I'm not a total man. I think these commercials are written for the young minds. I think that's something they might take into consideration in producing some Federal legislation.

Senator CULVER. I think that's an excellent suggestion, very helpful. What about coordination? This is the other problem we always run into. It's the genius of the American system that we have a million people doing the same thing, four of whom may find the right way to do it. The advantage of this system is that we don't lock into one way of doing things that some superdictator thinks is right and do it that way for years even if it is wrong. We have this potential for self-correction but we also have a constant state of chaos, overlap, and duplication. Everybody is off doing their own thing. How do we in this area get more of a semblance of rational allocation of resources and get our shoulder behind a common wheel and not have warring camps over prevention versus treatment and Federal versus State. The Federal Government has a fetish for prescriptions that are onerous from a State and local standpoint. I suppose you could write a pretty good Ph. D. about State and local relations. Nobody has a monoply on wisdom.

Where do we stand here by way of coordination? I suppose you both have been working here and John is working here. You get a grant to try your thing. He gets a grant to try his thing. I suppose if we throw enough darts at the board, one of them is going to hit. Can we talk a little bit about that a minute?

Mr. TAPSCOTT. First of all, we work very closely with the Department of Public Instruction. We, as the National Council on Alcoholism, are not in the business of moving into the educational system nor do we intend to. We do recognize that we have some obligation relative to identification and prevention and hopefully to evaluation and referral. Nothing would make us happier than seeing our agency communicating on an ongoing basis with the DPI or with the Des Moines school board in helping to instruct, if you will, educators in the field of alcohol use and abuse, and drug use and abuse, and yet I sympathize with the DPI and the work particularly that Mary and Dave have done.

They have, you know, a tremendous project and proposal but where do they go with it? It's there. The money isn't there, Senator. You know, we hear a lot of talking about these programs and we have a lot of flack but when it's all said and done, there is more said than done so consequently we have to look for little bits and pieces of money wherever possible to go out and put on pilot projects, take that research back to the local school board and say, "This is what we found in this particular area. Now, would you be willing to put up x number of dollars to implement this in additional schools or to implement it fully within the system?"

Then it comes down to a matter of priorities. I think we have to face the fact that people basically are not really concerned about chemical substance abuse and particularly alcoholism because it's so much a part of our society. That's when you are dealing with the local school boards. You are dealing with citizens. You are dealing with

representatives of these citizens and when priority items are set particularly in the area of alcoholism, it's at a lower level.

Senator CULVER. I happen to be quite prominently involved in the effort to stop the production of B–1 bombers.

Mr. TAPSCOTT. Congratulations.

Senator CULVER. Well, I'm still at it. We will be working on it again because it dies hard, because the supporters are well organized.

Dr. BENTON. Give us just a fraction of what has been spent.

Senator CULVER. Each B–1 bomber is $117 million a plane. Now, the total for alcoholism is $237 million. Even if you want to be very callous and insensitive about the human tragedy of alcoholism, its cost is enormous in terms of the money spent on alcoholic abusers by our juvenile justice, criminal justice, social service, and mental health systems. Yet, as you properly point out, there is a lack of an effective constituency to get these priorities in a little better shape. I know when we try in the Juvenile Delinquency Subcommittee to get funds for some of our other juvenile programs, it is just incredible how tenacious those watchdogs at the Treasury can be in cutting back on these programs.

I think we ought to approach both defense and juvenile programs with a comparable degree of scrutiny and toughmindedness and insist upon cost effectiveness. The irony is that those who stand up and beat the tub about how we waste money on social programs at the same time lead the pack supporting any costly new weapon system that someone has designed and that someone wants to produce. Nobody ever says, "Those guys really do waste money." Nobody ever says that.

I can assure you after 14 years in Congress with my set of priorities I do find it frustrating. It does require perserverance, as you say, John. You know very well from your own experience, that that's exactly what is necessary. I do think that's one of the sad things about the problem of juvenile alcohol abuse is that we don't get excited about it until it gets out in the white suburban area where the middle class lives. As long as it happens somewhere else, we don't worry about it. The crime rate, anything else, out of sight, out of mind. But I can assure you, we are going to keep trying.

Returning to the specific subject of issue, you also have a program, don't you, for disciplinary students with problems?

Mr. TAPSCOTT. That's the student assistance program I had reference to. It's an outgrowth of an employee assistance program we have, Senator, for behavioral problems of employed persons. We found that we were getting a goodly number of people or students who were coming as a result of family problems so we have tenatively set up a pilot project with one of the local high schools here and we are sent their, quote, as they call it, "incorrigible" student who has been suspended or under threat of suspension for discipline problems. That's the one that I mentioned is 2 months old and that 77 percent of those students referred to us in those 2 months have chemical problems, alcohol and/or drugs, and it's interesting to note again, and I think that it speaks to our lack of focusing in on this problem, that 86 percent of those people referred to us were females of which 80 percent had chemical problems.

We find that young females are much more susceptible particularly to chemical substance abuse if they come from an alcohol one or two parent home than the male at an earlier age. That does not negate the fact that the male will eventually become an alcoholic. We know that 50 percent of young people who come from alcoholic homes become alcoholics themselves. Sixty-eight percent of known hard drug users come from one or two parent alcoholic homes.

We really have not addressed those needs in relation to females and that was touched on today. That was the fact that we have no female facilities as such in this State or in this community. Of course, there again, the local communities can only do so much.

Senator CULVER. You know parental alienation, disfunctional homes, are the root not only of juvenile alcohol abuse but also child pornography and other problems the subcommittee deals with. You know unemployment and other systematic problems in our society undermine the family and conventional values so it is very difficult to keep a family together. It's just increasingly more and more difficult for a parent to cope with the complex pressures of modern society.

I was interested, Dr. Benton when you talked about the PTA. It seems to me we have the kind of society where you can buy a paperback on how to do anything except to be a good parent. We let anybody get married. You really have to go through more to get a fishing license.

Increasingly it seems that everyone is more and more impressed that you must do family counseling if you want to help troubled young people. If you don't take on the larger family problem, the reoccurrence of difficulties is almost inevitable.

It also interests me when we deal with social problems in this society politically, we are so intolerant about qualitative evaluation of programs. Here again the space program, the military—they have research and development, and they have testing. They go on and on. We read in the paper another one down at Cape Canaveral and it cost $300 million. Everybody says, "What do you think of that? Isn't that a terrible waste?" and the reply is "Well, you can't expect to succeed overnight."

You have to practice and conduct tests. When we deal with science and mathematics which lend themselves to a greater degree of certainty than the social sciences, we accept experimentation and failure, But it's fashionable these days to say Government can't do anything especially about social problems. Social programs are ineffective. That is usually a good copout for not doing anything politically about social problems. I think we have to get a greater degree of public understanding as to the complexity of these things and the willingness to really try to apply our resources to aggressive experimentation and effort.

Do any of you want to comment on that? It's just a little generalized.

Mr. WRIGHT. I would. Mary and I talked with school people and communities a good deal about a concept we call primary prevention. Basically what that means is promoting the personal and social growth of people and thereby inhibit or reduce the possibilities of disfunctional type of behaviors like alcohol and drug abuse but also child abuse and neglect, those type of issues. The core is there but we talked about coordination between programing.

We have a lot of juvenile justice programing in the State of Iowa that has nothing at all or wants no attachment to alcohol or drug abuse programs because it jeopardizes their funding source and it jeopardizes their position of power or influence but basically presenting many of the same strategies for preventing juvenile problems that we are, but they, you know, have that territorial kind of problem.

Senator CULVER. I want to thank all of you very, very much and we hope to keep in touch with you. I want to review very carefully in further detail your prepared statements and share them with some people in Washington and with some of my colleagues. We will see what we can do by way of some of these programs and also, your agency, Mr. Tapscott, is an excellent one.

Mr. TAPSCOTT. I think, Senator, you would find that you have extraneous opposition when you begin to ban liquor advertising from television.

Senator CULVER. I'm not insensitive to the interest groups that flourish in this business. Thank you very much. Our next speaker will be Dr. Harold Mulford, director of the Center for Alcoholism Studies, University of Iowa. It's a pleasure to welcome you here, Dr. Mulford, and I apologize for the delay in getting to you today. We are trying to do too much in a short time and I appreciate your cooperation.

In your statement I noticed, Dr. Mulford, that you are extremely critical of what you term inappropriate regimentation and standardization in the community alcoholism service centers in Iowa and I think you attribute this situation to the inflow of Federal funding and shift to State control of these centers. Would you tell us for our record what requirements the Iowa State Division on Alcoholism imposed which has led to this result and how this affects the services that are actually offered to the alcoholic?

STATEMENT OF DR. HAROLD MULFORD, DIRECTOR, CENTER FOR ALCOHOLISM STUDIES, UNIVERSITY OF IOWA, DES MOINES, IOWA [1]

Dr. MULFORD. Somehow, Senator, it has fallen to me to at least raise the question, does the emperor have any clothes on. In answer to your question, the direction of our alcoholism programs in the last 4 or 5 years, especially since Federal funds became available, is toward more regimentation, more standardization, and more paperwork, all in the name of "professionalization" and accountability.

When one looks at the JCAH standard operating manual, individually the standards are quite reasonable, quite plausible, but the net effect has been to discourage those alcoholics who are in the earlier stages of their drinking careers and who are most in need of help. For example, as the standards are implemented and interpreted in the local centers, they require appointment cards, scheduled 50-minute hours and 12 to 15 or more pages of forms that have to be filled out before the alcoholic can get any help.

Rather than improving the effectiveness of the treatment, what it does is to screen out the alcoholics who are, not "ready" for treatment. As a result, the centers can boast a good recovery rate because

[1] See p. 280 for Dr. Mulford's prepared statement.

they have screened out all cases except those that have reached a point in the natural maturing out process where they don't really need much help. This would explain the findings of several rigorously controlled studies, the most recent of which finds that 3 hours of advice by the center staff got results identical with the normal 1 year of hospital treatment.

Senator CULVER. You have established this community project in Washington, Iowa, which has been cited, by the HUD in Washington, D.C., as a model project dealing with community needs. Would you describe for us this project and the therapy that underlies its structure or its design?

Dr. MULFORD. An earlier witness mentioned Alcoholics Anonymous and I think everyone in the field agrees that science has not come up with a treatment that is superior to what Alcoholics Anonymous has been doing for 40 years. Originally Alcoholics Anonymous was a response to the fact that the, professional therapies were not appropriate to the alcoholic. Alcoholics Anonymous, as I see it, is only one of the sources in the community that, in combination with many other sources, the family, the employer, service agencies, and so on, contribute to the natural maturing out process. What's going on in the Washington center is kind of an extension of Alcoholics Anonymous.

A part of the AA philosophy restrains them from being very agressive in their outreach work to reach large numbers of alcoholics early in their drinking careers. What the community counselor, call him a "general practitioner" or "generalist" rather than a specialist, what he does in Washington county is reach out, to contact as many alcoholics as possible as early in their drinking career as possible. He reaches them through the courts, through the schools, through all of the social agencies and recruits them into this natural recovery process and makes maximum use of existing resources. He mobilizes and coordinates the efforts of all these forces that influence the alcoholic toward recovery.

Senator CULVER. You also mention in your statement that the Washington project is more cost effective than the State-run community centers. Do you have any comparative figures for us on these operations?

Dr. MULFORD. As I read the quarterly reports put out by the Iowa State Division monitoring system on all of the alcoholism centers, according to the June quarter, 1977 report, the unit cost was $800, $803 to be exact, per alcoholic per year and it has been climbing. This compares with an annual unit cost of $100 per alcoholic in the Washington center.

To put it in different terms, last year, 1976, the Washington center served 230 alcoholics on a budget of about $27,000. A nearby center which serves a much larger total population because it's in a larger county saw not many more alcoholics and had a total budget of $238,000, so the unit cost in the State centers is 8 to 10 times greater.

Senator CULVER. In your statement I think you mentioned you treat about three times as many people as in the State centers, is that correct?

Dr. MULFORD. I think I said that——

Senator CULVER. It says the average.

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Dr. MULFORD. They see about three times as many. About 18 percent of the Washington center cases are 20 years and younger compared with only about 6 percent, I believe, of the State. I think that's what you are referring to.

Senator CULVER. Do you have any evaluation of the effectiveness of your self-help approach in relation to juveniles?

Dr. MULFORD. No; I don't have any hard data. First I would point out that juveniles are not—juvenile problem drinkers are not all that different from adult problem drinkers except that they are in the very early stages, of course. I have made some comparative studies comparing effectiveness of the community centers like Washington with 6 weeks' treatment at Oakdale Hospital which I was associated with and could find no difference in the recovery rates. In addition to that, all of the research that we have to date making very rigorous comparisons of the effectiveness of one treatment compared to another treatment consistently finds no difference, and therefore we would have every reason to believe that the effectiveness of the Washington center on an individual level is no less—is just as good as any other known treatment. But the advantage of the Washington center, as I see it, is that they see ever so many more alcoholics.

Senator CULVER. What would be your suggestions as to how we could encourage and assist the establishment of these kinds of programs?

Dr. MULFORD. I would emphasize that I am not arguing that that approach is any more effective for any given individual alcoholic. I am just saying that in the aggregate sense they see so many more. If we don't know how to increase the recovery rate, we do know how to increase the base by reaching more alcoholics. In answer to your question, again, science is only beginning to get us some hard data. As the President said the other night, and I think as you mentioned a couple of times, there are just some problems that the Federal Government by itself cannot solve.

All I can do is to suggest some general guidelines, some general principles. I would first suggest that whatever the Federal Government does, that it be guided by the self-help principle. That is, help the community help itself and help the individual help himself; second, volume or traffic through the office—reach as many alcoholics as possible as early in their drinking careers as possible; and third, do no harm. That is, whatever is done by the Federal Government, care should be taken that it does not weaken the community or the individual's sense of responsibility for solving their own problems.

I think sometimes there is a tendency for special treatments that are brought in to offer themselves as this is the place where you can get your alcoholism treated. The community tends to sit back and say, OK, glad to get this problem off our shoulders. You do it. As yet we don't have any proven preventative or proven treatment. Finally, it's recommended that the Federal Government's role, and that of the State government as well, be limited to technical assistance, advice, suggested guidelines, and limited funding.

It is recommended that the Federal funding be in the form of revenue sharing directly to the local community and earmarked for alcoholism programs that include juvenile problem drinkers.

Senator CULVER. I want to thank you very much, Dr. Mulford, and commend you for your leadership in this area. We will be reviewing your full statement very carefully as we work to try and shape the direction of program efforts in this area from the Federal Government. Thank you.

Our final witness today is Mr. Gary Riedmann, director of the Iowa Department of Substance Abuse. I understand, Mr. Riedmann, you are accompanied by Jeff Voskans, the administrative officer of the department. Could you briefly describe the State's system for delivery of service to alcoholics which your department administers?

STATEMENT OF GARY RIEDMANN, DIRECTOR, IOWA DEPARTMENT OF SUBSTANCE ABUSE, DES MOINES, IOWA [1]

Mr. RIEDMANN. The State system basically tries to cover as broad an effort to provide services to people with alcohol problems as possible. We dealt with inpatient intermediate aftercare, outpatient and prevention efforts. We try to, with the limited amount of funds that we have, cover as broad a spectrum as possible. In doing that, we try to cooperate fully with self-help groups throughout the State.

Senator CULVER. What treatment programs does the department provide for juvenile alcohol abuse, and are our young people, as far as you know, availing themselves of whatever services you are providing now?

Mr. RIEDMANN. At the present time many are not, with two program exceptions. We have the program that you heard earlier that was a private, nonprofit, self-funded program.

Senator CULVER. In Sioux City?

Mr. RIEDMANN. Right, plus the Powell III in Des Moines to which we provide some help. Across the board we have not been funding specifically for juvenile programs. Historically that might be put into perspective beginning when the Federal strategy was developed. When we talked about the problem of alcohol or drug abuse, we talked about a middle-aged or older group of people who were called alcoholics and, on the other hand, we identified a group of young people who we could call drug abusers. I think the funding and strategy worked at these two extremes. What we found in effect was that funds were provided to intervene for those two populations. What we have also seen, and I think one of the reasons for this hearing, is we have come up with a very much larger population that we have to serve.

Regarding alcohol, we have not just the older or the middle-aged population of male alcoholics. We have a very large number of female alcoholics. We have apparently a very rapidly increasing younger group of male and female people with alcoholism and alcohol problems. It's becoming a much broader perspective than had originally been intended for the Federal strategy, and I think we attempted to solve part of the problem with the funding, but we haven't attacked the whole problem.

Senator CULVER. In terms of our subcommittee work, I think it would be helpful if you could provide us for our record what the breakdown is now of the amount of money from the Federal Government which Iowa has received for alcohol treatment and prevention services. Could you also provide the sources of these funds and the specific purposes for which they were utilized?

Mr. RIEDMANN. Again, I think this might relate to some of the confusion of the funding levels, too. In the State of Iowa we receive from

[1] See p. 283 for Mr. Riedmann's prepared statement.

the State for treatment, maintenance, and care about $950,000 for services in the State. We receive $750,000 in Federal formula funds to provide treatment and prevention services statewide. In addition to that, there are probably $375,000 in title 20 HEW funds which go into treatment services.

We have in the programs some CETA funds from the Federal Government as support services for programs. We have original poverty grants in the amount of $400,000 that come into the State. Also we have about $3 million for ASAP programs that has also come into the State.

Senator CULVER. So what is the total Federal funding?

Mr. RIEDMANN. We are talking about $8 million.

Senator CULVER. Is that total Federal funding in this area?

Mr. RIEDMANN. Right.

Senator CULVER. And very little of this money is used for prevention?

Mr. RIEDMANN. Right. I think of specific alcohol funds for the entire State, we might be talking about $100,000 going to prevention.

Senator CULVER. Out of the $8 million.

Mr. RIEDMANN. Yes.

Senator CULVER. You have virtually no real juvenile alcoholism emphasis?

Mr. RIEDMANN. What we have expected, in fact, is that the programs we fund are providing juveniles services. We did a check this past week on mental health centers and our treatment centers throughout the State. What we have found is that they are providing services for juveniles.

Senator CULVER. But you did that in anticipation of this hearing?

Mr. RIEDMANN. Right. We are not targeted specifically for juvenile services. We have found that we have not even allowed in the client records up to this time to show age breakdowns, for alcohol clients. We are changing that from the State level, and we are in the process of implementing a system to find out how many juveniles with problems we do have and insure that they are served. Also in the criminal justice area we have begun a very specific effort to identify the number of alcohol problems that we have in the population for the criminal justice system. I think Jeff might also add to that.

STATEMENT OF JEFF VOSKANS, ADMINISTRATIVE OFFICER, IOWA DEPARTMENT OF SUBSTANCE ABUSE, DES MOINES, IOWA

Mr. VOSKANS. Senator I would like to point out something. That $8 million mentioned really is not in the control of the department. I think that basically the department as the recipient, State department of chemical substance abuse funds now receives only $730,000 of Federal money. All the other funds that are in the total package are designated funds that go to specific programs and those programs have to apply for the money directly to the National Insititue on Alcohol Abuse and Alcoholism. So they receive those funds, but without controls of the State office. It seems a rather large sum when we say $8 million cash availability in Iowa. I would say it's closer to $10 million simply because there are, for instance, some research grants that go into the State for research into causes of alcoholism and so on.

State offices have no control on that research money whatsoever. Those are negotiated, funded, and directly sent to the providers so the State office is only responsible in a direct sense for $730,000 of Federal money that comes here to Des Moines. Those funds are distributed via contracts to local providers of services. We have at the moment 26 providers in the State of Iowa and 26 principal contractors. They in total include 55 satellite service centers and 17 halfway houses.

In addition to that, we also have four mental health institutes that are providing treatment of alcoholism, and in addition they are also providing some training. We also have private entities such as Powell III, chemical dependency unit of St. Vincent's Hospital, and so on.

I think if I may briefly allude and not for the sake of argument but merely clarification that the issue addressed of imposed rules and everything that would have to be, as a need of compliance for programs in the community, come from the following perspective: In Iowa we are trying to operate a $5.2 million program with a $2.2 million budget for cash availability. It means that the program people out in the communities, to sustain their functions, have to negotiate funds from other sources such as CETA, counties, cities, donations, and in some instances try to subscribe to a third-party payor or insurance carrier.

Recognizing that they need to sustain their operations in the community, programs can't solely depend on Federal or State dollars, and this is the handwriting on the wall. The recommendation by the Iowa Commission on Alcoholism with the agreement that the programs must agree (since they are nonprofit, private corporations) that they undergo evaluation by the Joint Commission on the Accreditation of Hospitals. This would help establish quality care, and make programs more eligible so that third-party payors or insurance carriers would subscribe to the cost of alcoholism so it has very little to do with any capricious attitudes on behalf of the State to do that.

I feel that that is the route we will have to go sooner or later. I think indeed prevention has been a rather neglected area. At the same time, when we really get down to nuts and bolts issues, I think we need to recognize that we really don't know what we mean when we say prevention. What are we really trying to prevent? On one end of the spectrum we have a situation where we all are subjected to constant and repetitious advertising promotion like Mr. Tapscott impressed. If you like to go "around the world," you have to have "gusto." On the other end of the spectrum we have to pick up the people that have already fallen down and try to rehabilitate them.

The end of promotion and private industry, is to make a dollar. To obtain a dollar here to solve the problem it is rather difficult because the rationale comes in saying it's ill will, immorality, self induced, and you name it, whatever term you like to employ, and they say why bother because he or she is only an alcoholic. I think the problem is not really whether it's a juvenile problem. I don't think it's only an adult problem. I think it's a total society problem.

I think we are trying to correct an individual within a structure and doing very little about the environment around him. Unless we change our attitudes about the environment and unless we become responsible in a sense where the responsibility should be, establishing a healthy attitude about the use of alcohol and drugs in material ways. Unless we develop that, I don't think that we are really going to have a smashing success in saying that simply because we had 10 hours of

school work or 5 lectures in this setting that we are going to succeed.

Senator CULVER. What would be a healthy attitude about alcohol reflected in a television commercial? If you were given a commission to design a healthy television commercial for alcoholic sales, what would it be like?

Mr. VOSKANS. Well, I think that first of all——

Senator CULVER. Obviously the person that gives you the gusto bit would be the last one to say that he is encouraging excessive drinking. He just wants to have good, healthy, social drinking and all the positive aspects of the grape. But given a free society and economy, how would you devise an advertisement for television you think would reflect a health attitude toward alcoholism?

Mr. VOSKANS. I don't think that issue really—that question can be answered directly what is a healthy attitude towards alcohol. I think at the moment when we are advertising alcohol, we are promoting the same.

Senator CULVER. Here is a point: Should we ban advertising?

Mr. VOSKANS. No; I don't think so.

Senator CULVER. Should we put warnings?

Mr. VOSKANS. I think there should be warnings addressed.

Senator CULVER. What if they did the ad—had the hero on the viking ship or whatever—followed by a warning, excessive alcohol use will kill you?

Mr. VOSKANS. I think excessive use is one thing that needs to be addressed. I hope we all recognize that alcohol is here to stay in our society. It's a question of how we cope with it and I think you don't address that issue of how we can cope with the alcohol used. Most approaches from rehabilitative or preventative points of view are that we are not talking about alcohol, we are talking about alcoholism. We are saying alcoholism creates these problems in our society.

This is what happens as a result of alcoholism. Of course, that's being pushed away by society in general because they say, "I'm not an alcoholic. I only drink a six pack a night or I only killed a pint today, so therefore, unless I sleep under certain bridges or live in certain environments, I'm not really an alcoholic," and I think this is where the public in general is being misled.

What's an alcoholic? Of course, to define it is rather difficult because there are many alcoholics, many definitions. The point is that I think that clear understanding needs to be among people that continuous and frequent use of alcohol will create some problems, and problems of such a magnitude that later the society has to cope with the individual and the family and so on.

Mr. RIEDMANN. Senator, I think a comment is important on a comparison with cigarette smoking, and the danger warnings, I don't know if that has been proven very successful as providing any hesitancy on the part of people to avoid smoking. I think the key factor to be considered is how overwhelming is the use and abuse of alcohol as a health problem across the country today? I think if we do come to the point where it is so obvious—which it may very well be coming because of the terrible and tragic results of such a broad public perception of alcohol—if it comes to the point that those damages are so great then certainly I don't know that we are talking about free enterprise alone. I think we are talking about a much broader social issue and I think that is the general consideration.

Senator CULVER. Your statement indicates that there is a need for better coordination of Federal, State, and local effort to combat alcohol abuse and misuse. What specific suggestions would you have for us there in terms of how to achieve better coordination and program activities?

Mr. RIEDMANN. As you know, we are a new Department of Substance Abuse and we have taken over two main Federal funding sources. We are talking about the National Institute of Drug Abuse and the National Institute of Alcohol Abuse and Alcoholism. What we have found up to the present time is that we have a most unusual pattern in the drug programs which have presently been serving the young people. What we have been finding is that 70 to 85 percent or at least 40 to 85 percent of the youth in those programs also have alcohol problems.

We are talking today about a polydrug problem when in effect we are also telling those programs from the Federal level, you can't treat a person that comes in with the major problem being alcohol abuse if you get funds from NIDA. The same thing with alcohol funds. You are out to treat drug abuse. Again, we are talking about a much broader problem than that.

I think the specific recommendation there is that the institutes work in a very much cooperative effort to support the local efforts on the State level. Also, in bringing Federal funds into the local level, there has been a mandated health systems review process of all Federal alcohol and drug health funds. I think that's a very important process to develop, a statewide input on finding out where those funds are going and developing a consistent planning mechanism.

I support that that emphasis be continued. In the area of prevention, I see very much a need again to continue increased cooperation of the Federal agency. We are talking about programs like the LEAA and NIAAA who are involved in the area of prevention. What these agencies do are very much cooperative efforts in the area of alcohol, other misuse and health problems. They have got to cooperate and provide adequate funding.

I think specifically in the area of prevention we need so much research before we can pour Federal dollars into programs to find out what they do. We are being asked by the Federal Government to show a comprehensive product before we have any support even to show what the product is going to be. We need both funding for prevention efforts and to do the research that's necessary.

I think what has been happening here in the last month, for instance, all of a sudden we receive almost no Federal dollars for prevention efforts and in the last month we receive about four Federal requests for proposals for prevention programs. All of a sudden they realized that prevention was a priority. They gave us a month to fill out proposals for comprehensive prevention programs for the State. Well, obviously they found out that that seemed to be asking a great deal from the States and somebody must have spoken very loudly so they changed it and gave us 5 weeks.

Somehow they are not addressing a long-term comprehensive approach to the problem, and, you know, we need both the cooperation of the agencies and the consideration for the problems.

Senator CULVER. Let me thank you both very much for your testimony here today. I am very grateful to you for your suggestions and this completes our testimony for today. I want to thank all the witnesses for their contributions and their informed and valuable statements that we have received. This hearing record will be carefully reviewed by the subcommittee and we will try to act constructively on a number of the very useful suggestions and proposals that have been heard.

The testimony, I think, clearly confirms the fact that the misuse of alcohol among young people has become an extremely serious problem, not only in our own State of Iowa but throughout the country.

We have heard how the excessive use of alcohol impairs the ability of young people to function at home, in school, and in employment situations and that there is a very close connection between abuse on the one hand and juvenile delinquency problems on the other.

I believe we would agree that programs of alcoholism treatment and prevention for young people must be aimed specifically at that age group. It is very properly suggested here that juvenile alcohol abuse is part of a larger social problem that has to be addressed in the context of that larger problem. Our children and youth march to a different drummer than adults and I think that we are now waking up to the fact that we have an alarming alcohol problem with our youth.

The basic attitudes of our society today toward alcohol and alcoholism have been described here. These attitudes make the problem of dealing with youthful abusers extremely difficult. If parents drink and consider drinking socially acceptable, why should the children be denied.

Our adult society which, a few years ago, panicked over the use of drugs by children and youth has failed to really see some of the potential problems and the danger of alcohol abuse.

Most people are oblivious to the fact that alcohol causes more health and social damage and economic loss to our society than all other drugs combined.

While the attitude toward social drinking is permissive, the attitude toward alcoholism is intolerant. Although alcoholism is recognized in informed circles as an illness, many people persist in regarding it as a behavioral problem. All of these attitudes complicate the problem of dealing with our young people.

It is less than a decade ago that we launched our first national program to try to cope with alcoholism and alcohol abuse and Senator Harold Hughes, of course, was in the vanguard of that initial effort. Now it is apparent that a comparable national effort is needed to meet the rapidly growing incidence of alcohol abuse among the young people. That effort must reflect some of the experience we have had in the last decade about coordination of programs and about the interrelationship between drug abuse on the one hand and alcohol problems on the other.

A further complication is the fact that many juvenile offenders are polydrug users and ingest various combinations along with alcohol to get new kinds of "highs."

We are a drug-dependent society, as was pointed out by one of our earlier witnesses. We use drugs, ranging from coffee and cigarette in the morning to the noon martini and sleeping pill at night. Alcohol enjoys a privileged place. Our society not only accepts alcohol consumption, it actively encourages it.

The message comes on strong through the media that drinking is fun. Given this cultural climate it will require an enormous, coordinated nationwide effort against the tide to convince youngsters that excessive drinking is also dangerous and to help those recover who have already become addicted.

The subcommittee is investigating what can be done at the Federal level to meet this emerging crisis. But as I suggested earlier, the main effort will have to be at the community level. It is my hope that this hearing will at least awaken some parents to the dangers of alcohol misuse by their children.

Youth alcoholism is a subtle and enormously complicated matter that cries out for sensitive public understanding. I hope this has been an initial hearing that will lead to more effective and constructive solutions. Thank you very much. The hearing will stand in recess until further call of the Chair.

[Whereupon, at 1:10 p.m., the hearing was adjourned, subject to call of the Chair.]

APPENDIX

PREPARED STATEMENTS SUBMITTED FOR THE RECORD

STATEMENT OF MITCHELL R. WORK, EXECUTIVE DIRECTOR, ALCOHOL AND DRUG ABUSE SERVICES, INC., DES MOINES, IOWA

JUVENILE ALCOHOLISM 1978, THE SUBTLE EPIDEMIC

There is a subtle and silent epidemic sweeping our county today, affecting this country's most precious natural resource, our young people. This epidemic is juvenile alcoholism. The extent of the problem extends throughout the country from urban centers to rural areas and communities. It does not seem to discriminate in terms of race, economic level or sex. It is destroying hundreds of thousands of young people and if not addressed, if not clearly and openly identified, will continue to take a heavy toll in young lives, family stability and ultimately on society itself by limiting the number of productive citizens contributing to the well being of America.

While we have been generally aware of the problem of teenage drinking for sometime, such behavior has often been tolerated and subtly encouraged by this society which has such ambivalent views toward alcohol. In fact, for many young people and adults, alcohol usage is viewed as a rite-of-passage, symbolizing entry to adulthood. While we have been aware of the problem, we have not taken it seriously, we have not understood its implications and consequently we have not implemented effective education, prevention, and treatment programs necessary to combat the spread of the epidemic—alcoholism among our young people.

In the following text, I will address the juvenile alcohol problem, as I understand it as the Director of ADASI, a comprehensive drug and alcohol treatment program in central Iowa. I will also be presenting to you a model for juvenile alcoholism treatment, as well as some specific recommendations that need, in my opinion, immediate attention not only here in Iowa, but throughout the Nation.

Assessing parameters of the problem

Part of the difficulty in accurately assessing the extent of this problem is a definitional one. Surveyors often have trouble agreeing with one another in establishing a definition of alcoholism and alcohol abuse. We must remember that alcohol usage is prevasive within our society and as a continuum the lines between alcohol usage, abuse, and alcoholism are unclear and often difficult to define. Recent studies, however, suggest the following extent of the problem:

1. Statewide trends: Within Iowa, teenage alcohol use and abuse has been identified as a growing problem. In a study conducted by Carl Chambers, et al., 1974, it was estimated that 17,000 adolescents in Iowa between the ages of 14 and 17 were "heavy drinkers". Further, the study found that of persons surveyed that had experienced alcohol-related problems, over 11 percent were 17 years of age or younger. In addition, almost one-half (45 percent) of those who worried about their drinking were between the ages of 14 and 24. Chambers also found extensive polydrug involvement among teenagers. An estimated 14 percent of youth 12 to 14 were active drug users who frequently mixed alcohol and other drugs in combination with one another.

These findings have been generally supported by studies done by the Iowa Drug Abuse Authority, the Iowa Department of Public Instruction and the "Des Moines Register and Tribune". In May 1976, the Iowa Drug Abuse Authority reported that earliest age of reported use of alcohol had dropped from 9 years of age in 1974 to 6 years of age in 1976. In a study conducted by the Iowa Department of Public Instruction, it was found that 25 percent of the students in grades

6 through 12 that were surveyed, began drinking at 9 years of age or younger. In addition, this particular study found that 28 percent of the students surveyed used alcohol more than once a month and 64 percent felt alcohol use was alright for special occasions.

2. Central Iowa trends: In Central Iowa, an Area Education District XI study found that 33 percent of the students surveyed used alcohol more than once a month and that 27 percent used alcohol more than once a week. In the Chambers study 17 percent of the youths in Central Iowa (Area C) were also found to be active drug users. In a poll conducted by the "Des Moines Register and Tribune", July 19, 1975, within Polk County public high schools, it was found that 70 percent of the students surveyed answered "yes" to the question, do you drink alcoholic beverages. Fifty-nine percent of these drank once a month or more. In addition, it was found that 41 percent has also used marijuana and that 16 percent had used hard drugs at least once.

The extensive use of alcohol by juveniles is further reflected in statistics by the juvenile justice system in Polk County. The Des Moines Police Department recorded 530 juveniles arrested in 1976 for a drug and/or alcohol-related offense. This amounts to approximately 26 percent of all Des Moines Police Department juvenile arrests. Twenty percent (473 cases) of all unofficial juvenile court cases were for drug and/or alcohol-related offenses. In 1976, 6.4 percent (55 cases) of all official juvenile court cases involved drug and/or alcohol usage.

The chief of juvenile probation in Polk County reports "a dramatic increase in juveniles with alcohol-related offenses". He also indicated that for the first time his office was dealing with juveniles that are hard core alcoholics. Polk County juvenile probation contacted ADASI late in 1977 requesting assistance in dealing with the adolescents involved in juvenile delinquency behavior with attending alcohol problems.

The annual projected caseload to be referred to ADASI by juvenile probation authorities was estimated to be 470 different persons per year.

Treatment services available

The needs assessment data available reveals not only a significantly large number of juveniles experiencing alcohol problems, but that this problem is frequently connected with juvenile delinquency problems. In addition, data also suggests that drinking is occurring at an earlier and earlier age. Yet treatment programs, funders and governmental bodies at the local, state, and national level, have largely neglected the need for specialized services for juveniles with alcohol problems.

In a review of juvenile alcohol services available throughout the State of Iowa, one can conclude that juvenile services are minimal to nonexistent. The traditional treatment delivery systems for alcoholism have been targeted primarily to adults and more particularly adult males. It is important that we look toward realigning our priorities in terms of treatment delivery, and that we do a better job of reaching young people with alcohol problems.

ADASI, Alcoholism and Drug Abuse Services, Inc., is vitally concerned about the treatment needs of juveniles with alcohol problems. However, at this time, such programming is minimal, with few funding sources available to help provide juvenile alcoholism services.[1] This becomes even more significant when one considers that ADASI is the primary service provider for alcoholism and drug abuse services in Polk County and central Iowa. However, at this time, juveniles are receiving specialized services only in the ADASI Juvenile Residence which has been recently relicensed to take in alcohol abusing juveniles.

If appropriate funding were available, however, a model, comprehensive, juvenile program could be developed by ADASI to service juvenile alcoholism and alcohol abuse needs through a continuum of care delivery system. This model program would be composed of the following components:

1. Education, prevention and early intervention services

This component would be involved primarily in dealing with schools, criminal justice and/or other groups, dealing primarily with youth in an effort to both educate and to involve juveniles in effective prevention strategies. Small group discussions and counseling would be a major component, although individual and family counseling would also be utilized. In addition, these groups would serve as

[1] NOTE: Outpatient and residential services are available at ADASI for juveniles with primary drug problems.

a basis for possible referrals to other services as needed. The prevention strategy to be utilized could be alternatives, peer assistance counseling and other affectively based group dynamic programs.

2. Detoxification

Those youths referred to ADASI as voluntary or court-referred clients for detoxification as a result of intoxication, could be treated at the existing ADASI detoxification facility if minor renovations were made. This would require the provision of appropriate medical care and support staff to insure that withdrawal and/or associated medical problems could be addressed.

3. Intermediate treatment

An intermediate residential treatment program that would last for 14 days could be provided as an adjunct to the detoxification as necessary. This would include a live-in treatment residence with intense counseling, both on group and individual basis. Treatment planning, as well as identification of any ancillary services required, would also be part of the heavily structured routine. This component would include 24-hour supervision and monitoring of all clients.

4. Residential care

Currently, ADASI is operating a residential facility for juvenile males, 14 through 17 years of age, experiencing substance abuse problems. Through the addition of a minimal number of staff members, the current facility capacity could be extended to include up to an additional 10 juveniles experiencing alcohol problems. This program involves a structured phase system through which client responsibility is stressed, and reintegration into the community through educational and/or vocational involvement is required. In addition, this highly structured program consists of individual, family and group counseling and general house meetings on an on-going basis, as well as the development of recreational and vocational activities.

5. Out-patient services

Currently, out-patient services are available for adults; but by adding from two-to-four staff, it would be possible to create a juvenile component to provide appropriate out-patient counseling on a group, individual and family basis. This program could be utilized for those juveniles in need of a less structured environment in which to deal with their alcohol problems. Such an approach could be used as a criminal justice alternative by juvenile court.

6. Aftercare services

Aftercare services could be provided to juveniles through the development of on-going support group activities and other related functions as an important reintegration tool for the client as he begins to re-enter society on a permanent basis. Linkage to programs such as Alateen would be considered as appropriate under aftercare services, as well as on-going contact by the assigned aftercare counselor. We encourage Alcoholics Anonymous to assist in the development of programs for juveniles with alcohol problems. Other services available to this component would also include educational and vocational assessment and placement through ADSAI's vocational component. Family involvement would also be encouraged.

We feel the above model targeted to juveniles is extremely necessary and needed to best serve the needs of central Iowa. In addition, ADASI's staff has experience in working with juveniles and could utilize that expertise in such a venture. Finally, with only minimal renovation, facilities and counseling centers, already in operation by ADASI, could be used to implement such a program. What is not available at this time is funding for such a program. Even more basic to the funding issue is a commitment on the part of the community and this country as a whole to combat juvenile alcoholism.

CONCLUSION AND RECOMMENDATIONS

In our experience in Central Iowa, as well as the data we have gathered reflecting the needs and trends throughout the entire state, juvenile alcoholism is a serious and growing problem of epidemic proportions. It is important that existing resources be reallocated to address the problem at the same time that new resources are also being developed, if we are to begin making a creditable effort to address the problem.

In an attempt to comprehensively address the full scope and nature of this problem, the following twelve recommendations are offered to better deal with juvenile alcoholism.

1. Definition of terms. We need to do a better job in defining exactly what is meant by such terms as social drinking, heavy drinking and alcoholism. This is necessary to determine at what points on the alcohol consumption continuum what kinds of treatment or prevention efforts are needed.

2. Measurement of the problem: We need accurate incidence and prevalence studies to measure the localized extent of drinking problems among young people. These studies should be financed by the federal government and made mandatory for each state as a requirement for receipt of federal funds. Specific action plans and programming could then be developed as approrpiate to each state. Currently, computer program designs have been developed with the capability of conducting such incidence and prevalence studies. An example of such a program is the Contingency Table Analysis Model developed by IMS, Ltd. of Ambler, Pennsylvania.

3. Establishment of Controls in Advertising Alcohol Consumption: Drinking is a learned behavior. Media messages to young people play a large part in influencing their attitudes and behavior. Television especially portrays alcohol consumption as glamorous; not only acceptable but *expected* of "successful and happy people".

4. Development of More Effective Education Strategies: Scare tactics have been shown to be ineffectual and counter productive in the area of both drug and alcohol prevention. New prevention programs which deal with drinking in a broader scope of behavior are needed. Purely cognitive and factual approaches often used by the public school system are incomplete. The problem needs to be addressed in the context of decisionmaking. Young people need to better understand the dynamics of decisionmaking which includes not only facts, but peer influence, values clarification, the importance of environment, affective education and self-concept. Better understanding of the decisionkmaking process will result in better decisions, regarding alcohol and drug use, juvenile delinquency and premarital sex.

5. Targeting of Effective Education Prevention Programming at Younger Age Groups: With the reported age of first use declining in recent years (6 years of age has been reported) primary prevention programs must deal with creative approaches to early elementary and preschool populations.

6. The Need for Innovative Prevention Programs: New prevention programs need to be encouraged. These might include alternatives or peer counseling programs which have proven successful and cost effective by training young people who can relate to other young people effectively. By developing peer counseling groups large numbers of young people can be reached at minimal cost. Most imperatively, a Federal commitment to prevention in terms of dollars is needed.

7. Funding for Comprehensive Juvenile Treatment Programs: The establishment of alcoholism programs targeted toward the unique needs of juveniles. This should include the establishment of treatment modalities which are currently made available to adults—detoxification, intermediate care, residential, out-patient, and aftercare. Heavy emphasis should be placed on family counseling. Staff in such programs should be trained in alcohol and drug abuse in order to competently deal with the polydrug abuse trends that are so common among young people.

8. Development of Special Adolescent Treatment Programs: Demonstration programs are needed that not only deal with the needs of the adolsecent but the unique needs of juveniles who compose special groups such as: females, Indians, children of alcoholic parents, and juvenile delinquents.

9. Development of Assessment, Education and Treatment Programs to be Used in Conjunction with the Juvenile Justice System: Those juveniles arrested or sent to juvenile court with an alcohol-related problem should routinely be assessed to determine if a heavy drinking or alcoholism syndrome has begun and to provide alcohol education and treatment as appropriate. Young people who are just establishing alcoholism patterns can be helped in many cases provided appropriate treatment services are made available. Family counseling and parent education sessions should also be included to provide comprehensive services. Effectiveness of such programs could be measured in long-term reduction in the incidence of juvenile delinquency and drinking.

10. The Need for Program Evaluation: If new programs are to be instituted which will require additional funding, evaluation components should be required to track education, prevention, and treatment outcomes to determine effectiveness in terms of reduced drinking and juvenile delinquent behavior.

11. Expanded Social/Psychological Research is greatly needed to identify the interlinking relationship between physiological, sociological, psychological, and

environmental factors as they impact juvenile attitudes, values and behaviors as they relate to juvenile delinquency generally and juvenile drinking patterns specifically.

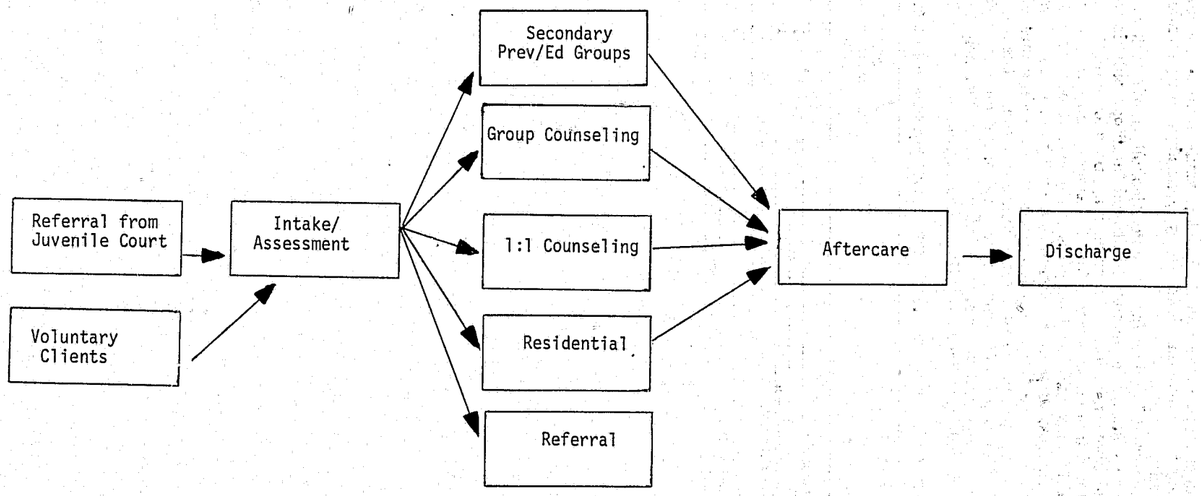
12. Increased Funding fcr Juvenile Alcoholism. We look to the federal government for assistance in making additional funding available to programs in order that the above-mentioned 11 areas may be adequately addressed through expanded and innovative prevention, treatment, and research efforts.

In closing, I would like to express the sincere thanks of ADASI and our clients for the interest of your subcommittee and yourself in addressing this pressing problem. In these times which are short on funding and long on controversy regarding alcoholism and substance abuse programs, it is a tremendous uplift for our staff and Board of Directors that we may come before you and talk openly about our needs and dreams. If we may be of further help to you, please do not hesitate to call upon us at any time. Thank you.

DRUG AND ALCOHOL RELATED OFFENSES AMONG JUVENILES IN POLK COUNTY FOR 1976

	Official juvenile court cases	Unofficial juvenile court cases	DMPD arrests
Violation of drug laws	28	136	92
Drunkeness	8	104	255
Possessing or drinking liquor	4	217	169
Driving while intoxicated	15	16	14
Total	55	473	530
Percent of total cases	6.4	20	26

FLOW CHART OF JUVENILES
TO ADASI FOR DRUG AND/OR ALCOHOL SERVICES



A STATEMENT
OF
SERVICES AVAILABLE
FROM

ADASI

ALCOHOL and DRUG
ABUSE SERVICES, INC.

OCTOBER
1977

24-811 O - 78 - 4

WHAT IS ADASI?

ADASI (Alcohol and Drug Abuse Services Incorporated) is a private, non-profit social service agency with major responsibility for providing comprehensive alcoholism and drug abuse prevention, treatment and rehabilitation services to Polk County and Central Iowa with residential treatment services available to persons residing anywhere in Iowa. ADASI is governed by a corporate Board of Directors who establish programmatic and fiscal policies. The Executive Director is responsible for the daily operation of the agency. There are two major service components of ADASI--ADASI Drug Services and ADASI Alcohol Services.

All services are strictly confidential and available through either individual inquiry or by referral from social service or criminal justice systems. Funding for ADASI comes from numerous federal, state, local and private sources including: National Institute on Drug Abuse; National Institute on Alcoholism and Alcohol Abuse; Department of Health, Education, and Welfare; Iowa Division on Alcoholism; Iowa Drug Abuse Authority; Iowa State Department of Social Services; Polk County Board of Supervisors; as well as other private and public agencies. While third party and private pay is encouraged, no client will be refused services on their inability to pay for treatment.

What We Believe: ADASI's Philosophy

ADASI believes that all clients are entitled to be treated in a confidential manner when seeking and obtaining services. Strict compliance with federal and state confidentiality laws is maintained. Client information can be made available to referring agencies through a written release statement signed by the client.

ADASI believes that all treatment must be individualized in order to address the unique needs of each client in treating the complexities of alcoholism and drug dependency.

ADASI is committed to cost effective delivery of quality services to clients experiencing alcoholism and/or drug problems.

DRUG SERVICES AVAILABLE

Four major service areas offered by ADASI Drug Services are: Education/Prevention, Outreach and Intervention, Treatment/Rehabilitation, and Reintegration.

I. Education/Prevention

Prevention programs are directed towards preventing drug abuse before it becomes a physical, physiological, and/or social problem. This includes dealing with the root cause of drug abuse--alienation, low self-esteem and anxiety. Drug education services include the dissemination of drug specific information to encourage a greater understanding of the physiological and psychological effects of chemical substances. It also includes training of parents, peers, teachers, and other significant persons who interact with potential drug abusers to identify early drug dependent behavior and act appropriately before a drug dependency or addiction develops.

A. Guided Group Interaction

This program deals directly with young people in small groups to help them openly discuss personal concerns and problems. Delivered in 15 or 30 week sessions, these programs include the following:

1. Values Clarification
2. Decision-making Skills
3. Life Planning
4. Survival Skills
5. Understanding Emotions
6. Self-esteem Enhancing Exercises

B. Alternatives Program

These programs stress that feeling good or "high" without chemicals is a possible and rewarding experience. Many activities are offered: camping, canoeing, sports, deep-muscle relaxation, yoga, and guided fantasy trips. Small groups from 6 to 12 persons are used in this process with trained facilitators to provide guidance and non-directive structure for all groups.

C. Teacher Training in Effective Drug Prevention

ADASI Drug Services has planned, delivered and evaluated comprehensive training programs for school personnel. This four-phase program includes instruction in drug specific data and the underlying causes of drug abuse. After training is completed, trainers develop teams which in turn develop drug prevention programs that meet the unique needs of their own particular school.

D. Prevention Effectiveness Training

This training is available from ADASI Drug Services staff with PET instructor licenses who combine effective communication techniques in a drug prevention context.

E. Drug Information Seminars

Drug information seminars are available to present drug specific information to lay and professional groups.

F. Lectures and Speaking Engagements

The ADASI Drug Services Education/Prevention staff are available to speak to community or youth groups on drug abuse and related topics. Appointments can be made by calling (515)288-9775.

G. Tours of the ADASI Drug Services Central Facility

Tours of the facility are available by appointment to interested groups by calling (515)288-9775.

II. Outreach/Intervention

Outreach and intervention services are aimed at identifying and communicating with those youth and young adults who are experimenting with various drugs of abuse, but who have not acquired a drug dependency or addiction. The goal of these services is to arrest the behavior before physical, psychological and/or social damage occurs. This is done by addressing the root causes of drug abuse and providing meaningful alternatives which will meet each individual's needs in a constructive way.

ADASI believes that effective outreach and intervention or secondary prevention services should be community-based. Thus, many of these services are offered through schools, churches and other social services agencies. Referrals to ADASI Drug Services programs come from teachers, physicians, and other human service workers.

A. Secondary Prevention Groups

Secondary prevention groups deal with confronting the experimenter in confidential sessions to allow him to reassess his current lifestyle directions and to identify root causes of drug abuse or other self-destructive behaviors. Emphasis is placed on honesty and group member support. Groups are facilitated by at least two trained counselors.

B. Peer Assistant Training

Peer assistant training is a peer counseling program developed by ADASI Drug Services to train young people to reach their peers in an effort to promote positive decision-making and to discourage the use of drugs. This program includes a comprehensive training session followed by actual group and/or individual peer training. Experienced young persons then assist in the training of new peer counselors thus perpetuating this program at minimal cost and supervision.

C. Individual Counseling

Individual counseling is available for those persons experiencing drug or drug-related difficulties and who seek the assistance of an ADASI Drug Services counselor on an individual basis.

D. Drugline (515)280-1111

Drugline is a 24-hour telephone counseling and referral service that is available through Community Telephone Counseling, Inc. and supported by ADASI. Concerns regarding drug use, abuse and related problems can be discussed with trained telephone counselors.

E. Free Medical Clinic

The free medical clinic services attract many persons to ADASI Drug Services for medical assistance on Monday and Wednesday evenings, from 6:30 - 9:00 p.m., from ADASI professional medical staff.

III. Treatment and Rehabilitation

All services provided by ADASI reflect our comprehensive approach to drug treatment. When another agency refers a client to ADASI Drug Services, treatment staff will remain in regular communication with the referring agency to assure continuity of care, an efficient and thorough intake and diagnostic process, the development of a treatment plan, and implementation of program services. Treatment services are monitored by ADASI Drug Services' Treatment Director and Medical Director to insure that quality treatment is provided in each service modality.

A. Outpatient Counseling/Therapy

By far the most utilized of ADASI Drug Services programs, outpatient staff are presently working with nearly 300 clients in individual and group outpatient counseling/therapy and other ancillary services. All outpatient clients have access to any ADASI service if that service is conducive to his/her treatment goals. These include such services as job training and placement, medical care, and psychological diagnosis. Outpatient clients may receive counseling or intensive therapy in individual or group sessions. Services may be obtained either at the Regional Treatment Center in Des Moines, or at county and neighborhood sites established in cooperation with other agencies throughout Polk and the surrounding counties.

B. Methadone Maintenance/Detoxification

For clients who are addicted to heroin or other opiates, ADASI Drug Services provides methadone maintenance and detoxification. For persons experiencing a short-term addiction to opiates (less than two years), a twenty-one day detoxification program is available. In the case of a client who has been addicted to heroin for a minimum of two years and, in the opinion of the intake staff requires a chemotherapeutic maintenance regimen for a period of time, a methadone maintenance program is also available. Methadone simultaneously prevents withdrawal symptoms and blocks the effect of heroin on the body. Persons on a maintenance program are expected to participate fully in other elements of ADASI Drug Services treatment program.

C. Family/Marital Counseling

Drug Abuse may involve many aspects of a person's life including his relationships with other family members. Therefore, family counseling is available to ensure involvement of spouses, parents, and other family members in the client's counseling and treatment.

D. Adult Residential Treatment

This residential facility has been designated a minimum security incarceration facility with a capacity of 27 male and female clients, ages 18 to 35 who have a history of drug dependence. This program is characterized by 24-hour supervision by staff who continuously monitor and assess the behavior and activities of clients. No adjudicated clients are allowed to leave the ADASI Drug Services facility unless specifically authorized to do so by court order or unless accompanied by a staff member. Services provided at the facility include group and individual therapy sessions, regular urinalysis, skill training, vocational rehabilitation, job placement, physical exercise, and other structured activities. The rehabilitation goal of the residence is to reintegrate all residential clients into constructive jobs or education training which will lead directly to constructive employment. Clients will, in most cases, be required to exhibit a history of successful employment and a lengthy drug-free record before being considered for release.

E. Juvenile Residential Treatment

This residential facility has been licensed by the Iowa Department of Social Services as a child care facility with a licensed capacity of 16 juvenile males, ages 14 to 18. This program is also characterized by 24-hour supervision by staff who continuously monitor and assess the behavior and activities of the clients. This community-based program is the first residential treatment facility in Iowa designed specifically for boys with substance abuse and delinquency problems. Educational placement and vocational assessment is an integral part of this treatment program. Client referrals are accepted from juvenile institutions and from state juvenile parole officers as a reintegration tool for those boys returning from the state juvenile institutions to the local community. Individual treatment plans are established for each boy through close cooperation and communication with the juvenile's probation or parole officer. Activities of the facility include individual and group therapy sessions, family counseling, urinalysis monitoring, vocational training, physical exercise, recreational activities, and the developement of personal maturity and decision-making skills, and other structured programs.

F. Specialized Criminal Justice Services

The above services are available to persons who have been adjudicated or are otherwise involved with the criminal justice system. ADASI cooperates with the courts and other criminal justice agencies in providing treatment and other specialized services as a formal stipulation of parole and probation, as part of a diversionary treatment plan in

lieu of incarceration, and/or as part of pre-sentence investigation and other diagnostic activities. Full reporting regarding client progress will be provided to authorized criminal justice officials by ADASI Drug Services personnel through a release of information signed by the referred client prior to referral. In addition to the services described above, criminal justice officials may want to make use of the following specialized services which are available from ADASI Drug Services. Services include: pre-sentence diagnosis and prognosis relative to a client's drug abuse problem and rehabilitation potential, physical examinations specifically designed to diagnose drug-related medical problems, medical/counseling intervention when a client undergoes withdrawal in another incarceration facility and other services.

G. Urinalysis Screening

Urinalysis screening is conducted by ADASI Drug Services' laboratory technician to screen for the presence of the following drugs: opiates, cocaine, methadone, barbiturates, amphetamines and non-barbiturate depressants.

H. Treatment Alternatives to Street Crime (TASC)

This program is designed as a referral mechanism for all individuals who are involved in the criminal justice system and could benefit from services offered by ADASI Drug Services. The three major components of the TASC program are the screening intake unit, the tracking and monitoring unit, and the evaluation unit. The screening intake unit attempts to identify all drug abusers entering the criminal justice system within the state, offer the TASC program to those offenders judged eligible according to pre-determined criteria, and recommend referral to the most suitable treatment program. The tracking and monitoring unit monitors the treatment progress of TASC clients to assure that previously established success/failure criteria are utilized to evaluate client progress. Those individuals violating these criteria will be returned to the criminal justice system for appropriate action. The evaluation unit is responsible for evaluating the internal mechanisms of TASC as well as for ensuring that each client is provided adequate treatment.

IV. Reintegration Services

Reintegration services are provided by ADASI Drug Services to assist clients in making a smooth transition from treatment to independent living within the community. An essential element of successful reintegration for most clients is a client's ability to secure meaningful employment. Secondly, a client must feel that the support offered to him through the services of ADASI Drug Services are still available upon his return to the community. These two concepts compose the fundamental elements of reintegration services.

A. Employment Assistance

The ADASI Drug Services EARDA program (Employability Assistance to Rehabilitated Drug Abusers) provides job-placement, job seeking skills training, and on-the-job training to outpatient clients of the ADASI

Drug Services Central Clinic. In this fashion, clients are not only afforded the opportunity to secure employment, but also to develop job skills. In addition, vocational/educational counselors are employed by both the Drug Services Adult and Juvenile Residences. These persons provide vocational/educational counseling and assistance in placement.

B. Follow-up Counseling

Follow-up counseling is provided to track the progress of clients as they re-enter the community and ensure that services are made available if problems arise. Follow-up counseling is provided to criminal justice clients through the TASC project. Follow-up counseling is provided to outpatient clients through the Drug Services Central Clinic follow-up counselor.

The follow-up counselor may make up to weekly contacts with clients as appropriate. Clients will remain on follow-up status from one month to a year. If a client should have difficulty in the reintegration process, he may be received again as an active client with the full range services available to him/her.

ALCOHOL SERVICES AVAILABLE

ADASI Alcohol Services stresses a continuum of care approach to provide services to persons experiencing alcoholism and alcohol abuse. Programs are directed towards assisting clients during all phases of the treatment and rehabilitation process. Services fall under four general categories: Education/Prevention, Outreach/Intervention, Treatment/Rehabilitation, and Reintegration Services.

I. Education/Prevention

Education/Prevention services are provided to disseminate information and encourage greater public understanding of alcoholism and alcohol abuse. The consultation component of the program involves a needs assessment relative to the requesting agency. This assessment then is developed into a specialized educational program. Services provided through these programs may include:

A. Curriculum Development

Alcoholism curriculums have been developed for numerous area colleges and high schools, including Area XI Junior College (School of Nursing) and Drake University.

B. Field Placement Program

Educational Placement experience at ADASI Alcohol Services has been provided to human service professionals. This program allows first-hand training and experience in the area of alcoholism and alcohol abuse.

C. Specialized Training/Seminars

Seminars are developed to provide specialized training in alcoholism, and dealing with the alcoholic. Seminars have been provided to area teachers and law enforcement officials.

D. Peer Counseling

Peer counseling programs have been developed to educate youth about alcohol, and to develop decision-making skills. These youth are then trained to assist other youth in developing these same skills.

II. Outreach/Intervention

The outreach program focuses on early identification and intervention. It attempts to expedite treatment early in the disease process. Outreach services are provided in an effort to maximize service delivery in the community. Services include:

A. Criminal Justice/Misdemeanor Program

ADASI Alcohol Services counselors go to the city jails on a daily basis. offering persons arrested for minor alcohol-related offenses the option to receive treatment rather than incarceration or fine.

B. Professional Referral

ADASI Alcohol Services works jointly with satellite offices in surrounding counties to facilitate referrals between appropriate agencies such as the criminal justice system, mental health agencies, social service agencies and other referral points.

C. Juvenile Outreach Program

This program offers any juvenile arrested for an alcohol-related offense the opportunity to receive treatment at ADASI Alcohol Services.

D. Collateral Services

ADASI Alcohol Services provides counseling, conferences, etc., to persons (employers, family, etc.) concerned with the alcohol use of a significant other. These discussions are directed toward developing appropriate interventions with an alcohol abuser. (In extreme cases, emergency commitments are available.)

E. Pre-placement Service

ADASI Alcohol Services provides short-term, structured living arrangements to persons prior to final placement. For example, if a person might be better served in a nursing home or mental health facility, s/he will be allowed to stay at ADASI Alcohol Services until other arrangements can be made.

III. Treatment/Rehabilitation

The treatment services offered by ADASI Alcohol Services reflect the great emphasis placed on continuity of care. A client may utilize any or all of the following treatment programs, depending on his/her unique needs. Major treatment programs include:

A. Detoxification

ADASI Alcohol Services utilize a social setting detoxification program with emergency medical care provided by Broadlawns Hospital. Detoxification is supervised by a physician's assistant provided by Broadlawns Hospital. The Physician's Assistant is on 24-hour call. Detoxification services are generally provided for up to 72 hours, but may be extended as dictated by the needs of the individual client. Admission to the detoxification unit is available 24-hours a day, 7 days per week.

B. Inpatient Program

ADASI Alcohol Services utilizes a highly structured residential treatment program beyond the initial detoxification period. The program usually lasts two weeks, however, a longer duration of treatment care is available. Services provided through the inpatient program include: on-going evaluation, alcoholism education, group counseling, individual counseling, AA groups, employment counseling, medical screening and antabuse therapy.

C. Intermediate Care

The ADASI Men's Residence provides a stable, supportive residential environment for those clients indicating a need for on-going treatment. The Men's Residences is designed to facilitate reintegration as well as continue the therapeutic process. The "intermediate care" facility is designed to bridge the gap between intensive treatment and independent living within the community. Services offered at this facility are an extension of those begun during the structured treatment program. This program is also available as a treatment alternative to the criminal justice system.

D. Outpatient Program

The Outpatient Program offers treatment and rehabilitative services, while allowing clients to continue to live at home and function within the community. With this goal in mind, the full range of treatment services are offered to outpatient clients including: group counseling, one-to-one counseling, alcoholism education, AA groups, antabuse therapy, and medical screening. As with all of the ADASI Alcohol Services, emphasis is placed on post-treatment planning for continued recovery.

IV. Reintegration Programs

The ultimate goal for all treatment programs is "continued recovery", emphasizing that recovery from alcoholism is a continual process. Reintegration services are provided to ensure that the recovery process continues as the client re-enters the community. ADASI Alcohol Services offers both aftercare and an array of support services to assist in the transition from treatment to independent living.

A. Aftercare

Continuity through the recovery process is the primary goal of ADASI Alcohol Services. To that end, a full range of aftercare services, designed for on-going client participation, is available. During this phase of involvement clients are encouraged to continue to utilize those treatment services most beneficial to their continued recovery. For example, monitored antabuse therapy or marital counseling may become an important part of this process. Any or all of ADASI services are available to the client through the aftercare program, however, involvement in AA is strongly encouraged.

B. Employment Assistance

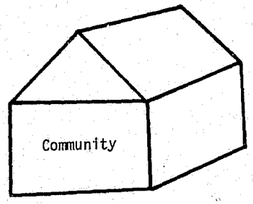
Assistance is given to clients both in vocational/educational assessment and job placement. In addition, clients may receive on-the-job training through ADASI's EARDA Program (see Drug Services). In this fashion, clients are provided an opportunity to upgrade their job skills and secure more meaningful employment.

C. Support Services

An office of the Department of Social Services is located within ADASI Alcohol Services Central Facility. The office is staffed by a Social Worker II, and a Program Aide, who assist eligible clients in securing food stamps, transportation, general relief, and placement.

ADASI

CLIENT SERVICES FLOW CHART



I. PREVENTION/EDUCATION

- A. Family Effectiveness Training
- B. Teacher Training
- C. Business/Industry Seminars
- D. Adult Education Program
- E. Public School Programs

II. OUTREACH/INTERVENTION

- A. Professional Referral
- B. Collateral Services
- C. Volunteer Training
- D. Misdemeanor Program
- E. Drug Line (24 hour)
- F. Peer Assistance Training

III. TREATMENT/REHABILITATION

- A. Family Therapy
- B. Residential Treatment (Adults and Juveniles)
- C. Inpatient Treatment
- D. Outpatient Therapy/ Counseling
- E. Methadone Maintenance/ Detoxification
- F. Antabuse Therapy
- G. Alcohol Detoxification

IV. REINTEGRATION

- A. Job Placement Program
- B. School Placement
- C. Housing/Food
- D. Supportive Counseling
- E. Aftercare

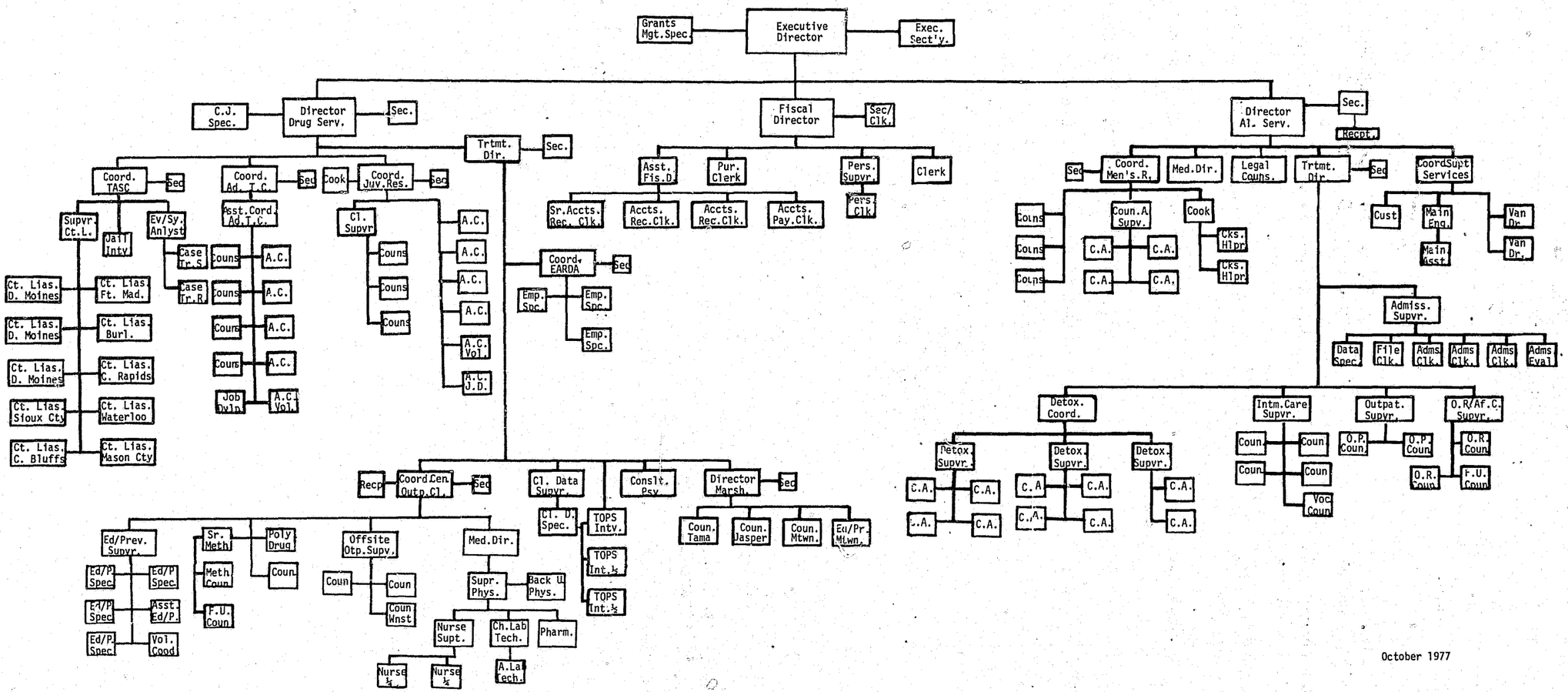
ADASI DRUG SERVICES
512 Ninth Street
Des Moines, Iowa
(515)288-9775

SERVICE:	PERSON TO CONTACT:
Criminal Justice/ Residential Treatment	Jon Royal, Director, Drug Services Steve Bump, Director TASC
Non-Court Commitments/ Clinical Information	Bob Johns, Director of Treatment
Outpatient Services/ Methadone Program	Lloyd Sundblad, Director Outpatient Clinic
Prevention/Education Programs	Bob Johns, Director of Treatment
Free Medical Clinic	Lloyd Sundblad, Director Outpatient Clinic
Employment Services	Leonard Peavy, Sr.; EARDA
Emergency	Drug Line, 280-1111

ADASI ALCOHOL SERVICES
1519 Hickman
Des Moines, Iowa
(515)244-3702

SERVICE:	PERSON TO CONTACT:
Criminal Justice/ Residential Treatment	Mike Oelrich, Director, Alcohol Services
Outpatient, Inpatient, Detoxification, Aftercare Services	Bill Fey, Director of Treatment
ADASI Men's Residence	Bob McKeever, 285-0823
Department of Social Services	Susie Finney, Social Worker II

ADASI ORGANIZATIONAL CHART



October 1977

ADASI

FUNDING SOURCES

September 1, 1977 - August 30, 1978

	ALCOHOL	DRUG	TOTAL
NIDA		335,000	335,000
POLK	513,000	220,000	733,000
TITLE XX POLK COUNTY	60,000	115,540	175,540
TITLE XX MARSHALL COUNTY		2,800	2,800
STATE OF IOWA	198,000		198,000
FOSTER CARE		234,000	234,000
IDAA		226,674	226,674
LEAA		395,489	395,489
TOPS		47,828	47,828
MARSHALLTOWN SCHOOL		1,000	1,000
TAMA COUNTY		4,000	4,000
OTHER COUNTIES	80,000	35,000	115,000
INSURANCE	40,000		40,000
PRIVATE PAY	15,600		15,600
EARDA		61,048	61,048
IOWA BUREAU OF CORRECTIONS		50,000	50,000
PSE	102,200	92,322	194,522
TOTAL	$1,008,800	$1,820,701	$2,829,501

ADASI
FACILITY SITES
February, 1978

Locations

Alcohol-Administration and Services
915 Hickman Road
Des Moines, Iowa 50314
(515) 244-3702

Alcohol-Men's Residence
66 Gruber
Fort Des Moines, Iowa 50315
(515) 285-0823

Alcohol-Adel Satellite Office
Public Health Nurse's Office
Dallas County Court House
Adel, Iowa 50003
(515) 933-3750

Drug-Administration and Services
512 9th Street
Des Moines, Iowa 50309
(515) 288-9775

Drug-Adult Residence
512 9th Street
Des Moines, Iowa 50309
(515) 288-9775

Drug-Juvenile Residence
1605 Woodland
Des Moines, Iowa 50309
(515) 243-1798

Drug-TASC Administration
512 9th Street
Des Moines, Iowa 50309
(515) 288-9775

Drug-Marshalltown Satellite Office
Box 242, 106 Kresge Building
Marshalltown, Iowa 50158
(515) 752-7211

Drug - TASC Satellites

Department Drug Services
427 E. Washington, Room 204
Council Bluffs, Iowa 52401
(712) 325-2400

Reality 10
324 Second Avenue SE
Cedar Rapids, Iowa 52401
(319) 366-7847

SE Iowa Council on Alcohol and Drug Problems
Box 1025
Burlington, Iowa 52601
(319) 753-0138

Department Court Services
219 Commerce Building
512 Nebraska Street
Sioux City, Iowa 51101
(712) 255-7911

ISP, Substance Abuse Program
IA State Penitentiary
Ft. Madison, Iowa 52627
(319) 372-5432. Ext. 322

Department Court Services
412 S. Federal
Mason City, Iowa 50401
(515) 424-0131

Blackhawk Drug Council
120 Independence Ave.
Waterloo, Iowa 50703
(319) 232-6889

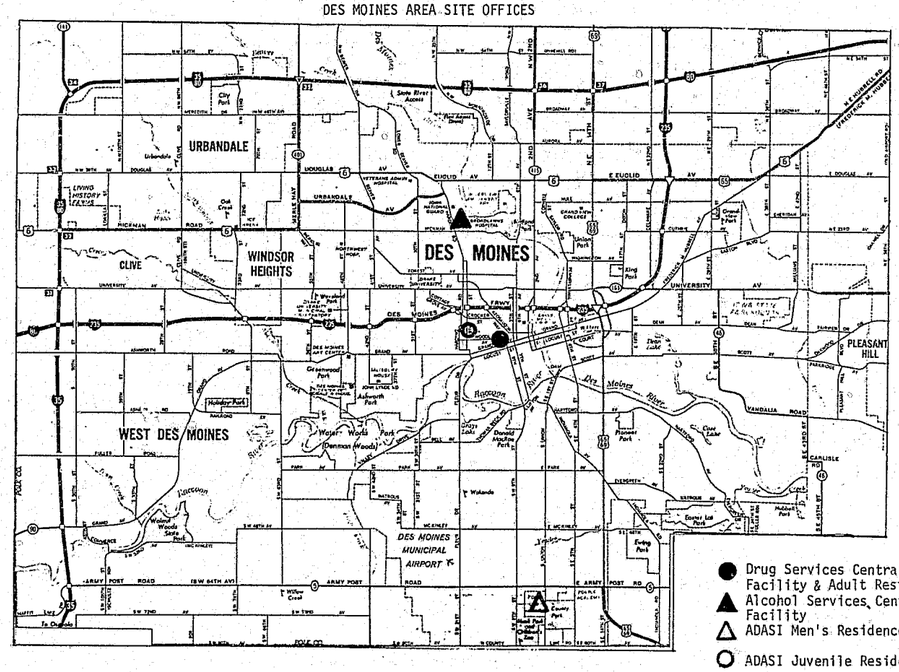
Tama Office
129 W. High Street
Toledo, Iowa 52342
(515) 484-4695

Newton Office
Box 661, 109 S. 3rd Ave. W.
Newton, Iowa
(515) 792-3330

Department Court Services
P.O. Box 220
Fort Dodge, Iowa 50501
(515) 576-7281

ADASI

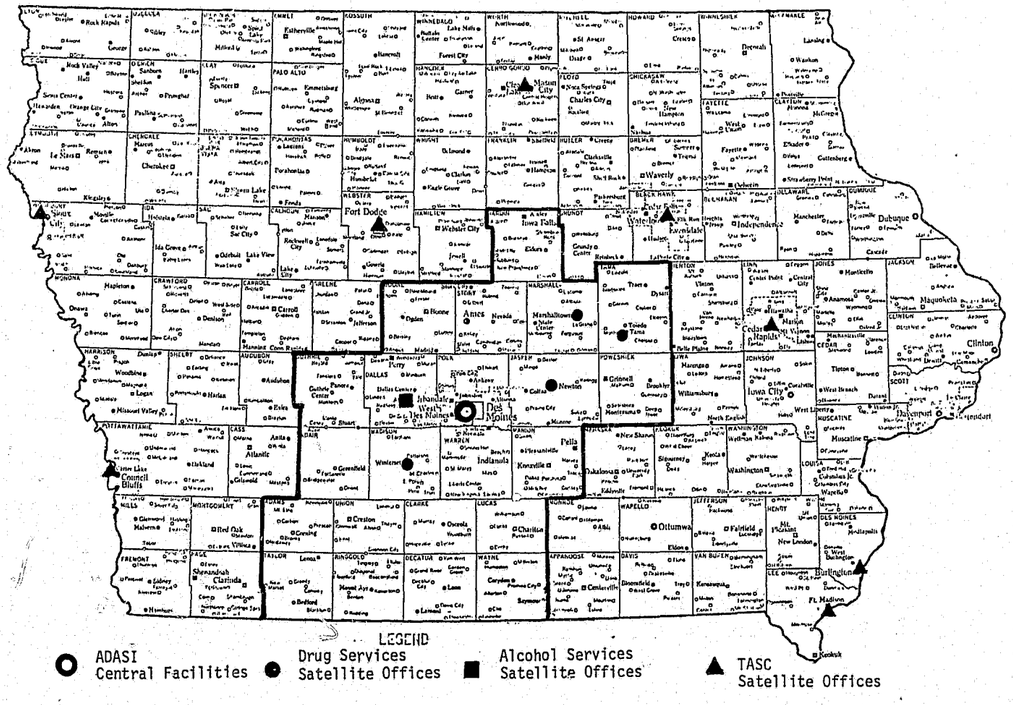
DES MOINES AREA SITE OFFICES



ADASI

PROGRAM FACILITIES AND PRIMARY CATCHMENT AREA

September, 1977



Description of The ADASI Male Juvenile Residence: Community-Based Treatment and Reintegration

March 1977

INTRODUCTION

The ADASI Juvenile Treatment Program is a community-based residential program for boys, ages fourteen (14) through seventeen (17) years old who have experienced drug related problems. Clients are referred by probation officers, parole officers, and institutions such as the Iowa State Training School for Boys at Eldora, and the Iowa State Juvenile Home at Toledo. While having a history of drug usage, most clients are referred for manifesting problems in adjusting to their home, school, and community situations. A major emphasis of treatment is provided through reintegration into the community. By securing a job and/or returning to school clients begin to test new behavior in the community while continuing to benefit from the support of the facility.

The ADASI program emphasizes the client's responsibility for himself and his accountability for his actions within the framework of a caring, family-type setting. A high staff to client ratio provides security within an open setting.

The Client's responsibility for their own destiny is stressed to the point of sharing responsibility for the house and the program, e.g., where practical house rules are negotiated with clients and clients are often included in decision-making processes such as considering the removal of a disruptive client or hiring staff.

Reintegration into the community is effected by a well monitored, gradual process of introducing the client to real life situations as he demonstrates readiness. As the boy moves through the program, he learns to anticipate, avoid, and correct negative or anti-social behavior. When he graduates from the program, the client will have demonstrated an ability to function adequately in his new setting for an extended period of time.

STAFF

The ADASI Juvenile Residence employs a clinical supervisor (M.A.), two casework counselors, a job and educational developer, two lead assistant counselors, full and part-time assistant counselors, and a cook in addition to the director and secretary.

The Clinical Supervisor is responsible for designing, implementing, and overseeing the treatment in the facility. He/she administers and interprets all diagnostic and psychometric tests with supervision from the consulting staff psychologist.

The Casework Counselors are responsible for developing treatment plans with each client, conducting individual, group, and family therapy sessions, and providing regular progress reports to referring criminal justice personnel. They are also responsible for monitoring the client's activity outside of the facility.

The Job and Education Developer is responsible for the assessment and placement of clients in appropriate jobs and/or vocational and educational programs. He/she also conducts regular job and school preparedness groups.

The Assistant Counselors are responsible for providing structure and counseling as a part of the overall team treatment approach, maintaining security and intervening in crisis situations.

JUVENILE RESIDENCE

TREATMENT PROGRAM PHILOSOPHY

ADASI's philosophy for treatment of adolescents is based on two fundamental assumptions. First, human beings do not become responsible if others assume the responsibility for them. Responsibility must be given gradually and built up over time to assure an end result of stable and integrated socially acceptable behavior. This process is not constant; clients will occasionally fail or regress in this process. When this occurs, unacceptable behavior must be addressed and alternatives explored. Individual responsibility is the cornerstone on which rests the task of building personal success rather than failure.

Our second assumption is that human beings require a safe, caring, atmosphere in which to risk new behavior and new approaches to altering their lifestyles. To us, safe and caring means a balanced combination of control, support and love.

We believe that every outcome of human endeavor is earned, be it positive or negative. In our treatment program, a client is rewarded for exhibiting positive behavior and responsibility. This results in privileges and advancement through the phases of the treatment program.

While in the program, all learning is geared to experiential learning through aspects of appropriate inter and intra-personal growth. By the time a client is ready to graduate, we intend that he exhibit a stronger self-concept, more individual responsibility, and possess educational and vocational skills sufficient to function satisfactorily in society.

TREATMENT PROGRAM

The treatment programming at the ADASI Juvenile Facility incorporates a Phase System and a Point System. The Phase System consists of an Orientation period and three phases, and serves three basic functions:

1. It recognizes that reintegration of the client into the community requires that certain skills be developed by the client and organizes this developmental process into a logical sequence which clearly delineates the skills being emphasized at each stage of the treatment process.

2. The division of this development process into steps also allows for a clear and orderly statement of privileges and responsibilities as they correlate with the individual's growth. In many ways this provides structure and security where the client can feel safe while he matures.

3. The third function of the Phase System is that it provides criteria for evaluating a persons progress and allows him to measure precisely where he stands in the program, as well as understanding what is required to move ahead. This serves some additional functions in that it reduces client anxiety, provides goals for the individual to strive for, and minimizes subjectivity by staff members.

The Point System is utilized to augment the benefits of the Phase System. It provides a mechanism whereby the client receives immediate feedback about his behavior and provides short-range goals and reinforcement for those clients requiring more immediate gratification.

Points apply only to the specific shift (12-hour period) and day (24-hour period). They are not cumulative, but rather acquired daily. The number of points acquired during a shift determines the privileges a client earns for the next shift. If a client earns a good shift, he is allowed outside recreational privileges for the next shift. If a client earns a neutral shift, he is allowed in-house recreational privileges for the next shift. If a client earns a negative shift, he is allowed no privileges and must remain in his room or hallways throughout the next shift. The number of points acquired for the day determines the quality of the day: good, neutral or negative. During orientation the client earns points for individual behaviors and duties performed. Through Phases One and Two ratings occur for increasingly larger clusters of behavior, placing greater responsibility on the client for his total behavior.

Clients receive points for satisfactorily performing a function within an allotted time frame. If the client is late or the performance sub-standard, the client earns a zero. During Orientation and Phase One, the client has the option to "buy back" half the points upon the first reminder from staff. By Phase Two, "buy back" is no longer an option.

To achieve a good day in Orientation, a client must acquire no fewer than 25 points and/or earn no more than one zero. For a neutral day the client's quota is 22 points and/or no more than 2 zeros. A negative day results from the acquisition of 21 or fewer points and/or 3 or more zeros. (See Chart).

To achieve a good day in Phase One and Phase Two, a client must acquire no fewer than 12 points and/or earn no more than one zero. For a neutral day the client's quota is 10 points and/or no more than 2 zeros. A negative day results from the acquisition of 9 or fewer points and/or 3 or more zeros. (See Chart).

Phase Three clients are no longer rated on points as it is our belief that points do not reflect reality for the client who will soon return to the community (he will not receive points for cleaning his room when he lives in his own apartment). Judgement of a good, neutral or negative day is based upon the client's general attitude and performance for each shift. Behavior while on pass is also considered.

ORIENTATION

A. General Description

Upon entry into the program, a client is in the Orientation Phase for a minimum of three (3) weeks. The purpose of orientation is to provide the client with a time to look inward at himself, to examine his past behavior, as well as his values, and to determine what aspects of his life he feels need change. The major emphasis during this phase of the program is on client introspection - to expend time in self-examination rather than inter-personal activities. It is also during this time that a client becomes acquainted with his new environment and the staff has an opportunity to become acquainted with the new client.

Initially, ADASI receives certain information about a client, including the reason for referral, client's presenting problems, and an account of recent successes and failures. In addition, a complete medical and social history is received. A staff member also conducts a referral interview with the referring agent in order to get additional information.

Upon the client's arrival, a staff member performs a strip search and shake-down of all possessions. A urine sample is taken for analysis to determine use of drugs and a room is assigned. A client sponsor is assigned to acquaint the youth with the facility and other clients in the facility. Rules and regulations are read and explained to the client.

Within 24 hours, a counselor is assigned and an initial contract for treatment is completed. The client is introduced to the Phase System and his questions are answered. His counselor completes the initial intake and the client is assigned the task of completing an autobiography. A physical examination is scheduled. Finally, waivers of confidentiality and permission to release information are obtained.

During the remainder of the orientation period, a review of his physiological and psychological functioning is completed. A treatment plan is developed with the assistance of the parole/probation officer. Counseling appointments are scheduled, educational and vocational needs are assessed, and job/school readiness training is begun. Gradually, the client becomes acquainted with the staff and other clients and group interaction training is initiated. The client's counselor completes an assessment of the client's family relationships and when appropriate, family counseling is begun.

During this period, a client is expected to participate in those in-house activities open to him. In addition, regular urinalysis is conducted to determine the use of illegal drugs. During orientation, the client has no outside contact other than with professionally involved persons. This restriction includes no visitors and no phone calls until completion of the Orientation Phase. The client is also not eligible for passes or furloughs during orientation. Because the emphasis of the Orientation Phase is on the client turning his energies inward, as many outside stimuli as possible have been removed from his environment. In addition, no sound equipment other than a radio will be in the client's possession during this Phase.

B. Responsibilities of an Orientation Client

1. Client must demonstrate a firm understanding of policies and rules.
2. Client must participate in scheduled daily activities.
3. Client must demonstrate good personal hygiene.
4. Client must participate in both room and house clean-up.
5. Client must participate in therapy groups.
6. Client must participate in job readiness training.
7. Client must participate in in-house mini-courses.
8. Client has mandatory wake-up time of 7:00 a.m.
9. Client has mandatory curfew time of 10:30 p.m. (Lights out).

Assessment of orientation clients occurs after the second week and every week thereafter until completion of orientation. After six weeks in orientation, removal of the client will be considered.

C. Privileges of an Orientation Client

1. Client may participate in afternoon recreational activities.
2. Client may smoke cigarettes.
3. Client may have a radio in his room.

D. Guidelines for Acceptance into Phase I

1. Minimum of 3 weeks in Orientation. Achievement of 2 consecutive "good weeks".
2. Understanding and adherence to the policies and rules of the program.
3. Demonstration of good personal hygiene.
4. Initiative and motivation toward assigned house duties.
5. Participation in assigned program activities.
6. Responsiveness to staff, clients and treatment.
7. Participation in therapy groups.
8. Participation in one-to-one counseling.
9. Participation in mini-courses.
10. Participation in job readiness training.
11. Achievement of specified treatment goals.
12. Urinalysis results.

PHASE I

A. General Description

Phase I is designated as a time in the program when the client continues to focus his energy and attention on himself while initiating examination of his relationships with others. The process of evaluating and identifying the client's problem areas is completed during this Phase. Plans are made for implementing the steps necessary to reach the goals established by the client and his counselor for helping him to become a successful person. The client is expected to put forth an earnest effort in working towards the attainment of his goals. Privileges are increased, as are responsibilities.

The goals of Phase I emphasize self-development. They include: (1) increasing level of involvement in individual and group therapy, (2) establishing goals for leisure time activities, (3) maintaining acceptable personal hygiene, (4) keeping living quarters neat and clean, (5) increasing cooperation with staff and other clients, (6) displaying respect for others day-to-day needs, (7) developing and implementing employment/educational plans, (8) assessing and understanding of interpersonal relationships, (9) regular and proper execution of household duties, and (10) displaying acceptable language.

Activities have been designed to assist the client in achieving his goals. In addition to the continuance of activities initiated in the orientation period such as group therapy and one-to-one counseling, various new activities are introduced. Visits from friends and family are encouraged. Budget planning is provided and the client is encouraged to open a savings account. The estimated average stay for a client in this Phase is six weeks.

B. Responsibilities of a Phase I Client

1. Client must maintain previous progress.
2. Client must participate in scheduled daily activities.
3. Client must continue to practice good personal hygiene.
4. Client must participate in both room and house clean-up.
5. Client must participate in therapy groups.
6. Client must participate in mini-courses.
7. Client has mandatory wake-up time of 7:00 a.m.
8. Client has mandatory curfew time of 11:00 p.m.
9. Client must be a cook's helper.
10. Client must participate in a physical fitness program.
11. Client must coordinate a volunteer project with other Phase I clients.
12. Client must formally introduce visitors to staff on duty.
13. Client must begin budget planning.
14. Client must be involved in a job or school by the end of Phase I.

C. Privileges of a Phase I Client

1. Client may participate in evening recreational activities.
2. Client may smoke cigarettes.
3. Client may have a radio in his room.

4. Client has ground privileges.
5. Client is eligible for $3.00 allowance per week.
6. Client may use the pay phone with the consent of his counselor.
7. Client may have visitors for one night per week.
8. Client is eligible for short passes (maximum of three (3) hours). upon the approval of his counselor. Longer passes, limited to a maximum of twelve (12) hours per pass, may be given based on treatment considerations.

D. Guidelines for Acceptance into Phase II

1. Minimum of 4 weeks in Phase I. Achievement of three (3) consecutive "good weeks".
2. Demonstration of good personal hygiene.
3. Timely and proper execution of work assignments.
4. Participation in group therapy.
5. Participation in mini-courses.
6. Participation in one-to-one therapy.
7. Participation in family therapy.
8. Achievement of specified treatment goals.
9. Development and implementation of physical fitness plan.
10. Participation in volunteer projects.
11. Involvement in appropriate leisure-time activities.
12. Appropriate conduct while friends and family are visiting.
13. Development and implementation of employment and education plan.
14. Budget planning and savings account management.
15. Ability to cope with stress.
16. Behavior while on pass.
17. Urinalysis results.
18. Maintenance of achievements in previous Phase.

PHASE II

A. General Description

Phase II turns the client toward focusing his energies externally rather than internally. While a Phase II client is expected to continue his assessment of his own self-development, he is now encouraged to learn and develop inter-personal relationship skills, leadership skills, and appropriate decision-making skills. Becoming aware of and clarifying the client's values is an integral part of this process and will be emphasized in Phase II.

The goals of Phase II are directed toward development of values and vocational skills. Those goals include: 1) increasing the level and quality of the client's involvement in group, family, and individual counseling; 2) utilizing the valuing process in decision making; 3) becoming successfully involved in a job and/or school; 4) serving as an acceptable role model for new clients; 5) accepting responsibilities of client sponsorship; and 6) demonstrating a high level of cooperation with and respect for clients, staff, and others.

The activities of Phase II aid the client in reaching these goals. Training is received in decision making and values clarification. Mini courses such as planned parenthood and proper money management are offered. The client also receives preparatory training for being a client sponsor. The estimated average stay for clients in Phase II is seven weeks.

B. Responsibilities of a Phase II Client

1. Client must maintain previous progress.
2. Client must participate in scheduled daily activities.
3. Client must participate in both room and house clean-up.
4. Client supervises other clients in house clean-up duties on a rotating basis.
5. Client must participate in therapy groups.
6. Client must participate in mini-courses.
7. Client has a mandatory wake-up time of 7:00 a.m.
8. Client has a mandatory curfew of 11:30 p.m.
9. Client must participate in a physical fitness program.
10. Client must formally introduce visitors to counselor on duty.
11. Client must keep job until another approved job is found.
12. Client must facilitate house group meetings.
13. Client must be a sponsor to a new client.

C. Privileges of a Phase II Client

1. Client may participate in afternoon and evening recreational activities.
2. Client may smoke cigarettes.
3. Client has ground privileges.
4. Client is eligible for $3.00 allowance per week.
5. Client may have phone privileges.
6. Client may have visitors three times a week.
7. Client may have sound equipment in his room.
8. Client may select his own room in the Phase II area with the approval of his counselor and the clinical supervisor.
9. Client may return to the facility to sleep while on pass.
10. Client may earn passes up to 48 hours based on treatment considerations, but are not guaranteed.

D. Guidelines for Acceptance into Phase III

1. Minimum of 5 weeks in Phase II. Achievement of four (4) consecutive "good weeks".
2. Demonstration of good personal hygiene.
3. Timely and proper execution of work assignments.
4. Participation in family/group therapy.
5. Participation in mini-courses.
6. Participation in one-to-one counseling.
7. Achievement of specified treatment goals.
8. Continuation of physical fitness program.
9. Involvement in appropriate leisure-time activities.
10. Conduct while friends and family are visiting.
11. Maintenance of employment and/or educational involvement.

D. Guidelines for Acceptance into Phase III (Continued)

12. Budget planning and savings account management.
13. Ability to cope with stress.
14. Appropriate conduct while on pass.
15. Demonstration of leadership skills.
16. Demonstration of valuing and decision-making skills.
17. Performance in client sponsorship program.
18. Performance in house management program.
19. Urinalysis results.
20. Maintenance of skills and achievements of previous Phases.

PHASE III

A. General Description

The Phase III client has exhibited the skills and abilities to indicate that he is prepared to leave the program and become a responsible member of the community. He is given the opportunity, under supervision, to try his acquired skills. Privileges are greatly increased, so the client can prove that he indeed can handle a minimally structured living situation. Staff monitors this process and is available for support and help.

The client is expected to continue his responsibilities within the facility as well as serving as a role model for other clients. Upon graduation, the client is expected to have the skills necessary to live in the community successfully.

In addition to maintaining the success he has already achieved, the client must: (1) perform successfully in school and/or work; (2) demonstrate clear and effective leadership skills; and (3) maintain an adequate savings plan.

The goals established prepare the client for integration into the community. They include: (1) demonstration of financial planning skills, including consumer skills, insurance knowledge, etc.; (2) securing approved living and transportation arrangements; and (3) demonstration of an adequate understanding of himself.

The activities designed for Phase III afford the client an opportunity to implement the skills he has acquired throughout the program. He assumes resident assistant responsibilities and continues to facilitate house group meetings.

The client receives extended passes of up to five days out of the facility and must establish his own transportation and housing for graduation. He also receives additional financial counseling and instruction. Clients remain in Phase III for an estimated five weeks.

B. Responsibilities of a Phase III Client

1. Client must matinain previous progress.
2. Client must participate in scheduled daily activities.
3. Client must participate in both room and house clean-up.

B. Responsibilities of a Phase III Client (Continued)

4. Client supervises other clients in house clean-up duties on a rotating basis.
5. Client must participate in therapy groups.
6. Client must participate in mini-courses.
7. Client performs successfully in school and/or work.
8. Client must provide his own work and school transportation.
9. Client must facilitate house group meetings.
10. Client must supervise activities for other clients.
11. Client assumes client sponsorship responsibilities.
12. Client assumes resident assistant responsibilities.

C. Privileges of a Phase III Client

1. All recreational activities are optional.
2. Client may smoke cigarettes.
3. Client has ground privileges.
4. Client may have phone privileges.
5. Client may have visitors three times a week.
6. Client may have sound equipment in room.
7. Client may select his room in the Phase III area with approval of his counselor and the clinical supervisor.
8. No wake-up time is required if client is meeting his responsibilities.
9. No curfew time is required if client is meeting his responsibilities.
10. Physical fitness training becomes optional.
11. No formal introduction of visitors to staff on duty is required.
12. Client may leave job site for lunch.
13. Client may have passes up to a maximum of five (5) days out and two (2) days in.

D. Guidelines for Graduation

1. Achivement of four consecutive "good weeks".
2. Demonstration of good personal hygiene.
3. Timely and proper execution of work assignments.
4. Participation in family/group therapy.
5. Participation in mini-courses.
6. Participation in one-to-one counseling.
7. Completion of treatment plan.
8. Appropriate employment and/or education performance.
9. Exhibiting sound money management.
10. Demonstration of consumer skills and banking skills.
11. Ability to cope with stress.
12. Demonstration of positive behavior while on passes.
13. Performance as a peer leader.
14. Demonstration of decision making skills.
15. Performance in client sponsorship program.
16. Performance in house management program.
17. Performance of resident assistant responsibilities.
18. Participation in group activities.
19. Appropriate attitude toward authority.
20. Acceptable housing accomodations.
21. Establishment of acceptable transportation arrangements.
22. Urinalysis results.
23. Approval of referring agent.
24. Maintenance of skills and achievements of previous Phases.

DAILY SCHEDULE

ORIENTATION

7:00 A.M.	WAKE-UP
7:00 to 8:30	BREAKFAST CLEAN-UP: HOUSE, ROOM, SELF
8:30 to 9:00	FREE TIME
9:00 to 10:00	GROUP MEETING
10:00 to 12:00 P.M.	MAJOR HOUSE PROJECT (RA SCHEDULED) POSITIO
12:00 to 1:00	LUNCH AND CLEAN-UP
1:00 to 3:00	PHYSICAL RECREATION ACTIVITY
3:00 to 4:00	MINI-COURSES: JOB READINESS TRAINING
4:00 to 5:00	FREE TIME
5:00 to 7:00	DINNER MEAL AND HOUSE CLEAN-UP
7:00 to 10:30	FREE TIME, HOME WORK ASSIGNMENT FROM STAFF IN HOUSE ACTIVITIES AS EARNED; GROUP THERA
10:30	CURFEW

DAILY SCHEDULE

PHASE I & II

7:00 A.M.	WAKE UP
7:00 to 8:30	BREAKFAST CLEAN-UP: HOUSE, ROOM, SELF
8:30 to 9:00	FREE TIME
9:00 to 10:00	GROUP MEETING
10:00 to 12:00 P.M.	MAJOR HOUSE PROJECT - POSITION
12:00 to 1:00	LUNCH AND CLEAN-UP
1:00 to 3:00	PHYSICAL RECREATION ACTIVITY
3:00 to 4:00	MINI-COURSES
4:00 to 5:00	FREE TIME
5:00 to 7:00	DINNER MEAL AND HOUSE CLEAN-UP
7:00 to 10:00	ACTIVITY; COUNSELOR GROUP THERAPY
10:00 to 11:00	FREE TIME
11:00	CURFEW: PHASE I
11:30	CURFEW: PHASE II

DAILY SCHEDULE

PHASE III

7:00 to 9:00 A.M.	POSITION - R.A. DUTIES
9:00 to 10:00	GROUP MEETING
10:00 to 12:00 P.M.	POSITION - R.A. DUTIES
12:00 to 1:00	LUNCH POSITION
1:00 to 3:00	ACTIVITY- R.A. - POSITION
3:00 to 5:00	FREE TIME - IF COMPLETED MINI-COURSES
5:00 to 7:00	DINNER POSITION R.A. DUTIES
7:00 to 10:00	GROUP - POSITION
10:00 to 11:00	GROUP POSITION
11:00--------	FREE TIME - - - NO CURFEW

ORIENTATION POINT SHEET

DAY ACTIVITIES	MAXIMUM POINTS POSSIBLE																				
WAKE UP	2																				
ROOM CLEAN-UP	2																				
HOUSE CLEAN-UP	2																				
AM ACTIVITIES	2																				
LUNCH	2																				
PM ACTIVITY	2																				
PERSONAL GROOMING	2																				
DINNER	2																				
RESPECT FOR OTHERS	2																				
FOLLOWING INSTRUCTIONS	2																				
TOTAL DAY POINTS																					
NIGHT ACTIVITIES	MAXIMUM POINTS POSSIBLE																				
NIGHT CLEAN-UP	2																				
PM ACTIVITY	2																				
PERSONAL GROOMING	2																				
CURFEW	2																				
RESPECT FOR OTHERS	2																				
FOLLOWING INSTRUCTIONS	2																				
TOTAL NIGHT POINTS																					
DAY TOTAL																					

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PHASE I & II POINT SHEET

DAY ACTIVITIES	MAXIMUM POINTS POSSIBLE																	
WAKE UP ROOM CLEAN-UP HOUSE CLEAN-UP	2																	
AM ACTIVITY LUNCH	2																	
PM ACTIVITY DINNER	2																	
FOLLOWING INSTRUCTIONS RESPECT FOR OTHERS	2																	
TOTAL DAY POINTS																		
NIGHT ACTIVITIES	MAXIMUM POINTS POSSIBLE																	
HOUSE CLEAN-UP CURFEW	4																	
FOLLOWING INSTRUCTIONS RESPECT FOR OTHERS	4																	
TOTAL NIGHT POINTS																		

PHASE III POINT SHEET

DAY SHIFT RATING																		
NIGHT SHIFT RATING																		
DAY TOTAL																		

PHASE FLOW CHART
ADASI JUVENILE RESIDENTIAL PROGRAM

	ORIENTATION	PHASE I	PHASE II	PHASE III
RESPONSIBILITIES	INCREASE SELF AWARENESS AND ESTABLISHMENT OF PERSONAL GOALS Know rules & regulations Good personal hygiene Room & house clean-up Attend therapy groups Attend mini-courses Attend job-readiness training 7:00 A.M. wake-up 10:30 P.M. curfew	DEVELOPMENT OF INTRA AND INTER PERSONAL SKILLS Maintain previous progress Good personal hygiene Room and house clean-up Attend therapy groups Attend mini-courses 7:00 A.M. wake-up 11:00 P.M. curfew Cook's helper Participate in physical fitness program Coordinate volunteer project Introduce visitors to staff Begin budget planning Involved in school and/or work by end of phase	DEVELOPMENT OF LEADERSHIP AND LIFE COPING SKILLS, VALUES CLARIFICATION AND VOCATIONAL SUCCESS Maintain previous progress Room & house clean-up Supervise clean-ups Attend therapy groups Attend mini-courses 7:00 A.M. wake-up 11:30 P.M. curfew Participate in physical fitness program Introduce visitors Maintain employment/ education Facilitate house meetings Sponsor a new client	POSITIVE ROLE MODELING AND DEMONSTRATED PREPAREDNESS FOR COMMUNITY RE-ENTRY Maintain previous progress Room & house clean-up Supervise clean-ups Attend therapy groups Attend mini-courses Maintain employment/education Provide work and school transportation Facilitate house meeting Supervise client activities Sponsor a new client Assume resident assistant responsibilities
PRIVILEGES	Afternoon recreational activities May smoke cigarettes May have radio.	Afternoon & evening recreational activities May smoke cigarettes Ground privileges $3.00 allowance per week Phone privileges with counselor's consent Visitors one night per week Passes May have radio	Afternoon & evening recreational activities May smoke cigarettes Ground privileges $3.00 allowance per week Phone privileges Visitors three times per week Sound equipment in room Select his own room May return to facility to sleep while on pass Passes	Recreational activities optional May smoke cigarettes Ground privileges Phone privileges Visitors three times per week Sound equipment in room Select his own room No wake up time if responsibilities are being met No curfew time Physical fitness optional No formal introduction of visitors May leave job site for lunch Passes
ESTIMATED TIME IN PHASE	4 Weeks	6 Weeks	7 Weeks	5 Weeks

DEFINITIONS

Good Day: A Good day is achieved by acquiring the required minimum number of points and no more than one zero. (See Attachment A).

Neutral Day: A Neutral day is achieved by acquiring the required minimum number of points and no more than two zeros. (See Attachment A).

Negative Day: A Negative day is achieved by acquiring fewer than the required minimum number of points or three or more zeros.

Good Week: A Good week is achieved in one of 3 ways:

(1) By achieving 5 Good days and 2 Neutral days.
(2) By achieving 6 Good days and one Negative day.
(3) By achieving 7 Good days.

Good Shift: Indicates appropriate behavior for the shift. It is achieved by obtaining the minimum number of points required for that Phase and entitles the client to all privileges of the next shift.

Neutral Shift: Represents the gray area between appropriate and unacceptable behavior. It is achieved by obtaining the minimum number of points required for that Phase and entitles the client to only in-house privileges of the next shift.

Negative Shift: Indicates sub-standard performance. It results when the client fails to achieve the minimum number of points required for that Phase. A client who earns a Negative shift is not eligible for privileges during the following shift.

Neutral Week: To achieve a Neutral week a client must achieve no fewer than 4 Good days and no more than 2 Negative days.

Negative Week: A Negative week indicates performance at a sub-standard level. It is composed of fewer than 4 Good days or more than 2 Negative days.

Position: Indicates client's job status within the house, e.g. resident assistant is the highest position a client may hold. Other positions include cook's helper, gardener, etc.

Buy Back: The Buy Back process is intended to give the client a second chance. When a client fails to earn points for satisfactorily performing a function on time he is allowed a second chance to earn points when reminded by staff. If he discharges his duty on the first reminder he receives half the number of possible points. By Phase Two Buy Back is no longer an option.

Merit Ladder: All Orientation and Phase I and Phase II clients are eligible for the Merit Ladder. The Merit Ladder is based on the percentage of points earned out of the possible total points for the entire week. The top two clients on the Merit Ladder will receive special recognition and awards.

APPENDIX A

POINT QUOTAS

ORIENTATION

QUALITY OF DAY	MINIMUM NUMBER OF POINTS		MAXIMUM NUMBER OF ZEROS
Good	25 - 32	and/or	1 or fewer
Neutral	22 - 24	and/or	2 or fewer
Negative	21	and/or	3 or more

PHASES ONE AND TWO

QUALITY OF DAY	MINIMUM NUMBER OF POINTS		MAXIMUM NUMBER OF ZEROS
Good	12 - 16	and/or	1 or fewer
Neutral	10 - 11	and/or	2 or fewer
Negative	9 or fewer	and/or	3 or more

PHASE THREE

Point system not used.
Rewards based on overall behavior.

ORIENTATION

QUALITY OF SHIFT	MINIMUM POINTS FOR DAY SHIFT	MINIMUM POINTS FOR NIGHT SHIFT
Good	16 or more	9 or more
Neutral	14 - 15	8
Negative	13 and below	7

PHASES ONE AND TWO

QUALITY OF SHIFT	MINIMUM POINTS FOR DAY SHIFT	MINIMUM POINTS FOR NIGHT SHIFT
Good	6 or more	6 or more
Neutral	5	5
Negative	4	4

Note: For further clarification refer to Daily Point sheets.

CONTINUED

1 OF 7

STATEMENT OF DR. WILLIAM L. JACKSON, GORDON CHEMICAL DEPENDENCY CENTER, SIOUX CITY, IOWA

The Gordon Chemical Dependency Center came into being as the result of a felt need by several prominent active members of the Siouxland community for drug and alcohol treatment for adolescents and adults. Despite an NIAAA study showing 2,040 youths between the ages of 16 and 21 with alcohol problems in Iowa area IV alone, the treatment resources in our immediate area severely limit their adolescent populations. Unfortunately, juveniles generally constitute from 10 to 30 percent of the population in these programs, with the numbers usually closer to the lower figure. Obviously these resources, which service a five state region, are woefully inadequate to deal with young substance abusers.

Gordon is one of the few treatment centers in the country designed solely for adolescents. We believe that a specialized treatment program is necessary, for adolescent psychology is different than adult psychology. The ultimate ends are the same for the adults and juvenile problem drinker, but the means of achieving those ends are different. Our program aims for a resocialization of the dependent adolescent as well as his family. We seek to make the child look at himself to understand what he is doing, why, and that he alone has the responsibility to change. He must become motivated to achieve the meta-goals of total abstinence from all mood altering chemicals, no further involvement with the criminal justice system, and satisfactory performance in a vocational and/or educational setting. Intensive family involvement and extensive aftercare are critical components of our program.

Gordon is an inpatient treatment center, which requires a minimum stay of 60 days. During his stay, the child participates in confrontative group therapy with his peers, as well as individual counseling sessions. The program entails a 60 day lecture series to thoroughly acquaint the client with the disease process of chemical dependency and the 12 steps of Alcoholic Anonymous. The lectures also cover topics relating to a wide range of emotions with which the adolescent must deal. Following the inpatient stay, we provide one to two years of follow up counseling.

The family involvement in our program, which we believe to be of the utmost importance, is the factor which sets us apart from any other treatment center. Family members are asked to attend our eight week lecture series, weekly family group sessions, and at least two individual family conferences. We also strongly urge family members to live in for at least seven days to gather an intimate knowledge of the treatment process.

Through our program, we hope that our clients achieve contented sobriety, increased levels of social skills, a healthier self concept, full responsibility for behavior, satisfactory school or job performance, and for those 50 to 65 percent of our clients with criminal justice contact, no further involvement.

Successful treatment requires that we be able to identify those in need of it. We feel that there is a need within the school system and the juvenile justice system for those with familiarity and the training necessary to identify the abuser.

It is clear that a relatively high proportion of adolescent alcohol abusers are involved in delinquent activities. In view of this, we feel that treatment programs, rather than detention, will better serve to rehabilitate the abuser. These treatment services must be available, and the juvenile courts must have the authority to enforce treatment by imposing substantial consequences for leaving a program.

STATEMENT OF DR. STAN HAUGLAND, MEDICAL DIRECTOR, POWELL III TREATMENT CENTER, IOWA METHODIST MEDICAL CENTER, DES MOINES, IOWA

Senator Culver, I appreciate the opportunity to share with you some concerns and experiences in the field of chemical dependency.

For the past three years I have been aware that the average age of admission to Powell III-Iowa Methodist Medical Center, has been steadily dropping. The average age of patients five years ago was 46 and currently is 39. I believe that the reason for this is the increased number of individuals under the age of 20 (see Addendum A). We are primarily an alcoholism treatment center for adults although we have admitted young people down to the age of 14 simply because no treatment beds were available in a hospital type setting in the Greater Des Moines Area. In retrospect we have had a waiting list for individuals for the

past year and a half. Some of these could not wait and were referred out of state for treatment. The majority of these are sent to the Twin City Area where adolescent treatment centers have been well established (see Addendum B).

The extent of alcohol usage of experimentation among adolescents has been well studied by Mary Hayes of the Iowa Department of Public Instruction several years ago. The study indicates beyond reasonable doubt that alcohol and other mood altering chemicals are being widely used in our school system and that this usage increases with frequency and amount from sixth grade on.

Usage or experimentation does not necessarily mean alcoholism or chemical dependency. The question is, how much alcoholism is there among the students? By definition alcoholism is drinking to the extent that it interferes with daily living whether that be declining performance at school, absenteeism, disrupted interpersonal relationships, legal problems, mental and physical deterioration. In my opinion good reliable base data as to the extent of trouble associated with drinking alcohol and taking other mood altering drugs among adolescents is not available. There is a great need for a well done study to ascertain the magnitude of this problem amongst teenagers.

I believe the problem is becoming more serious simply because of the increased demand for services on Powell III-Iowa Methodist Medical Center. We also are aware that many of our older patients started drinking and taking drugs at an early age. It is common for a patient to relate their first drinking experience occurred back in the grades. Over the next few years this often led to experimenting with street drugs such as uppers, downers and Marijuana. During the late high school years we notice that many of them switched over to beer and lessened street drug intake. After high school and beyond beer and/or hard liquor became the drug of choice. This pattern was far from universal but occurred frequently enough in our middle-age alcoholics to indicate that dependence or usage of mood altering chemicals began quite young.

Is alcohol abuse or drug abuse more common amongst adolescents today compared to ten years ago? On the surface it appears so. However there is a complicating variable and that is we are living in an era that recognizes the illness of alcoholism and chemical dependency and further that something can be done about it. I believe people are more willing to come forward and seek help as compared to ten years ago. Again, data is lacking to indicate whether or not this increase of people seeking help is due to increased numbers of young people becoming addicted versus increased numbers of young people willing to seek help or parents that are less ashamed to deal with the problem.

So what is the cause? Senator Hughes said there are probably as many reasons for alcoholism as there are alcoholics which conservatively approximates ten million in our country. In taking admission histories I have noted a recurring pattern which indicates that early usage of alcohol or other drugs began often as an experiment. This occurred frequently as a response to peer pressure which is extremely powerful amongst adolescents. Although it began as an experiment in response to peer pressure, the individual learns early that it does change one's feelings and may provide a welcome escape from anxiety or enable one to get into the mainstream of "the action", to gain peer acceptance, to feel high, to feel free etc. ad infinitum. Whatever the reason anyone drinks or takes mood altering pills, we do drink to feel different and somehow the alcoholic or drug dependent individual seems to get "hooked" on this feeling. This explains the reason why it has been termed by workers in this field a "feeling disease" and also explains why, in our treatment modality we focus on an individual's feelings and how they have coped with them in an inappropriate way.

Our treatment here at Powell III is a mixture of reality therapy with strong AA orientation. We use mainly group therapy in helping individuals get in touch with their feelings and how they have coped with feelings in an inappropriate or ineffective manner by relying on drugs or alcohol (see Addendum C). Patients learn new behavior and develop alternative "highs" to the taking of drugs or alcohol and most importantly they learn to do this with other human beings rather than trying to do it alone. These positive coping mechanisms are learned mainly through groups over a five to six week period of time. Working with each other they learn to get high on interpersonal relationships. They develop support through a new peer system that places a high value on abstinence and on caring and sharing. In treatment we spend very little time looking for the cause of one's chemical dependency. By the time we see most of our patients they have been drinking or using drugs for years and looking for the cause is like looking for the cause of a fire while the blaze goes unchecked. We are more concerned in our pro-

gram helping the patients accept the fact that they have a problem and accept the responsibility for that problem. As a result, recovery is also their responsibility. We as a staff can help in many ways and can act as role models but rarely if ever can we "fix" them. The alcoholic has to learn to help himself with the help of others and with the help of a higher power. Recovery is long and difficult even in the best of treatment centers. It frequently is costly.

The result of going through this difficult learning-living experience is an increased measury of self-respect, a healthy sense of self-worth and a notion that one can live one day at a time without depending on mood altering chemicals. Old fashioned virtues of honesty, caring and sharing replace the negative self-destructive behavior prior to treatment. A healthy sense of self-worth replaces a deep sense of worthlessness that seems to be a common denominator of this illness.

Our recovery rates range between 65 and 70 percent in adults. By recovery I mean people that are free from mood altering chemicals and claim an improved quality of life. Recovery rates amongst adolescents is not clear at this time. I do note that many are recommended by my staff into an extended program which may take anywhere from six months to years in some cases. Very little is available in Iowa for extended care for adolescents.

Regardless of the individual's age, the families are brought into our program and efforts are made to help them work through the multitude of problems associated with this illness.

Our adolescent patients come from a variety of backgrounds such as broken homes, but also seem to come from homes that "have it together". There may indeed be some biochemical or physiologic sensitivity to alcohol or mood altering drugs in certain individuals that lend them more susceptible to developing chemical dependency. Answers to these possibilities are currently under research.

Social factors undoubtedly play a significant part as well. We are living in an era when people believe they should not have troubles or problems. or, if they do have problems there should be some remedy that will help them go away quickly. We believe in instant health, instant happiness and instant success, not necessarily in that order. We are affluent and can afford the quick and expedient solutions for whatever problems arise, but they are chemical solutions for human problems and rarely last or are very effective. We are inventive and now we have pills to wake us up, slow us down, make us happy, sad or in touch with the cosmos and eventually, of course, in the end stages the patient is not in touch with anything. Because of the ongoing birth of new drugs, polydrug use is common and it is safe to say that 25 to 30 percent of all our admissions currently are "hooked" on two or more drugs such as alcohol and Valium. Adolescents commonly use and abuse multiple drugs as is common amongst women.

I believe we need another adolescent treatment center in central Iowa and we at Iowa Methodist Medical Center intend to do just that within the next 12 months. Centers restricting their admissions to adolescents provide a more acceptable peer support system than can be had in a center with all ages. I believe this center should be attached to our hospital as this seems to reduce the hesitancy to seek help or in other words reduces the stigma of this illness. Further, we can provide a multi-disciplinary staff of professionals and para-professionals that currently seem most effective.

I do not believe more and more treatment centers are the answer. The reason this is currently a high priority is simply the demand for services is so great. More and more treatment centers, in my opinion, will not keep up with the increasing demand and therefore massive efforts must be made in the area of education and prevention. An education program that perhaps provides counseling down into the earliest years of school. Such a program should be continued throughout the students' educational years and should be a high priority item in our educational system. This should provide concrete data about drugs in a non-judgemental way as well as help individuals learn to develop meaningful interpersonal relationships that will help in solving the problems of daily living.

I vigorously recommend that advertising be curtailed in respect to alcoholic beverages. Appropriate warnings should be placed on them much the same as with cigarettes. Further, we need to develop guidelines on when not to drink, such as on an empty stomach, not using it to calm one's nerves and not to solve problems. Alcohol has been with us since the beginning of time and has social value but must be used wisely and with discretion.

I believe that through effective leadership, through research and meaningful education, some effective preventive measures can be brought to bear with our Number One health problem. Number One in terms of causing disability, auto-

mobile accidents, absenteeism, divorces and insecurity amongst children, diminished life expectancy and much individual suffering within the patient.

Elliott Richardson, one of the most respected men in government, indicated years ago when he was Secretary of HEW that alcoholism was our Number One health problem. I do not believe this has changed and it remains to be our Number One health problem.

STATISTICAL SUMMARY, POWELL III

	1973–74	1974–75	1975–76	1976–77	Total
Powell III inpatient treatment center:					
Total admissions, March 1973, to July 31, 1977					1,910
Males (percent)	79	80	81	79	
Females (percent)	21	20	19	21	
Average age	46	44	44	39	
Powell III outpatient treatment center:					
Total admissions Nov. 1, 1976, to July 31, 1977					61
Number completing the program				41	
Average age				40	
Females (percent)				11	
Powell III aftercare program (Jan. 1 to July 31, 1977):					
Registered in aftercare					145
Trained growth group facilitators					23
Growth groups in town					11
Out-of-town growth groups					6
Followup results (recovery rates):					
Total questionnaires mailed					4,235
Total returned (26 percent)					1,093
No chemicals, life improved (percent)	58	46	64	66	
Some chemicals, life improved (percent)	11	27	14	19	
No better or worse (percent)	23	15	15	13	
Don't know (percent)	8	12	7	2	

Teenagers, Jan. 1–Dec. 31, 1977

Numbers of inquiries	54
Number admitted	39
Percent	72
Number not admitted	15
Percent	28
Of those admitted:	
Referred elsewhere	15
Percent	38
Left AMA	8
Percent	21
Graduated (staff would have recommended further treatment for the graduates had there been appropriate facilities)	16
Percent	41
Teenager admissions this year	8
Referral source by—	
Parole officers or courts	13
Percent	33
Service centers	12
Percent	31
Family	9
Percent	24
AA and former patients	4
Percent	11
Schools	1
Percent	1
Sex of teenagers:	
Male	24
Female	15
Age of teenagers:	
14 yr	1
15 yr	5
16 yr	10
17 yr	11
18 yr	7
19 yr	5

Treatment of Alcoholism and Chemical Dependency by Therapeutic Community Approach

(By Raymond Moore, Ph. D., and Stanley Haugland, M.D.[1])

How to deal with crisis! This is the goal of this Iowa alcohol treatment program. Alternatives to chemicals are sought in a close "community" environment.

The concepts of Alcoholics Anonymous (AA) have been combined with community mental health concepts at the Iowa Methodist Medical Center to form a therapeutic community treatment program. This is an intensive inpatient experience in a general hospital setting which lasts approximately four weeks. Over 1,500 patients have been treated in this program.

The key element in this program has been that of maximizing the visibility of each patient while he is in a highly structured but highly benevolent community. Each patient receives a regular flow of information about himself back from the immediate and surrounding community. This extensive feedback facilitates patient learning about unconscious motives, interpersonal style, defenses, and especially the system of excuses and rationalizations. It is through the latter that the patient has given himself permission to continue regular intoxification and (1) disrupt his family, (2) jeopardize his health, (3) sacrifice job performance, and (4) disregard himself and those who depend upon him.

There are 60 members in this treatment community (40 patients/20 staff). This means 60 pairs of eyes and ears probe all corners of the unit. When the patients individually are living in harmony with the community value system (not just verbalizing) they are appreciated and valued by the whole community. They are made aware of this through appreciative words and gestures. On the other hand, when a patient is unfair, phony, or violates the value system in any one of many possible ways, the offender is immediately confronted and a penetrating analysis of his motives is undertaken by the entire community.

CRISIS INTERVENTION

It is not possible to be intoxicated regularly over a significant period of time and maintain health, care-of-self and family, job performance, safety, etc. Up to a point the patient is able to juggle priorities by using manipulation, denial, excuses and neurotic mechanisms. Eventually, however, health breaks down, family and employer rejection appears and the person faces a crisis (a problem which is novel and cannot be handled quickly with existing coping and defense mechanisms).

The patient enters treatment faced with termination of employment, divorce, imprisonment, and/or severe health problems. He is filled with rage, resentment, and the belief he can con his way through the program. But if the pressure is maintained and the crisis is kept alive, he must grow and develop new coping mechanisms in order to resolve the crisis. Patients are detoxified, isolated from the outside world at first, and placed in a treatment community, but they are not yet members of the community. They wear green hospital pajamas and robes. They stand out visually from other patients who are wearing street clothes. The new patients differ also in attitude from the community members, which is why they are not yet welcomed into the community.

All patients attend daily lectures, movies, small group and individual counseling. However, the core of the program is the daily community setting (meeting) which is attended by all the patients and staff. New patients are expected to recite from memory the first three AA steps and concepts listed below:

Step 1: "We admitted we were powerless over alcohol and other drugs, that our lives had become unmanageable."

The concept of Step 1 is: "That we are powerless because it is an illness. We didn't ask for it, but we are victims. Our lives always have been, are now, and always will be unmanageable since we can't accurately predict the outcome of every situation. We can only be responsible for the effort we put into whatever we do and take credit for the effort. If we put forth our best effort we can handle the outcome whatever it is."

Step 2: "Came to believe that a power greater than ourselves could restore us to sanity."

The concept of Step 2 is: "That the power is the AA program. Sanity is reality. Reality is seeing things as they really are and acting appropriately."

[1] The authors are associated with the Powell III Alcohol Treatment Unit at the Iowa Methodist Medical Center in Des Moines, Iowa. Dr. Haugland is medical director of the Unit.

Step 3: "Made a decision to turn our will and our life over to the care of God as we understood him."

The concept of Step 3 is: "Follow the AA program. Not one person has failed who has sincerly followed the AA program. It works."

It is difficult for the new patient to recite these first three AA steps and concepts at a large meeting, but the community knows that after the patient leaves treatment, pressures will build, everything will go wrong at times, and the patient must have the program at a reflex level. Patients are tutored for this recitation by more experienced patients, and the tutors comment on the new patient's attitudes while trying to learn the first three AA steps.

The community relates to each patient in a way that allows negative behavior to create its own crisis which patients discover cannot be resolved by more of the same. For example, if a patient uses passivity as his major coping mechanism, others will not do his treatment work for him in this program. He will not progress in the program until he makes an effort on his own behalf. As he sits back passively and watches other patients move on through treatment, as family and employer show concern that he is making no progress, it soon becomes conspicuous to him that his passivity is not controlling people as usual, but his passivity is getting him more deeply into trouble. Manipulation, sympathy seeking, hypochondriasis to avoid responsibility, and other negative behavior become a heavy burden to the patient in this community rather than a free ticket through treatment. The heroes of this community are the patients who put forth their best effort with good intentions. There is indifference to status outside the community, whether they be university president, physician, or Pulitzer Prize winner.

Rote memorization of these first AA steps is only the beginning of the patient's treatment. The patient must now begin to apply these to his/her life. We ask the patient to apply these to both what he has been and what he is currently.

TAKE A PERSONAL LOOK

The patient has not yet learned the lessons of his own past experience, therefore he has had to repeat the same mistakes again and again. If he does not learn these lessons in treatment he will continue to repeat these mistakes in the future. He has not yet learned because he has not fully faced the destructive consequences of his chemical dependency. Excuses and defenses have kept him from facing these realities. They must be destroyed by the treatment program. The patient is forced to look at his own history. Each patient is assigned to make a list of the ways in which he/she has interfered in the lives of others, a second list of his/her insanities while drinking, and a third list of the unmanageabilities of his or her life. When completed the patient must read these lists at the daily community meeting. The lists must be specific. The community will not accept vague, general statements.

If the patient says, "I've been unkind to my wife," the community will respond, "That's too vague. Be specific. Exactly what words did you say to your wife. Exactly what actions did you take toward your wife." In addition, the emphasis is on the specifics of the patient's negative behavior. If the patient lists the positive things he has done for his wife, the community may respond, "Your virtues did not get you into treatment. The only virtue we want to see right now is your honest effort to fact your negative behavior." For the sake of the patient's recovery, the community will expect a comprehensive list of specific items which truly represent a patient's negative behavior. If a patient has three children and does not mention any specific ways in which he or she has interfered in the lives of the children, the patient will be asked to take a penetrating look at this. One day each week the patient's family and/or other concerned persons spend the entire day in the program with the patient. On these days, the patient receives an enormous amount of feedback about the history of his or her negative behavior.

The patient is asked to study the unmanageable aspects of his or her life. He has been involved in damaging situations in the past and will have to face more of these unmanageable predicaments in the future. The patient's current feelings about the unmanageable aspects of his or her life are of considerable interest. For example, if a patient's brother stole the family business away from the patient 20 years ago, this was indeed an unfair blow. But the patient should have grieved and detached himself from the lost business long ago. If the patient is still deeply upset and resentful, 20 years later, it probably should indicate at least two things to him. First, this unhappy fate may serve as an excuse for drinking and drug use. Second, such a long term resentment indicates omnipotence and an infantile belief the patient can somehow turn reality around even after the situation resolved itself many years ago. The frustration tolerance is increased in our patients as a result of their taking a look at and accepting the unmanageabilities of their lives.

FEEDBACK ON CURRENT BEHAVIOR

In addition to facing past negative behavior and past unmanageabilities, we strive to maintain a psychological atmosphere which is immediately responsive to the here-and-now. Staff and patients alike are actively giving each other many "positive strokes," so much so that an outside observer might interpret this as excessive flattery over small achievements. In the transition from dependency on chemicals to dependency on one-self, there is a necessary intermediate step of dependency on positive feedback from others. The eventual goal is for the patient to get high on liking himself or herself, but the detached and shy patient who has been getting high on chemicals cannot make this enormous transition in one giant step. The patients become very dependent upon being liked by other community members, and this dependency is not chemically destructive to their health or their functioning. With support from other community members, patients will eventually be able to get high on the fact that he or she is a person who puts forth his or her best effort with good intentions. Many patients will never reach this ideal completely, and will remain dependent upon peers in AA and other chemically free groups, but this interpersonal dependency is far superior to the alternative of chemical dependency.

Getting patients to give each other positive strokes is easy. But of equal importance is the difficult problem of getting Patient A to confront Patient B when Patient B is not putting forth his best effort or when Patient B has bad intentions and is not following the program. For example, imagine Patient B spontaneously goes up to a staff member who has just given a lecture, and Patient B tells the staff member, "That's the best lecture I've ever heard. You really opened my eyes to everything." Now let's imagine that Patient B goes further down the hall, out of the range of the staff member's hearing, and comments to a group of patients that the lecture was stupid. If Patient A happens to overhear the flattery to the staff member and the contradictory comments to the patients, Patient A should confront Patient B on his dishonesty. We are constantly facilitating confrontation between patients by explaining that it is difficult to confront, and that Patient A will be risking his popularity with Patient B. But if Patient A places his popularity above Patient B's treatment, then Patient A probably places his popularity above his own treatment, and Patient A had better take a look at his priorities. If any patient is allowed to leave treatment with his or her excuses and dishonesty intact, that patient must understand he will slowly commit suicide by using these excuses for further chemical dependency. If Patient A really cares about Patient B, Patient A must do everything possible to destroy Patient B's excuses and dishonesty.

OTHER FEEDBACK

In addition to feedback at the community level, patients also receive feedback in small groups and on an individual basis with their counselors. Patients dig more deeply into their problems in small groups because there is more time available. But the theme of the work in small groups is harmony with each patient's work in the community. Weekly one-to-one sessions with the counselor are designed to explain to each patient his or her individual treatment plan and review his or her progress in terms of specific goals which have either been met or need further work. Flow sheets are useful in this regard, where goals are itemized and re-evaluated regularly. It is not the intention of the one-to-one sessions to treat the patient over on the sidelines, away from the community. We are committed to a group therapy model because the mutuality brings out in patients a harmony with the concept of the "higher power" of AA. When people get close to each other, they begin bringing out good things in each other. When patients first come into the program they are convinced they cannot stand to stay even an hour, let alone a month, but somehow the other patients manifest a desire to stay. This same positive mutuality between patients fosters courage to face one's dishonesty, destructiveness, carelessness, etc. Together, patients can find more courage, honesty and caring than they were previously able to find as individuals. However, we are not so naive that we believe all mutuality is positive. We also see patients who are bringing out the *worst* in each other. We welcome this, too, as more grist for the "therapy mill." For example, if two or three patients gang up and support each other's rebellion against the treatment program, they are asked to take a look at the destructive influence they are having on each other. They are asked to look at the fact that if they prevent another patient from getting the program, they are hastening that patient's death, facilitating a destructive effect of that patient on his or her family, etc., etc. We ask patients to take responsibility for

the bad influence they may have on another patient's treatment, and if they cannot curb this bad influence then to voluntarily stay away from that other patient.

SUMMARY

In summary, before coming into treatment, chemically dependent persons maintain their self destructive use of chemicals by excuses and defenses. Nevertheless, eventually, chemical use leads to a crisis which forces the patient into treatment. This crisis may be damage to health, marriage, threat of prison term, loss of job, etc. In treatment the patient is made visible and given an enormous amount of feedback to destroy the excuses and defenses through which he previously gave himself permission to continue chemical use. At the same time, the patient is offered alternatives to chemicals, such as an improved self concept, increased frustration tolerance and the positive mutuality of the community.

"I DON'T MIND MY KIDS DRINKIN'! JUST SO THEY STAY AWAY FROM THEM MOOD ALTERIN' DRUGS!"

STATEMENT OF BOB M., RECOVERING ALCOHOLIC, DES MOINES, IOWA

I. SERIOUSNESS OF THE PROBLEM

There are many here who will not agree with what I have to say today. I extend the consideration to you and I am sure that you will extend to me the same privilege. I feel that I am professionally capable of addressing the issue at hand due to my work in the field. Consequently, what I have to say will be straight to the point and simple.

The seriousness of alcoholism in the juvenile population can be clearly shown by a few simple facts that have been found in a nationwide survey. It was found that 50 percent of all youngsters 15 through 19 years said that they had been in one or more situations in the past month where alcohol was present. Forty percent of these were girls. Thus, girls are not much less involved than boys. Twenty-five percent of the youngsters 15 years of age or younger had been in a situation where alcohol was present and three out of five admitted to having been drunk one or more times in the past month.

In the year 1977, the New York school system conducted a survey and found that 12 percent of the students in the 9th grade through the 12th grade had a serious drinking problem or were in fact alcoholic.

In the assessment of juvenile drinking in the state of Iowa, which I have conducted in two counties, I find that the 12 percent figure is a fairly true figure; and I am convinced that this is a fairly accurate figure nationwide. My only problem with this survey is that it is more than it has been brought out to be. I base this opinion on the fact that most juveniles who are surveyed, identified through the court systems and treatment centers are juveniles on the lower end of the economic scale and social prominence. Unfortunately, juveniles from low income families are viewed differently and related to differently by their community than are their middle class neighbors, and they become socially humiliated in the end. In the final analysis, it is now becoming apparent that the experimentation with regular use of alcohol is starting at earlier and earlier ages, promising us even a deadlier picture for the future. Action must start now.

II. RECOMMENDATIONS—"THESE ARE ONLY MY OPINIONS."

My first recommendation is to have all beer advertisements banned from television. If they are allowed to advertise the "gusto", "the real thing", etc., then the adverse things that can happen by drinking their product should also be shown.

Educational institutes have not built in, or if they have built into their curriculums the study of alcoholism, they are not teaching the subject. In my opinion, it should start in the fifth (5th) grade and continue into the twelfth (12th) year of school.

Communications must be broadened between treatment centers, parents, A.A., and schools in order that they are all working toward the same goal—not on the philospohy that alcohol is bad—but on the question of what does happen to people when they drink, and the chances of becoming an alcoholic. I recommend that juveniles with alcohol problems be identified by treatment centers, A.A., and school personnel who have overcome an alcohol problem and who can be used as group leaders. They could set up a program similar to Alcoholics Anonymous. A separate educational system could be devised for parents who have juveniles with alcohol problems, since juveniles complain that at certain times they are expected to behave as adults, but are left to whatever resources are available considered to be used instead of using alcohol to relax and have fun. I recommend that as much attention be give to the parents in the area of education of alcohol as is given to the juveniles. I recommend that early identification and education be geared up to its highest level for the treatment centers, A.A., schools, and parents.

I further recommend that the Federal Government set up special grants to achieve the above-mentioned recommendations, not for a few years but for a minimum of five years as it takes three years to get a program set up. Alcoholics Anonymous, I am informed, is beginning to take the juvenile problem very seriously, and will, in all probability, come up with a program for recovery from alcoholism for the juveniles as they have for the older generation, but it is also the responsibility of the Government to help treatment centers get their programs off the ground; A.A. cannot do it alone. If the problem is left to A.A., we will find, being the mobile society we are, that once the juvenile comes into contact with

alcohol, it becomes a means of establishing their own identity and maturity, and a status symbol in our society today for the juvenile is to see how much he or she can drink. If juveniles continue to believe this, we will continue to crank out 350,000 alcoholics a year. And lastly, I recommend that A.A. do all in its power to cooperate with the juvenile programs that are set up to deal with the juvenile alcoholic problem, since they have dealt with the situation longer than any organization I know of.

III. HOW A.A. WORKS—"THESE ARE ONLY MY OPINIONS."

A.A. works because of its twelve steps, twelve traditions, and the third legacy. It is not supported financially by the Federal or State government, or any organization. It is selfsustaining. There are no dues or fees. The only requirement to join is a sincere desire to stop drinking. A.A. is supported primarily by contributions from its members. It does not get involved in public controversies or take a stand on any issues—political, moral, or religious. A.A. is a program that was founded to provide a set of guidelines by which to live in a spiritual way.

"Upon entering A.A., we soon take quite another view of this absolute humiliation of alcoholism. We learn that only through utter defeat are we able to take our first steps toward liberation and strength. Whether we be agnostic, Atheist, or former believer, we can stand firm that an open mind can lead us to faith and why A.A. meeting is an assurance that God will restore us to sanity if we rightly relate ourselves to Him. We like to be assured that the grace of God can do for us what we cannot do for ourselves. A.A. gives us a chance to make changes in our lives and attitudes, which permits us, with humility as our guide, to move out from ourselves toward others and toward God. A.A. teaches us that we shall want to hold ourselves to the course of admitting the things we have done, meanwhile forgiving the wrong done us, real or fancied." [1]

"We learn through A.A. to avoid extreme judgments, both of ourselves and of others involved. We must never exaggerate our defects or theirs. A quiet, objective view will be our steadfast aim. Still more wonderful is the feeling that we do not have to be specially distinguished among our fellows in order to be useful and profoundly happy. Not many of us can be leaders of prominence, nor would we wish to be. Service gladly rendered, obligations squarely met, troubles well accepted or solved with God's help. True ambition is the deep desire to live usefully and walk humbly under the grace of God. A.A. works because we have no leaders, but only trusted servants, and it is our obligation that anytime, anywhere, an alcoholic calls for help, we are responsible." [2]

I could go on and on for this committee, but let me sum it up this way: A.A. is a program that was founded by two drunks on a spiritual level that gave the twelve steps and twelve traditions by which the alcoholic may live a sober and happy life, and a membership with the millions of alcoholic men and women who have banded together to solve their common problems and to help the fellow suffers in recovery from that age-old baffling malady of alcoholism. A.A. works because it is a very simple program, and is not obligated to any organization in the world, including the Federal Government, and that experience has taught us that "anonymity is real humility at work. It is an all-prevailing spiritual quality which today keynotes A.A. life everywhere. Moved by the spirit of anonymity, we try to give up our natural desire for personal distinction as A.A. members, both among fellow alcoholics and before the general public. We are sure that humility, expressed by anonymity, is the greatest safeguard that Alcoholics Anonymous can ever have, and that the twelve steps and twelve traditions are our only salvation." [3]

[1] "Twelve Steps and Twelve Traditions", Alcoholics Anonymous.
[2] "Twelve Steps and Twelve Traditions", Alcoholics Anonymous.
[3] "Alcoholics Anonymous", Alcoholics Anonymous.

- Administrative leadership (planning and evaluation, inservice training, curriculum integration, school policy and community involvement)

A responsibility of the Department of Public Instruction Substance Abuse Prevention program is to assist Iowa schools to carry out effective prevention education programs. In order to offer this service baseline data was needed. Information about youth use patterns was available from such studies as those done by Research Triangle Institute and others. Information specific to Iowa was needed to:

- Develop relevant and valid state guidelines in substance education.
- Develop appropriate consultative service to local schools and communities in the area of primary prevention programming.
- Develop specific inservice training for local school personnel to be conducted in cooperation with area education agencies.
- Identify drug information appropriate for specific grade levels.
- Obtain data as documentation for grant proposals to federal and state funding sources.
- Provide information for the development of prevention education sections of the comprehensive state plans of the Iowa Department of Substance Abuse.

The first of three procedures to obtain this data was the 1975 Iowa Study of Alcohol and Drug Attitudes and Behaviors Among Youth to obtain population characteristics of students in grades 6, 8, 10 and 12. The characteristics surveyed included:

- Attitudes and values regarding substance use
- Self-reported use, age and setting at onset of use
- Perception of availability of alcohol, marijuana and other drugs (uppers, downers, hallucinogens)
- Knowledges
- Peer and parental drug using models
- Motives for use and non-use
- Substance education experiences
- Availability of related library and media materials
- Perception of person most effective to teach about drugs and alcohol
- Sources of drug information
- Sources for and utilization of help for problems
- Free time activities

A summary of the survey is entered with this statement. The salient points are as follows.

Iowa young people who use alcohol do so to avoid being square, to feel grown-up and to avoid dealing with problems. Those who choose not to use alcohol did so because they had better things to do and for fear of danger to their health.

Their school experiences most commonly included printed materials, films, lectures and assemblies. They knew less than half of the knowledge questions asked in the survey. Most feel their school program is of some or no value. The classroom teacher was considered a good source of information but ineffective in teaching about alcohol.

They obtain alcohol from home or from adults over eighteen. Generally speaking they believe their friends use alcohol and that their parents did not know they use or disapprove.

The second survey was an Alcohol and Drug Education Questionnaire distributed to all Iowa superintendents. Information was specifically needed to:

- Determine the extent and quality of alcohol and drug education now taking place.
- Determine what curriculum materials schools were using and how they were developed.
- Describe the content of current alcohol and drug education.
- Identify the roadblocks which prevent good alcohol and drug education from being implemented.
- Determine current teacher competencies.
- Determine the status of school policies and rules regarding students involved with alcohol and drug use.

Data from this questionnaire shows that a majority of the schools do not have a planned sequential program, goals or objectives for alcohol education or evaluation procedures.

Classroom experiences emphasize factual information about alcohol. There is very little discussion of alternatives to alcohol use, responsible use or abstinent lifestyles. The decision-making process related to alcohol situations and the use of helping services were infrequently mentioned.

Inadequate teacher competencies and a lack of a planned curriculum were considered to be the major roadblocks to implementing alcohol education.

The third source of data about prevention education needs came from teachers, representing fifty-eight percent of Iowa school districts, who participated in prevention education workshops. Their responses to a workshop questionnaire can be summarized by the following needs:

- More current and useful factual information and classroom resources.
- Additional inservice and training in affective education and methods related to alcohol education, i.e., group facilitation, valuing, decision-making, critical thinking.
- Planning, implementation and coordination of local alcohol education programs.
- Parental and community support and involvement in the schools alcohol and drug education programs.

The Department of Public Instruction Prevention Program has prepared a curriculum guideline, Alcohol and Other Drugs, which provides direction to local school districts for developing a comprehensive abuse prevention program. The content centers around six major outcomes, with grade level developmental outcomes which each student will have the opportunity to do before the completion of grade twelve.

The major outcomes are:

1. HUMAN BEHAVIOR - The student will understand the basic factors in human behavior related to substance abuse: psychological, physiological and sociological.

2. SCIENTIFIC FACTS - Student will know impartial scientific facts about alcohol and other drugs.

3. CONSFQUENCES - Student will know the probable consequences of any alcohol and drug use to the individual, to the family and to the community.

4. PREVENTION - Student will know that the individual, his/her family and the community have interrelated responsibilities for the prevention of alcohol and drug abuse.

5. ALTERNATIVES - Student will know personally relevant and satisfying behaviors to substance abuse.

6. DECISION-MAKING - Student will be able to employ decision-making skills to make responsible decisions relative to personal alcohol and drug use or non-use.

This approach considers alcohol use to be a behavior choice in response to human needs. Any impact on use patterns will come about through the use of process skills such as decision-making or goal setting which makes factual information relevant to the individual's lifestyle.

These guides have been distributed to all Iowa school attendance centers. Distribution was followed by seventeen one-day workshops conducted throughout the state introducing the guideline, the human behavior approach, methods and resources.

The Department of Public Instruction Substance Abuse Prevention Program provides technical assistance to local schools in curriculum development, teacher inservice, coordination with related agencies and peer programming (an opportunity to train young people to use prevention skills).

Recommendations

The Substance Abuse Prevention Education program recommends that the Federal government:

- Encourage schools to foster the mental/emotional health of young people by funding projects to provide school personnel with training in this area and by providing funding assistance to school districts for increasing elementary school counseling services.
- Encourage commercial television stations (networks) to "balance" their media messages regarding the consumption of alcohol (i.e., not everyone needs a martini/beer to relax after work).
- Encourage the beverage alcohol and advertising industries to reduce their advertising appeals directed at making associations between basic needs and needs satisfaction through alcohol consumption.
- Encourage other community education systems (non-school) to provide primary prevention programming.
- Merge prevention education and public information functions of NIAAA and NIDA.
- Encourage through federal funding the establishment of early intervention programs for youth. Current federal laws and regulations do not allow local substance programs to be reimbursed for such services to clients.

The Substance Abuse Prevention Education program recommends that the State government:

- Establish a consultant position in each of Iowa's fifteen education agencies to work with local schools in developing alcohol and drug education goals and curriculum, to provide teacher inservice and to engage parent and community involvement in prevention efforts.
- Identify health education separate from physical education in the Iowa school code.
- Require that health education programs for all students K-12 be carried out by, or with the assistance of, professionally prepared staff.
- Establish an educational priority to prepare teachers, both preservice and inservice, in affective education skills, coordinating efforts within the existing educational services.
- Provide funding to continue alcohol education program direction through the Department of Public Instruction.

State of Iowa
DEPARTMENT OF PUBLIC INSTRUCTION
Curriculum Division
Grimes State Office Building
Des Moines, Iowa 50319

Report of the ALCOHOL AND DRUG EDUCATION QUESTIONNAIRE Completed by Superintendents of Iowa Schools

Drug and Alcohol Program

Prepared June, 1977

Report of the ALCOHOL AND DRUG EDUCATION QUESTIONNAIRE

Introduction and Rationale

The Iowa Department of Public Instruction is releasing a new publication, Alcohol and Other Drug Education Guide K-12, during the summer of 1977.

In planning for the dissemination and utilization of the new guide it was necessary to assess the current status of alcohol and drug education in Iowa and to identify the issues which must be addressed in moving toward the implementation of comprehensive alcohol and drug education.

Information was needed specifically to:

- -determine the extent and quality of alcohol and drug education now taking place.
- -determine what curriculum materials schools were using and how they were developed.
- -describe the content of current alcohol and drug education.
- -identify the roadblocks which prevent good alcohol and drug education from being implemented.
- -determine current teacher competencies.
- -determine the status of school policies and rules regarding students involved with alcohol and drug use.

Since school administrators are responsible for decisions about curriculum priorities and releasing teachers for in-service training, it was decided that superintendents would be the most reasonable source of information. The questionnaire also served to make superintendents aware of the new guide and the scope of alcohol and drug education.

Procedure

A nineteen item pencil and paper questionnaire was prepared by the Department of Public Instruction Alcohol and Drug Education staff.

The Department of Public Instruction Regional Consultants distributed the questionnaire at meetings of superintendents from each of the fifteen AEA regions of the State during March and April, 1977. All superintendents in attendance were asked to complete and return the questionnaire at the meeting.

Accompanying the questionnaire was a checklist for superintendents to indicate the number of teachers who might participate in a one-day alcohol and drug education workshop and the month it would be most convenient for their school district to release staff.

Two hundred and fifty-nine questionnaires were returned to Department of Public Instruction. (There are 449 Iowa school districts). Representation by AEA is shown in the following list.

Table I. SUPERINTENDENTS IN AEA COMPLETING QUESTIONNAIRE AND CHECKLIST.

AEA	NUMBER	AEA	NUMBER
1. Keystone	16	9. Mississippi Bend	15
2. Northern Trails	7	10. Grant Wood	23
3. Lakeland	22	11. Heartland	40
4.	17	12.	10
5. Arrowhead	40	13. Loess Hills	18
6.	5	14. Green Valley	9
7.	18	15.	20
		16.	5

RESULTS

Extent of Alcohol and Drug Education

Ninety-two percent of the school districts reported offering alcohol and drug education. It is offered as frequently at the elementary school level (76%) as it is in junior high (86%) or senior high (80%).

Curriculum

A planned, sequential K-12 program was reported by thirty-six percent of the schools. Half of the districts teach alcohol and drug education as a separate unit; the unit is integrated with a number of different subject areas in the school program.

A planning committee was involved in developing alcohol and drug education goals and curriculum in 20% of the districts. Teachers and administrators were members of the planning committee in all fifty-one districts. Counselors were on the committee in 66% of these districts but parents and students were represented in only 27% of the districts having planning committees. (Table II)

Only twenty-seven school districts (10%) report any systematic evaluation of their alcohol and drug education program. Twenty-six percent (26%) of the superintendents felt their current alcohol and drug education efforts were successful in preventing alcohol or drug abuse.

Less than 16% reported using any specific model or guideline for their own program. Seventy percent of the school districts have used materials from a national source for alcohol and drug education. (Table III)

Table II. MEMBERSHIP OF PLANNING COMMITTEE (Question 4)

Position	Number of schools including N=51
Teachers	50
Administrators	49
Counselors	34
Parents	15
Students	13
Central Staff	10
Other	10
Outside Experts	7

Table III. CURRICULUM DEVELOPMENT (Questions 2, 3, 5, 6, 7, 8)

Item	Yes	No N=259	No Response
Planned, sequential curriculum	95	152	12
Separate instructional unit	124	128	12
Local Planning Committee	51	211	2
Evaluation	26	231	3
Used other curriculum as model	42	210	9
National materials used	183	61	17
Consider your program effective	69	90	104

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The alcohol and drug education experiences which superintendents felt were used most frequently this last year were books, pamphlets, and tapes, films and library materials. Discussion groups led by an alcohol or drug counselor and the IPBN series "Inside Out" or "Self Inc." were least frequently reported. Talks by medical people, ex-alcohol or drug users, and law enforcement personnel were in the middle of the frequency range. (Table IV)

Curriculum Content

The major emphases in alcohol and drug education as reported by superintendents were presentations of factual information and the personal and societal consequences of alcohol and drug use. Building positive self-concepts and developing interpersonal skills received moderate emphases while abstinence as a lifestyle, responsible use of alcohol and alternatives to alcohol and drug abuse were infrequently emphasized. (Table V)

Superintendents were asked to rank alcohol and drug activities which they personally considered effective in preventing abuse. Individual counseling, talks by health professionals, group discussion of alcohol and drug issues and values clarification were ranked at the top of a list of twelve items. Talks by an ex-alcoholic, addict, clergy, or law enforcement officers and role-playing alcohol and drug situations were considered to be the least effective in preventing alcohol and drug abuse. (Table VI)

Concerns

Superintendents were asked to identify the major roadblocks to implementing alcohol and drug education. The major roadblocks were perceived to be a lack of clearly developed goals, inadequate teacher in-service, inadequate teacher competencies and determining appropriate curriculum content. The least important roadblocks were reported to be a lack of community support, no outside technical assistance and the lack of classroom time. (Table VII)

Teacher Competencies

Seventy-five percent of the teachers who are teaching alcohol and drug education are doing so as part of a course or class they are assigned to teach. Forty-eight percent of these teachers conducting alcohol and drug education have taken some course or workshop about alcohol and drugs and 31% have participated in valuing or communication skills training. Only 13% of the school districts have offered in-service training for alcohol and drug education. (Table VIII)

Policies

In 48% of the schools, parents of students suspected of using drugs or of problem drinking would be notified. In 35% of the schools notifying parents would vary with individual cases.

Less than 1% of the schools have a policy which prohibits direct referral of students with alcohol and/or drug problems to a community service.

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Table IV. FREQUENCY OF ALCOHOL AND DRUG EDUCATION CLASSROOM EXPERIENCES (Question 9)

Classroom Experience	Yes	No	No Response
Books, pamphlets, tapes	231	26	3
Films	227	30	3
Library and factual information material	207	51	3
Lecture by medical person	141	116	3
Lecture by ex-addict or alcoholic	137	120	3
Lecture by law enforcement	126	131	3
Assemblies	124	134	3
"Inside Out" or "Self Inc." on educational t.v.	76	181	3
Discussion groups led by alcohol or drug counselor	54	203	3
Other	20	237	3

Table V. MAJOR EMPHASIS IN ALCOHOL AND DRUG EDUCATION (Question 10)

Emphasis	Rating
Facts about effects on health	3.84
Impact on family and society	3.63
Consequences	3.61
Building self-concept	3.54
Interpersonal relationships	3.25
Personal Psychology	3.14
Responsible use of prescription drugs	3.10
Decision-making	3.02
Information about helping services	3.04
A helping adult to talk to	2.98
Alternatives to drug and alcohol use	2.90
Responsible use of alcohol	2.87
Abstinence	2.57

- Criteria for the selection of print and film media.
- Use of media and community resource people to complement and not supplant the alcohol and drug education curriculum.
- Classroom learning experiences which puts the focus on the human behavior of alcohol and/or drug use and not the chemical.
- Treatment of alcohol and drug education as one area of study within a more comprehensive health education curriculum in grades K-12.
- Evaluation of the district's alcohol and drug education program.

The Alcohol and Drug Education staff at the Department of Public Instruction will offer assistance to local school districts in any of the need areas identified above. An Alcohol and Drug Education Guide (K-12) is available to school districts to assist their personnel in framing their local alcohol and drug education curriculum.

Local school administrators, teachers, and curriculum committees can request alcohol and drug education assistance by contacting:

Dr. David A. Wright
Drug Education Consultant
Department of Public Instruction
Grimes State Office Building
Des Moines, Iowa 50319
(515)281-3021

Ms. Mary Hays
Alcohol Education Consultant
Department of Public Instruction
Grimes State Office Building
Des Moines, Iowa 50319
(515)281-3170

Superintendent Checklist

In order to plan the number of workshops needed to introduce the new Alcohol and Drug Education Guidelines, superintendents were asked to indicate anticipated participation by their staff members.

The totals from the superintendents checklist are as follows:

Teachers who will very likely attend a one-day workshop this fall:

Elementary	276
Junior High	221
Senior High	235
No Response	732

No teachers will be attending: 16 Districts

Would prefer some other arrangement: 32 Districts

Dates preferred for one-day workshop:

September	74
October	89
November	40
No Response	108

Wanted copies of guide: 233 Districts - 2958 Copies

Wanted copies of the summary of the Alcohol and Drug Education Questionnaire: 184 Districts

Report of the Iowa Study of Alcohol and Drug Attitudes and Behaviors Among Youth[1]

INTRODUCTION AND RATIONALE

Alcohol and drug using problems among young people are a costly societal concern. Automobile accidents, loss of human potential and health and welfare costs, to name a few. Since schools have contact with nearly all the target population, school age children and youth it is to be expected that efforts to reduce or prevent substance abuse have in a large part been school centered.

In an effort to direct effective educational programing in Iowa, it was necessary to assess the current status of substance use and substance education experiences within the state.

Baseline data was needed specifically to:

Develop relevant and valid state guidelines in substance education,

Develop appropriate consultative service to local schools and communities in the area of primary prevention programing,

Develop specific in-service training for local school personnel to be conducted in cooperation with area education agencies,

Identify drug information appropriate for specific grade levels,

Obtain data as documentation for grant proposals to federal and state funding sources, and

Provide information for the development of prevention education sections of the comprehensive state plans of the Iowa Division on Alcoholism and the Iowa Drug Abuse Authority.

The Department of Public Instruction Alcohol and Drug Education Programs developed a survey instrument, entitled the Iowa Study of Alcohol & Drug Attitudes and Behaviors Among Youth to obtain data regarding population characteristics of Iowa students in grades 6, 8, 10 and 12. The characteristics surveyed included:

Attitudes and values regarding substance use,
Self-reported use, age and setting at onset of use,
Perception of availability of alcohol, marijuana and other drugs (Uppers, downers, hallucinogens),
Knowledges,
Peer and parental drug using models,
Motives for use and non-use,
Substance education experiences,
Availability of related library and media materials,
Perception of person most effective to teach about drugs and alcohol,
Sources of drug information,
Sources for and utilization of help for problems, and
Free time activities.

PROCEDURE

Selection of sample

A stratified random sampling representing populations and geographical distributions within the state was used to determine the sample. Four population categories, urban, semi-urban, semi-rural and rural, were determined by school district enrollment with some influence being exerted by population of a town or city within the district. The geographical distribution was based on four regions incorporating the fifteen Iowa Area Education Agencies (AEA). This provided the capacity to analyze data by AEA's at a future time. Eighty-six schools were identified in the original drawing with the expectation of twelve students being selected from each of grades six, eight, ten and twelve. (86 schools x 4 grades x twelve students=4128). An overdraw of one hundred twenty-eight was allowed for drop outs. The Iowa Center for Research in School Administration, Iowa City, was contracted to draw the sample.

Administrators of selected school districts were contacted by a letter inviting them to participate. They were asked to do the following:

1. Return a statement indicating willingness to participate.
2. Designate a local staff person for further communication.
3. Select students and obtain parents' consent.
4. Indicate a time and location for the questionnaire to be administered.

[1] Prepared by Mary Hays, Drug and Alcohol Education Program, State of Iowa Department of Public Instruction, Curriculum Division, Grimes State Office Building, Des Moines, Iowa 50319.

5. Have the students available at the designated time and site.
6. Assign a local staff person to be present for the survey.

Local schools were asked to select fifteen students, an over sample of three per grade, from the total enrollment list in each of grades six, eight, ten and twelve. To reduce the amount of work for local staff, and because the sampling technique for selecting school districts or buildings was considered adequate in reducing sampling error, procedures for the selection of students were left to the discretion of the local school official. It was suggested that they divide the total enrollment for each participating grade level by fifteen. Using this number, (N), every N name would be part of the sample. In schools where there were less than twenty-nine students in a grade, or a homeroom with students assigned randomly, the intact group became the sample. (See Appendix B.)

A one hundred twenty-four item questionnaire was prepared. The questionnaire was then field tested with one hundred twenty sixth grade and junior high students for clarity of language, and to verify the administration time of only one hour.

The questionnaire was administered during the school day by an out of school volunteer to avoid local bias and to reassure students regarding confidentiality. These volunteers, selected by the Alcohol and Drug Education staff in the Iowa Department of Public Instruction, were drawn from among individuals who had been involved with community drug prevention programs and who lived geographically near the school. They were given no training but were given the name of the local contact person and the time, date and local site or were directed to verify arrangements with the contact person. Bundles of questionnaires were sent to volunteers by Iowa Parcel Service.

All participating schools were scheduled to conduct the survey sometime between October 15 and November 25, 1975. On the designated day the volunteer delivered and administered the questionnaire at a central building or individual schools depending on local convenience. A local teacher was also present. The volunteer had been asked to stress frankness and honesty and to guarantee confidentiality, Questionnaires were identified only by the grade level on item three and a school code number placed on the outside. Students were encouraged to ask for interpretations of questions or words they did not understand since the purpose was to gather as much information as possible.

Answers were marked directly on the questionnaire. Completed questionnaires were collected and returned to the Iowa Department of Public Instruction by Iowa Parcel Service. All questionnaires were then delivered to the Iowa Center for Research in School Administration whose contract included the transfer of responses from the questionnaire to IBM cards and to tabulate data both on printout and tape. All survey data is stored at the Management Information Center, Iowa Department of Public Instruction.

RESULTS

The Iowa Study of Alcohol and Drug Attitudes and Behaviors Among Students, a questionnaire, was completed by three thousand, six-hundred students in grades six, eight, ten and twelve. The grade distribution is as follows:

TABLE I.—STUDENTS IN EACH GRADE COMPLETING QUESTIONNAIRE

Questionnaires completed	Grade				
	6	8	10	12	Total
Girls	499	464	427	423	1,813
Boys	490	510	410	377	1,787
Total	989	974	837	800	3,600

Responses to the items have been arranged in four sections as follows:

I. Population Characteristics.
   A. Student Descriptors.
   B. Attitudes About Alcohol and Other Drugs.
   C. Student Knowledges About Alcohol and Other Drugs.
   D. Students' Use of Alcohol, Marijuana and Other Drugs.
   E. Perceived Motives For Use of Substances.
II. Drug Using Models.

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III. Education Experiences.
A. In School Substance Education.
B. Related Educational Experiences.
C. Students Perception of School Policy.
D. Non-School Options for Help.
IV. Free Time Activities.

The data from the one-hundred twenty-three items is reported here in percentage of the grade samples and total sample (3,607), rounded to the nearest whole number. The percentages will not total one hundred percent where responses are ranked or where multiple responses to an item were solicited. An interpretation of the data precedes each section.

Population characteristics

A. Student descriptors: Fifty-six percent of the students in this study spend most of their time on a farm or in a small town. Twenty percent are in a county seat town or in a suburban area near a larger city. Twenty-four percent live in an urban area.

Half of Iowa students in this study have less than $5 per week to spend during their school year. Thirty percent of the seniors report having $20 or more to spend per week.

Definite household rules were reported by 80 percent of the students and half of these, 40 percent felt they were part of developing the rules. Seventeen percent of the sixth graders and 14 percent of the eighth graders did not know if there were household rules. Twenty percent of the seniors indicated there were no rules, they made their own decisions.

Thirty-two percent of the students spend their free time with friends at home or at the friend's home. Twenty percent go out with friends and 20 percent spend free time at school or church activities. Eighteen percent are with a boyfriend or girlfriend and 15 percent spend free time alone.

Sixty-nine percent believe that laws should be obeyed even if they do not agree with the law. There is a slight increase in the number of twelfth grade stdents, 13 percent who would disobey an unreasonable law is slightly higher than sixth graders, who marked that response, 7 percent. (See table II.)

B. Attitudes about alcohol and other drugs: Students were asked to indicate the extent to which they agreed or disagreed with statements regarding alcohol, marijuana and other drugs. Thirty-six percent of the sixth graders disagreed with the statement that there is "nothing wrong with drinking beer" while seventy-four percent thought marijuana was dangerous. Their concern about marijuana drops with only thirty-three percent of the seniors indicating concern about either alcohol or marijuana. Eighth and tenth graders showed much less concern about alcohol than either sixth or twelfth.

Iowa students indicate a strong concern about drugs. Seventy-five percent of all students disagreed with the statements that there is "nothing wrong with most drugs" and that it is "ok to use drugs for difficult times."

Seventeen percent of the students report that their parents do not know they use alcohol while 13 percent know of their child's use and disapprove. This represents the attitude of about one-third of the parents of alcohol using students. Forty-eight percent of the students said they did not use alcohol.

Seven percent of the total sample or about one-third of those who report drug use, reported their parents disapproved or thought they used drugs too much. (See table III.)

TABLE II.—STUDENT DESCRIPTORS [1]

Descriptor	Grade 6	8	10	12	Total
Community size (item 5):					
Farm	29	29	32	29	29
Small town (up to 2,500)	30	29	25	27	27
County seat (2,500 to 19,000)	11	14	18	16	15
Suburban area near a larger city	4	6	5	6	5
In an urban area (20,000 to 99,000)	11	13	12	12	12
In a larger city (100,000 and more)	16	11	8	10	12
Amount of money available to spend per week (item 6):					
$5 or less	69	62	42	17	49
$5 to 10	18	27	36	30	27
$10 to 20	5	7	13	22	11
$20 to 40	3	2	7	17	7
$40 or more	6	2	3	14	6

TABLE II.—STUDENT DESCRIPTORS [1]—Continued

Descriptor	Grade 6	8	10	12	Total
Definite household rules where you live (item 8):					
Yes, made and enforced by parents	44	45	42	27	40
Yes, I help make them	34	35	43	49	40
No, I make my own decisions	4	5	7	20	8
No, I wish there were	1	2	0	0	1
I don't know	17	14	9	4	11
Major free time associate other than family (item 12):					
At home by myself	19	21	13	8	15
At home with friend or at friends home	54	37	21	9	32
At school or church	7	8	15	11	20
Go out by myself	6	6	4	4	5
Go out with friends	7	17	27	32	20
With boyfriend or girlfriend	8	11	20	37	18
Views about alcohol and drug laws (item 13):					
All laws obeyed	85	68	63	57	69
Ignored if unreasonable	7	13	14	13	12
Inappropriate laws disobeyed until changed	2	4	3	5	3
Laws limit freedom	4	8	11	13	9
More laws than necessary	2	7	9	11	7

[1] Reported as percent of sample.

TABLE III.—ATTITUDES ABOUT ALCOHOL AND OTHER DRUG USE [1]

Students attitudes	Grade 6	8	10	12	Total
Nothing wrong with most drugs (item 15):					
Agree	9	12	14	14	12
Neutral	13	12	12	12	12
Disagree	77	76	73	74	77
OK to use drugs to get over difficult times (item 16):					
Agree	8	11	15	10	11
Neutral	13	14	13	14	13
Disagree	79	75	72	76	76
Marijuana is dangerous (item 17):					
Agree	74	57	39	33	52
Neutral	10	14	20	19	15
Disagree	16	29	41	49	33
Would use drugs to decide if they are bad (item 18):					
Agree	5	11	13	19	78
Neutral	8	12	13	13	11
Disagree	87	78	74	71	11
Nothing wrong with drinking wine or beer (item 19):					
Agree	30	46	58	64	48
Neutral	34	24	22	17	25
Disagree	37	30	20	19	27
Alcohol alright for special occasions (item 20):					
Agree	48	64	74	75	64
Neutral	25	19	13	13	18
Disagree	27	17	13	12	18
There are more laws about alcohol and drugs than are necessary (item 21):					
Agree	13	16	21	23	18
Neutral	24	28	29	32	27
Disagree	64	56	49	46	54
Parents attitude toward child's use of alcohol (item 108):					
They don't know	7	17	28	18	17
They know and wish I did not	7	8	14	26	13
They think I use it too much	1	2	2	4	2
They know and don't mind	3	6	8	16	8
None of the above	8	12	14	15	12
Do not use	74	55	35	21	48
Parents attitude toward child misusing or abusing other drugs (item 109):					
The don't know	3	7	14	15	9
They know and wish I did not	5	4	5	9	6
They think I use it too much	1	2	1	1	1
They know and don't mind	1	1	1	1	1
None of the above	3	3	3	4	3
Do not use	87	85	77	71	80

[1] Reported as percent of sample.

C. Students knowledges about alcohol and other drugs: Ten items were specific facts about alcohol and drugs. The item, "definition of tolerance for a drug" was answered accurately by the largest number of students, 54 percent. Fifty-three percent knew that the amount of alcohol in a drink is related to the affect on the brain and 40 percent accurately marked "time" as a cure for a hangover. Thirty-eight percent knew that any drug can produce psychological dependence. Thirty-nine percent to fifty-four percent of the students marked "don't know" on five of the items.

Students accuracy increased with higher grade levels with one exception. Seniors incorrectly called "a fine white powder" heroin. (See table IV.)

D. Students use of alcohol, marijuana and other drugs: Students were asked to indicate the frequency of use of three kinds of substances, alcohol, marijuana and drugs. Drugs were defined in the survey instrument as uppers, downers and hallucinogens like L.S.D.

The use of alcohol gradually increased from sixth grade through grade 12. Sixty-three percent of sixth graders report no use while 16 percent of the seniors report no use. Twenty-five percent in all grades report alcohol use less than once a month.

Alcohol use from one to four times a month is characteristic of 9 percent of the sixth graders, 24 percent of the eighth graders and 38 percent of tenth graders. Forty-six percent of the seniors use alcohol 1–4 times per month.

TABLE IV.—STUDENTS' KNOWLEDGE ABOUT ALCOHOL AND OTHER DRUGS

Percent of students sample marking given responses [1]	Grade 6	8	10	12	Total
What is a bitter tasting white powder' (item 65):					
No way to know by sight or taste [2]	5	3	3	2	3
Amphetamine	2	2	5	6	4
Heroin	25	41	43	46	38
THC	2	2	3	3	2
Don't know	66	53	46	45	53
Can become psychologically dependent (item 66):					
Any drug substance [2]	33	37	42	42	38
Any stimulant	8	13	17	21	14
Any depressant	2	3	4	3	3
Any hallucinogen	4	6	7	8	6
Don't know	54	41	31	26	39
Similarly between cocaine, marijuana, and heroin (item 67):					
Legally controlled substances [2]	14	18	35	51	28
Medically classified as analgesics	17	15	9	6	13
Nothing in common	7	9	10	9	9
Don't know	62	58	46	34	51
Death likely from sudden withdrawal from substances (item 68):					
Opiates	6	11	26	32	18
L.S.D	27	36	35	32	32
Marijuana	6	2	0	0	2
Barbiturates [2]	8	8	7	6	7
Don't know	53	44	33	29	41
Tolerance to a drug requires that a person (item 69):					
Require more of the drug for effect [2]	27	47	66	81	54
Requires same amount of the drug for effect	18	10	6	3	10
Cannot use the drug	3	3	3	2	3
Requires a smaller amount of drug for effect	4	4	4	2	4
I don't know	47	36	21	13	30
An alcoholic is (item 70):					
Inherited physical disease	3	3	2	2	3
Person who lives on skid row	1	1	1	1	1
Can't go 1 day without alcohol	77	79	82	77	79
A member of AA	3	3	1	2	2
Can control amount he or she drinks	6	4	2	3	4
All of the above	5	5	3	4	4
None of the above	6	6	9	10	7
Which drug increase the effect of alcohol on the body? (item 71):					
All of the above [2]	10	16	33	39	23
Tranquilizers	10	11	16	15	13
Antihistamines	3	6	4	3	4
Sedatives	3	3	4	5	4
Don't know	74	65	44	38	56
Rules of thumb for driving after drinking (item 72):					
Wait an hour for every drink consumed [2]	8	16	45	52	29
Can walk a straight line	31	25	12	8	20
Drink 1 cup coffee for every 2 drinks	5	4	3	1	4
OK to drive after less than 3 drinks	22	26	16	19	21
Don't know	33	30	23	20	27

TABLE IV.—STUDENTS' KNOWLEDGE ABOUT ALCOHOL AND OTHER DRUGS—Continued

Percent of students sample marking given responses [1]	Grade 6	8	10	12	Total
Rate alcohol reaches the brain depends on (item 73):					
Percent of pure alcohol in the drink	47	51	54	62	53
Whether alcohol is mixed with soda or water	2	1	1	1	2
Number of different kinds of drinks	11	8	7	5	8
Drinking experience	5	8	14	15	10
Don't know	35	32	25	17	28
Cure for hangover (item 74):					
Time [1]	15	32	56	64	40
Another drink	3	4	3	7	4
Nonalcoholic drink like coffee or tomato juice	31	29	17	14	23
Aspirin	2	3	4	5	3
Cold shower	15	13	5	2	9
Don't know	34	23	15	10	21

[1] Reported as percent of sample.
[2] The most appropriate answer in each item.

Seventy-seven percent of Iowa seniors report little or no marijuana use (67 percent said never and 10 percent less than once a month). Nine percent use marijuana one to four times a month while 13 percent use two or more times a week.

The use of drugs, including uppers, downers and hallucinogens, is reported by very few of the students in this sample. Eight percent of the seniors report use less than once a month and 83 percent never. Five percent of the juniors and seven percent of the seniors report use one to four times a month. (See table V.)

Age of first use: By age 11, 42 percent of the total sample have tried alcohol; 26 percent first tried alcohol between age 13–15, 22 percent report never using alcohol.

Two percent tried marijuana by age eleven, 14 percent by age 15. Eighty percent report never using marijuana.

Two percent have tried drugs by age 11, another 6 percent by age 15. Eighty-nine percent report never using drugs. (See table VI.)

Locations of first use: First use of alcohol occurs at home for nearly half of the students. Ten percent identified friends' home as first use site. Car, ball park and other public places were the sites of initial use for 19 percent. School was reported by less than 1 percent to be the site of first alcohol use.

For the 20 percent reporting marijuana use, 6 percent said friends' home, 6 percent said other places and 5 percent said school was the site of initial use.

The location for first drug use was identified as friends home by 3 percent and school, car or own home by 2 percent. Ninety percent report no drug use. (See table VII.)

Perceived availability: Twenty-six percent of the students report that alcohol can be obtained by persons over 18 purchasing for them and 24 percent get it from home. Twenty-one percent had no idea where to get alcohol.

Friends who have a supply or who will purchase are the perceived source for marijuana by 20 percent and for drugs by 13 percent. Eight percent and seven percent of the students reported they could buy marijuana or drugs at school. Half or more of the students reported having no idea where to get marijuana or other drugs. (See table VIII.)

TABLE V.—STUDENTS USE[1] OF ALCOHOL, MARIJUANA AND OTHER DRUGS (DOWNERS, UPPERS, HALLUCINOGENS LIKE LSD)

Frequency of use (per month)	Grade 6	8	10	12	Total
Alcohol (beer, wine, whiskey) (item 28):					
Never	63	44	26	16	39
Less than once a month	24	29	29	20	25
Once a month	4	8	10	9	8
2 to 3 times a month	3	12	20	22	14
Once a week	2	4	8	15	7
2 to 3 times a week	1	2	6	14	5
4 or more times a week	1	1	1	4	2
Marijuana (item 29):					
Never	98	89	78	67	85
Less than once a month	2	5	7	10	4
Once a month	0	2	3	2	2
2 to 3 times a month	0	2	3	5	2
Once a week	0	1	3	2	1
2 to 3 times a week	0	1	4	6	3
4 or more times a week	0	1	3	7	3
Drugs (uppers, downers, hallucinogens) (item 30):					
Never	94	96	90	83	92
Less than once a month	1	3	5	8	4
Once a month	0	1	2	2	1
2 to 3 times a month	0	0	2	4	1
Once a week	0	0	1	1	1
2 to 3 times a week	0	0	1	1	1
4 or more times a week	0	0	0	1	0

[1] Reported as percent of sample.

TABLE VI.—AGE OF 1ST USE[1]

Age of 1st use	Grade 6	8	10	12	Total
Alcohol (beer, wine, whiskey) (item 22):					
Doesn't apply, never use	40	25	13	8	22
9 or younger	33	28	22	15	25
10 to 11	20	22	15	8	17
12 to 13	1	18	22	17	14
14 to 15	0	2	21	32	12
16 to 17	0	0	1	15	4
18 or older	0	0	0	1	0
Don't remember	6	6	7	5	6
Marijuana (item 27):					
Doesn't apply, never use	97	83	73	57	80
9 or younger	1	1	0	0	0
10 to 11	2	3	1	1	2
12 to 13	0	8	9	5	6
14 to 15	0	1	15	19	8
16 to 17	0	0	1	17	4
18 or older	0	0	0	1	0
Don't remember	0	0	1	1	1
Drugs (uppers, downers, hallucinogens) (item 23):					
Doesn't apply, never use	94	94	87	76	89
9 or younger	2	0	0	0	1
10 to 11	1	1	1	0	1
12 to 13	0	4	3	2	2
14 to 15	0	1	8	10	4
16 to 17	0	0	0	10	2
18 or older	0	0	0	1	0
Don't remember	2	1	0	1	1

[1] Reported as percent of sample.

TABLE VII.—LOCATION OF 1ST USE[1]

Location of 1st use	Grade 6	8	10	12	Total
Alcohol (item 24):					
Doesn't apply, never use	41.0	26.0	13.0	8.0	23.0
My own home	38.0	51.0	47.0	38.0	46.0
Friends' home	4.0	10.0	14.0	16.0	10.0
School building or school grounds	.1	.4	.4	1.3	.5
In a car	.5	2.0	8.0	19.0	7.0
Other	5.0	8.0	8.0	7.0	7.0
Park, stadium, restaurant, etc	2.0	4.0	9.0	12.0	5.0
Marijuana (item 25):					
Doesn't apply, never use	97.0	87.0	73.0	57.0	80.0
My own home	1.0	2.0	2.0	2.0	2.0
Friends' home	0	5.0	8.0	12.0	6.0
School building or school grounds	0	1.0	1.0	1.0	.5
In a car	0	2.0	7.0	16.0	1.0
Other	0	1.0	3.0	3.0	6.0
Park, stadium, restaurant, etc	1.0	3.0	7.0	11.0	2.0
Drugs (uppers, downers, hallucinogens) (item 26):					
Doesn't apply, never use	97.0	95.0	88.0	78.0	90.0
My own home	2.0	1.0	1.0	2.0	2.0
Friends' home	1.0	2.0	3.0	6.0	3.0
School building or school grounds	0	0	4.0	4.0	2.0
In a car	0	1.0	1.0	4.0	2.0
Other	1.0	1.0	1.0	2.0	1.0
Park, stadium, restaurant, etc	0	1.0	3.0	4.0	2.0

[1] Reported as percent of sample.

TABLE VIII.—PERCEIVED AVAILABILITY[1]

Source	Grade 6	8	10	12	Total
Alcohol (item 34):					
Home	33	33	17	9	24
Friend or relative	7	14	20	12	13
Purchase it myself	1	1	3	39	10
Someone over 18 would purchase for me	8	20	46	34	26
No idea	41	25	12	2	21
Other	10	6	2	4	6
Marijuana (item 35):					
From friend or relative, who has or will buy it	8	15	27	35	20
Buy it at school	2	7	11	12	8
Buy it on the street	4	4	4	6	5
Don't know but probably could get some	6	10	17	20	13
Don't have any idea	70	55	39	23	48
Other	10	8	3	5	7
Drugs (uppers, downers, hallucinogens) (item 36):					
From a friend or relative, who has or will buy it	7	9	15	23	13
Buy it at school	4	5	9	11	7
Buy it on the street	4	5	6	4	5
Don't know but probably could get some	6	9	16	21	13
Don't have any idea	72	65	49	35	57
Other	8	6	4	5	6

[1] Reported as percent of sample.

Perceived motives for use or nonuse of substances: Students were asked to choose two items from a list of motives for substance use or non-use. The choices were ranked in order of frequency of selection.

The first two reasons for using alcohol were to avoid being labeled straight or square (44 percent) and to feel grown up (31 percent). Liking the taste, to avoid problems and for excitement followed in that order. The ranking of motives was quite similar across the four grade levels.

To be accepted and liking the feeling of being high were ranked first as reasons for using marijuana and drugs. Curiosity and to avoid problems were next for both substance items. (See table IX.)

Danger to health was the top reason for non-use of alcohol (51 percent), marijuana (54 percent) and other drugs (67 percent).

Better things to do was the reason ranked second for not using alcohol and other drugs and fourth as a reason for not using marijuana. Friends disapproval of use or having a friend killed or injured were at the bottom. or low, as reasons for non-use of alcohol, marijuana or drugs. (See table X.)

Models for substance use

Friends use of substances: The majority of sixth graders are not aware of alcohol use among their friends; 30 percent say none use and 45 percent don't know. Five percent said most or all of their friends use alcohol. The data reverses for seniors with 68 percent reporting that all or most of their friends use while 12 percent report none or don't know.

Only 9 percent of sixth graders think their friends use marijuana. Twenty-five percent of the seniors say all or most of their friends use, and 33 percent say some of their friends use marijuana.

Nine percent of the seniors think that all or most of their friends use drugs. Sixty-nine percent don't know or think that their friends do not use drugs. (See table XI.)

TABLE IX.—PERCEIVED MOTIVE FOR USE (OR ABUSE) OF SUBSTANCES[1]

Reasons for Use, Ranked	Grade 6	8	10	12	Total
Alcohol, (item 40–41)	N=958	N=950	N=794	N=786	N=3, 488
To avoid being labeled straight or square	36	50	53	42	44
To feel grown up	52	40	25	19	31
Like the taste	29	27	21	22	25
To avoid dealing with problems	28	23	23	23	24
Exciting	8	20	21	22	23
Like feeling high	27	17	25	33	22
Curiosity	13	15	14	9	13
Easier to talk	7	7	9	19	10
Glamorous	5	5	5	4	9
Marihuana (item 44-45)	N=954	N=954	N=793	N=788	N=3, 489
To be accepted	61	60	48	41	53
Like being high	27	27	33	41	32
Curiosity	30	34	31	30	31
Avoid dealing with problems	26	28	29	21	26
Socializing is easier	22	16	24	27	22
To reject parental values	10	16	18	19	15
Exciting	10	10	10	10	10
Glamorous	7	4	3	1	4
Increase appreciation of art, music, etc	2	3	3	5	3
Drugs (abuse) (item 48–49)	N=921	N=924	N=777	N=769	N=3, 391
To be accepted by friends	51	56	47	35	48
Like being high	37	33	32	33	34
Mixed up	24	24	23	28	25
Curiosity	22	22	23	22	22
Boredom	16	14	19	25	18
Stress	17	17	19	20	18
Excitement	17	21	18	16	18
To feel better	17	14	17	16	9
Increase appreciation of music, art, etc	3	3	3	5	3

[1] Percent of students selecting item as 1 of 2 choices.

TABLE X.—MOTIVES FOR NONUSE (OR NONABUSE) OF SUBSTANCES[1]

Reasons for nonuse, ranked	Grade 6	8	10	12	Total
Alcohol (item 38–39)	N=824	N=688	N=434	N=303	N=2, 249
Dangerous to health	65	53	36	30	51
Better things to do	34	45	59	57	45
Don't like taste	22	32	34	32	29
Family doesn't drink	22	19	19	27	21
Fear of alcoholism	30	19	13	9	21
Against beliefs	9	8	9	16	10
Costs	4	7	12	11	7
Friends disapprove	7	7	7	5	7
Friend killed in alcohol related incident	6	6	7	5	6
Marijuana (item 42–43)	N=923	N=873	N=649	N=588	N=3, 033
Dangerous to health	70	47	47	37	54
Don't want to	32	34	40	42	36
Leads to other drugs	22	23	24	17	22
Better things to do	12	20	26	28	21
Illegal	18	18	15	19	18
Family disapproval	15	16	15	13	15
Against beliefs	7	10	12	18	11
Not enjoyable	6	6	5	9	6
Birth defects	5	5	6	8	6
Lose energy	18	6	3	3	5
Costs	1	29	4	5	3
Friends disapproval	2	4	3	3	3
Drugs, not abusing (item 46–47)	N=926	N=914	N=712	N=678	N=3, 230
Dangerous to health	69	64	67	69	67
Better things to do	26	35	41	43	36
Family disapproves	40	34	23	17	30
Fear of addiction	30	31	28	23	28
Against my beliefs	14	12	19	28	17
Friends disapprove	9	9	7	6	8
Fear of arrest	2	7	7	60	7
Costs	2	4	6	6	4
Friend killed	3	4	3	4	3

[1] Percent of students selecting item as 1 of 2 choices.

TABLE XI.—FRIENDS' USE OF SUBSTANCES[1]

Number of friends perceived to use substance	Grade 6	8	10	12	Total
Alcohol (item 31)	N=969	N=965	N=798	N=793	N=3, 525
All or most of them	5	23	46	68	33
3 to 4 of them	7	12	12	11	11
1 to 2 of them	14	18	15	9	14
None	30	17	6	4	15
Don't know	45	31	20	8	27
Marijuana (item 32)	N=966	N=965	N=796	N=791	N=3, 518
All or most of them	2	7	18	25	12
3 to 4 of them	2	7	8	16	8
1 to 2 of them	5	11	17	17	12
None	55	42	30	23	39
Don't know	38	33	28	19	30
Drugs (item 33)	N=968	N=963	N=795	N=789	N=3, 515
All or most of them	1	3	6	9	5
3 to 4 of them	1	3	5	7	4
1 to 2 of them	3	7	12	16	9
None	58	54	44	41	50
Don't know	37	34	33	28	33

[1] Reported as percent of total sample.

Parents use of alcohol and tobacco: Fifty-five percent of parents, mothers and fathers, use alcohol occasionally or regularly and 37 percent use tobacco 4 or 5 times a day or more. Generally speaking, a higher percent of fathers used these substances than mothers with the exception of tobacco 4 or 5 times a day. (See table XII.)

Educational experiences

A. Substance education experiences: Students were asked which of a list of seven educational experiences were conducted in their school. Most frequent (60 percent) were informational material such as books and pamphlets and classroom films, lectures and discussions. Special assemblies were reported by 45 percent; 25 percent marked talks by an ex-alcoholic or addict, law enforcement and

medical personnel. Twenty-two percent reported special discussions or rap sessions.

Nineteen percent felt their school experiences were of great value and 18 percent felt they were little or no value. Sixty-three percent felt these experiences to be of some or considerable value. (See table XIII.)

Effective alcohol and drug education teachers: Students were asked to use a five point scale from very effective to not effective to score eleven different kinds of people who might do drug education. A counselor from a treatment center or a former user were scored highest in effective to teach about alcohol and drug education. A doctor, health teacher and parents were next in that order. (See table XIV.)

Best sources of substance information: Books and pamphlets ranked highest as best sources of information followed by classroom teacher, parents and TV in that order. School assemblies and current users were at the bottom of the list. (See table XV.)

TABLE XII.—PARENTS USE OF ALCOHOL AND TOBACCO [1]

Parents use	Mother	Father	Total
Alcohol (item 104–105):			
Never	37	21	29
Occasionally	33	47	40
Beer or other drink every day or so	8	22	15
Several drinks a day	1	7	4
Smoking (item 106–107):			
Never	65	45	55
Several times a week	5	12	9
4 or 5 times per day, regularly	22	40	31
Pack or more a day	7	4	6

[1] Reported as percent of total sample.

TABLE XIII.—*Specific substance education*

Substance education experience (item 75–83):	*Total*
Books and pamphlets	60
Classroom film, lectures, discussion	60
Special assemblies	43
Talk by ex-alcoholic or addict	25
Talk by law enforcement person	25
Talk by doctor, lawyer, nurse, pharmacist	24
Special discussion or rap session	22
None of the above	9

Value of experience (item 84)	Grade 6	8	10	12	Total
Little or no value	20	20	14	17	18
Some value	19	27	40	46	32
Considerable value	24	34	36	31	31
Great value	38	20	10	6	19

TABLE XIV.—*Person most effective in teaching about alcohol and drugs* [1]

Person (item 51–63):	*Total*
Counselor from alcohol or drug center	81. 0
Former user	74. 0
Doctor	73. 6
Health teacher	65. 0
Parents	53. 0
Policeman	46. 0
School nurse	39. 0
College student	36. 0
Clergy	36. 0
School counselor	35. 0
Teacher	31. 0
Nonuser, older than you	22. 0
Nonuser, same age	15. 0

[1] Ranked in total sample.

TABLE XV.—BEST SOURCES OF SUBSTANCE INFORMATION [1]

Source (item 50)	Grade 6	8	10	12	Total
Books and pamphlets	18	20	23	27	22
Classroom teacher	14	21	14	10	15
Parents	30	14	8	7	15
TV	21	14	13	9	15
Friends	5	11	16	13	11
Experiences	2	5	12	21	9
Brothers and sisters	3	4	3	3	3
School assemblies	3	5	8	10	6
Current user	4	5	4	2	4

[1] Ranked in total sample.

TABLE XVI.—BEST METHOD TO COMBAT DRUG ABUSE AMONG TEENAGERS [1]

Method (item 14)	Grade 6	8	10	12	Total
Drug education courses	37	27	20	22	27
Testimony from former users	25	27	27	20	25
Stronger laws and enforcement	12	12	18	18	14
Providing alternatives to getting high on drugs	7	11	16	21	13
No problem	1	1	2	3	2
Don't know	10	21	17	6	18

[1] Ranked in total sample.

Educational experiences—Continued

BEST METHODS TO COMBAT DRUG ABUSE

The best methods to combat drug abuse were ranked the same by all grade levels with drug education (27 percent) and testimony from former users (25 percent) at the top of the list. Increased law enforcement and programs which offer alternatives to drugs were next. Eighteen percent had no idea of how to combat drug abuse. (See table XVI.)

B. Educational experiences which are not drug specific: The problems of alcohol and drug abuse are related to self-concept, decision-making and socialization aspects of the individual. Educational experiences which touch these areas may occur anywhere in the school program as well as in specific substance education.

Seventy-six percent of the students are not aware of opportunities to learn about themselves (33 percent said no, 24 percent said don't know). Thirty-nine percent knew an adult who could refer them to help for V.D., drug or pregnancy problems. Sixty-one percent said they didn't know or, no, there was not such a person.

Eighty-five percent said they did not know or that there was not a source of street drug information. Sixty-five percent reported that library materials about alcohol and drugs were available.

Opportunities to study about things of personal interest were reported by 51 percent. Seventy-four percent said they had a chance to learn decision-making and 79 percent felt they learned how to discuss and express their opinions with others.

Learning job seeking skill was apparent to 77 percent. Sixty-three percent felt they had the opportunity to learn about their emotions and 65 percent felt they had opportunities for success. (See table XVII.)

C. Students perceptions of school policies relating to substances: Seventy percent felt that students are suspended for using alcohol on school property and 69 percent perceived suspension for using marijuana or other drugs on school property.

TABLE XVII.—EDUCATIONAL EXPERIENCES WHICH ARE NOT DRUG SPECIFIC[1]

Service of opportunity in local school	Grade 6	8	10	12	Total
Classroom experiences or counseling to learn about themselves (item 85):					
Yes	20	26	28	25	24
No	29	25	34	46	33
Don't know	52	50	38	29	43
Adult who will refer to services for V.D., pregnancy, suicide or drug problems (item 88):					
Yes	33	39	43	44	39
No	22	19	21	27	22
Don't know	46	42	37	29	39
An accurate source of street drug information (item 86):					
Yes	14	13	16	15	15
No	41	41	41	51	43
Don't know	45	47	44	34	42
Library materials about alcohol and drugs (item 87):					
Yes	53	65	70	73	65
No	17	11	9	10	12
Don't know	30	24	21	17	23
Study about things of interest to me such as V.C., jobs, money, parenting (item 98):					
Yes	32	46	61	68	51
No	33	28	25	24	28
Don't know	35	25	14	9	22
Learn to use decisionmaking (item 99):					
Yes	72	72	75	76	74
No	13	15	16	17	15
Don't know	15	13	9	7	11
Learn to discuss my ideas, opinions, viewpoints and listen to others (item 101):					
Yes	79	76	79	82	79
No	9	12	13	12	11
Don't know	12	12	9	6	10
Job seeking skills (item 102):					
Yes	71	76	80	81	77
No	11	13	11	13	12
Don't know	18	11	9	7	12
Learn to understand and handle feelings (item 100):					
Yes	71	60	60	61	63
No	14	20	26	28	21
Don't know	16	20	14	11	15
Opportunities for success (item 103):					
Yes	66	65	65	66	65
No	11	17	20	22	17
Don't know	23	19	17	12	18

[1] Reported as percent of total sample.

Fifty percent of the students felt the police were called for students possessing marijuana; 24 percent felt police were called for students possessing alcohol.

Twelve percent felt that students were used as undercover informants while 58 percent didn't know. Fifty-five percent did not know if personal information was discussed among teachers and principals while 28 percent marked that such matters were discussed.

Notification of parents in suspected drug use situations was marked yes by 50 percent of the students; 41 percent did not know.

Nine percent thought that a police liaison handled drug and alcohol problems in their school but 55 percent did not know. Twenty-five percent reported that locker searches had been conducted in their school. Thirty-nine percent did not know if such action had taken place. (See table XVIII.)

Nonschool options for help with drinking or drug problems: Students were asked to mark which person from a list they would most likely contact for a drug or alcohol related problem. The order of ranking was similar in all four grades. "A close friend" ranked first in the total sample. Sixth graders chose parent first and a close friend second. Ranking third was "don't know where I would go", marked by 13 percent of the total sample. (See table XIX.)

D. Students discussion with parents, peers and other adults: Students were asked how often in the last month they had discussed problems, concerns or ideas with a parent or other adult. One-third did not talk with a peer or a parent and 68 percent had not talked with another adult. One-third had talked with a peer or parent once or twice and 20 percent had talked once or twice with another adult. Thirty-five percent had talked with peers three or more times about problems, concerns or ideas; 31 percent with their parents and 11 percent with another adult. (See table XX.)

TABLE XVIII.—STUDENTS PERCEPTION OF SCHOOL POLICIES RELATING TO SUBSTANCES[1]

Action taken in situation involving substances	Grade 6	8	10	12	Total
Students suspended for using alcohol on school property or at school events (item 89):					
Yes	45	75	80	81	70
No	8	4	4	4	5
Don't know	47	21	16	15	25
Students suspended for using marijuana or other drugs on school property or at school events (item 90):					
Yes	33	25	80	81	69
No	9	4	4	4	5
Don't know	59	21	16	15	25
Police called for student possessing marijuana at school (item 91):					
Yes	33	42	46	50	42
No	9	9	4	6	7
Don't know	59	49	50	43	51
Police called for student possessing alcohol at school (item 92):					
Yes	26	24	23	25	24
No	13	18	23	27	20
Don't know	60	58	55	48	56
Students are used as undercover informants (item 93):					
Yes	11	11	13	15	12
No	23	30	32	37	30
Don't know	66	59	56	48	58
Student personal information is discussed among teachers and principal (item 94):					
Yes	29	27	26	32	28
No	16	18	19	16	17
Don't know	54	56	56	52	55
Parents of suspected drug using stdent are notified by school officials (item 97):					
Yes	47	54	52	47	50
No	8	8	9	12	9
Don't know	46	38	40	41	41
Police lialson handles drug and alcohol problems in school (item 95):					
Yes	10	9	7	8	9
No	28	33	41	47	37
Don't know	62	58	52	44	55
Locker searches for drugs have been conducted (item 96):					
Yes	11	27	29	36	25
No	38	33	35	36	36
Don't know	50	40	36	28	39

[1] Reported as percent of total sample.

TABLE XIX.—NONSCHOOL OPTIONS FOR HELP WITH DRINKING OR DRUG PROBLEMS[1]

Person most likely to contact for help (item 37)	Grade 6	8	10	12	Total
A close friend	22	33	41	48	35
Parents or guardians	36	23	13	10	21
Don't know where I would go	14	14	14	11	13
Brother, sister or other young relative	6	9	10	10	9
Crisis line, or treatment center	5	6	7	6	6
A trusted adult	4	4	8	7	6
School counselor or teacher	3	6	4	3	4
Clergy	4	3	3	5	4
Family doctor	5	2	0	1	2

[1] Reported as percent of total sample.

TABLE XX.—FREQUENCY OF STUDENTS DISCUSSION WITH PEERS, PARENTS AND OTHER ADULTS[1]

How often in the last month did you—	Grade 6	8	10	12	Total
Talk with a peer about concerns, problems or interests (item 110):					
Not at all	47	37	25	16	33
Once or twice	35	35	33	32	34
3 to 5 times	9	14	10	21	16
6 or more times	9	14	22	30	18
Talk with parent(s) (item 111):					
Not at all	35	36	33	27	33
Once or twice	36	35	36	35	36
3 to 5 times	16	19	20	23	19
6 of more times	13	10	11	15	12
Talk with person over 25 (item 112):					
Not at all	77	73	76	53	68
Once or twice	14	19	23	30	21
3 to 5 times	6	7	8	12	8
6 or more times	4	2	3	5	3

[1] Reported as percent of total sample.

Student activities

A. Student participation in selected activities: Students indicated the number of times they took part in selected, non-school activities during the last month.

Sixty-one percent participated in individual team sports once a week or more and 51 percent did outdoor activities such as hiking or fishing.

In a week 30 percent worked at a part time job; 42 percent worked on a hobby or collection; and 82 percent watched TV and 28 percent attended a club or organizational activity one or more times.

Sixty-one percent of the total sample do not date at all; 26 percent of the seniors do not date while 35 percent date six or more times a month. Thirty-nine percent of the juniors and 49 percent of the seniors go out and hang around with friends six or more times a month.

Forty-three percent do not participate in church activities and 25 percent do so once or twice a month. Twenty-nine percent said they did not take part in a community activity; 71 percent did so once a month or more. Seventy-seven percent take part in an activity of personal interest once a month or more. (See table XXI.)

TABLE XXI.—FREQUENCY OF STUDENT PARTICIPATION IN SELECTED ACTIVITIES [1]

Activity participation during the last month	Grade 6	8	10	12	Total
Individual or team sport; basketball, tennis (item 115):					
Not at all	16	19	23	27	21
Once or twice per month	22	17	13	16	17
3 to 5 times	23	19	16	17	18
6 or more times	40	45	47	41	43
Outdoor activity; fishing, biking (item 116):					
Not at all	16	16	21	26	19
Once or twice per month	30	27	30	32	30
3 to 5 times	22	26	24	21	23
6 or more times	32	31	25	22	28
Work at a part time job (item 117):					
Not at all	72	62	56	31	56
Once or twice per month	12	17	13	8	13
3 to 5 times	5	9	10	11	8
6 or more times	10	12	22	49	22
Work on hobby, collection or art work (item 122):					
Not at all	21	29	30	30	27
Once or twice per month	35	31	32	26	31
3 to 5 times	23	22	18	20	21
6 or more times	21	18	20	24	21
Watch TV (item 120):					
Not at all	3	3	2	2	2
Once or twice per month	3	4	7	11	6
3 to 5 times	7	7	10	17	10
6 or more times	88	87	81	70	82
Attend club or organizational activities (item 118):					
Not at all	56	49	41	39	46
Once or twice per month	23	28	27	23	25
3 to 5 times	12	14	20	21	17
6 or more times	9	9	12	16	11

TABLE XXI.—FREQUENCY OF STUDENT PARTICIPATION IN SELECTED ACTIVITIES [1]—Continued

Activity participation during the las month	Grade 6	8	10	12	Total
Go out on dates (item 119):					
Not at all	88	72	50	26	61
Once or twice per month	8	15	21	18	15
3 to 5 times	3	6	15	21	11
6 or more times	2	7	15	35	14
Go out or hang around with friends (item 121):					
Not at all	33	20	11	9	19
Once or twice per month	32	28	23	19	25
3 to 5 times	17	23	27	23	22
6 or more times	18	29	39	49	33
Participate in church activities (item 123):					
Not at all	39	43	43	49	43
Once or twice per month	31	26	24	20	25
3 to 5 times	20	17	20	18	19
6 or more times	11	14	14	14	13
Take part in a school or community activity (item 113):					
Not at all	32	32	26	25	29
Once or twice per month	40	35	28	27	33
3 to 5 times	17	20	20	23	20
6 or more times	11	13	26	25	19
Take part in an activity of personal importance or interest (item 114):					
Not at all	32	28	16	13	23
Once or twice per month	35	33	29	28	32
3 to 5 times	18	19	24	26	21
6 or more times	14	20	31	34	24

[1] Reported as percent of total sample.

SUMMARY

The students in this survey characteristically live in a rural environment and have definite household rules in their homes. They spend their free time with "friends at home or at their friends' homes" or at "school or church activities". Half of them have about five dollars a week to spend but a third have twenty or more dollars per week for spending. Students believe laws should be obeyed even if they don't agree with them. Among upper grade students there is an upward trend in the number who would disobey an unreasonable law.

Although younger Iowa students consider marijuana to be more dangerous than alcohol, by the senior year only one third show a concern about either substance. Three-fourths of the students maintain the attitude that drugs (uppers, downers and hallucinogens) are neither safe nor an appropriate way to deal with difficult situations. Approximately half of the students using alcohol or other drugs perceive that their parents do not know it while a third say their parents disapprove.

Iowa students' knowledge about substances expectedly increases with higher grade levels. Of greatest concern is the large number who marked "do not know" to the knowledge items or marked inaccurate information (such as identifying a white substance as heroin or recommending tomato juice to cure a hangover).

Nearly half of Iowa students have tried alcohol by grade six and three fourths have experimented with alcohol by age fifteen. The largest number of students report experimentation with marijuana or drugs occurs in grade twelve.

The first use of alcohol for a majority of students occurs in their own home. "At a friend's home" or "in cars" are the next most common sites for initial use. Marijuana and drugs are first used in friends' homes or in cars. Virtually no initial use of any of these substances occurs at a school site. "Friends over eighteen" and "homes" are the top sources of alcohol for Iowa students. Marijuana and drugs are reportedly obtained from friends or relatives who have or will buy for them.

Substances are used to "avoid being labeled square or straight" and because they like the "feeling of being high." "Danger to Health" and "better things to do" were the strongest deterrents to substance use.

Students feel that the best way to combat drug and alcohol abuse among teenagers is education yet more than half feel that their substance education experiences were of moderate or no value.

Media (books, pamphlets, tapes and TV programs) were ranked as the most frequent substance education experience. These kinds of materials are also considered the best source of information. School assemblies which continue

to happen for nearly half of the students ranked very low as a source of information.

Although "drug education" ranked highest in combating drug abuse, the classroom teacher ranked near the bottom in effectiveness to teach about alcohol and drugs. An ex-alcoholic or addict or counselor from a treatment center were ranked at the top for effectiveness in teaching about drugs and alcohol.

Students in general feel they have opportunities to study topics of personal interest, decision-making, communication and job seeking skills. A majority of the students do not experience opportunities to learn about themselves, an adult in their school who can refer them to help for personal problems or street drug information. Students ranked "contacting a friend for help with a drug or alcohol problem" far above the second choice, parents or guardian.

Twice as many students felt that the police are more likely to be called in for marijuana possession than for possession of alcohol. Three-fourths do feel that suspensions from school are carried out equally for marijuana or alcohol use on school property. Half of the students feel that parents are notified in case of suspected substance use.

Students generally do not know about police liaison arrangements, locker search policies, students as undercover agents or the treatment of confidential student material.

A large majority of Iowa students participate in team or individual sports, have hobbies and do not date.

Slightly less than half have part time jobs, participate in organizational activities and report non-church participation.

Three-fourths said they participate in a community activity and an activity of personal interest once a month or more.

Implications

Substance education concerns which emerge from the Iowa Study of Alcohol and Drug Attitudes and Behaviors fall into two categories; the manner in which substance education is conducted and the content emphasis.

Students expect education to combat drug problems and they identify the classroom teacher next to library materials as valuable sources of information. But their evaluation of current substance education and effective "teachers" clearly indicates the need for improvement.

Although the classroom teacher is professionally trained to implement learning and has the greatest access to students, his or her effectiveness can be improved through accurate knowledge of substances, and understanding of the role substance use plays in society and an openness to present material in an objective manner.

At the same time those persons from treatment centers or who are recovering alcoholics or addicts must be aware that scare tactics have minimum effect on preventing substance use and that alternative behaviors must be found to replace the benefits students perceive from alcohol and drug use.

The survey verifies the effect peers have in influencing use, in passing information and in giving help to friends. Substance education planners should recognize peer influence as a resource in substance education and utilize it to the best advantage.

High quality media materials (books, pamphlets, cassettes and films) should be made readily available instead of special assemblies.

Substance education must continue to include scientifically accurate information treating alcohol as an equal or greater hazard than other drug substances. Substance education also means a knowledge of the human body, its care and maintenance.

A large part of substance education must be non drug specific. Young people need to understand their social development and how to establish themselves in the social structure. Decision-making, including analysis of the consequences of behavior, in another non drug specific part of substance education. A third component is finding and recognizing altered states of consciousness, or highs, in non substance using ways.

The Iowa Study of Alcohol and Drug Attitudes and Behaviors conducted in the fall of 1975 indicates a need for teacher in-service, peer programming and a comprehensive substance education curriculum.

State of Iowa
DEPARTMENT OF PUBLIC INSTRUCTION
Curriculum Division
Grimes State Office Building
Des Moines, Iowa 50319

Substance Abuse Prevention Education (SAPE)

The young people of Iowa live in a substance-using environment. During their lifetime, they will make several personal decisions about their use or non-use of these substances. The schools of Iowa can help prepare young people to make personally and socially responsible decisions related to alcohol and other drugs.

The Department of Public Instruction developed the Substance Abuse Prevention Education (SAPE) Program to assist schools and communities in preparing young people for making these decisions. The SAPE program functions on two levels: the local school-community level and the state government level.

State Level

The SAPE program provides the following services:

CONSULTATION - and technical assistance on substance abuse prevention education programming to:

Iowa Department of Substance Abuse
Iowa Department of Public Instruction
Iowa Legislature
Other governmental units as requested

EDUCATION POLICY - consultation and technical assistance on substance abuse prevention and intervention issues to Iowa Department of Public Instruction and other educational administration groups.

TRAINING - conducts state-wide and regional workshops for:

Iowa educators
Other governmental units as requested

MATERIALS - reviews, prepares and distributes prevention education materials for Iowa schools.

RESEARCH - collects, analyzes and interprets data from a biannual youth survey (Iowa Study of Alcohol and Drug Attitudes and Behaviors Among Youth).

Local Level

The SAPE program provides the following services to schools and community groups:

CURRICULUM - consultation in the design and implementation of substance education curricula.

SCHOOL POLICY - consultation in the design and interpretation of school policy related to substances.

PLANNING - assistance in planning primary prevention programming.

TRAINING - inservice training of school personnel to conduct substance education programs.

AWARENESS - workshops/presentations on substance abuse prevention education.

PEER COUNSELING - assistance and training to establish peer counseling programs.

EVALUATION/NEEDS ASSESSMENT - assistance in design and conduct of needs assessments and substance education program evaluations.

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SAPE...

Functions

The SAPE program also functions as:

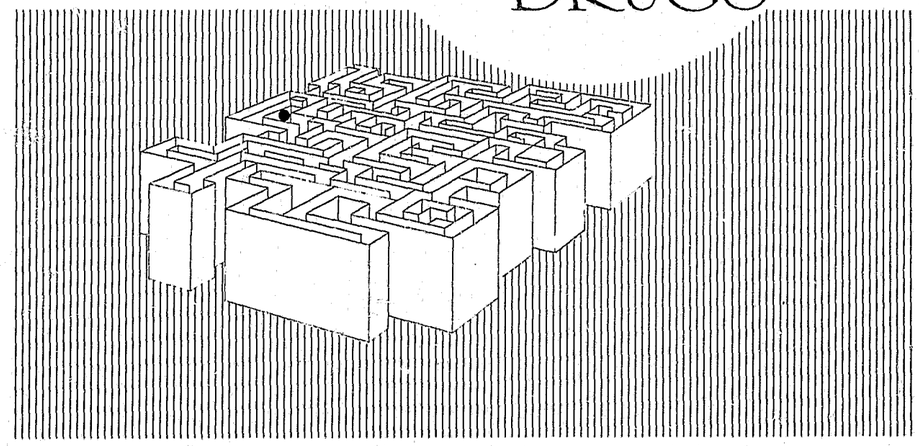
- An advocate within state government for the primary prevention of substance abuse.
- An agent to introduce successful innovations in primary prevention programming.
- A liaison between some non-governmental organizations and Iowa schools to foster their mutual interests and efforts toward the primary prevention of substance abuse.
- A facilitator for regionally funded prevention education programming.

Activities

The SAPE program is currently involved in the following major activities:

- Implementing Alcohol and Other Drugs, An Instructional Framework for Substance Education in Grades K-12.
- Establishing peer helping programs in Iowa secondary schools.
- Conducting the 1977-78 Iowa Study of Alcohol and Drug Attitudes and Behaviors Among Youth.
- Establishing summer workshops to prepare Iowa teachers to conduct substance abuse prevention programs.

ALCOHOL and Other DRUGS



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Alcohol and Drug Education Guidelines

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Special acknowledgment is due to the Iowa Drug Abuse Authority and the Iowa Division on Alcoholism for their financial and professional assistance in preparing and publishing this *Guide.*

Many of the classroom activities described in the *Guide* have been drawn from the *Teacher Activity Packages for Grades 2–6* developed by Cooperative Educational Service Agency Number Eight in Appleton, Wisconsin and from *Alcohol Use and Traffic Safety Volume I – Volume IV* prepared by the Maryland State Department of Education.

Table of Contents

Chapter One
Introduction

We live in an alcohol and drug using society. The use and abuse[1] of alcohol and drugs by young people and older people is a frequent occurrence across ethnic and socioeconomic groups and across geographic areas and population concentrations. Twentieth century America has a large number of problem drinkers and alcoholics, drug dependent people, casual and regular users of marijuana, and people who misuse prescription and non-prescription drugs Our young people live in this environment and they must make personal decisions about their use or non-use of these substances. The schools of Iowa can help young people to develop skills to make responsible decisions related to their own alcohol and drug use or non-use behaviors.

Need for a Guide

The present Code of Iowa (Chapter 257.25. School Standards) requires that schools provide health education which includes "the effects of alcohol, tobacco, drugs, and poisons on the human body." This instruction is to be provided to students in grades 1 – 12. The law does not specify how students are to be instructed about these substances. School personnel have interpreted this mandated responsibility in a variety of ways.

Many school districts have requested assistance from the Department of Public Instruction in establishing their curricular offerings in alcohol and drug education. This guide is intended to be of assistance to school personnel in their development and implementation of alcohol and drug education curricula.

Purpose of the Guide

The purposes of the Alcohol and Drug Education Guide are to assist school districts and teachers to:

1. develop a rationale for alcohol and drug education;
2. define what alcohol and drug education is intended to do (curriculum goals and objectives);
3. develop an instructional framework for alcohol and drug education;
4. determine where alcohol and drug education can be integrated into existing school curricula and/or correlated with other subject areas.

The major emphasis of this guide has been directed toward the development of an instructional framework for alcohol and drug education. The instructional framework presented in Chapter Three and the remaining text in the guide are directed at accomplishing the purposes stated above.

Philosophy of the Guide

The *Alcohol and Drug Education Guide* is based on the philosophy:

1. that a primary responsibility of the school is to provide students with learning experiences and skills which will enable them to function successfully in a rapidly changing society without the use or abuse of alcohol or other drugs;
2. that alcohol and drug abuse are serious social problems to which the school, as a primary influence in the the socialization of children, must respond;
3. that the response should be manifested in a carefully planned, well coordinated K – 12 alcohol and drug education curriculum, the focus of such curriculum being the development of mentally, physically, and socially healthy young people;
4. that the most effective alcohol and drug education program is a synthesis of content (cognitive) and behavioral (affective) approaches adjusted to the needs and concerns of the students and community;
5. that students, school personnel, parents, and community resources should be involved in the planning, implementation, and evaluation of the program.

[1]Use is defined as the consumption of any quantity of alcohol or drugs for any purpose.

Abuse is defined as the habitual use by self-administration of drugs or alcohol to the extent that the use interferes with the physical, psychological, vocational, or social functioning of the individual.

Because this philosophy of alcohol and drug education focuses on the human behavior of alcohol and drug use and abuse, rather than on the substances themselves, the major empahsis of the guide is on the affective and health promoting realms of education.

Organization of the Guide

The Alcohol and Drug Education Guide is organized into four sections:

Chapter One – **Introduction.** Presents a brief explanation of the need for a guide, the purposes of the guide, philosophy of the guide and the possible uses for the guide.

Chapter Two – **Alcohol and Drug Education.** Presents some background perspective for alcohol and drug education; presents a definition of alcohol and drug education; and offers some suggestions for the integration/correlation of alcohol and drug education with other school curricula.

Chapter Three – **Instructional Framework.** Presents a K – 12 scope and sequence for alcohol and drug education; describes developmentally appropriate student outcomes; offers content statements and activities to develop these student outcomes; and lists teacher and student resources for each level of instruction.

Chapter Four – **Teacher Resources.** Includes a glossary of terms used in the guide, a set of guidelines for the selection of audiovisual materials and a listing of additional resources available to the teacher.

Use of the Guide

The Alcohol and Drug Education Guide is not intended to be a total curriculum that every school district is required to follow. Rather, the guide is a starting point from which teachers and administrators can build a comprehensive program of alcohol and drug education.

The information contained in the guide can be used by curriculum committees to plan and implement comprehensive K – 12 alcohol and drug education curricula. On another level, the guide is intended to be of help to teachers in their determinations of what content, materials, and methods are suitable for meeting their students' needs in alcohol and drug education.

Educators should also be aware that many of the outcomes and activities suggested in this guide are also suggested in resource guides and curricula in other subject areas. Many of the activities and outcomes related to the affective domain and mental and social health are inherent in such educational programs as career education, social studies, family living, educational television productions, and comprehensive school health education. For this reason a detailed outline of activities for fostering the emotional and social growth of young people has not been included in this guide.

Chapter Two

Alcohol and Drug Education Is . . . . . [1]

The National Education Association (NEA) has defined "drug education" as "A learning process that influences an individual emotionally, intellectually, psychologically, and socially, and that may result in the modification of attitudes that influence behavior. It not only involves the formal mechanisms of presenting information but also includes a series of experiences and influences that help shape the environment – the atmosphere of the school, the life style present at home, the attitude of parents, the pressure within a peer group, the popular culture, the personal experiences with or without drugs, and the availability of alternative mechaisms employed to carry out certain kinds of behavior."[2]

The NEA Task Force recognized the complex interaction of factors which influence alcohol and drug use and abuse. Actual school approaches to alcohol and drug education reflect considerable variance among school personnel in their respective definitions of this term.

Approaches to Alcohol and Drug Education

Most alcohol and drug education in schools has been based on an **information giving** approach. The information presented to students was centered on the substances and the harmful physiological, psychological and/or sociological consequences of alcohol and drug use and/or abuse. The approach has been effective with students who agreed with the information presented and the value positions of the communicator. Many students, however, have not been persuaded to not use or abuse alcohol and drugs.

The information giving approach assumed that people make rational decisions from a basis of factual information. Most people tend to ignore reliable information (1) when confronted with strong peer pressure to conform, (2) when the expected behavior does not fit one's life style or values, or (3) the person is faced with personal problems for which no other coping mechanisms are apparent. Additionally, the alcohol and drug use or non-use behaviors of an individual are strongly related to that person's **perceptions** of the risks (physical, psychological, and social) versus the gains involved in such behaviors. These perceptions are strongly influenced by models presented by significant others and the individual's felt personal needs, life style, values, and prior experiences with alcohol and drugs.

A second approach (psychosocial) focuses on the sociological and psychological aspects of alcohol and drug use and abuse. The use of alcohol and drugs is viewed as a complexly derived human behavior. People have motives for their use or non-use of these substances. The educational approach examines these motives and their influence on alcohol or drug use decisions. The educational approach examines human needs in relationship to the alcohol and drug use patterns and norms in American society. The various forms of social control on the use of alcohol and drugs are related to the individual's decisions to use or not use these substances.

The psychosocial approach assumes that young people can learn to understand and cope with the causes of alcohol and drug abuse.

A third approach (comprehensive) presents alcohol and drug education within the framework of confluent education. There are cognitive aspects of alcohol and drug education such as accurate information and concepts about alcohol and other drugs. The learner also brings feelings, attitudes, and values to learning experiences about alcohol and drugs. In this approach the teacher is responsible for providing information and tools related to alcohol and drug education while providing an atmosphere and processes where students can relate that content effectively to their own life experiences.

Alcohol and drug education is "process" oriented in this approach. The individual is to internalize the processes of self-knowledge, valuing, decision making, and the assumption of personal responsibility for one's behavior. The processes are directed toward the individual assuming personal responsibility for his/her own alcohol or drug use or non-use.

1. Much of the content in this chapter is based on data collected from Iowa students in "The Iowa Study of Alcohol and Drug Attitudes and Behavior Among Youth," (Iowa Department of Public Instruction, 1975), and on the prevention recommendations from the National Institute on Drug Abuse and the National Institute on Alcoholism and Alcohol Abuse.

2. *Drug Education: An Awakening. A Report of the NEA Task Force on Drug Education.* (Washington, D.C.,: National Education Association, 1972), p. 7.

The assumption underlying the comprehensive approach is that most people will not choose self-destructive behaviors if they are aware (1) that constructive alternative behaviors are available to them for meeting their needs and (2) that they can freely choose a constructive behavior from these alternatives. The responsibility for the choice and consequences of self-destructive or growth promoting behavior lies within the individual.

The instructional framework presented in Chapter Three contains elements of the three approaches presented above. The school district and/or classroom teachers can adopt any or all of the framework depending upon their approach to alcohol and drug education.

Objectives of Alcohol and Drug Education

A curriculum development committee or individual teachers should determine what the classroom experiences in alcohol and drug education are designed to accomplish. The process of setting goals and objectives for alcohol and drug education should include a consideration of issues such as: What is the role of the school in preventing alcohol and drug abuse? When should alcohol and drug education begin? What concepts should be taught and what methods should be used to influence young people at different developmental levels? Should it be integrated into all or part of the existing curriculum?

The educational approach and objectives for alcohol and drug education will probably be most influenced by the attitudes, knowledge, and skills of local teachers. Any alcohol and drug education curriculum, particularly one that deals with students' personal behaviors, attitudes, and feelings, will depend on the competencies and needs of local teachers.[3]

The setting of goals and objectives for alcohol and drug education should involve as many teaching faculty as possible. Teachers and school administrators who are to implement a curriculum must be a part of the development of it. The philosophy, content, activities, and teaching methods of an alcohol and drug curriculum must belong to the teachers who are to implement it.

An alcohol and drug education curriculum should specify some desired student outcomes as a result of units of instruction or learning activities. The objectives (outcomes) presented in Chapter Three were developed to help teachers and curriculum committees with this task.

3. *Doing Drug Education. The Role of the School Teacher.* (Rockville, Maryland: National Institute on Drug Abuse, 1975).

Correlation or Integration With Other Subjects

Alcohol and drug education as a part of comprehensive health education can be correlated or integrated with other subject areas throughout the elementary and secondary levels. For example, correlation or integration could occur with other major subject areas as follows:

Biology -- Effects of alcohol and drugs on the circulatory, respiratory, nervous, and other body systems; possible physiological harm to the body resulting from alcohol and drug abuse/use.

Chemistry -- Chemical properties of alcohol, drugs and poisons; effects of substance use on chemical exchange of oxygen and carbon dioxide in the blood and lungs; process of alcohol metabolism; percent concentration of alcohol in blood.

Driver Education ahd Safety -- Decision making related to alcohol and drug use and driving, responsibility of drivers for safety of others; home and school rules related to safe use of substances.

English -- Reading and interpreting popular magazine articles or books to identify their pro or con positions on alcohol and drug use; analyses of media advertisements, themes of rock music, and contemporary theatre.

Family Living -- Relationships of parenting and family communications to alcohol and drug abuse prevention; effects of alcohol and drug abuse on the family unit; self-medication and the abuse of prescription and nonprescription drugs; alternative family life styles and the non-use of substances.

Government -- Legislation and agencies concerned with the manufacture, distribution, sales and taxation of alcohol and drugs; the economics of the alcohol and drug industries; federal, state, and local efforts to prevent alcohol and drug use and abuse; rehabilitation and treatment of chemically dependent people.

History -- Use of alcohol and drugs by humans throughout history; legislative attempts to control alcohol and drug use.

Physical Education -- Alcohol and drugs and their relationships to fitness and athletic performances; alternative activities to alcohol and drug use.

Psychology -- Life coping skills and mental health related to alcohol and drug use/abuse; motivations for alcohol and drug use/abuse, alternative ways of meeting needs.

Social Studies -- Alcohol and drug abuse as a social problem; alcohol and drug use related to norms and customs of societies; alcohol and drug use related to crime, poverty and social inequalities; alternatives to boredom, alienation and loneliness; peer, parental, and societal influences on alcohol and drug use decisions.

Chapter Three
Instructional Framework

The effectiveness of instructional programs in alcohol and drug education is reflected in the attainment of desired changes in student behaviors, attitudes, and knowledges. In order to accomplish these objectives with students, a comprehensive instructional approach should be used. This comprehensive program should clearly specify what changes in behavior, attitudes, and knowledges are desired, what learning activities are appropriate and at what developmental stages it is most relevant to introduce program concepts. This chapter attempts to provide this framework for instructional programs. The instructional framework is predicated on the assumption that alcohol and drug education will be correlated/or integrated with other curricular areas such as health, mental health, affective education, psychology, social studies, career education, life science, and family living.

The materials included in this chapter are intended to be helpful to classroom teachers and curriculum committees. Each school district and teacher is encouraged to modify the instructional framework to fit their local situations and the needs of their students.

Organization of the Instructional Framework

The instructional framework is organized in two basic ways: (1) by six major outcome areas and (2) by four age levels. The scope and sequence chart presented in the guide illustrates these organizational features.

The instructional program is organized according to six major student outcomes. At the conclusion of a student's secondary education (Level IV), the student will:

(A) Understand the basic factors of human behavior related to alcohol and drug use. (HUMAN BEHAVIOR)
(B) Know impartial scientific facts about alcohol and other drugs. (SCIENTIFIC FACTS)
(C) Know the probable consequences of any alcohol and drug use to the individual, to the family, and to the community. (CONSEQUENCES)
(D) Know that the individual, his/her family, and the community have interrelated responsibilities for the prevention of alcohol and drug abuse. (PREVENTION)
(E) Know personally relevant and satisfying alternative behaviors to alcohol and drug abuse. (ALTERNATIVES)
(F) Be able to employ decision making skills to make responsible decisions relative to personal alcohol and drug use or non-use. (DECISION MAKING)

There are four developmental levels or age ranges used in this framework. Each color section in this chapter represents alcohol and drug education appropriate to students in the following age ranges:

Level I	(grades K–3) Red
Level II	(grades 4–6) Green
Level III	(grades 7–9) Orange
Level IV	(grades 10–12) Blue

At each level (i.e. Level I) there are several specific student outcomes listed. These specific outcomes are developmental interpretations of the six major outcomes.

Each age level section (i.e. Level II: 4–6) of this chapter is organized to include:

- A brief description of the developmental needs and interests of students
- Specific age level outcomes under each major outcome area (Human Behavior, Scientific Facts, Consequences, Prevention, Alternatives, Decision Making)
- Content statements related to each specific age level outcome
- Classroom activities matched with each specific age level outcome
- Additional teacher and student resources are listed on the last page of each age level section.

Classroom teachers should read through the scope and sequence chart and their age level sections of this chapter. Teachers will note that it is impractical for one classroom teacher or subject area to be responsible for completely developing all of the student outcomes. In order to accomplish the student outcomes, several teachers must plan together with due consideration of their teaching strengths and the developmental needs of their students. Consideration should also be given to vertical articulation between age levels. (Levels I and II, Levels II and III, etc.)

The instructional framework is also an attempt to address the needs of the individual teacher. It is the classroom teacher who must decide what content, activities, and methods are appropriate for meeting the developmental needs and interests of his/her students. The students' interests and developmental needs should serve as the guide for setting objectives for learners and the selection of learning experiences.

Level 1

Grades K-3

Grades K–3. In these grades the emphasis should be on maintaining good health. Children should be taught respect for medicines and other potentially dangerous substances. Children need to know about common medicines and how they are used. Children should know the difference between candy and sugarcoated vitamins or aspirin. Children should learn that drugs used under a doctor's prescription or for a definite illness are proper and beneficial. The concept that unknown substances might produce psychological or physiological harm should be developed. These unknown substances include another person's medicine or pills or substances offered by friends or found somewhere.

The primary developmental task during this period is learning to deal with others socially and cooperatively. Concerns of the student fall primarily into feelings about self, one's skills, and one's ability to get along with others. The teacher can build on the student's beginning acceptance of him/herself as a person in his/her own right with unique talents and worthwhile skills. The teacher should help students develop understandings of why people do what they do, how to set personal goals, and why respect for rules and laws is important.

Teachers should discuss healthy ways to handle stress and upset feelings through work, play, and talking with others. Children should learn constructive alternatives for handling anger, fear, frustration, anxiety, loneliness, jealousy, and prejudice.

Children can begin to understand problem solving and decision making as dynamic processes. The negative concepts of running away, denying that problems exist, or avoiding problems should be discussed. Authority figures such as parents, teachers, and police officers should be presented as potential "helping" people.

Through the four year span, children should learn that what they do does affect others and is of concern to others. Children should also learn that there is always more than one choice available, that each choice has its advantages/disadvantages in terms of positive or negative consequences. Each child should know that he/she must be ready to accept the consequences when he/she has made a decision.

MAJOR OUTCOME A: STUDENT WILL UNDERSTAND THE BASIC FACTORS IN HUMAN BEHAVIOR RELATED TO SUBSTANCE USE: PSYCHOLOGICAL, PHYSIOLOGICAL, SOCIOLOGICAL. (HUMAN BEHAVIOR)

CONTENT	ACTIVITIES
Specific Outcome: 1. List five need areas all people share (physical, social, intellectual, emotional, and spiritual).	
1. People depend on each other to provide basic needs for food and shelter, care, love, friendship, learning, and activity. Human behavior reflects the nature of their needs. All people have the same types of needs. As people mature they learn more complex and efficient ways of achieving their goals or satisfying their needs.	1A. Students collect pictures of people engaged in pleasurable activities. Discuss how the activity might be satisfying some need(s) and why people seem to be enjoying the activity. B. Ask students to draw stick figures which illustrate their methods of satisfying needs in each of the five need areas. Ask them to label the stick figure pictures, and invite them to share the pictures and meanings with classmates.

CONTENT	ACTIVITIES

Specific Outcome: 2. Describe one's feelings about self and how these feelings affect one's behavior.

2. Everyone has feelings which will need to be resolved.

Fear, worry, anger, sadness, happiness, and love are natural feelings.

Children can become more aware of their feelings so that they may cope successfully with different emotions.

Children need to (and can learn to) cope with anger in social situations.

Children can learn positive ways of coping with fears of failure or rejection.

How the individual sees himself/herself is the basis for healthy mental growth and development.

Everyone can be proud of something; you need not be "best" to feel proud.

Feelings about self change frequently; an individual can take steps to change negative feelings about self.

2A. Students will identify the most common feelings people might have (happiness, anger, sadness, hurt, etc.). Draw faces showing these feelings and label the pictures with common "feeling words."

B. Have students dramatize:

- Why I'm afraid to go to the doctor or dentist.
- Pretend that you are a new student in school. What do you feel and why? What actions do you take to make you feel more comfortable?
- Someone crowding in front of you on the bus or at the drinking fountain.
- Your mother blamed you for doing something that your little brother/sister did.

2C. Completing unfinished sentences about various moods or states of mind:

- When I am happy I like to
- I am sad when my friends
- When I am angry I
- When I want to be happy I
- Being alone is
- I am proud that I

D. **"How Did I Do Today"** – Each child prepares an individual log noting listening, reading, friendliness, meeting personal goals, giving compliments, cooperation at play, etc. Each child responds to each activity on the list by checking a symbol of happy face, blank face, or sad face. Students can share their "proud of" responses with a classmate or the whole class.

E. **Last Week's Good Feelings.** Ask each child to make a list of things that made him/her feel good last week. Then have each child think of ways he/she can act to produce similar good feelings this week.

Last Week's Bad Feelings. Ask each child to list the things that made him/her feel bad last week. Ask each student to select two items from this list and to think of ways that he/she could prevent the bad feelings from happening again.

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CONTENT	ACTIVITIES

Specific Outcome: 3. Describe how the actions of other people affect one's feelings.

3. People communicate feelings to others verbally and/or non-verbally.

   People often misunderstand what you say to them verbally and non-verbally.

   People can learn to understand and accept differences in others.

   Humans need affection and acceptance from others.

3A. List words/phrases on the board and ask students to act out these expressions without talking. Ask students to keep score (How many words/phrases did I interpret correctly?) Samples include:

Goodbye	Come here	Good for you
Hello	I'm sad	That's neat
I don't know	I'm happy	Be quiet
Yes	I don't care	You're the one
Okay	That stinks	Listen
Hooray	We won	Please
	I understand	

Discuss what happens if you misinterpret what someone communicated to you.

B. Through discussion, the class develops a list of appreciation phrases they hear or use in daily routines. This list might include: "Thank You," "Congratulations," "Nice going," "That's neat," or "Wow, you did a good job." The list is posted on a bulletin board or a wall for students to see.

The phrases are written on slips of paper and placed in an "Appreciation Box" which will be used in a role playing activity. The children are divided into pairs and each pair draws one slip of paper. The pair then plans a skit that illustrates feelings that might be associated with the phrase. The skits are presented to the class and discussed by the class.

CONTENT	ACTIVITIES

Specific Outcome: 4. Describe how belonging to a group affects one's feelings and behavior.

4. People learn from others through imitation, advice, experience.

   Children can learn to enter social groups easily and to participate in them constructively.

   Considering other people's perspectives will help one to get along with others.

   Positive approaches to social situations usually pays off in positive relationships and can improve the way things get accomplished.

   Children are members of family groups; family members perform different roles.

   Families communicate likes and dislikes, goals and aspirations, problems, and expectations of one another.

4A. Ask students to name types of groups to which they belong. For each group named, ask students to give their ideas concerning the reasons for the group's existence and how the group expects members to behave.

B. Dramatize ways of being friendly, of making others feel comfortable at school.

- To a new pupil
- To a person who has been teased about being fat, skinny, wearing glasses, an unskilled ballplayer, etc.
- To being left out of a peer group

C. Dramatize children's roles in the family (e.g. parent and child purchasing new clothes, parent and child repairing things at home, family activities during holidays, sibling cooperation). Discuss how these roles might influence a child's attitudes and behaviors.

MAJOR OUTCOME B: STUDENT WILL KNOW IMPARTIAL SCIENTIFIC FACTS ABOUT ALCOHOL AND OTHER DRUGS. (SCIENTIFIC FACTS)

CONTENT	ACTIVITIES
Specific Outcome: 1. Explain the purpose of medicines.	
1. Medicines are of benefit when they: Prevent infection Relieve pain Assist the body to correct itself	1A. Brainstorm reasons for using medicines. List them on the board. Ask students to tell about medicines they may have taken and why they were prescribed. Cluster the reasons and medicines according to the classes presented in the **content** column.

CONTENT	ACTIVITIES
Specific Outcome: 2. Describe the role of parents, pharmacists, and other health professionals in dispensing medicines.	
2. Parents and health professionals are responsible for prescribing and administering medicines. Nurses, dentists, and doctors are health professionals. Medicines should be administered to young children by a responsible adult who understands the directions for use, proper dosage, and special health characteristics of the child.	2A. Students and teachers prepare two lists, health workers or agencies and health needs. Using a poster, worksheet, matching, board, etc., match the need to the work. B. List the following people and ask students which they would allow to give them medicine? Candy? Help? Strangers, Parents, Friends Doctor, Nurse, Dentist Teacher, Principal

CONTENT	ACTIVITIES
Specific Outcome: 3. List home and school rules for using medicines, poisons, and other substances.	
3. Home and school rules about medicines, poisons, and other substances are designed to protect children from harm. Sample rules: – Medicines and drugs found in the medicine cabinet should be controlled by parents. – Children should take medicine only at the direction of a parent or responsible adult such as a health professional. – Children should not take medicine alone. – The directions on the containers of any medicine tells how it should be used; these directions should be followed exactly. – It is important to follow the doctor's directions about taking medicines. – Family members should not share medicine with others in the family unless so directed.	3A. Students discuss ways of preventing small children from accidentally poisoning themselves on medicines and household products. B. Students and teachers generate a list of school rules about the use of medicines, poisons, and other substances.

CONTENT	ACTIVITIES
Specific Outcome: 4. Identify harmful household products (substances).	
4. A poison is any agent which if introduced into an organism may chemically produce an injurious or deadly effect. Many medicines, if taken in excessive amounts, are poisonous (toxic) in their effects. Many natural, chemical, or synthetic substances are potentially poisonous as they are harmful when misused. All dangerous substances should be kept in their original containers to guarantee proper labeling and retain the directions for use, warnings, and antidotes.	4A. Teacher prepares a bulletin board of symbols or words or warning labels. Each student should be able to read and interpret these symbols. Students should be able to relate the symbols of the skull and crossbone and RX to possible harmful effects. B. Things Safe and Unsafe to Eat. Display common household products such as nail polish, aspirin, Drano, turpentine, cough medicine, etc., and have children classify them as: – Items safe for me to eat – Items **not** safe for me to eat – Items safe to eat **only** when given to me by a qualified adult

MAJOR OUTCOME C: STUDENT WILL KNOW THE PROBABLE CONSEQUENCES OF ANY ALCOHOL AND DRUG USE TO THE INDIVIDUAL, TO THE FAMILY, AND TO THE COMMUNITY. (CONSEQUENCES)

CONTENT	ACTIVITIES
Specific Outcome: 1. Give examples of how misuse of medicines or household substances will very likely result in physical harm.	
1. Refer to information about poisons contained in other reference. There are many dangers arising from the misuse of medicines: – An overdose of any medicine or drug can be toxic causing illness or death from poisoning, burning, or distorted functioning of body systems, especially the nervous system. – Use of someone else's medicine, use without following directions, improper administration of a drug, and ingestion of an unknown substance can also be toxic to an individual who proves allergic to the substance or whose body chemistry cannot tolerate the substance. – In case of misuse of a medicine or drug, a physician should be contacted immediately.	1A. Students and teacher list the consequences of using some common household products incorrectly. Ask pupils to suggest responses to accidental poisoning (e.g. What should you do?, Whom should you tell?, When should you call?, What should you do with the container?). B. Pupils describe situations. "What can happen if you. . ." – Ignore the labels on a medicine bottle? – Use someone else's medicine? – Take more medicine than you should? – Use old medicines? – Use medicines for the wrong purpose? – Use an unknown medicine (one whose source and purpose are unknown)? Ask pupils: Who can give you help if you misuse medicines? What should you do? Whom should you tell? Whom should you call?

MAJOR OUTCOME D: STUDENT WILL KNOW THAT THE INDIVIDUAL, HIS OR HER FAMILY, AND THE COMMUNITY HAVE INTERRELATED RESPONSIBILITIES FOR THE PREVENTION OF ALCOHOL AND DRUG ABUSE. PREVENTION

CONTENT	ACTIVITIES
Specific Outcome: 1. Describe the ways rules, regulations, and laws help protect one's health and safety; particularly those related to medicines and poisons.	
1. Rules and regulations about medicines, poisons, and other substances are designed to protect our health and safety. The Federal Food and Drug Administration carries out laws intended to insure that foods, drugs, and cosmetics are safe, pure, sanitary, and honestly packaged and labeled. State laws closely follow Federal laws and regulate the production, sale, and distribution of foods, drugs, and alcohol. Rules and regulations about medicines are designed to: – Identify the people who are responsible for giving medicines – Ensure the correct medicine for an illness – Ensure the proper dosage – Ensure the proper frequency of use – Ensure that the medicine is of a high quality	1A. Use a voting list asking students "How many of you ever. . ." – Got help from a police officer, fire fighters, teacher? – Talked to a stranger – man, woman, older students? – Took food from a strange person? – Used medicine (aspirin, cold tablets, etc.) without your parents knowing? – Others When the list is finished allow students to ask the teacher questions or make comments. Note the particularly dangerous behavior(s) reported by the students during the voting list. Discuss the dangerous and safe behaviors in relationship to home and school rules. B. Ask students to survey their parents concerning the rule: We must ask a qualified adult whether something is safe to eat or drink. Ask the parents and students to generate a list of "qualified adults" and what substances they are qualified to give to children. Discuss the lists and the reasons for discrepancies.

CONTENT	ACTIVITIES
Specific Outcome: 2. Identify and respect persons who help protect and maintain one's health and safety.	
2. Community workers, such as police officers, health professionals, and fire fighters, help maintain community health and safety.	2A. Ask students to survey their parents and older siblings about the ways police officers, health professionals, fire fighters, doctors, nurses, and pharmacists help maintain the health and safety of children. Discuss each adult's role(s) in providing preventive measures and during health emergencies.

CONTENT	ACTIVITIES

Specific Outcome: 3. Identify dangerous situations involving medicines and poisons and appropriate responses to the situations.

3. There are safe and appropriate ways to behave with medicines and poisons.

   Children can determine instances where people are being responsible in their use of medicines and household products.

3A. Teacher and students identify characteristics of responsible and irresponsible behavior in situations involving medicines and household products. These characteristics are listed on opposite ends of the blackboard (e.g. responsible on far left – irresponsible on far right). Several students are asked to indicate how they would behave. Each child demonstrates his/her rating by moving to some place along the continuum line. Allow students to explain their reasons for assuming their positions.

Sample situational statements:

A. You have a bad cough and your friend offers you a cough drop – you accept it.
B. You are home alone. You see a bottle of children's aspirin. You eat some because they taste good.
C. You are in the bathroom alone. You see some pills on the shelf that look like "M & M" candy. You eat them.
D. A friend at school has some medicine the doctor gave him/her for his/her stomachache. Your friend offers you some and you take it.
E. You have been sick. Your doctor has prescribed some medicine for you. You can't stand the taste of it, so you refuse to take it. Ask students to suggest safe alternate behaviors to each of the situations.

MAJOR OUTCOME E: STUDENT WILL KNOW PERSONALLY RELEVANT AND SATISFYING ALTERNATIVE BEHAVIORS TO ALCOHOL AND DRUG ABUSE. (ALTERNATIVES)

CONTENT	ACTIVITIES

Specific Outcome: 1. Identify ways in which people behave in order to meet their needs.

1. People have needs which they attempt to satisfy.

   There are five dimensions of interrelated human needs.[1]

   Physical

   1. To sleep, rest, and exercise
   2. To grow and develop
   3. To be healthy

   Intellectual

   1. To think about, learn about, and master a wide range of subjects
   2. To collect, store, and use information
   3. To develop communication skills

   Social

   1. To interact with others
   2. To make friends
   3. To establish meaningful relationships

   Emotional

   1. To express feelings such as happiness, excitement, and joy
   2. To express feelings such as anger, aggression, depression
   3. To give and receive love
   4. To maintain self-esteem

   Spiritual

   1. To enjoy beauty
   2. To develop a coherent and workable set of values
   3. To relate oneself to broad human issues and values.

   People choose several different ways to satisfy their needs.

1A. Teacher defines and discusses the term, "Need." Demonstrate the five dimensions of human needs by using examples.

   Use questions such as the following to help students classify needs and how they are met:

   1. Why do you come to school? (to learn, to think, to play, to be with my friends, because my parents want me to)
   2. How do you feel when it is raining on Saturday? (angry, mad, upset, sleepy, depressed, happy, peaceful)
   3. How do you feel when it is a beautiful day and you are going on a picnic? (joyful, thankful, excited, exhilarated, hungry, lazy)
   4. How do you feel when someone gives you a real compliment? (happy, warm, peaceful, doubtful)
   5. How do you feel when you have told the truth when a lie might have made things easier for you at that time? (happy, proud, scared, peaceful, relieved, worried)

B. Ask students to list ten of their favorite activities (behaviors that make them feel good). For each of the ten activities, ask them to identify the need dimension(s) being satisfied and whether they do the activity by themselves or with others.

1. *Alcohol Use and Traffic Safety, Vol. II.* (Baltimore, Maryland, Maryland Department of Education, 1974), p. 2.

CONTENT	ACTIVITIES
Specific Outcome: 2. Identify appropriate responses to feelings.	
2. Appropriate responses to feelings bring satisfaction to the person and are acceptable to those around him/her; inappropriate responses to feelings leave the person dissatisfied and create uncomfortableness with others. The appropriateness of one's responses to feelings is defined according to the interaction of three factors: – Personality of individual – Small group processes – Societal norms and customs	2A. Use the following questions to initiate student discussion about ways others help you deal with your feelings: – What has someone said or done lately to make you feel good about yourself? – What have you said or done recently to make someone else feel good about him/herself? – Have you said or done something recently to make someone feel bad about him/herself? – What makes you feel good about yourself? – Are you proud of something you have done? – Do you think it is more important to do something to impress someone or to do something so that you feel good about yourself? B. Role play various ways people react to their feelings of hate, fear, love, anger, depression, exhilaration.

CONTENT	ACTIVITIES
Specific Outcome: 3. Identify an adult he/she can talk with.	
3. Many adults will be helpers/listeners for children. Adults and children have many of the same needs.	3A. Ask students to identify adult sources that are readily available to them. Each child should identify his/her source(s) within the following groups: Friends, parents, relatives, teachers, neighbors, and possibly church. From this list ask students to choose two people they can talk to about a personal problem. Ask students to identify some situations when it would be wise to talk to someone. B. Review the five need dimensions. Identify ways adults and children satisfy their common needs. Ask students "Who helps adults meet their needs?" and "How do children help adults meet their needs?" and vice versa.

CONTENT	ACTIVITIES
Specific Outcome: 4. Recognize personal interests.	
4. People vary in their personal interests. Some interests we share in common with others, but there are many interests that are unique to individuals. A person's unique interest does not mean that the person is unacceptable or less worthwhile to know. All people have some types of mental, physical, and creative abilities.	4A. Listen to the song, *"These Are A Few Of My Favorite Things."* Allow students to take turns naming things that make them feel good and explain why they feel this way. B. Ask children to rank these groups of interests in order of their preference and to share the reasons with a small group of classmates. Examples: Cheeseburgers / Television / Bike riding Family picnics / Birthday party / Skating Fancy restaurant / Playing ball / Listening to music C. Students and teacher discuss different types of mental, physical, and creative abilities. Each student constructs "Me" buttons using scraps of various types of materials such as construction paper, tissue paper, string, and fabrics. Each button should be unique since the student represents his/her abilities. The students will then share with others the significance of their "Me" buttons.

MAJOR OUTCOME F: STUDENT WILL BE ABLE TO EMPLOY DECISION MAKING SKILLS TO MAKE RESPONSIBLE DECISIONS RELATIVE TO PERSONAL ALCOHOL AND DRUG USE OR NON-USE. (DECISION MAKING)

CONTENT	ACTIVITIES

Specific Outcome: 1. Demonstrate the use of a problem solving process.

1. Children attempt to solve several personal issues or problems each day.

   Children can learn some problem solving skills.

   One problem solving process includes:

   (1) Define the problem
   (2) Gather pertinent data
   (3) Look at possible choices
   (4) Examine own values, interests, and needs in relation to choices
   (5) Consider short- and long-term effects of various choices
   (6) Rank the choices in order of preference and arrive at a decision
   (7) Follow through on the decision
   (8) Evaluate the effects of the action taken

1A. **What Would You Do?** Ask the students to suggest a common problem, one they might have at home or school with peers or siblings. Ask a group of students to role play the problem and its resolution. Discuss how the role players and class feel about the solution. Compare the role play to the problem solving process. What elements were present? What elements were missing?

CONTINUED

2 OF 7

CONTENT	ACTIVITIES

Specific Outcome: 2. Identify a safe behavior in situations which involve medicines and poisons.

2. Children should feel safe even when encountering strangers in controlled environments such as at home or in school.

Children should learn to feel safe with professionals such as doctors, police officers, etc.

Children should learn to avoid contact with strangers in public places, on the street, in stores. in buses and trains, etc.

Children are faced daily with situations in which they must choose a safe behavior.

Children do not often consider alternative behaviors or the consequences of their choices.

2A. Students identify choices that they have made during the day which were safe/unsafe. For example: crossing the street, playing "chase" or wrestling while waiting for the bus, riding their bicycles on the street, etc. Ask them what other actions they could have taken and what the likely consequences of each alternative choice might be.

B. **You Decide: Open Ended Stories**

"The Stranger"

You are walking home from school alone, and a car stops near you. You do not know the man who is driving the car, but he smiles and asks you if you want a ride. He says he knows where you live because he has seen you playing in the neighborhood. He says, "Get in. I'll give you a ride."

Questions for students:

- What would you do?
- Are there some family/school rules that apply?
- What else might you do?
- Is the risk of possible harm to yourself a factor in your decision?

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Level I
Selected Resources

Books & Booklets

Fauscher, Jane. *One Little Girl.* New York: Behavioral Pub. Laurie is a little girl who does some things fast and some things slow. The story is about her feelings when she was called "slow child" and how the problem was resolved. (Outcome No. A)

Poison Prevention in Kindergartens and Primary Grades. U.S. Department of Health, Education and Welfare. Washington, D.C.: Public Health Service Publication No. 1381, 1965.

Simon, Sidney. *I Am Loveable & Capable.* A story of being put down and how our behaviors affect others. (Outcome No. A)

_____ *Super Me, Super You.* National Coordinating Co., Washington, D. C. (Outcome No. A)

Other

First Things. Guidance Associates, Pleasantville, N.Y.: Filmstrips presenting moral dilemmas.

Values Corner Kit. Wayne Paulson. Minneapolis: Winston Press, 1976, (Outcome No. E)

Level II

Grades 4-6

Level II: Developmental Needs and Interests

Grades 4--6. Students in this developmental level are becoming aware of their increased responsibility for their own behavior and for the decision governing their personal alcohol and drug use that they will make in the near future. Students need to learn the various non-medical roles substances (alcohol and drugs) have in our society. The potential hazards of alcohol and drugs to body systems and overall health should be presented.

Concepts presented in earlier grades about mental health and life coping processes should be further developed. These concepts include how emotions affect behavior, the interactions between feelings and thought processes, the relationship between emotions and body condition, and the effects of self-image on reactions to criticism, praise or prejudice. Discussions and experiential learnings should be planned to develop the topics of problem solving, decision making, understanding behavior, expressing feelings honestly and constructively, active listening, and group belonging and acceptance.

Other sources of information (peers, television, older siblings) begin to challenge parents as sole authority. The sources are often not consistent in the behaviors they encourage. The child will need to learn skills for successfully dealing with disapproval and rejections from significant others.

Motives for not using and using alcohol and drugs should be discussed. Children need to become familiar with the concepts of drug/alcohol dependence, drug/alcohol abuse, and the prevention of substance abuse.

MAJOR OUTCOME A: STUDENT WILL UNDERSTAND THE BASIC FACTORS IN HUMAN BEHAVIOR RELATED TO SUBSTANCE USE: PSYCHOLOGICAL, PHYSIOLOGICAL, SOCIOLOGICAL. (HUMAN BEHAVIOR)

CONTENT	ACTIVITIES

Specific Outcome: 1. Identify ways in which people attempt to meet their needs by using substances.

1. People seldom associate their use of alcohol and other drugs with their needs.

   Medicinal substances are generally used to heal injuries, cure or prevent diseases, or to eliminate the symptoms of disease (meet physical needs).

   Needs that are met by the use of alcohol and other drugs may be satisfied by the use of alternative practices and products.

   The use of substances has been associated with meeting the following needs:

   Physical
   - To ease physical discomfort and pain
   - To relieve tension and anxiety
   - To satisfy thirst
   - To stimulate or depress appetite

   Intellectual
   - To satisfy curiosity
   - To overcome inhibitions to creativity
   - To avoid making decisions

   Social
   - To lessen constraint among strangers
   - To celebrate a warm environment
   - To create a warm environment
   - To comply with others' standards
   - To improve business relations

1A. Students answer questions designed to determine their attitudes toward the reasons people give for drinking and abstaining.

Which, if any, of the following are good reasons for drinking alcohol in **moderation?** You may circle more than one.

escape problems	feel grown-up
relieve nervousness	pressure from friends
tradition	to relax
get "high"	to be sociable
like the taste	religious ceremonies
to celebrate	to go against beliefs of parents
fun	

Discuss: Are any of the reasons mentioned above related to the five dimensions of human needs? What needs are related to the reasons people give for abstaining from using alcoholic beverages? Are there non-alcoholic methods of satisfying the needs? Why do some people reject alternatives to drinking?

B. Students discuss the following list of reasons presented by drug users for their use of drugs:

- Mental stress from personal, social, family problems
- The appeal of drug effects ("a chemical cure for every ailment")
- Peer group pressure
- Boredom
- Loneliness
- Involvement in drug life styles (conforming behavior)
- Inability of people to (cope) deal with personal problems or social interaction
- A low level of self-esteem

Discuss these reasons as they relate to the five dimensions of human needs. Are there non-drug behaviors which can satisfy the needs? Why do some people reject alternatives to using drugs?

(CONTINUED ON NEXT PAGE)

CONTENT	ACTIVITIES

Emotional
- To reduce loneliness
- To overcome shyness
- To overcome personal disappointment
- To overcome feelings of inferiority
- To cope with anger and frustration
- To rebel against authority
- To gain peer status
- To escape from unpleasant situations
- To enhance pleasant feelings
- To release inhibitions

Spiritual
- To participate in religious rituals
- To celebrate special events
- To try out another life style

CONTENT	ACTIVITIES

Specific Outcome: 2. Identify differences in family practices in the use of alcohol and other drugs.

2. Family and community practices in the use of alcohol and other drugs are based on religious customs, cultural beliefs, family rules, and the family's perception of the social norm.

   Families communicate attitudes and values toward substances to their children.

2A. Students should be informed about survey techniques. Each student is instructed to arrange short interviews with adults in two neighborhood families. Instruct students to not name the people they interviewed. Questions should reflect the following issues:

- What types of alcohol are consumed and when?
- Who is permitted to drink in the family? Why? Where?
- Are there any family rules about drinking?
- What age is reasonable for young people to begin drinking? Why?

Each student returns his/her survey data to the teacher who tabulates the data for each issue. The teacher presents a summary of the class survey. Class discussion should focus on the reasons for differences in family practices.

B. Other research activities might be:

- Interview adults who lived during Prohibition
- Polling people on ethnic attitudes toward alcohol
- Researching attitudes of religious denominations toward alcohol and other drugs
- Attitudes of people from other countries

CONTENT	ACTIVITIES

Specific Outcome: 3. Identify ways that peers might influence one's choice of substance use or non-use.

3. Acceptance is a basic human need. People sometimes do things their peers suggest in order to be accepted and/or recognized.

Peer groups can exert positive or negative influences on their members.

Peers can influence decisions to use or not use substances by using one or more of the following forms of control:

(1) Group norms
(2) Invoking feelings of guilt/shame
(3) Criticism/ridicule
(4) Ostracism
(5) Isolation

There are some personal characteristics which generally help people develop friendship (e.g. respect for others, being helpful, personal sharing, generosity, showing concern, accepting others).

3A. Small group discussion:

- What is a peer? Peer Influence?
- Can you think of a time when you were influenced by your peers to do something?
- Have you ever been persuaded to do something you knew was wrong?
- Do you have beliefs so strong that you would not do as your peers did?
- Have you ever called anyone a name to persuade them to do something?

3B. Small group discussion:

- What is a friend?
- What do you do with your friends that you would not do with others?
- How does it feel to have a friend?
- When might you not want friends?

Discuss with the class how friendships can involve both positive and negative peer influence.

CONTENT	ACTIVITIES
Specific Outcome: 4. Describe advertising techniques used to promote the consumption of alcohol and other drugs.	
4. Advertising attempts to persuade people to buy a product. Advertising techniques include portrayals of a product as meeting some human need(s).	4A. Students and teacher survey Saturday morning television programs for children. In surveying the commercials, identify the products and the need or feeling that the commercials attempt to portray. In class decide if the claims for a product's capacity to satisfy a need or produce a feeling are probable or not. B. List familiar commercials on TV pertaining to medicine/drug products. Have children point out the "make believe" ideas or feelings portrayed (e.g. stomach bug in Pepto-Bismol, hammers in head for Anacin, No. 4607 type headache, etc.) Have children discuss what the different commercials encourage the TV viewer to think and to do. Is this persuasion good or bad? Have children explain their answers.

MAJOR OUTCOME B: STUDENT WILL KNOW IMPARTIAL SCIENTIFIC FACTS ABOUT ALCOHOL AND OTHER DRUGS. (SCIENTIFIC FACTS)

CONTENT	ACTIVITIES

Specific Outcome: 1. Describe the effects of alcohol and commonly misused drugs on body systems.

1. A **drug** is any biologically active agent which when inhaled, ingested, or injected alters the physical or psychological functioning of the individual.

   Any substance which enters the body or comes in contact with it has multiple effects on the body.

   Any substance which can change the physical or psychological processes of the human organism is potentially harmful.

   A specific drug or alcohol can affect individuals in different ways and one person in different ways at different times.

   The amount you take, or variations in dosage, can influence the nature and magnitude of the substance's effect.

   Drugs and alcohol have multiple effects on body systems and the inter-related functions of these systems.

1A. Distribute diagrams of the internal view of the human body. Students trace the passage of alcohol through the body, indicating important points along the way where it can affect organs such as the liver, heart, stomach, brain. Include a discussion of possible short-term and long-term effects of alcohol on the body organs.

B. Using the same diagram of the human body, trace the passage and effects of a common household poison, coffee, sleeping pills, and aspirin.

Discussion questions for activities A and B:

- How do substances get into the body?
- How do substances get to body systems?
- Why do substances affect certain parts of the body more than others?
- How do substances affect the brain, nervous system, heart, blood, and perceptions?
- How does the body get rid of substances?

CONTENT	ACTIVITIES

Specific Outcome: 2. Give examples of substances classified as stimulants, depressants, hallucinogens, narcotics, and volatile substances.

2. Substances may be classified as stimulants, depressants, hallucinogens, narcotics, and volatile substances.

   - Stimulant drugs (i.e. caffeine, nicotine, amphetamines)
   - Depressant drugs (i.e. alcohol, barbiturates, tranquilizers) slow down the work of the central nervous system.
   - Alcohol (ethanol) is a depressant drug.
   - Hallucinogens (i.e. LSD, mescaline, peyote) are mind-distorting agents. They distort the messages of sight, sound, taste, smell, and touch.
   - Narcotics (i.e. codeine, morphine, heroin) are strong pain relieving agents. Narcotics also include some synthetic chemicals that have a morphine-like action, such as methadone.
   - Volatile substances (i.e. airplane glue, paint thinners, and nitrous oxide) contain chemicals such as toulene, acetone, naptha, and ethyl ketone, which are poisonous when taken by mouth. The psychological effects from inhaling the vapors are similar to those of barbiturates and alcohol. Inhaling the vapors of these substances can cause severe harm to the abuser.
   - Marijuana should be classified separately since it does not fit existing classification methods.
   - Mind-altering drugs (psychoactive) are inclusive of all the substances classified above since the substances primarily affect the central nervous system.

2A. Divide class into five working groups. Each group will prepare a definition for one of the categories of substances (stimulants, depressants, narcotics, hallucinogens, volatile substances) and write it as a heading on large pieces of paper. The whole class can participate in listing substances on the appropriate sheet.

Discussion questions related to each substance on the class chart might include:

(a) Origin of the substance (i.e., from plants, synthetic; derived from another drug)
(b) Description of the substance in its original form
(c) Form(s) in which the substance is sold
(d) Medical use, if any
(e) Effects on the mind and body systems
(f) Some slang terms commonly associated with the substance

CONTENT	ACTIVITIES

Specific Outcome: 3. Explain medical uses of commonly used drugs.

3. Medicines are drugs which are specifically developed to cure disease, prevent disease, or reduce their symptoms.

   Medicines and drugs include:

   (1) Vitamins and minerals for disease (mainly nutritional) prevention.
   (2) Vaccinations and immunizations for prevention of specific diseases.
   (3) Antibiotics for disease and infection control.
   (4) Chemical preparations for disease and infection control.
   (5) Stimulants and depressants for control of nervous function.
   (6) Preparations which reduce pain, also by control of nervous function.
   (7) Substances which help regulate body systems/functions.

3A. Students are asked to list various types of drugs such as patent medicines, narcotics, antibiotics, anesthetics, antiseptics, barbiturates, stimulants, and tranquilizers. Students match the type of medicine with its function in: physical fitness, malnutrition, respiratory disease, metabolic disorders, emotional difficulties, mental acuity, mental illness, treating injuries, treating infections. Discuss potential dangers of prescribing your own medicines and using a drug for other than its intended purpose.

CONTENT	ACTIVITIES
Specific Outcome: 4. Give examples of the role that drugs played in improving the quality of health.	
4. Drugs are beneficial to people when the drugs: prevent infection, prevent premature death, prevent epidemics, decrease infant and maternal mortality rates, ease pain and suffering, aid in surgery, control chronic diseases and disorders.	4A. Suggest student reports on "health heroes" who made medical discoveries which helped to reduce the impact of human diseases. For example, health heroes such as Alexander Fleming (penicillin), Edward Jenner (small pox vaccine), Jonas Salk (poliomyelitis vaccine), and Louis Pastuer (rabies innoculations) developed medicines that dramatically changed the incidence and impact of major diseases. B. Discuss the term antibiotic. Have selected students research and report to the class their findings on streptomycin, auromycin, penicillin, and neomycin. In their reports have them consider: origin of antibiotics, medical use, affect on mortality rates for certain diseases, and effects of the antibiotic on the body and mind (including perhaps the adverse side effects and tendencies to build drug sensitivity).

CONTENT	ACTIVITIES

Specific Outcome: 5. Describe the differences between the terms: a) substance use and abuse and b) prescription and non-prescription drugs.

5. People have many different understandings for words like alcoholic, drugs, prevention, abuse, responsibility.

Substance use refers to the consumption of any quantity of a substance for any purpose.

Substance abuse is variously defined as: (a) the use by self-administration of any substance in a manner that deviates from the accepted social and medical practices within a given community or society; (b) the habitual use by self-administration of any substance to the extent it interferes with the psychological, physical, vocational, or social functioning of the individual.

Drug use under medical prescription may be beneficial for many individuals.

Prescription drugs are made according to the doctor's directions and are prepared by a pharmacist. Medicines which can be purchased without a prescription are called non-prescription drugs.

Drugs can be misused or abused when someone:

- Uses medicine prescribed for someone else
- Takes more than the prescribed or recommended amount
- Does not follow the prescribed or recommended time table
- Uses non-prescription drugs unwisely
- Takes drugs for kicks

With continuous substance use, the individual might become dependent on the drug or alcohol without being conscious of the effect.

5A. Point out the need for the class to have common understanding of terms in order to discuss them.

A. Have students write descriptions of two fictitious people, one of whom they feel is an alcoholic, the second a social drinker. Students in small groups are instructed to:

- Read each other's papers.
- Look for agreement in the description of an alcoholic or a social drinker.
- Arrive at a common definition of words such as abstinence, use, misuse and abuse.

B. Teacher ask class what kind of medicines they are familiar with; i.e., names of medicines they have taken when they were sick, or have seen in their medicine cabinet, or have heard mentioned. Using the list, classify the substances as prescription or non-prescription; their beneficial uses and harmful uses; and what constitutes responsible/irresponsible use.

Classroom discussion questions:

(1) What are the differences between these medicines?
(2) Why are prescriptions necessary?
(3) Does it matter **who** takes the medicine? Why?
(4) Does it matter how much of the medicine is taken? Why?
(5) Under what conditions might a person take the wrong medicine?

CONTENT	ACTIVITIES
Specific Outcome: 6. Define the term alcoholism.	
6. An alcoholic is a person who is an excessive drinker. The person's dependence on alcohol has reached such a degree that it noticeably disturbs or interferes with his/her physical or mental health, interpersonal relations, and his/her satisfactory social and economic functioning. These personal and social characteristics describe alcoholism.	6A. The class should review their definitions of alcohol use, misuse and abuse, and the term abstinence. Present the definition of an alcoholic reported in the content statements. Would the class want to modify this definition? B. Class discussion: What should my attitude be toward alcoholism? (a) alcoholics are sick (b) alcoholics can be helped (c) alcoholics need greater public assistance and support (d) alcoholism can be prevented

CONTENT	ACTIVITIES

Specific Outcome: 7. Explain the statement that alcohol is the major drug of abuse in the United States.

7. Alcohol use and abuse is the number one drug problem in the United States and our third major health problem.

   Alcohol use and abuse collectively costs the nation and each state several hundred million dollars each year.

7A. Divide the class into five study groups. Each group should gather information relative to one of the following topics and present the information to the class:

   (1) Costs to Iowans of treating alcoholics
   (2) Automobile accidents that are alcohol-related
   (3) Persons in jail as a result of alcohol-related crimes
   (4) Tax revenues and sales volume for alcoholic beverages in Iowa
   (5) Alcoholism or problem drinking as a factor in divorce
   Optional (6) Alcoholism or alcohol abuse as a factor in child abuse or child neglect

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CONTENT	ACTIVITIES
Specific Outcome: 8. Describe antidotes and emergency procedures to counteract the toxic effects of ingested poisons in household products and aspirin.	
8. Many children die or become very ill each year from accidental overdoses of aspirin, medicines, and non-prescription drugs. Many children die or are physically harmed from accidental ingestion of household products. Some conditions under which a person might take the wrong medicine include: (a) Not reading the label (b) Taking medicines in the dark (c) Accepting substances from strangers (d) Using another person's medicine (e) Taking medicine from an unlabeled bottle The Food and Drug Administration requires that antidotes be described on labels of poisonous subtances.	8A. Explain the concept of antidotes and describe first aid procedures to follow in cases of accidental poisoning and overdose. B. Dramatize a situation in which a four-year-old brother or sister has accidentally ingested aspirin, prescription drugs, or non-prescription drugs. Emphasize procedures to follow in getting help (i.e., call the police department or rescue squad, read the label, determine how much ingested, etc.)

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MAJOR OUTCOME C: STUDENT WILL KNOW THE PROBABLE CONSEQUENCES OF ANY ALCOHOL AND DRUG USE TO THE INDIVIDUAL, TO THE FAMILY, AND TO THE COMMUNITY. (CONSEQUENCES)

CONTENT	ACTIVITIES
Specific Outcome: 1. Explain how the misuse of medicines, alcohol, and non-prescription drugs might result in physical harm to oneself.	
1. Any substance has potential for physical harm. Misuse of prescription and non-prescription drugs is a dangerous practice. Prolonged use of drugs and alcohol often leads to other health problems for the individual. It is dangerous to experiment with substances or to take them on a dare. Non-prescription drugs, when used with other drugs and/or alcohol, can cause serious interaction effects. Non-prescription drug use is most dangerous when the use masks the symptoms and delays the treatment of a serious illness.	1A. Ask students to list at least three dangers of self-diagnosis and medication. B. Have the class prepare a list of questions about the consequences of substance use. Invite a recovered alcoholic or drug addict to talk to the class about the questions they have prepared.

CONTENT	ACTIVITIES

Specific Outcome: 2. Know that there are legal controls for the use or possession of alcohol and most drugs.

2. The public establishes laws controlling the manufacture, sale, or possession of alcohol and most drugs and violations are punishable by law.

The Food and Drug Administration defines **prescription drugs** as those drugs, medications, and medical devices subject to regulation by physician's prescription which are "habit forming," "toxic," "potentially harmful," or whose "method of use" are not safe except under the supervision of a physician.

Each state is given the right by the 21st Amendment to the Constitution of the United States to determine the method of alcohol control within its own borders.

States control alcohol through:

- Licensing the manufacture and distribution of alcoholic beverages.
- Licensing the sales of alcoholic beverages.
- Laws and ordinances regarding sales, consumption, employment, education, advertisements and promotions, importation, enforcement, and treatment of alcoholics.

States license physicians to prescribe and pharmacists to prepare medicines.

2A. Invite a law enforcement person to talk with the class about the laws and penalties associated with possession, sales, and use of alcohol and "controlled substances."

B. Interview a local bar and/or restaurant owner. During the interview ask the owner to describe the procedures for obtaining and maintaining a license to sell alcoholic beverages. Are there state laws and ordinances controlling to whom he/she might sell alcoholic beverages and the days and hours during which drinks may be sold? Is the owner responsible for injuries to a drunken patron served in his/her business?

CONTENT	ACTIVITIES

Specific Outcome: 3. Describe the possible harm to self from "taking a dare" involving the use of known and unknown substances.

3. Any substance (alcohol or other drugs) has the potential for causing physical harm to the user.

   There are no "quality controls" to guarantee the purity or effects of any drug sold "on the streets."

   There are no guarantees that a substance offered to a young person is indeed what it is purported to be.

   Trial and error learning about substances is an inaccurate and dangerous method.

   The possible risks to self from using known and unknown substances are:

   - Injury to self/others
   - Legal action
   - Loss of self-esteem
   - Loss of respect from family
   - Loss of respect from peers
   - Feelings of guilt/shame

3A. Role play scenes in which parents discover that their son or daughter is drinking or is drunk. After each role play, ask the actors to discuss the feelings which they had while role playing. Invite discussion from the class on the different ways each might have been played.

Parent – You have just found your 12-year-old son in the park at 9:30 p.m. drinking beer with two friends. A neighbor called to let you know about it. At home you have allowed him to drink a glass of beer on occasion, but that is all. You get out of your car and walk over to him. What, if anything, do you say and/or do?

Son – Your parents have allowed you to drink a glass of beer on occasion, but you wanted to see what it would be like to drink more. You persuaded a friend to get some beer from his older brother. You have been sitting in the park drinking since 7 p.m. You are drinking your fourth can of beer and feeling slightly drunk. Suddenly, your father walks up to you. What, if anything, do you say or do?

Discuss the possible harm to self for the son and the possible harm to self of the father. What other risks were involved?

B. Conduct a class voting with these options (OK behavior, in-between, not OK behavior) with some short situation statements. Allow time for students to explain their positions. How many people think it is OK? In-between? Not OK? to do:

- On your way home from school you find some pills on the sidewalk. Your friends dare you to eat some. You eat one of the pills.
- You have a pain in your stomach. A friend at school has some medicine the doctor prescribed for his/her stomach pain. Your friend offers you some and you take it.
- Two high school students who live in your neighborhood offer you some beer. You say "No thanks."

CONTENT	ACTIVITIES

Specific Outcome: 4. Identify the possible benefits of using alcohol and other drugs.

4. Substances can be beneficial to people by preventing or controlling diseases or by making it possible for them to participate in the typical world.

   Many substances have legitimate medical uses.

   Some substances are used by people to deal with tension, anxiety, and stress; at best, the substance use offers short-term relief.

4A. Work with the class to generate lists of reasons why people would and would not use each of the following substances: alcohol, marijuana, aspirin, and antibiotics. As a class go through each of the lists to determine which reasons are detrimental and which are beneficial to the user. Ask students to explain some of their reasons. For example: alcohol use

Benefits	Detriments
relaxation	organic effects
stimulation	non-nutritive
acceptance by peer group	possibility of death
social status	costs a lot of money
sign of adulthood	possible loss of judgment
pleasure	danger of becoming an alcoholic
escape from stress	possible loss of friends
	possible loss of family
	risk of accidents
	possible loss of job

MAJOR OUTCOME D: STUDENT WILL KNOW THAT THE INDIVIDUAL, HIS OR HER FAMILY, AND THE COMMUNITY HAVE INTERRELATED RESPONSIBILITIES FOR THE PREVENTION OF ALCOHOL AND DRUG ABUSE. PREVENTION

CONTENT	ACTIVITIES

Specific Outcome: 1. List ways society tries to prevent individuals from becoming abusers of alcohol and drugs.

1. People decide to use or not use substances for a wide variety of reasons.

   Society attempts to prevent individuals from becoming substance abusers through:

   (1) Federal, state, and local laws governing the sale, manufacture, and distribution of legal and illegal substances.
   (2) Law enforcement agencies which carry out laws.
   (3) Establishing court systems to prosecute offenders.
   (4) Provision of rehabilitation and treatment services for substance dependent people.
   (5) Provision of preventive educational services.
   (6) Reliance on voluntary compliance with laws, rules, and regulations.
   (7) Provision of services for young people with family problems.
   (8) Provision of youth and adult support groups such as Alateen, Alcoholics Anonymous, Synanon, etc.
   (9) Establishing social norms governing substance use or non-use.

1A. Teacher review definitions of substance use and abuse with the class.

B. Ask students to write responses to scenarios in which they play "Dear Abby" in response to a letter about a family alcohol problem and a family drug problem.

Direct small groups to listen to each student's replies. Within the group discuss the best response and why. The teacher summarizes student replies and relates them to content statements.

Dear Abby:

My father frequently goes on drinking sprees, some of which last for several days. When he's not drinking he is kind and generous. But when he drinks too much he is mean, sloppy, and sometimes violent. He sometimes spends so much on liquor that the family has to do without much food. What can I do? I am . . . years old.

Signed,
Confused

How will you respond?

CONTENT	ACTIVITIES
Specific Outcome: 2. Explain the role of laws, rules, and regulations in the prevention of substance abuse.	
2. Production, distribution, and sale of medicines, cosmetics, and alcohol are regulated by Federal and State laws. Laws, regulations, and rules are intended to insure the safety and well-being of the population. These formal controls are intended to discourage the misuse or abuse of alcohol and other drugs. Laws and regulations have the following general effects on the use and abuse of substances: – They make some drugs (alcohol and non-prescription drugs) legal and easily available. – They control the age of the purchaser of substances. – They attempt to control the availability of illegal drugs. – Some laws and regulations are not consistently enforced or uniformly applied. – They attempt to deter the use and abuse of illegal drugs. – They provide millions of dollars for the enforcement of drug laws and the prosecution of offenders. – They provide several million dollars for the treatment and rehabilitation of chemically dependent people. – They give authority to physicians and pharmacists only to prescribe and prepare medications.	2A. Ask students to verbally identify the person or agency responsible for: – Making safe drugs – Writing prescriptions – Filling prescriptions – Reading labels and following directions – Keeping drugs in a safe place – Administering drugs to children (medicines) – Purchase of non-prescription drugs – Sale of alcoholic beverages – Treatment of alcohol or drug abusers – Enforcing laws concerning the sale, use, or possession of "controlled substances." – Establishing personal attitudes toward alcohol and toward illegal drugs.

CONTENT	ACTIVITIES
Specific Outcome: 3. Identify ways to prevent oneself from misusing or abusing alcohol and drugs.	
3. An individual can take action to: – Develop and maintain a healthy body. – Learn to get along with other people. – Decide upon personal values and goals in life and to seek to achieve them. – Know sources of help for substance use problems. – Know sources of help for personal problems. – Seek personally satisfying non-chemical alternatives. – Learn to make responsible decisions. – Critically analyze information on television, in newspapers, in magazines, and films about substances. – Have a sound base of information about substances and their effects.	3A. Discuss with the class the individual's responsibility for the prevention of substance abuse. B. As a class, brainstorm ways by which an individual can prevent him/herself from becoming a substance abuser.

CONTENT	ACTIVITIES
Specific Outcome: 4. Identify personal attitudes related to substance use and to substance abuse.	
4. Young people need to become aware of their attitudes and values in order to make responsible decisions about substance non-use or use.	4A. Conduct a class vote in which students are presented with three options (agree, unsure, and disagree). Students are presented with the following statements related to the use or non-use of alcohol **(Students are allowed the privilege to "pass"):** – There are good reasons for drinking alcohol. – There are no good reasons for getting drunk. – There are good reasons for never drinking alcohol. – There's something wrong with people who never drink. – People who don't drink and say it's because they don't like the taste are really just afraid to drink. – It's really difficult to have a good party unless people have a few drinks in them. – There are good reasons for teen-agers to drink. Discuss the right of people to abstain from alcohol use. What does the term "tolerance of other people's behavior" mean? Can you think of ways by which parties and other social gatherings can be planned and conducted so that the preference of some people to abstain or responsibly use alcohol can be honored?

CONTENT	ACTIVITIES
Specific Outcome: 5. Identify the community services available to help with alcohol and drug problems.	
5. Many public agencies and private organizations provide services for people (including families) with drug and alcohol problems. Young people are not often aware of the resources available to them in their communities. Young people would most often go to their peers and then to their families for help in dealing with their alcohol/drug problems.	5A. Class discussion questions: – Where can chemically dependent people get counseling and treatment in your community? Within fifty miles of school? – Where can husbands/wives and children get help for their problems related to a chemically dependent family member? B. Students generate a list of names of people or agencies that a person might contact to seek answers to drug/alcohol questions. Ask students to individually respond to the following questions by identifying the resource person or agency: – Who would you rather talk with about your own alcohol/drug problem? – Who would you rather talk to about your friend who has a drug/alcohol problem? – Who would you trust to give you truthful information about alcohol and drugs? – Who would probably know the laws concerning marijuana? – Who is probably best trained to help people solve their personal problems? – Who probably knows most about what a certain drug does to the human body?

MAJOR OUTCOME E: STUDENT WILL KNOW PERSONALLY RELEVANT AND SATISFYING ALTERNATIVE BEHAVIORS TO ALCOHOL AND DRUG ABUSE. (ALTERNATIVES)

CONTENT	ACTIVITIES

Specific Outcome: 1. Identify ways by which people meet their needs without using substances (the alternatives concept).

1. Childhood can be a period of great joy.

   Children can learn to be "turned on" by using their senses in relation to familiar surroundings and everyday events.

   Some young people do not realize that there are alternative ways for meeting their needs.

   Many people do **not** choose to use alcohol or other drugs because they perceive that they have "better things to do." They perceive the "better things to do" as more stimulating (needs satisfying) than using substances.

   Some more stimulating alternatives include:

   - Enjoying one's friends or family
   - Learning a new skill
   - Taking a vacation trip
   - Playing a game
   - Going fishing or hunting
   - Helping other people
   - Working on a hobby

1A. Design a **Joy Box.** Decorate it, both on the inside and outside, with a collage of pictures children enjoy most. Place this box somewhere in the room. For one week have each child place in the box slips of paper expressing those things he/she has enjoyed each day. At the end of the week, read the slips of paper that express those things they enjoy. Then discuss such questions as:

- How are these things you enjoy different from those things others enjoy?
- How are they alike?
- How is the feeling of joy related to meeting your needs?

Discuss reasons why some children might have no enjoyable experiences to report?

- How can you give joy to another person?
- How can you give joy to yourself?

B. **Enjoy Journal** Ask students to keep a daily journal for one week in which they complete the following open-ended statements:

- I enjoy going to . . .
- I enjoy tasting . . .
- I enjoy touching . . .
- I enjoy seeing . . .
- I enjoy hearing . . .
- I enjoy doing . . .
- I enjoy feeling . . .
- I enjoy watching . . .

Divide the class into small groups so that each student might share his/her enjoy statements. Ask students to describe the sensory experiences that they most enjoyed.

As a total class review some of the sensory effects of alcohol, depressants, and stimulants. Ask students to review their **Enjoy Journals** and consider how each enjoyable sensation might be distorted by using each type of substance. Encourage students to share their observations with the total class.

CONTENT	ACTIVITIES
Specific Outcome: 2. Identify alternative activities afforded through community agencies and programs.	
2. A community does offer some agencies and programs that meet youth needs for new experiences, adventure, self-understanding and development, accomplishment, belonging, feeling important, and discovering new abilities.	2A. Distribute a list of needs to each student in class. Ask them to identify agencies or programs which might help them meet their needs (e.g. intellectual needs: school, library, museum, etc.). Reproduce the original list on the blackboard and ask students to identify their selection of agencies/programs. Some agencies are unfamiliar to most students. Ask some selected students to interview personnel at the agency and report back to class. B. From the information gathered in activity 2A, develop a directory of alternative activities and programs available to people in your community.

CONTENT	ACTIVITIES
Specific Outcome: 3. Identify alternative activities afforded within the school environment.	
3. A school does offer many opportunities for young people to meet their needs.	3A. Distribute a list of needs to each student in class. Ask them to identify school activities, classes, programs, and services which might help them meet their needs. Reproduce the original list on the blackboard and ask students to identify their matches of elements of the school environment with needs.

MAJOR OUTCOME F: STUDENT WILL BE ABLE TO EMPLOY DECISION MAKING SKILLS TO MAKE RESPONSIBLE DECISIONS RELATIVE TO PERSONAL ALCOHOL AND DRUG USE OR NON-USE. (DECISION MAKING)

CONTENT	ACTIVITIES

Specific Outcome: 1. Demonstrate the decision making process in relationship to the use of medicines, alcohol and other drugs.

1. Every person must make many decisions, yet few people are taught a decision making process and how to use it.

   Conscious use of the decision making process can increase personal happiness, satisfaction, and self-esteem.

   Decision making is a learned process. The process must be practiced to be learned.

   Maturity is a process of becoming accountable for oneself; of making one's own decisions; and of accepting the consequences of one's behavior.

   A six point test has been developed by Dr. Harry Emerson Fosdick[2] which reflects upon one's value system and facilitates decision making. The six points are:

   (A) Does the course of action you plan to follow seem sensible and honorable to you? If it does, it is probably right.
   (B) Does it pass the test of sportsmanship? In other words, if everyone followed this same course of action, would the results be beneficial for all?
   (C) Where will your plan of action lead? How will it affect others? What will it do for you?
   (D) Will you think well of yourself when you look back at what you have done?
   (E) Try to separate yourself from the problem. Pretend for a moment that it is the problem of the person you most admire. Ask yourself, "How would that person handle it?"
   (F) Hold up the final decision to the glaring light of publicity. Would you want your family and friends to know what you have done? The decisions we make, in the hope that no one will find out, are usually wrong.

1A. Two open-ended stories are presented in class and students collectively discuss their responses according to three aspects of decision making (considering the alternatives, weighing the consequences of each alternative, and choosing from alternatives).

Temptation. One of the neighbor's children is about your age. You are at his/her home and his/her parents are not home. Nobody is in the house except you and your neighborhood friend. The neighbor friend goes into the refrigerator and takes out a can of beer. He/she says to you, "Do you want some?"

A Headache. You mother went next door for a few minutes to visit the neighbor. You have a headache. You know exactly where the aspirin are kept because you have seen your mother and father take them. You can't read the label but you know what the aspirin bottle looks like.

B. Each student is given a copy of the six points presented by Dr. Harry Emerson Fosdick. Using the stories presented in 1A ask each student to examine his/her decisions for each story in relation to the points on the handout. Ask students to share their decisions and observations related to the handout with the class.

2, Harry Emerson Fosdick. *Decision Making: Teacher Activity Package, Grades 2 – 6.* (Appleton, Wisconsin: Cooperative Educational Service Agency, 1973), Number Eight, p. 3.

CONTENT	ACTIVITIES
Specific Outcome: 2. List the reasons why a person might or might not make the decision to use alcoholic beverages.	
2. Review information generated in other sections about motives for substance use and non-use. Substance users and abusers have frequently given as reasons for their use behaviors: (1) To find temporary relief from tension and frustration (2) To escape problems (3) To compensate for feelings of depression, inadequacy, and insecurity	2A. Students are given the following written instructions: A new law has just made it legal for anyone to drink as much alcohol as they want at any age. Your parents have just told you that whether you drink or not and how much you drink is completely up to you. Will you now do any drinking or any more drinking or drink more openly? If you will, why will you? If you won't, why won't you? Upon completion, the class breaks into small groups and students are given written instructions to discuss which they think are good reasons for deciding not to drink or to drink. Why are these good reasons? Groups report their conclusions to the class and respond to comments and questions from the class and teacher.

CONTENT	ACTIVITIES

Specific Outcome: 3. Describe the application of a problem solving process as a non-chemical method of dealing with personal problems.

3. Problem solving is a process for dealing with unmet needs or conflicts.

Actions taken by oneself or in cooperation with others can help to resolve personal problems.

Actions which can be undertaken by a child:

- Seeking and offering help
- Following recommendations of qualified advisors
- Developing compensatory interests and skills
- Exploring new ways of dealing with problems
- Recognizing and responding appropriately to "warning signals" imposed by the problem
- Setting and working toward new goals
- Taking time to reflect and reassess
- Realizing that problem resolution is difficult.

Actions undertaken by child with the help of others.

- Being receptive to the advise of qualified advisors
- Gaining new understanding of and perspective of the problem
- Assessing progress periodically and redefining goals
- Letting other people help you when dependence is necessary
- Borrowing from the experience, skills, and faith of others

A problem solving process involves:

(1) Defining the problem
(2) Gathering pertinent data
(3) Looking at possible responses
(4) Examining own values, interests, and needs in relation to possible responses
(5) Considering short- and long-term effects of various responses
(6) Ranking the possible responses in order of preference and arriving at a decision
(7) Following through on the decision
(8) Evaluating the effects of the action taken.

3A. **Others Feel Pressures Too.** To help students gain more insight into daily pressures of others, ask them to interview a cross section of parents or guardians, teachers, and other students to find out what these people consider to be their everyday pressures. Additionally, students should ask these people how they deal with the pressures. Then ask students to form a panel and discuss those pressures that are common to parents or guardians, teachers, and students, exploring ways to minimize the pressures of each group. Discuss with the class the relationship between "pressures" and personal problems. How many people applied a problem solving approach to deal with their pressures?

B. Have the children experience a "problem" in the classroom (e.g. blindfold the students for thirty minutes and carry on class as usual during the period). After the experience discuss how different people coped. What methods did they use to deal with their problem? What needs were not being met? What does frustration feel like?

Pamphlets

"Alcohol Do You Know Enough About It?" Addiction Research Foundation, Toronto (Outcome No. B)

"Drinking Myths", U.S. Jaycees, Tulsa, Oklahoma, (Outcome No. B)

"Drugs A Primer For Young People", Phoenix, Arizona: Do It Now Foundation, 1971. (Outcome No. B)

"Questions & Answers About Drug Abuse", U.S. Government Printing Office, 1973. (Outcome No. B)

"What Everyone Should Know About Alcohol", Greenfield, Mass: Channing Bete Co., (Outcome No. B)

"What Everyone Should Know About Drugs", Greenfield, Mass., Channing Bete Co., (Outcome No. B)

Books And Booklets – Curriculum

Finn, Peter and Platt, Judith. *Alcohol & Alcohol Safety: A Curriculum Manual For Junior High Level: A Teacher's Activities Guide.* U.S. Government Printing Office. (Classroom activities).

Hammer, Earl. *You Can't Get There From Here.* New York: Random House, Inc. Novel about a boy who spends a day in New York City trying to find his father who is an alcoholic.

Milgram, Gail C. *What Is Alcohol? Why Do People Drink?* Brunswick, New Jersey: Center of Alcohol Studies, Rutgers University. Presents reasons why it is important to learn about alcohol. Diagrams, photographs.

Simon, Sidney, *I Am Lovable And Capable.* Niles, Illinois: Argus Communications. A story of what it does to a person when he or she is put down.

Other

Bread and Butterflies. Iowa Public Broadcasting Network. A classroom television series which reinforces career education. Nine programs from the series are directly related to outcomes presented in this guide.

Inside/Out. Iowa Public Broadcasting Network. A classroom television series presenting social and personal situations which confront elementary children. Designed to be used with follow-up discussion and activities. Thirty-three titles.

Jackson Junior High. Cambridge, Mass: Abt Associates. A film series for grades 5 through 8 on alcohol education. Teachers manual and student booklet. Four titles.

Paulson, Wayne. *Deciding For Myself.* Minneapolis: Winston Press. A values clarification package.

Level III

Grades 7-9

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Level III: Developmental Needs and Interests

Grades 7–9. Junior high school students are caught in the confusion of early adolescence. They are in search of ways to gain emotional independence from the family; to achieve an individual identity and some consistency in personal values; to achieve a mature sexual identity and to understand the roles of "adolescents" and "adults" in our society. The emphasis in school programs should be toward developing self-understanding and effective life coping skills.

Discussions should be directed toward understanding the complex nature of an individual's behavior. The concept that human behavior is a response to meeting one's emotional, social, intellectual, moral, or physical needs should be developed. Students should understand how needs conflicts are related to their particular developmental concerns. The roles of family, peers and social institutions in influencing the individual's behavior and values should be explored. The personal and social controls on alcohol and drug use should be discussed within this behavioral context.

Junior high students should recognize how emotional conflicts, unsatisfied needs and unrealistic expectations of self and others can cause developmental problems. Life coping processes should be discussed in relation to these topics. Positive problem solving responses include identifying the real problems, gathering facts and opinions, consideration of alternatives and consequences, and dealing with less than perfect solutions. Classroom experiences should reinforce constructive coping processes.

Student understandings of social development should include the respect of the rights and feelings of others, being dependable and reliable, and assuming the responsibility for one's behavior. The ability to think and to make decisions as a member of a group is part of social development. How one's self-concept and values affects behavior in groups should be discussed. Peer pressure to use alcohol and drugs should be related to these aspects of social development.

Alcohol and drug use should be discussed as human behavior resulting from diverse motivations. Examination of these motivations should include non-chemical alternative behaviors for meeting one's needs or resolving personal problems.

MAJOR OUTCOME A: STUDENT WILL UNDERSTAND THE BASIC FACTORS IN HUMAN BEHAVIOR RELATED TO SUBSTANCE USE: PSYCHOLOGICAL, PHYSIOLOGICAL, SOCIOLOGICAL. (HUMAN BEHAVIOR)

CONTENT	ACTIVITIES

Specific Outcome: 1. Describe methods used by adolescents to satisfy their needs.

1. Individuals within the adolescent stage of development attempt to satisfy the same needs in different ways.

   Adolescents seek fulfillment of many of the following needs:

   (a) General feeling of well-being and physical relaxation.
   (b) Expansion of physical senses – intensification or enrichment of sensory input.
   (c) Psychological and emotional experience, especially that which occurs within a personality.
   (d) Interpersonal relations, acceptance in groups, feelings of communication among individuals.
   (e) Experience of mental and intellectual processes, such as thoughts, ideas, problem solving, etc.
   (f) Artistic creativity, the performance or aesthetic appreciation or experience of creative works or artistic phenomena.
   (g) Styles of behavior and attitudes, especially cognitive styles, cultural styles, and life styles.
   (h) Experiences generated by identification with or involvement in social causes or political movements.
   (i) Experience of a guiding philosophy of life.
   (j) Personal identity, including goals, purpose, and values.
   (k) Experiences with religious, spiritual, or mystical characteristics
   (l) Need for risk taking, adventure, exploration.

   Each person responds to his/her needs with some type of behavior; some responses are constructive and some are self-defeating.

   Young people can learn growth facilitating ways of dealing with developmental concerns such as alcohol and drug use, peer pressure independence/dependence, failure, sexuality, etc. Life coping skills are methods of dealing with developmental concerns. Examples of life coping skills are decision making, confronting, risking, asserting, experimenting, withdrawing, fantasizing, valuing, and understanding defense mechanisms.

1A. Teacher and students can generate a comparable list of needs or the teacher can reproduce the list for the students. Ask students to brainstorm possible actions which teen-agers might employ to fulfill these needs. From these lists, ask students to indicate which methods they personally use. Discussion should contrast the more comprehensive list of the class with their more restricted personal lists. Ask students to identify sources and forms of control which might limit their ability to fulfill their needs.

OR

1B. Review with the class the five dimensions of interrelated human needs (physical, intellectual, spiritual, social, emotional). Ask them to identify specific developmental needs within each dimension that are characteristic of adolescents (e.g. Social: peer group acceptance). Brainstorm ways that adolescents attempt to meet their developmental needs.

CONTENT	ACTIVITIES
Specific Outcome: 2. Identify examples of peer influence on decisions to use or not use substances.	
2. Peer pressure is a very strong force in determining one's choice of behavior. Peer group acceptance is a strong need for most teen-agers, the peer group can control behavior by use of ostracism or ridicule. Some people are willing to forego personal values and beliefs to belong to a certain group. Students need to become aware that they have both a need for group membership and a need for individuality.	2A. Have students explain why they associate with a particular peer group. What is expected of the members of the group? Are dress, behavior, appearance, and attitudes related to peer group acceptance? Discuss the following: – What are the desirable features of belonging to a peer group? – What are the undesirable features of belonging to a peer group? – Do parents, teachers, and other adults belong to a peer group? – How can a person deal with a peer group when they want him/her to do something that is counter to the individual's values? B. Ask small groups of students to make a chart to list reasons why someone might pressure someone else (to abstain, to drink, to get drunk, to use unknown pills). Discuss and record whether individuals who exert pressure can be discouraged or resisted; if so, how?

CONTENT	ACTIVITIES
Specific Outcome: 3. Identify the influence of the family on decisions to use or not use substances.	
3. The family (parents and siblings) communicates its attitudes toward alcohol and other drugs verbally and non-verbally and through its behavior toward alcohol and drugs. Most low-risk groups of drinkers have come from families where: ● If they drink, parents present a constant example of drinking responsibility and in moderation. They teach by example. ● "Ground rules" for using alcohol – or not using it – are well established in the family, agreed upon by all. ● Excessive drinking is not acceptable to the family. Over-indulgence is not looked upon as comical or responsible. ● Drinking is considered by parents to have no moral importance. To them, it's neither virtuous nor evil. ● Drinking is not viewed as an escape, a proof of adult status, or anything else. ● Drinking is not engaged in for its own sake, but as a part of other activities. ● No pressure is placed on a family member or a guest to drink. ● No social significance is attached to a person saying, "No, thank you. I don't drink."	3A. Discuss responsible drinking. Ask students to establish the ground rules for using alcohol (or other substances) they would follow if they were grown up in their own home. 3B. Identify a space in the classroom where students can stand along a line. One end of the line is called "No Alcohol" and the other end is called "Alcohol Anytime." Students are asked to take a position along the line, or continuum, which most nearly represents how they want alcohol to be in their lives. Allow students to talk about their position. Have them move to the position they think their parents would take; consider the reasons for differences or similarities.

CONTENT	ACTIVITIES

Specific Outcome: 4. Identify the roles of mass media and advertising in influencing decisions about substance use or non-use.

4. Advertising, media, music, and fashion often portray alcohol and other drugs as part of the "good life."

Media messages portray specific substances as meeting some human needs.

Media messages often distort reality as to who uses substances and how often substances are used.

Media messages are often designed to appeal to the following needs:

A. **Physical** (fitness, relaxation, beauty/appearance, sexuality)
B. **Intellectual** (curiosity, adventure, aspirations, achievement)
C. **Social** (status, esteem, success, acceptance, attractiveness to opposite sex, identification, hero worship, conformity to custom, fashion or accepted ideas of others, individuality, facility in talking with others, reinforcement of sex role stereotypes)
D. **Emotional** (security, self-expression, being loved, reinforcement, self-esteem, sexual identity, guilt)
E. **Spiritual** (appeal to values, reinforcement of beliefs and attitudes, improvement of the quality of life)

4A. Ask students to complete the following attitude survey by marking Agree – Unsure – Disagree with each item:

(1) Alcohol companies shouldn't be allowed to advertise their products at all.
(2) Alcohol companies should not be allowed to advertise beer/wine on television.
(3) Drug companies shouldn't be allowed to advertise their products at all.
(4) Drug companies should not be allowed to advertise non-prescription drugs on television.
(5) Television programs have stimulated drug use.
(6) The recording industry has promoted the use of alcohol and drugs.

Ask students who "agree" with the role of advertising suggested in the survey to explain their positions; those who disagree should also be given a chance to explain their positions.

B. Students volunteer to keep a detailed written list of their exposures to alcohol for two days. Examples of types of exposure are:

(1) Advertisements on TV, radio, billboards, or newspaper
(2) Liquor stores and bars
(3) References to alcohol in conversations
(4) People drinking in reality or in movies or on TV
(5) News accounts of alcohol related accidents.

After collecting exposure references, students report to the class. The class then discusses what influence such exposure probably has on children, teen-agers, and adults and why, and whether people who have different exposure experiences may end up with different attitudes toward alcohol.

CONTENT	ACTIVITIES

Specific Outcome: 5. Identify the internal (self) controls which a person can apply to decisions about substance use or non-use.

5. The individual's decision to use or not use alcohol and/or other drugs can be viewed in terms of: safety to self/others, health and welfare of self/others, and possible alternative ways of meeting needs.

Alcohol and drugs may have positive or negative effects on people's behavior and well-being. Adolescents choose to not use or to use substances on the basis of their perceptions of the risks and gains of the behavior.

For example, substances might be perceived to have **positive effects** such as:

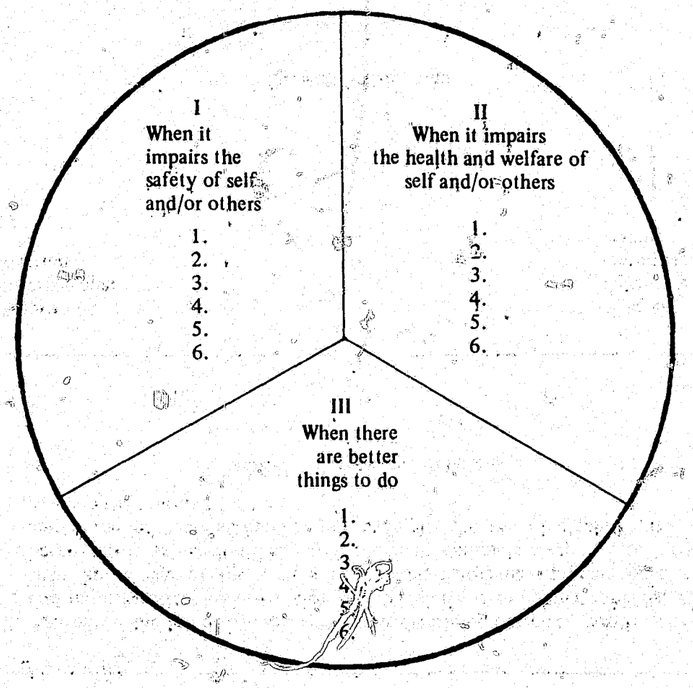
(a) Enhanced interpersonal relations
(b) Increased self-esteem
(c) Optimal ability to coordinate motor skills
(d) Enhanced awareness or perception of environment
(e) Increased physical well-being
(f) Reduced feelings of anxiety or stress
(g) Pleasure, it feels good

For example, substances might be perceived to have **negative effects** such as:

(a) Decreased quality of interpersonal relations
(b) Deterioration of motor coordination
(c) Decreased awareness and perception of the environment
(d) Damaged self-esteem
(e) Masking other problems that should be resolved
(f) Frustration if expectations do not meet needs
(g) A deterioration of physical health
(h) Interference with satisfying other needs
(i) Use behavior conflicts with personal and/or family values

5A. Elicit from students situations in which people who sometimes drink, chose **not** to drink. Record the learner's responses under the appropriate heading on a large circle graph. Display the graph in the classroom. Discuss with the class: Who controls these decisions?

REASONS FOR DECIDING NOT TO DRINK ALCOHOL



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CONTENT	ACTIVITIES

The individual is influenced in his/her non-use, use, and abuse of substances by several different external source of control:

- Family and other admired adults
- Community groups
- Peer groups
- Legal authorities
- Manufacturers
- Media
- Church

The above sources of control are external to the individual, but they do attempt to influence the person's choice of substance, the amount and frequency of use, the age of onset, and the setting in which the substance is used.

Substance abuse is usually blamed on, or rationalized with something outside the user him/herself i.e., schools, parents, peers, etc. and to agree with these topics is to deny that people have internal sources of control over their behavior.

People can use life coping skills to constructively deal with their problems and frustrations and to satisfy their needs. Personal coping skills are the internal source of control.[3]

3. The Self, Inc. series (15 programs) is broadcast over the Iowa Public Broadcasting Network. The entire series and teacher guides is designed to assist junior high school students to develop life coping skills. Use of these materials is recommended as readily accessible teaching content and activities.

B. Reproduce the list of content statements describing perceived positive effects and negative effects of substance use. Ask students to compare this list with their knowledge of the effects of alcohol, marijuana, amphetamines, and barbiturates. Ask each student to individually complete a report card for use and abuse of each substance. For example, the use of alcohol might be evaluated as follows:

Subject: Interpersonal Relations

A	B	C	D	E
Improve interpersonal relations				Decrease the quality of interpersonal relations

Subject: Self-Esteem

A	B	C	D	E
Increase self-esteem				Damage self-esteem

Have small groups collect grade sheets from their classmates. One small group would compute the average grade for each "subject" and the cumulative grade point average for one condition, i.e. the abuse of marijuana. Discuss the results with the class in terms of their perceptions of the risks and gains for self in each condition.

MAJOR OUTCOME B: STUDENT WILL KNOW IMPARTIAL SCIENTIFIC FACTS ABOUT ALCOHOL AND OTHER DRUGS. (SCIENTIFIC FACTS)

CONTENT	ACTIVITIES
Specific Outcome: 1. Classify substances according to their physiological and psychological effects.	
1. Substances may be classified as stimulants, depressants, hallucinogens, narcotics, or volatile substances. Marijuana and its derivatives are classified separately. The effects of drugs and alcohol vary widely according to such factors as mind set, the setting, previous experience, body tolerance, amount ingested, and the concentration of active ingredients. All substances are potentially dangerous. Any substance which can alter the physical or psychological processes of the human organism is potentially dangerous and is subject to misuse and abuse. Physical and/or psychological dependence may arise from continuous or repeated use of alcohol and other drugs.	1A. The teacher and students should brainstorm a list of thirty commonly used drugs and alcoholic beverages. From this list the teacher asks students to help categorize these substances according to their effects. The activity can be further developed to include: (1) Students may be asked to name the two most dangerous substances on the list to one's physical health and the two substances most dangerous to one's mental health. (2) Students may be asked if each class of drugs has a beneficial use, and, if so, what their uses are. B. Have the class organize itself into six groups and ask each group to research one classification[4] of substances (including marijuana as a separate class). Ask each group to develop a report to the class which includes the following information: (1) Origin of the substances within a classification (2) Forms in which the substances are sold (3) Medical use of the substances (4) Physical and psychological effects (5) Possible harm from use/abuse (6) Slang terms commonly associated with the substance (7) Likely composition of the substance as sold "on the street" (8) Legal restrictions and penalties (9) Possible harm to self if used in combination with alcohol and other drugs

4. Alcohol is classified as a depressant drug.

CONTENT	ACTIVITIES

Specific Outcome: 2. Discuss the concepts of drug allergies and drug side effects.

2. Some people have immunity to or are resistant to the effects of some poisons and medicines; other people are very susceptible to their possible harmful effects.

An **allergy** is any abnormal reaction or hypersensitivity to a specific substance.

Many times adverse reactions to drugs are really a reaction to substances with which the drug is mixed or combined.

Medical professionals must be especially aware of a patient's allergies in prescribing drugs.

Medically, a **side-effect** is a result of drug therapy in addition to or in an extension of the desired therapeutic effect.

With many drugs of abuse, the "rush," euphoria, hallucinations, distorted perceptions, etc. might be the desired "side-effects" of the drug.

Sometimes the "side-effects" of these drugs are quite harmful resulting in death from depression or over-stimulation of vital processes or resulting in mental or emotional disturbance.

The drug side-effects or drug allergic responses are impossible to predict accurately for any individual using drugs purchased "on the street."

From three to five percent of all U.S. hospital admissions result from drug reactions to prescribed medicines.

2A. Select students to interview a physician or pharmacist and report back to the class information about the possible side-effects of and allergic reactions to (1) antibiotics and (2) antihistamines. Ask the professional what dangers are present in using these substances in combination with other drugs and alcohol.

B. Ask students to relate personal experiences with adverse reactions to a drug such as sulfa drugs, penicillin, aspirin and immunizations. Why was the drug taken? What were the adverse effects? How did the doctor treat the undesirable reaction?

CONTENT	ACTIVITIES

Specific Outcome: 3. Identify the differences between prescription and non-prescription drugs.

3. Medicines can be divided into prescription and non-prescription categories.

Non-Prescription Drugs:
- There are thousands of non-prescription drugs that most people can use safely to relieve minor **symptoms** for a short period of time.
- Non-prescription drugs are not intended to cure diseases only to temporarily relieve discomfort.
- When using non-prescription drugs, the consumer must rely on the information on the label and possibly the advice of the pharmacist.
- Information on the label can assist the consumer to choose the appropriate drug for the symptoms; understand conditions under which the drug should not be taken; directions for the correct use; and possible side effects.
- There is always a danger of adverse drug reactions.
- There is always a danger in the practice of self-diagnoses and self-medication.

Prescription Drugs:
- Prescription drugs can only be sold by a licensed pharmacist with a doctor's authorization.
- In the United States two billion prescriptions are written each year; representing tens of billions of doses taken.
- RX drugs are generally more powerful than non-prescription drugs and are often used to combat a health problem over a longer period of time.
- Consumers should learn the benefits and risks of the prescribed medication from the doctor or pharmacist:

  (a) What the drug is supposed to do
  (b) Possible side effects
  (c) Correct dosage for physical size and medical history
  (d) Generic name and costs
  (e) Directions for use
  (f) Interaction problems with other substances

3A. Invite a local pharmacist to discuss prescription and non-prescription drugs with the class. Ask students to prepare a list of questions they would like answered and share this list with the pharmacist before he/she meets the class.

CONTENT	ACTIVITIES

Specific Outcome: 4. Describe the risks in using alcohol in combination with other drugs.

4. The concentration of alcohol in the body at any time determines the effect of alcohol on the nervous system.

   Alcohol used with other depressant drugs (mainly barbiturates) poses an immediate threat to life.

   The effect of the combined use of alcohol and other drugs is unpredictable. The combined effect:

   (a) May cause an antagonistic action.
   (b) May be greater than the sum of the individual effects.
   (c) May be different from the effect of either of the active components alone.

   For example:

   (1) Prolong the action of one drug (antihistamines)
   (2) Produce toxic symptoms with a lesser than toxic amount of either drug.
   (3) Partially reduce some symptoms without affecting others.
   (4) Potentiate the effects that would be expected by either drug alone (barbiturate plus alcohol result in severe CNS depression).

4A. Invite a physician or other knowledgeable person (nurse or pharmacist) to speak on the ways in which various drugs interact and to discuss the importance of a patient's history in determining which drugs will be prescribed for him/her. What precautions do physicians give their patients when prescribing drugs? Does the doctor caution patients about hazards in combined use of medicines and alcohol? The medicine and other drugs? What responsibility does the pharmacist have? What responsibilities does the patient have?

B. Have students rank each of the following drug products according to the degree of risk to life when taken in combination with alcohol. Place a number from the rating scale next to the name of each drug product.

Not Dangerous	Slightly Dangerous	Moderately Dangerous	Very Dangerous
1 2 3	4 5	6 7	8 9 10

- Sleeping pills
- Diet pills
- Cough medicine
- Cigarettes
- Coffee
- Aspirin
- Marijuana
- Penicillin
- Antihistamines
- Root beer
- LSD
- Tranquilizers

CONTENT	ACTIVITIES

Specific Outcome: 5. Describe antidotes and emergency procedures to counteract the toxic effects of ingested substances.

5. **(Refer to antidote and first aid materials included in many first aid texts.)**

   Many junior high students are involved in babysitting duties. It is particularly important that they understand that 105,000 cases of poisoning each year involve children less than six years of age. Most of these cases are ingestion of aspirin, medicines, and cleaning and polishing agents.

5A. Ask the school nurse to discuss with the class:

- Emergency procedures for various kinds of poisoning.
- The type of information emergency rooms and hospitals and physicians need to know about the poison or drug taken.
- The effects of common poisonous substances on the body.
- How to contact the nearest center for emergency treatment of poisoning.

B. Ask a person from an alcohol/drug treatment unit and/or hospital emergency room to discuss the management of drug overdose/adverse drug reaction emergencies.

CONTENT	ACTIVITIES
Specific Outcome: 6. Describe ways in which intoxication changes the behavior of a driver and interferes with the operation of a vehicle.	
6. Nervous system functions related to driving (judgment and thought, sensory awareness, and motor coordination) are depressed by alcohol. – All traffic situations are inherently complex and potentially dangerous. – The addition of alcohol use to any traffic situation increases the complexity and dangers of that situation. – The likelihood of a traffic crash rises sharply with each alcoholic drink a driver consumes in a given period of time. For adolescents, on the average, serious driving impairment occurs after consuming two 12 ounce cans of beer within a one hour period.	6A. Reproduce the National Safety Council Drinking-Driving Crash Chart and discuss with the class how to interpret it. Help the students interpret the chart's meaning by asking questions such as: – Using what you know about alcohol's effect on the body, why do you suppose a person's chance of being involved in a crash increases with each drink? – What do you think would happen to the lines on the chart if each drink was consumed in a three-hour period instead of a two-hour period? A one-hour period instead of a two-hour period? B. Ask students to describe drinking-driving situations which might threaten their personal safety. How might the situations be changed to protect one's safety and that of the driver?

CONTENT	ACTIVITIES

Specific Outcome: 7. Discuss the differences between prevention and treatment of substance abuse.

7. Prevention is directed toward forestalling the occurrence of chemical dependencies and the individual and social problems associated with substance abuse.

   Prevention rests upon the way an individual makes his/her life decisions in a complex social environment.

   Primary substance abuse prevention is a constructive process designed to promote personal and social growth of the individual toward full human potential and thereby inhibit or reduce physical, mental, emotional, or social impairment which results in or from the abuse of chemical substances.

   Treatment involves medical and/or psychological care for persons who have chemical dependencies.

   Treatment is expected to help the chemically dependent person to abstain from drug and/or alcohol use and to develop personal goals and behavior patterns to replace substance abuse.

   Treatment of individuals for alcohol or drug dependencies is difficult and often ineffective.

   A chemically dependent person can receive treatment, counseling, and rehabilitation services through a variety of agencies and organizations.

   Substance abuse and chemical dependencies are not limited to any one economic group or subculture within our society.

7A. Small groups develop definitions for prevention, treatment, and rehabilitation and an example of each.

   On three large pieces of paper write the definitions for each term as agreed upon by the class. Divide each sheet into three columns: Methods Used, Agency to Deliver Service, and Location of Agency. Class lists methods, agencies, and locations in appropriate columns.

B. Invite a counselor from an alcohol/drug treatment unit to talk with the class about the kinds of services provided and the difficulties encountered in assisting chemically dependent persons. Ask the counselor about his/her perceptions of the role of family members in treatment and rehabilitation of dependent persons **and** the families role in prevention.

CONTINUED

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CONTENT	ACTIVITIES
Specific Outcome: 8. Interpret the terms Alcoholic, Problem Drinker, Social Drinker, and Abstainer.	
8. An alcoholic is a person who has a behavioral disorder characterized by compulsive uncontrolled drinking which interferes with the drinker's ability to function personally and in society. Alcohol use behaviors range from abstinence, moderate or social use, to excessive drinking and alcoholism. There is a potential for harm or problems to self or others at any point on the continuum of use behaviors. Alcohol users differ from one another in the damage they do to themselves and others and in their motives for the use of alcohol. The person starting to use alcohol cannot know in advance whether he or she will be a moderate drinker or an alcoholic.	8A. Small groups develop definitions of Problem Drinker, Alcoholic, Abstainer, and Responsible User. On four large pieces of paper write the definitions for each term as agreed upon by the class. Divide each sheet of paper into four columns: Physical Characteristics, Social Characteristics, Motives and Problems Associated With Behavior. Discuss the definitions and the functional problems associated with the user behaviors. Contrast motives between user classes. B. Discuss with the class alcohol use statistics for adolescents and the statement: The person starting to use alcohol cannot know in advance whether he or she will be a moderate drinker or alcoholic. What are the unique problems presented by youthful use of alcohol? Do adolescents consider their motives for drinking?

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CONTENT	ACTIVITIES
Specific Outcome. 9. Relate drug research to life expectancy.	
9. The Food and Drug Administration helps protect the public from harmful drugs. — Testing, research, and quality control are required before new drugs may be sold to the general public. Prescription drugs such as penicillin, tetracycline, and insulin have served to reduce the life-threatening aspects of infectious diseases and chronic/genetic diseases. Medical research has helped humans to live longer and more comfortable lives. The success of pharmaceutical research has also contributed to a public mind set that there is "a pill for every ill." There are many diseases for which there are no drug cures in existence.	9A. Class research and discuss how medical research has increased the comfort and life expectancies of persons with epilepsy, diabetes, heart disease, Parkinson's disease, and tuberculosis. B. Class research and discuss the uses and benefits of the following: anesthetics, antibiotics, antiseptics, hormones, anticoagulants, vaccines C. Compare the mortality rates for disease in 1900 to that of 1930 and 1970. Notice the shift from mortality due to communicable disease to mortality due to chronic degenerative and environmental diseases.

MAJOR OUTCOME C: STUDENT WILL KNOW THE PROBABLE CONSEQUENCES OF ANY ALCOHOL AND DRUG USE TO THE INDIVIDUAL, TO THE FAMILY, AND TO THE COMMUNITY. (CONSEQUENCES)

CONTENT	ACTIVITIES

Specific Outcome: 1. Identify the problems associated with the use of alcohol and other drugs for the individual, family, and community.

1. Any substance has a potential for physical, social, or mental harm.

   The prolonged use of alcohol or other drugs, which may or may not lead to chemical dependence, often leads to other health problems for the individual.

   Substance abuse causes problems for society: accidents, homicides, increased crime, child abuse, costs for welfare, treatment and rehabilitation, enforcement of laws, increased costs of auto and health insurance, loss of productivity at work, etc.

   The abuse of alcohol and/or drugs can have an impact on career opportunities.

   Moderate or occasional use of alcoholic beverages has little, if any, residual effect on the health of the user. The immediate aftereffects of alcoholic indulgence must be considered as a health or safety risk to self and others.

   Individual problems do not disappear as a result of the use of alcohol and/or other drugs; they remain to be resolved.

   Problems to individuals associated with the use and abuse of substances might include:
   - Physical or psychological dependency.
   - Medical care for alcohol and other drug dependencies is expensive.
   - Treatment and rehabilitation of chemically dependent persons is often unsuccessful.
   - Many accidents involve drivers or pedestrians under the influence of alcohol and/or other drugs.
   - Alcohol used with other drugs may be fatal.
   - Many homicides and suicides are directly related to alcohol use.
   - Crime and prostitution are directly related to alcohol and drug abuse.
   - Family disintegration and child abuse/neglect are directly related to alcohol and drug abuse.
   - There is a direct relationship between excessive use of alcohol by a mother and mental retardation/birth defects of her children.
   - Loss of employment, work absenteeism, accidents on the job are directly related to alcohol and drug use.

1A. Conduct panel discussion of the Effects of Drug and Alcohol Abuse on the Community. Ask panelists to direct their remarks to the following questions:

   (1) How does substance abuse effect family and peer group relationships?
   (2) What financial demands are made on the abuser, the abuser's family, and to the community?
   (3) What relationship does substance abuse have to crime/delinquency in the community?

B. Discuss with the class the direct or indirect impact of alcohol/drug use or abuse upon career options, e.g. one's acceptance or rejection by medical schools, law schools, certification to teach, employment by government agencies, and employment in general.

C. Invite a guest speaker from a social services agency to discuss the problems he/she sees that are related to alcohol use: financial, work efficiency, child abuse/neglect, divorce, alcohol-related crime, etc.

CONTENT	ACTIVITIES

Specific Outcome: 2. Identify certain risks or dangers of alcohol use to which teen-agers are uniquely susceptible.

2. Risks or dangers include:

   - Because most teen-agers are smaller and weigh less than adults, their bodies are less able to dilute blood alcohol concentrations.
   - Psychological intoxication is greater for teen-agers.
   - Young people need to learn constructive ways of meeting personal problems.
   - Because of their growth – and consequently their inexperience with drinking – teen-agers are more likely than most adults to become ill from drinking a given amount of alcohol.
   - Adolescents are particularly susceptible to accidents. They tend to overestimate their skills for operating a motor vehicle.
   - Young people more willingly take risks, but their judgment is often inconsistent. Alcohol use dangerously confounds the process of making decisions and judgments.

2A. Prepare descriptions of three adolescents who use alcohol in different ways. Discuss with the class: Who are "problem drinkers?" What characteristics of alcoholics does each student present? Why are these characteristics particularly difficult to deal (cope) with as adolescents?

B. Discuss with students the adolescent's frequent response to parental confrontation about his/her substance use: "It's my body and my life so why can't I do what I want to?" What are some parental responses which can be constructive? Some adolescent responses?

CONTENT	ACTIVITIES

Specific Outcome: 3. Explain how laws govern the personal use, sale, and possession of alcohol and drugs.

3. Control of substance use and abuse is difficult.

Federal, state, and local governments play a significant role in regulating drug and alcohol production, sale and distribution.

There are legal penalties for the possession, sale, and distribution of drugs.

Laws and law enforcement have been viewed as one strategy for the prevention of substance use and abuse. This approach assumes that punishment and threats of punishment will deter undesired behavior.

Punishment and threat of punishment only deters a behavior to the degree that, and as long as, punishment regularly and speedily follows a sufficiently high percentage of deviant behaviors.

3A. Discuss with the class: Does current legislation properly reflect what society does with alcohol and drugs? Does the present Controlled Substances Code satisfactorily control the sale of drug substances? Are there other sources of control on substance use which are as effective or more effective than the legal source of control?

B. Using scenarios where a minor has been involved with a substance related violation; respond as a judge (or small groups as a jury) to decide:

(1) Who is to blame?
(2) Is punishment in order?
(3) What punishment would be appropriate?

Situations:
A 22-year-old man is accused of having illegally bought a six-pack of beer for a 13-year-old boy who had asked him to do it as a favor. The boy got drunk and went swimming at midnight and drowned. The man was a friend of the boy's father and felt he was just doing the kid a favor.

A 35-year-old man saw a 15-year-old youth refused service by a package store and offered to buy for him. The youth agreed and the man bought him a fifth of whiskey. The boy got drunk on it and stole a car. He killed a pedestrian before totaling the car on the freeway.

A 15-year-old girl asked her older sister to buy a bottle of wine for her to celebrate her boyfriend's birthday. The sister complied. The girl and her boyfriend (17-years-old) drank the bottle in the local park. They began to get silly and loud and the neighbors called the police to complain about the noise. The girl and boy were arrested on a charge of disturbing the peace.

CONTENT	ACTIVITIES
Specific Outcome: 4. Describe the relationship of drug abuse to illegal drug traffic, crime, and delinquency.	
4. Dependency upon alcohol or other drugs costs a large amount of money. The street price for illegal drugs is quite high; people are quite often not getting what they have paid for. The profits derived from the manufacture, distribution, and sales of drugs are quite high; people will risk jail terms to obtain the financial gain.	4A. Ask selected students to research and report to the class about the Bureau of Narcotics and Dangerous Drug. B. Investigate the involvement of drug abusers/alcohol abusers in acts of crime. What is the costs to an alcoholic or drug dependent person to maintain their addictions? What are the costs to the community in terms of stolen merchandise from local stores and stolen property through burglary?

MAJOR OUTCOME D: STUDENT WILL KNOW THAT THE INDIVIDUAL, HIS OR HER FAMILY, AND THE COMMUNITY HAVE INTERRELATED RESPONSIBILITIES FOR THE PREVENTION OF ALCOHOL AND DRUG ABUSE. PREVENTION

CONTENT	ACTIVITIES

Specific Outcome: 1. Explain how the use and abuse of substances might be prevented by controls that exist in society.

1. Prevention of substance abuse is a responsibility of the total society including the public and private schools, families, peer and reference groups, mass media, business and industry, government agencies, churches, and volunteer organizations.

   There are formal and informal controls on substance use. Laws, regulations, official government policies, or institutional sources of control such as church and school exert formal controls.

   Informal controls include custom, family rules, social and peer group attitudes, and subcultural norms.

   Four basic strategies have been used in attempts at preventing substance abuse.

   These strategies include:

   (a) Coercion/threat of formal sanctions
   (b) Education/persuasion
   (c) Eliminating causes/motives
   (d) Provision of satisfying non-chemical alternatives

   Primary prevention means that it is more effective to prepare an individual to resolve or cope with problems than to have society try to remedy those problems after they have occurred.

   There will always be individuals for whom the use of any substance will present potentially serious medical, psychological, and/or social problems.

1A. Voting on prevention/control issues. Ask students to respond agree – unsure – disagree on each of the following statements:

   (1) Marijuana use should be de-criminalized.
   (2) People should be allowed to use any substance they choose to use.
   (3) Society has an obligation or responsibility for the health and welfare of its members.
   (4) The people in our society have adopted the idea that all their ills and problems can be solved by taking a pill.
   (5) Most people can learn to make responsible decisions about alcohol use.

   Discuss with the class how public and personal attitudes toward the use of alcohol and other drugs affect the type(s) of prevention activities undertaken by a community.

B. Discuss with the students the following sources of control on alcohol and drug use (family and other admired adults, community groups, peer groups, legal authorities, manufacturers, and media). Using the following headings ask the students to identify ways in which the sources of control can act to prevent substance abuse.

Source of Control as Prevention Agents

Family and Adults	Community Groups	Peer Groups	Legal Authorities	Manufacturers	Media

(CONTINUED ON NEXT PAGE)

CONTENT	ACTIVITIES
	C. Discuss with students the roadblocks to prevention of alcohol abuse caused by community attitudes toward alcohol use. Ask students to suggest ways that they could modify the following community attitudes: – That being drunk is amusing. – That something is "wrong" with someone who chooses not to drink alcoholic beverages. – That a drink, in a social sense, has to contain alcohol to be a drink. – That being a good host means pushing refills the moment glasses are half empty.

CONTENT	ACTIVITIES
Specific Outcome: 2. Identify local efforts to prevent substance abuse.	
2. Many substance abuse prevention programs focus mainly on the facts about substances or whom, where, and when substances are used. The substance use is the focus of the program. Other substance abuse prevention programs focus on the positive psychological/social growth of young people. The emphasis is upon understanding substance abuse as human behavior. Communities attempt to prevent substance use and abuse through: – Establishment of laws and law enforcement agencies – Establishment of public and private agencies to implement laws controlling substance sales and – Establishment of public and private agencies to implement laws controlling substances sales and advertising – Provision of community agencies to deal with mental health and family problems – Establishment of alternative activities for residents – Provision of comprehensive alcohol and drug service centers	2A. Students research and report on the following organizations/agencies as they relate to the prevention of alcohol and drug abuse: **State** – Iowa Bureau of Criminal Investigation – Iowa Department of Mental Health – Iowa Department of Social Services – Iowa Division on Alcoholism – Iowa Drug Abuse Authority – Iowa JAYCEES **Local** – Youth Organizations – Local Treatment Centers – Local Mental Health Centers – Civic government – Service clubs – Others Reports should include the organizations' responsibilities, services, and possible impact as resources to local prevention efforts.

CONTENT	ACTIVITIES
Specific Outcome: 3. Discuss ways by which peers, siblings, and older youth can influence (positively) the non-use of substances by junior high school students.	
3. People learn by observing others; peers, siblings and older youth can influence the behavior of others by their actions and their attitudes. Peer groups are often more influential in changing attitudes and behaviors of adolescents than are media, teachers, parents, or church. Teen-agers can take a large measure of the responsibility for the prevention of substance abuse among their peers. Peer group sanctions can be powerful deterrents to substance use. Teen-agers most often communicate with their peers about personal problems or developmental concerns.	3A. Ask each student to make a plan to positively affect someone's non-use of substances (including cigarettes). Ask them to try to execute the plan and report their results to class. B. Ask the class to develop a list of ways by which a teen-ager can act to postively influence the non-use of substances by his/her peers e.g/ use communication skills in actively listening to peers, recognize early signs of personal inadequacy in dealing with problems and seek help, risk suggesting and acting on non-chemical alternatives, positively reinforce others' decisions to not use substances or to use alcohol responsibly, etc.

CONTENT	ACTIVITIES

Specific Outcome: 4. Analyze the contributions of the family in the primary prevention of substance abuse.

4. Families experience problems. There are methods by which families solve their problems.

A family can offer support, acceptance, and direction to any of its members.

Intra-family communications provide an opportunity to share attitudes and concerns about substance use, and to explore satisfactory alternatives to drug and alcohol use.

Families model the use of substances which children incorporate into their own guidelines for living.

Parents can help their children by being positive role models in the way they use substances themselves, e.g. by showing that they can have pleasure and socialize without alcohol or other drugs.

4A. Family problem solving. Role play a family group that considers a situation in which a teen-ager in the family has been discovered to be using alcohol/marijuana. Have the role players try to reach a solution based on the following:

(1) The problem(s) must be identified
(2) Each person should be able to state his/her feelings
(3) Every solution should be examined seriously
(4) In finding a solution, both parties may have to compromise

Explain that this is not the only way to deal with family disputes (e.g. constructive arguments)

B. Ask students to share their ideas/positions on a values continuum. Instruct students to look across a continuum drawn on the black board and to mark their position with an X. The extremes of the continuum are:

Everything Natural: The families in my community would use nothing that contains chemicals – no drugs, no food preservatives, no deodorants, no prescriptions, no stimulants.

Everything Chemical: The families in my community would use a chemical for every purpose – to go to sleep, to wake up, to study, to increase athletic performance, to feel good all the time, to smell good.

Discuss with the class:

What would the families in your community be like if **everything natural** prevailed? Why?

What would the families in your community be like if **everything chemical** prevailed? Why?

What efforts would be necessary to get families to move from the "everything chemical" end of the continuum toward the "everything natural" end? Would this be desirable?

CONTENT	ACTIVITIES

Specific Outcome: 5. Discuss personal value positions on the use and abuse of substances.

5. Each individual has his/her own particular beliefs, attitudes, and values about alcohol and other drugs. Sometimes individuals are unaware of these value positions about substance use and abuse.

"Seven Criteria for a Value":[5]

(a) Choosing freely
(b) Choosing from alternatives
(c) Choosing from careful consideration of the consequences of each alternative
(d) Prizing, being glad of one's choice
(e) Prizing, being willing to publicly affirm one's choice
(f) Acting upon one's choice, incorporating choices into behavior
(g) Acting upon one's choice repeatedly, overtime

A value judgment is a personal reaction to a statement or situation based on "feelings." These feelings help us decide whether something is good or bad, acceptable, or unacceptable. Either our own personal preferences or the standards set by a social group determine our value judgments.

A factual judgment is one that is based on direct experience or observation. It can be tested (by using the scientific method) for its accuracy. Factual judgments usually don't involve the question of good or bad, although we may have strong feelings about the "facts."

5. Sidney B. Simon, Leland W. Howe and Howard Kirschenbaum. *Values Clarification: A Handbook of Practical Strategies for Teachers and Students.* (New York: Hart Publishing Co., 1972).

5A. **Drug List:** Ask students to fill in the two lists on this page by ranking the following substances from most harmful to least harmful on each list.

Marijuana	Cigarettes	LSD	Aerosol sprays
Barbiturates	Cough medicine	Aspirin	Insecticide
Amphetamines	Alcohol	Growth hormones for cattle	Other _____

	Most Harmful to Individual	Most Harmful to Society

Discuss with students whether their rankings were based on value judgments and/or factual judgments.

B. Divide the class into small groups. Ask the students to individually complete a substance attitude inventory. The small groups are given fifteen minutes to seek group consensus on rankings. Each group has ten minutes to discuss the roles that personal values played in group decision making. A member of each group should present his/her group's position and reasoning to the whole class.

CONTENT	ACTIVITIES

Specific Outcome: 6. Describe how to use agencies which offer assistance to people with mental health, substance abuse, and family problems.

6. There are community agencies and organizations which offer assistance to people with mental health, substance abuse, and family problems.

   Many of these agencies/organizations are supported through tax dollars or community contributions and are available to anyone at little or no cost.

   Many of the community agencies are accessible to minors and maintain confidential relations with their clients.

   The activities of public and private agencies are regulated by laws and licensing standards in an attempt to insure the quality of health services.

   The basic treatment of alcoholism or drug dependencies begins with the individual's recognition that he/she has a problem.

6A. Describe a situation in which an individual is attempting to get help for a personal/family problem. Ask students to list several sources that could provide him/her with information and assistance. As a class describe the procedure that the "young person with a problem" should follow in securing the necessary help.

6B. Ask students to identify sources of help to which they can turn for information and guidance. Make a class chart showing problems and types of resources.

Problem	**Appropriate Resource** (List at least three resources for each problem)
• A mother who is an abuser of alcohol	
• A group of classmates who will not accept you	
• A peer who threatens to commit suicide	
• A friend who intends to "run away"	

MAJOR OUTCOME E: STUDENT WILL KNOW PERSONALLY RELEVANT AND SATISFYING ALTERNATIVE BEHAVIORS TO ALCOHOL AND DRUG ABUSE. (ALTERNATIVES)

CONTENT	ACTIVITIES

Specific Outcome: 1. Identify several alternative behaviors one can employ to satisfy one's needs without using substances.

1. A model presented by Alan Y. Cohen illustrates some relationships among legitimate human experiential needs, substance use, and possible alternative activities. This is a useful model for developing the concept of satisfying non-chemical alternatives.

   Some viable alternatives to substance use include:

   - Establish realistic goals
   - Develop skills and participate in leisure time activities
   - Develop and use problem solving skills
   - Develop and use interpersonal communication skills
   - Participate in activities to help other people
   - Develop non-chemical methods of dealing with everyday pressures

   People can reduce anxiety and stress through the use of non-chemical alternatives.

   Personal skills in problem solving and communicating with others are useful tools in dealing with feelings of alienation, loneliness, boredom, depression, and frustration.

1A. Present the model suggested by Alan Y. Cohen in class. Ask students to add other alternative activities to the list for each category. Each student should check the activities he/she uses in meeting each of the needs described by Cohen. Many of the activities will not be familiar to all of the students so ask some students to find out more about the activities and present them to the class.

B. Instruct each student to list ten or fifteen "loves," activities which he/she most enjoys. At the top write the following categories:

   - When did I last do this?
   - How often do I do this?
   - Do I need a friend or can I do it alone?
   - Does it require money?

   From this data relative to their ten or fifteen "loves," have each student make a statement about two alternative activities that he/she would choose to do soon.

CONTENT	ACTIVITIES
Specific Outcome: 2. Identify settings in the home, school, and community as possible resources for satisfying some needs.	
2. Alternative activities to the use or abuse of substances are limited only by the imagination of interested people who are willing to share their knowledges and interests with others.	2A. Review the five dimensions of interrelated needs (Physical, Intellectual, Social, Emotional, and Spiritual). Print the five dimensions on the blackboard. Ask students to recall needs under each heading (i.e., physical: to eat, sleep, rest, and exercise and social: to make friends and emotional: to express feelings such as happiness, excitement, and joy.) Divide the class into five work groups (one group for each need dimension) to identify human resources for satisfying each specific need. The work group will have to determine if a specific need can be satisfied by oneself or through the assistance of others. Ask each work group to record their information and report the information to the class. B. Ask students to develop a list of recreational facilities and services available in their community. Compile the information into an activity guide for use by individuals at different stages of development. Include examples of recreational activities that would satisfy each of the five dimensions of needs; e.g. physical, intellectual, social, emotional, and spiritual. Discuss the ways in which these activities can serve as alternatives (alternative strategy) to the use of substances.

CONTENT	ACTIVITIES

Specific Outcome: 3. Discuss abstinence as a choice of life style.

3. Although alcohol use is socially accepted, there is a large and responsible minority for whom alcohol use is an unnecessary or unwanted part of their life style.

   Approximately twenty-five percent of the adult population in the United States practice abstinence from the use of alcohol as a part of their life style.

   Motives for the non-use of alcohol and other drugs include the following:

   - Fear of dependency on substances or health concerns.
   - Person feels secure and emotionally mature.
   - Person adopted a non-use life style.
   - Person accepted as an individual without bias and prejudice.
   - Person participates in viable alternatives ("I have better things to do").
   - Person respects the values of family and friends.
   - Person afraid of being caught and imprisoned for illegal activity.

3A. Discuss the non-use motives presented as content statements. Emphasize that non-use of substances is one responsible (OK) life style.

   Ask students to focus on a set of questions anyone might ask of his/herself before using alcohol or drugs. What are the likely responses to these questions when making decisions about alcohol? About marijuana? About amphetamines?

   - What can it do to my family life?
   - How will my behavior affect my school work or job?
   - How might the substance affect my health?
   - How might my friends feel toward me?
   - Isn't there something better to do?
   - How could substance use affect my future?

B. Brainstorm with students methods of demonstrating one's acceptance of a friend or peer who chooses to abstain from using alcohol or drugs.

MAJOR OUTCOME F: STUDENT WILL BE ABLE TO EMPLOY DECISION MAKING SKILLS TO MAKE RESPONSIBLE DECISIONS RELATIVE TO PERSONAL ALCOHOL AND DRUG USE OR NON-USE. (DECISION MAKING)

CONTENT	ACTIVITIES

Specific Outcome: 1. Apply the decision making process to situations involving alcohol and other drugs.

1. In order to make responsible decisions, one needs accurate information and several life coping skills including:

   - Decision making skills
   - Communication skills
   - Inter- and intra-personal skills
   - Skills in clarifying one's values
   - Understanding of personally satisfying alternative behaviors

   Young people have many difficult decisions to make and sometimes it is hard for them to consider the future consequences of their actions.

   Often the desire to conform with the expectations or behaviors of peers leads them to make choices that produce conflicts with parents and/or own long-range self-interests.

   Responsible decisions result in behavior that demonstrates respect and concern for oneself and others.

   Responsible decisions enhance individual development and promote healthy human interaction.

   Adolescents who have developed alternative behaviors for satisfying their needs are less likely to seek social situations where the focus of activity is drinking or using other drugs.

   A decision making process involves these steps:

   - Define the problem (what has to be changed – what is the difficulty)
   - Gather pertinent data
   - Look at choices (what are the possible alternatives)

1A. Discuss four ways one can go about making decisions:

   - Doing the first thing that comes into your mind without stopping to think at all.
   - Thinking only of yourself, your own feelings, and what you would like to do now.
   - Thinking of other people as well as yourself, but only for the present.
   - Thinking of other people besides yourself and what you would like to do at the moment; applying some type of decision making process.

B. Ask students to identify situations where drug or alcohol use is common to young people. Example: Two boys have some marijuana or beer in a parking lot after a ball game. They encourage some others to try the beer or marijuana. The class brainstorms possible behaviors or responses the other persons could do. Using the information generated by the class, go through the decision making process examining the alternatives and consequences. Role play several alternatives suggested by the students.

C. Role play situations which display the use, non-use, or abuse of a substance.

Example:

A Saturday night party for ninth graders in a basement of a home where marijuana is available. The parents are not at home. The characters are described as follows:

Pam – The daughter of a minister. She had led a very sheltered life, and has just begun dating two weeks ago. She has had a crush on Bill for one and one-half years, and was very excited when he asked her to be his date for this party. She has never smoked marijuana before, and has received many lectures from her father on the evils of drugs.

Bill – The school's football hero. His parents are divorced, and he lives with each parent six months out of a year. Each parent tries to show their affection by allowing Bill the freedom to do anything he wants. He has smoked marijuana many times.

(CONTINUED ON NEXT PAGE)

CONTENT	ACTIVITIES
• Examine own values, interests, and needs in relation to choices • Consider short- and long-term effects of various choices (for self and others) • Rank the choices in order of preference (most helpful effects – most realistic) • Arrive at a decision • Follow through on the decision Possible responses to substance use situations include: • Conform to the group's behavior • Avoid or ignore the situation • Behave in accordance with one's values • Work out a compromise to the situation • Refer the situation to an adult authority • Confront the behavior of others	Jane – Voted the girl most likely to succeed by her class. She has good grades, is active in school clubs and sports, and is well liked by her peers and teachers. She has smoked marijuana once, but did not like it. George – Wants to be a doctor. He does not think that there is anything morally wrong with marijuana use, but he is aware of the legal penalties regarding the possession and use of this drug. Jim – The class clown. He will do almost anything for kicks. He brought marijuana to the party and offered it to the group. Discuss the possible decisions of the role players and how emotions may have influenced these decisions. Discuss the techniques used by the role players to influence their peers to use marijuana; how could each person have altered the situation so that no one would have decided to use the substance?

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Pamphlets

"Alcohol A Family Affair". Supt. of Documents or National P.T.A. (Outcome No. A)

"Alcohol Some Questions And Answers". U.S. Government Printing Office. (Outcome No. A, D)

"Drinking Myths". U.S. Jaycees, Tulsa, Okla. (Outcome No. B)

"Drugs A Primer For Young People". Phoenix, Arizona: Do It Now Foundation. (Outcome No. B).

"Interim Report". Numbers 1, 2, 3, & 4, Task Force on Responsible 'Decisions About Alcohol', Education Commission of the State, Denver, (Outcome No. A, D).

"Thinking About Drinking". U.S. Government Printing Office. (Outcome No. B, E, F)

"Questions & Answers About Drug Abuse". U.S. Government Printing Office, 1973. (Outcome No. B).

Books & Booklets

Chemical Survival For Western Men and Women. Phoenix, Arizona: Do It Now Foundation. (Outcome No. B)

Facts About Alcohol And Alcoholism. NIAAA. Supt. of Documents, Washington, D.C.: (Outcome No. B).

Finn, Petter & Platt, Judith. *Alcohol & Alcohol Safety: A Curriculum Manual for Junior High Level: A Teachers Activities Guide.* U.S. Government Printing Office. Available from AEA Media Centers.

Huffaker, Clair, *Flap.* Popular Library. Novel about a group of Indians who get drunk and take over a bulldozer to protect their land.

Hyde, Margaret. *Alcohol; Drink or Drug.* New York: McGraw-Hill Book Co. Talks about problem drinking but also about how wine, beer, whiskey, and other drinks are made.

Lee, Essie. *"Alcohol, Proof of What?"* New York: Julian Messner Publishing Co., 1976. First person stories of young persons involvement with alcohol. Analyzes reasons for drinking or obstaining. (7–12) (Outcome No. A, C, D)

Other

Finn, Peter and others. *"Jackson Junior High"*. Cambridge, Mass. Abt Associates. A film or TV series for grades five through eight on Alcohol Education. Four titles. Teacher manual and student booklet.

Self, Inc. Iowa Public Broadcasting Network. A classrom television series which presents emotional and social problems which confront 11 – 13 year olds. Designed to be used with follow-up discussion and activities. Teacher's guidelines.

Level IV

Grades 10-12

Level IV: Developmental Needs and Interests

Grades 10–12. High school students can deal with the concept of multiple determinants of alcohol and drug abuse. Students can also understand that alcohol and drug abuse are social issues toward which they as young adults must respond.

Most students question many of the values they had previously accepted. Students can understand how their values affect their personal behaviors and styles of decision making or problem solving. Adolescents can understand some of the long-range consequences of the decisions they make.

Students are aware of their developing life styles. Their decisions related to personal use or non-use of alcohol and drugs should be examined in relationship to one's choice of life style. Students should consider how a life style which includes alcohol and drug use might infringe on the rights and welfare of others.

Adolescents can discuss the role of parents in preventing alcohol and drug abuse among family members. Parenting skills, including family problem solving and communications, should be a topic discussed with students.

Students are interested in alternative ways of meeting their needs and solving personal problems without using alcohol and drugs. Students need to see that these options exist.

Factual information about alcohol and drug effects should include discussions of known effects (good and bad). Students should know the various psychological, social, and environmental factors that might modify the effects of a given dose of alcohol and drugs. Students should become informed consumers of prescription and non-prescription drugs.

MAJOR OUTCOME A: STUDENT WILL UNDERSTAND THE BASIC FACTORS IN HUMAN BEHAVIOR RELATED TO SUBSTANCE USE: PSYCHOLOGICAL, PHYSIOLOGICAL, SOCIOLOGICAL. (HUMAN BEHAVIOR)

CONTENT	ACTIVITIES
Specific Outcome: 1. Interpret reasons why people use and abuse substances.	
1. Substance use is a behavior in response to human needs. The reasons for using or not using alcohol and other drugs are strongly related to the attitudes and values of self, parents, peers, and society at large. Some motives might include: – To facilitate interpersonal relations – To impress others – To be accepted by a peer group – To influence others to have sexual relations – To get "high," a method of feeling free and having fun – To deal with boredom, anger, loneliness – To deal with personal "crises" – To avoid dealing with personal problems or frustration – To express hostility or feelings of helplessness – Psychological and/or physiological dependence on the substance	1A. Discuss and analyze the use and abuse of substances in relationship to each of the following factors: (1) Desire for group acceptance and approval (2) Family patterns of use/peer patterns of use (3) Social customs (4) Desire for relaxation and pleasure (5) Boredom or to avoid unpleasant feelings such as anger, anxiety, sadness (6) Appeals of advertising on television and in magazines (7) Messages communicated in popular films and music B. Invite a recovering alcoholic, a former drug user or a person from an alcohol/drug treatment center to talk with the class. The focus of their discussion should be the function or need(s) that substance abuse served for them.

CONTENT	ACTIVITIES

Specific Outcome: 2. Analyze the influence of peers on adolescents' decisions to use or not use substances.

2. The needs for peer group acceptance and group recognition play a significant role in substance use decisions.

   One of the most important ways of dealing with peer pressure is to have someone discuss the feelings in him/her which caused him/her to apply the pressure.

2A. Role play peer pressure experience. Small teams of three or four people will encounter each other in a situation where team A is trying to persuade team B to use a substance such as marijuana or alcohol. After a five minute limit the experience is debriefed.

- Did anyone change their mind.
- What were the kinds of feelings you experienced.
- What were the feelings when a person yielded to pressure? Resisted pressure?
- Feelings when a fellow team member yielded? Or resisted? Or pressured?
- What were the most persuasive arguments?

B. Ask students to individually write brief responses to the following instructions:

Describe two times you have tried to pressure a friend to do something. What did you do to pressure him/her? Were you with other friends? Why did you want him/her to do what you were pressuring him/her to do?

Within small groups share each other's papers. Ask the small groups to:

- Make a chart and list all the reasons why someone might pressure a peer to (a) abstain (b) drink (c) drink excessively.
- Discuss and record which, if any, of these reasons justify exerting pressure and which do not.
- Discuss and record how individuals who exert pressure can be resisted.
- Each small group should report to the class and respond to questions and comments.

CONTENT	ACTIVITIES
Specific Outcome: 3. Analyze the influence of adult models on adolescents' decisions to use or not use substances.	
3. Adult models of substance use are perceived and copied by young children and young adults. Many young people associate alcohol use with adulthood; they are imitating what they perceive as adult behavior.	3A. Discuss the empirical data that indicates that children from families in which one or both parents are alcoholics are over represented in alcoholic populations as adults. Discuss the same data source that also indicates children of totally abstinent families are also over represented in the adult alcoholic population. B. Dear Abby Scenarios: Ask students to write a response to one or more scenarios in which they play "Dear Abby" in response to someone writing her a letter about a family alcohol/drug problem. Example (1) My mother spends all day watching soap operas and nibbling potato chips and neglects my two younger brothers and the house. My father has two jobs to support us and isn't home too much. When I get home from school she's already had several drinks and gets mad at the slightest thing I do. What can I do? Example (2) A school counselor writes: "A question frequently asked by students is this: My father gets bombed every night, double bombed on weekends, fills the house with smoke, then raises hell when I smoke and gets crazy if I have a drink. Does he have a right to keep me from doing the things he says are bad for me when he doesn't practice what he preaches?" Can you give me, a counselor, some advice on what I should say to these kids? Students break into small groups and are given written instructions to: (1) Read each other's replies, discuss the best response and why and (2) Write this down. Groups read their responses to the class and respond to comments and questions from the class and teacher. The teacher should identify coping skills to be used if the advice is followed.

CONTENT	ACTIVITIES

Specific Outcome: 4. Identify the social norms for the use of alcohol and other substances and the influences these norms have on individual decisions about use or non-use of substances.

4. Our society is "chemically oriented," where alcohol and drug use is an established practice.

   Drug and alcohol use is affected by constantly changing social, political, and personal values.

   Norms comprise the rules, regulations, and attitudes that determine the behavior of a group of people. **Informal** norms might include social pressures and customs. **Formal** norms might be laws, regulations, or policies from an official source such as government, church, school, or a company. These norms are derived from social values and are an influence in a person's decision to use or not use substances.

   American society is characterized by an ambivalence toward alcohol and drug use; there are contradictions within the value structures regarding the appropriate function of alcohol and other drugs.

   These conflicts in value structures contribute to the ambivalence and uncertainty with which young people approach the decision to use or not use a substance.

   American society has failed to develop and adopt clear and consistent guidelines for making responsible decisions about using or not using substances.

   Most young people see drinking as a way of achieving adult status and identity.

4A. Suggest that an individual or group prepare a survey instrument to identify local norms for the use of alcohol and non-prescription drugs. Groups such as Jaycees, churches, country club, 12–17 year olds, 18–25 year olds, P.T.A., and local businesses should be surveyed. A summary of the survey should indicate the variety of perceived norms amongst these groups.

B. Role play situations in which parents discover that their son or daughter is drinking or is drunk. After each role play, ask the actors to discuss the feelings which they had while role playing. Invite discussion from the class on the different ways each role might have been played. Discuss the guidelines for alcohol use that were or were not present.

   Parent. Your 15-year-old daughter has just returned from a date and is obviously very high. She is silly and giggly and is having trouble walking in a straight line. You have let her drink a little wine on holidays since she was 10, but that is all. What, if anything, do you say or do?

   Daughter. You have just returned from a date with your boyfriend. You and he got a bottle of wine from his older brother to celebrate your date's 16th birthday. You had about half of the bottle and are feeling very good and a little silly. You expected your parents to be asleep when you get home, but your father opened the door for you. What, if anything, do you say or do?

   New scenarios can be created by varying:

   1. Age and sex of the drinker
   2. The reasons and circumstances under which he/she was drinking
   3. How much he/she drank and how he/she behaves as a result
   4. Who is present when the youth is caught; e.g., mother, father, brother, sister, teacher, police officer
   5. Child's knowledge that one or both parents did similar things when they were young
   6. Child's knowledge that his/her friends do the same things
   7. Parent's knowledge that child's friends do the same things

CONTENT	ACTIVITIES

Specific Outcome: 5. Discuss personal characteristics which may precede substance abuse.

5. Young people who abuse substances seem to share some common psycho-social characteristics:[6]

   (1) A low self-concept
   (2) An inability to form a stable identification with his/her parents or other adult figures.
   (3) An inordinate compliance with peer group behaviors.
   (4) Feelings of social alienation, isolation from others, with less ability to communicate.
   (5) Uncertain of values and priorities, experiencing difficulty making decisions.
   (6) Rejection of parental values and life styles.

   These characteristics have **not** been established as the causes of substance abuse.

   Alcohol and other drug dependencies are difficult to deal with since dependent persons will deny that they have problems controlling their use.

5A. Small group discussion: Social and personal characteristics which may be typical of potential alcohol or drug abusers. Within each group determine what are: High risk personalities?
   High risk behaviors?
   High risk periods in one's life?
   High risk communities?
   High risk life styles?

   The discussion should include past experiences, the present and projections for the future. Are there ways of coping with the "high risks" without using alcohol and/or drugs?

B. Discuss reasons for drug abuse and alcoholism, e.g. boredom, loneliness, lack of coping skills, emotional problems, etc. Ask students the following questions:

   (1) How can these behaviors be a destructive (non-constructive) method of dealing with problems?
   (2) Why do people choose these methods?
   (3) What problems do the behaviors solve?

6. Bernard Segal. "Family Background, Personality Characteristics, and Use of Drugs, Alcohol, or Non-use of Either Among College Students." (Paper presented at the 20th International Institute on the Prevention and Treatment of Alcoholism, Manchester, England, 1974), pp. 165-170.

CONTENT	ACTIVITIES

Specific Outcome: 6. Analyze the impact of alcohol and drug industries on the use of substances.

6. The alcohol and drug industries are interested in promoting the use of their products. The production and sales of alcohol and drug products represent a multi-billion dollar industry. For example, the sales figures[7] for a one year period include:

Alcoholic beverages	$25 Billion
Cigars and cigarettes	$12 Billion
Coffee, tea, and cocoa	$2.5 Billion
Psychoactive drugs obtained by prescription	$2.5 Billion
Illegal drug sales	$2 Billion

Advertising is the principal method of promoting the use of alcohol and drug products. The alcohol and tobacco industries spend more than $1 million daily to promote the sales of their products.

Tax revenues (state and federal) on the production and sale of alcoholic beverages are collected in terms of billions of dollars annually.

The beverage alcohol industry affects our economy in several ways:

(A) Agriculture and allied industries
(B) Employment provided in the manufacture and distribution of beverages (alcohol and "mixers")
(C) Consumer costs and producer profits
(D) Production of containers
(E) Taxes received from the sale of alcoholic beverages

6A. As a class activity have students develop alternative products to advertise to replace alcoholic beverages and non-prescription drugs. Explain to students that alcohol and drug advertising is a very large source of revenue for the broadcast and print media. In order to replace such revenues, media producers and decision makers will need equally or more attractive sources. What products might be substituted?

B. Discuss the possible consequences of replacing all alcohol and drug production with an increase in the production of solar energy and low cost housing. The discussion should indicate the effects to federal, state, and local government due to a decrease in liquor tax revenues, possible layoffs of drug and alcohol industry workers, possible loss to farmers who produce grains, grapes, etc. Would the change in national priorities be possible? Or desirable? What should be done to safeguard an adequate supply of medicines?

7. Joel Fort and T. Cory Christopher. *America Drugstore A (Alcohol) to V (Valium).* Boston: Educational Associates, 1975), p. 6.

CONTENT	ACTIVITIES

Specific Outcome: 7. Discuss the factors which influence alcohol and drug effects.

7. Alcohol and drugs affect individuals in different ways.

Alcohol and drugs influence people's behavior according to the interaction of several factors:

Physiological Factors

(a) Quantity – amount ingested
(b) Quality – purity and/or concentration of dose
(c) Effects of other dilution or "cutting" substances
(d) Presence of food in the stomach
(e) Rate of ingestion and rates of metabolism/clearance
(f) Individual differences (genetic make-up, tolerance, health status)
(g) Presence of other drugs (alcohol will tie up metabolism and liver functions)

Psychological Factors

(a) Previous use experiences
(b) Expectations of effects
(c) Motives for use
(d) Anxiety over use
(e) Mental health of user
(f) Mood/mind set
(g) Personal values

Social Factors

(a) Expectations of others – group norms
(b) Individual perception of expected behavior
(c) Setting (place and time)
(d) Family and religious values

7A. Ask students to identify the interacting factors which could affect the physiological and behavioral effects of alcoholic beverages in the following situation:

John and Bill are the same age, body build, and height. They are at a party. Both have had two cans of beer in the past hour. John is showing no effects and is acting the way he usually does. Bill, who is usually shy and reserved, has become the life of the party. Who might account for the differences in the behavior of the two boys? What additional information would you want to have before you evaluate the situation?

B. Distribute the list of indicators about "How Much is Too Much Alcohol?" (Institute for Family Research and Education)[8] to the class. Ask students to discuss this list in relationship to judgments, mind set, setting, and pharmacological effects of the psychoactive substance alcohol.

"Too much" is when you've had a few and you show one or more of these signs:

- You feel fantastically confident, but you are drinking more and more and faster and faster.
- You can't walk straight, but you're sure you can drive.
- You insist you can walk straight, but you can't.
- You're making others very uncomfortable, but you insist you can handle more.
- Your normal fears and anxieties become exaggerated.
- You tell the people who are worried about you: Leave me alone – I'm all right.
- You are easily offended, especially by people who care about you.
- You are unconcerned about your own safety.
- You really don't care about anyone else (but you're not usually like that).
- You are the most spiteful and hurtful to the people who have loved and cared for you the most.

8. Institute for Family Research and Education. *Juice Use.* (Syracuse University: Ed-U Press), p. 3.

MAJOR OUTCOME B: STUDENT WILL KNOW IMPARTIAL SCIENTIFIC FACTS ABOUT ALCOHOL AND OTHER DRUGS. (SCIENTIFIC FACTS)

CONTENT	ACTIVITIES

Specific Outcome: 1. Classify alcohol and other drugs according to their effects on the mind and body.

1. It is important to put all chemical substances (alcohol, vitamins, non-prescription drugs, narcotics, etc.) into a clear perspective according to their effects on mind and body.

   This can be done by locating substances on a continuum based on the pharmacological effects of the substance (e.g. strong dependency producing to weak dependency producing) or a continuum based on a substance's potential to do the greatest physical harm to the greatest number of people.

   The dependency producing property of a substance is a function of physical and psychological influences it exercises.

1A. Selected small groups investigate and report on LSD (Peyote, Mescaline, etc.), Cocaine, Heroin, Barbiturates, Alcohol, Marijuana, Amphetamines and Non-prescription drugs. Each report should be prepared and copies reproduced for each member of class. Each report should include:

- Slang names
- Historical background
- Source (origins – synthetics derivative)
- Medical use
- Immediate and long range effects on mind and body
- Symptoms of abuse/dependency
- Dangers of abuse
- Regulations and controls
- Media impact on popularity
- Concurrent use with pregnancy and possible effects on infant/embryo

The small group should present the report as a panel with opportunities for the class to ask questions.

B. Make four charts to demonstrate the effects of each of four substances (alcohol, marijuana, amphetamines, and tranquilizers) on the mind and body. For each chart four columns should list the effects of the substance on thought and judgment, sensory awareness, motor coordination, and non-conscious functions (heart rate, blood pressure, respiration, digestion, etc.) **Example:**

Effects of Alcohol

Thought and Judgment	Sensory Awareness	Motor Coordination	Non-Conscious Functions
Affects Ability to:	Affects Ability to:	Affects Ability to:	Affects bodily functions:

CONTENT	ACTIVITIES

Specific Outcome: 2. Identify beneficial and harmful effects of alcohol and drugs on the body.

2. The body is a complex biomechanical machine; how well the machine operates is dependent upon what goes into it.

   No substance taken into the body produces only the psychological or physiological effects that the user wants: no substance has only one action.

   A great deal is known about the harmful effects of alcohol; less is known about the other drugs.

   Many pain and anxiety reducing drugs are valuable for those purposes but little is known about the way the drugs actually work.

   There are many beneficial effects of properly used drugs.

2A. Students investigate the beneficial and harmful effects of the various types of substances: alcohol, non-prescription drugs, narcotics, antibiotics, anesthetics, hormones, tranquilizers, antihistamines, antiseptics, barbiturates, amphetamines, hallucinogens, and sedatives. Compare the values and risks in terms of the following functions and disorders:

- Physical fitness
- Hepatitis
- Malnutrition
- Respiratory disease
- Metabolic disorders
- Emotional disorders
- Logical thought
- Pregnancy
- Reducing pain
- Mental illness
- Sensory perception
- Communicating with others
- Sexuality
- Terminal illness (e.g. cancer)

CONTENT	ACTIVITIES

Specific Outcome: 3. Analyze and interpret the accuracy of drug and alcohol information from all sources.

3. Information about alcohol and other drugs varies in accuracy depending on the source and purpose of the message.

   Local doctors and pharmacists do not test drugs, but rely on the manufacturers, professional researchers, and the FDA for information.

   Advertising is used to create a demand for alcohol and drug products. These messages frequently distort or omit accurate information.

   The Federal Trade Commission can insist that all advertising claims for non-prescription drugs be fully substantiated by facts.

   A peer's assessment of a substance he/she is using regularly will be based on rationalizations or personal biases.

   Social attitudes and public opinion about "legal" and "illegal" substances are in large measure controlled by the information presented by a variety of "special interests" sources.

3A. Ask students to select a historical period and subject for a class presentation on the topic: "The Media and Substance Use Messages." Possible topics might include media coverage of (A) 1865–1875 return of morphine addicted soldiers, (B) 1890–1920 paregoric use by women and children, (C) 1898 Bayer Company introduces heroin, (D) 1920's Prohibition tried and repealed, (E) 1930's Marijuana the Menace, (F) 1937 Passage of Harrison Narcotics Act and the Marijuana Tax Act, (G) 1960's glue sniffing, (H) 1965 LSD, (I) 1968-1972 establishment of Bureau of Narcotics and Dangerous Drugs and the "war against drug abuse."

B. Ask students in your class to rank sources of information about substances which they rate most highly for credibility. Discuss the results of this class survey and the reasons for their choices.

CONTENT	ACTIVITIES

Specific Outcome: 4. Evaluate common alcohol and drug myths.

4. Alcohol and other drugs may affect the same person differently in different situations.

   The term "intoxification" means one thing: there is enough alcohol in the body to have a toxic (depressant) effect on the brain.

   Detoxifying or "sobering up" only takes place when the liver can metabolize the alcohol in the blood.

   Some typical alcohol and drug myths are as follows:

   - Most alcoholics are skid row bums
   - Most alcoholic people are middle-aged or older
   - It's only beer
   - The really serious problem in our society is drug abuse
   - Drinking is a sexual stimulant
   - Marijuana leads to "harder drugs"
   - Illegally manufactured drugs like heroin, LSD, and amphetamines are physically worse for you than the legally manufactured drugs, like nicotine, alcohol, and barbiturates.

4A. Ask student groups to develop booklets similar to *Drinking Myths* (U.S. Jaycees) for *Marijuana Myths, Amphetamine Myths, Tranquilizer Myths, Barbiturate Myths, Vitamin Pill Myths* and *Tobacco Myths*.

B. Ask students to develop a list of practices used by many people to increase their ability to drive after drinking. This list might be developed after talking with parents, older brothers/sisters, other students, police officers, etc. Compile a list of practices and corresponding comments about the validity of each practice. For example:

Drinking black coffee	Ineffective
Inducing vomiting	Ineffective: alcohol is already in bloodstream. Vomiting a natural occurance to avoid overdose.
Eating a large meal	Somewhat effective: delays absorption from stomach and intestines.
Allowing at least one hour time between drinking each one ounce drink	Effective: Sufficient time to metabolize alcohol.

CONTENT	ACTIVITIES

Specific Outcome: 5. Describe procedures for being an informed consumer of prescription and non-prescription drugs.

5. Many consumers will pay more than twice the amount for a given drug than would be required if a truly free market existed.

   - The present patent system allows drugs to be sold by the brand name only and according to what the market will bear.
   - Generic name drugs can often cost five to ten times less than brand name drugs, even though both are subject to the same federal standards for purity and effectiveness.
   - Ask your physician for the generic name of a prescription drug.
   - As a citizen one can support legislation to bring the price closer to the cost of production and sale with a fair margin of profit.
   - As a citizen one can support legislation which would restrict the prescription of amphetamines as "diet pills."
   - The consumer should ask for a prescription with either the lowest priced brand name or the generic name of the drug to get the best price possible.
   - Most pharmacies do not carry a wide range of brands for any particular drug. Shop around the pharmacies to find the best price.
   - Another cost to the consumer is the pharmacist's charge for services.
   - Three to five per cent of **all** hospital admissions result from drug reactions to prescribed medicines.

Review content statements from Level III on pages 71–108.

5A. Ask students to conduct a survey of local pharmacies for their prices on a generic named drug such as Reserpine, U.S.P. of 1,000, 0.25 mg. tablets. Have them list from most expensive to least expensive the retail prices for several brand names e.g. Smith, Kline, and French (Eshasorp) $46.00 to Wolins $0.59.

B. Ask students to conduct a survey of local pharmacies to determine the local pharmacists' fee for services policy.

CONTENT	ACTIVITIES
Specific Outcome: 6. Identify procedures to help in drug and alcohol emergencies and crises.	
6. Additional information about drug and alcohol emergencies can be found in references such as *Chemical Survival for Western Man and Woman* (Do It Now Foundation). Alcohol overdose (passing out) procedures include: (A) Moving the person to safe place (B) Checking vital signs (C) Contact medical assistance if vital signs are depressed severely (D) Positioning body with head to side (E) Rechecking person frequently.	6A. Discuss procedures for handling overdoses of alcohol and other drugs. B. Have two students demonstrate a safe procedure for caring for a person who has "passed out" from an overdose of alcohol.

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CONTENT	ACTIVITIES
Specific Outcome: 7. Evaluate the effects of alcohol and other drugs upon driving behaviors and performance.	
7. The progressive effects of alcohol use: (A) Loss of intelligent behavior (self-control, judgment, decision making) (B) Decrease in muscular control (increased reaction time and difficulties in motor coordination) (C) Influence on the sense organs (vision, hearing, equilibrium) (D) Unconsciousness (decreased rate of breathing, heart action, body temperature).	7A. Discuss with the class the progressive effects of alcohol use and its relationship to driver performance. Establish some "principles of responsible drinking and driving." B. Ask students to list ways in which the drinking driver might affect the safety of himself/herself and passengers in the vehicle, the safety of passengers in other cars, and the safety of pedestrians (especially children).

MAJOR OUTCOME C: STUDENT WILL KNOW THE PROBABLE CONSEQUENCES OF ANY ALCOHOL AND DRUG USE TO THE INDIVIDUAL, TO THE FAMILY, AND TO THE COMMUNITY. (CONSEQUENCES)

CONTENT	ACTIVITIES

Specific Outcome: 1. Discuss the detrimental effects of drug and alcohol dependency to the individual, the family, and the community.

1. The treatment and rehabilitation of chemically dependent persons is difficult and many times unsuccessful.

   Drug and alcohol dependencies are related to automobile accidents, crime, social, occupational and family problems.

   Many experts feel that an alcoholic affects the lives of at least four other people. . . family, friends, schoolmates, neighbors, and co-workers.

   Many people are willing to take the necessary risks to sell and distribute drugs because of the large financial returns on their investment. These profits are made at the expense of individuals and the community.

   Decisions made about substance use can have an impact on future plans for life, work, and health.

   Some basic facts about alcohol use:

   - For every heroin addict in the United States today, there are at least fifteen alcoholics.
   - Alcohol plays a major part in half or more of our highway deaths.
   - Drunkenness accounts for one third of all U.S. arrests.
   - Each year, alcohol drains the national economy of fifteen billion dollars in property damage, lost working time, medical bills, etc.
   - There are an estimated nine million alcoholics in the United States.
   - Alcoholism is a family disease. Someone else's alcoholism has an impact on the lives of an estimated forty million children, parents, and mates.

1A. Invite a representative of Ala-Teen or Ala-Non programs to discuss their function(s) and the type of services they provide.

B. Ask students to develop a list of effects of continued and excessive use of alcohol in:

   (1) resistance to disease
   (2) nutritional deficiencies
   (3) impairment of the nervous and digestive system
   (4) alcohol psychosis
   (5) longevity

C. Ask students to work in pairs to research one of the following consequences of substance abuse (Match a pair of students to each area):

   - Family relationships
   - Group relationships
   - Future careers
   - Potential for dropping out of school
   - Financial demands on user/user family
   - Delinquency and crime
   - Child abuse/child neglect

After completing the research, these students should present a seminar on the social consequences of substance abuse.

CONTENT	ACTIVITIES

Specific Outcome: 2. Demonstrate a knowledge of the laws and regulations concerning the use, sale, and possession of alcohol in Iowa and the possession of alcohol in Iowa and the possible consequences of violating these laws.

2. Refer to the Code of Iowa for specific citations of Iowa laws.

A national survey[9] revealed that arrests of persons under 18 years of age for alcohol-related offenses (drunkenness in public, drunken driving, and liquor law violations) increased nationally by 135 percent between 1960 and 1973.

Driving while under the influence arrests increased by four hundred percent in the same period.

Automobile insurance premiums reflect in large measure the cost of alcohol-related accidents. Everyone pays these increased premiums.

The sale, possession, and distribution of alcohol has been defined by Iowa law with penalties established for violations of such.

2A. Students write brief response to the following scenario.

You have been appointed the new Director of Automobile Laws (DAL) with complete power to make any laws you want regarding the use of alcohol by drivers and pedestrians. What actions, including possible penalties or rehabilitation measures, will you prescribe for the following offenses:

- Driving with open container of alcohol in car
- Driving when drunk
- Being about to drive when drunk
- Driving when drunk and (a) killing a pedestrian, (b) getting into a property damage accident with another car, (c) driving into a telephone pole.
- Being a drunk pedestrian and causing an accident by suddenly walking across the street in the middle of the block.
- Purchasing alcohol for a minor who is subsequently killed while driving under the influence of alcohol.
- Driving when drunk and killing one of the passengers.

During the following class the students break into small groups and are given instructions to agree on what measures should be prescribed and why. Groups report conclusions to the class and respond to questions and comments from class and teacher. Teacher would indicate actual laws and initiate discussion on relationship between student's chosen action and actual laws.

B. Select an actual legal violation involving alcohol from the newspaper, police department, or court system (omit names of people involved) and determine the Iowa laws which applied.

9. *Second Special Report to the U.S. Congress on Alcohol and Health.* (Department of Health, Education, and Welfare, June, 1974), DHEW Publication No. (ADM) 74-124.

CONTENT	ACTIVITIES

Specific Outcome: 3. Demonstrate a knowledge of the laws and regulations concerning the use, sale, and possession of "controlled substances" in Iowa and the possible consequences of violating these laws.

3. (Refer to the Code of Iowa for specific citations of Iowa Controlled Substances Laws)

   Iowa laws have defined personal sale, possession, distribution and manufacture of "controlled substances." There are definite penalties prescribed for violations of these laws.

   Federal schedules of controlled substances includes minor tranquilizers such as Librium, Valium, and Dalmone under Schedule IV.

   Under Iowa law, "addiction" to the use of drugs is a ground for revocation or suspension of a license to practice a profession.

   The Department of Public Safety is directed to revoke a person's driver's license upon his/her conviction for driving a motor vehicle while under the influence of a narcotic, hypnotic, or other drug.

   Other states have much more severe collateral consequences of being convicted of a drug offense.

3A. Conduct a simulation game of the arrest and trial of two teen-age boys (girls) for the possession with intent to deliver a controlled substance (marijuana or amphetamine). Assign roles to students as: two dealers, one teen-age witness, two narcotics officers, a prosecuting attorney, a public defender, four parents of the defendants, juvenile court judge, a social worker and an eleven person jury. Remaining students should be observers and recorders of the proceedings. Allow two weeks so that students can have the opportunity to research their roles.

B. Ask a select group of students to prepare a flow chart which shows the procedures followed by law enforcement and juvenile court officials with juveniles arrested, charged, and ajudicated for the sale of a controlled substance. Particularly identify the options available to the defendant and officials during the procedures. Display and discuss the chart in class.

CONTENT	ACTIVITIES

Specific Outcome: 4. Demonstrate a knowledge of the consequences of driving while under the influence of alcohol (and other drugs); both immediate and long range.

4. (Refer to the Code of Iowa for specific citations of these laws).

Driving while under the influence of alcohol or other drugs is an illegal act which is punishable by law. A conviction for violation of these laws has an immediate effect on driving privileges, insurance premiums, insurability, and employment.

Alcohol plays a role in fifty percent of all highway deaths of the alcohol-related fatalities, an estimated two-thirds involve problem drinker-drivers. The other one-third of alcohol-related accidents involve social drinkers, particularly heavy social drinkers and young drivers who are learning to drink at the same time that they are learning to drive. **10**

The driver's license may be suspended or revoked as a penalty of the conviction for driving while under the influence of drugs.

People on prescribed medications often do not know how these substances might affect driving performances.

Combined use of drugs or drugs and alcohol have some dramatic effects on perceptions, reaction time, speed of movement and judgment – all integral parts of safe driving practices.

4A. Ask a select group of students to prepare a flow chart which shows the procedures to be followed by a police officer who has detained an individual for suspicion of a violation of one of Iowa's drinking driving laws. Identify the agencies involved in the procedures and the types of records which are developed for the individual case. Display and discuss the chart in class.

B. Ask students to individually rate each of the following drug products according to the degree of risk taken when combined with driving. Place a number from the continuum next to the name of each drug product.

Not dangerous			Slightly dangerous			Moderately dangerous			Very dangerous
1	2	3	4	5	6	7	8	9	10

1. Sleeping pills
2. Diet pills
3. Cough syrup
4. Cigarettes
5. Coffee
6. Aspirin
7. Antihistamines
8. LSD
9. Alcohol and prescription drugs
10. Marijuana
11. Tranquilizers

10. Ibid.

CONTENT	ACTIVITIES

Specific Outcome: 5. Describe the possible consequences of one's responses toward a person whose behavior has been changed by alcohol or drugs.

5. "The nature and intensity of the situation and the possible consequences of one's response determine the appropriateness of the response to a person whose behavior has been changed by alcohol or drug use."

   Variations in the nature of the situation:

   (a) Location of the interaction
   (b) The number, kind, and relationship of the people involved

   Variations in the intensity of the situation:

   (a) Amusing, entertaining
   (b) Bland, innocuous
   (c) Slightly embarrassing to and awkward for one or more people
   (d) Very embarrassing to one or more people
   (e) Potentially hazardous to one or more people
   (f) Immediately hazardous to one or more people

5A. Students role play one or more scenarios in which a boyfriend or girlfriend is drinking excessively in his or her date's company. Students should be encouraged to create their own role profiles. After each role play, participants read their role profiles to class and discuss the feelings they had while role playing. Non-participants discuss how they might have acted or what they might have said had they been involved. Discuss the possible consequences of all role playing situations. What were the variations in setting and intensity? What types of responses were made? What were the likely positive and negative consequences?

B. Discuss the various responses one can make to a person whose behavior has been changed by alcohol or other drugs. Ask students to give examples of situations which might be best handled under one of the following response categories (avoid or ignore situation, acquiesce to the situation, work out a compromise to the situation, confront the situation directly, refer the situation to an adult authority).

(CONTINUED ON NEXT PAGE)

CONTENT	ACTIVITIES

Alternative responses and possible consequences

(A) Responses:
- Avoid or ignore the situation
- Acquiesce to the situation
- Work out a compromise
- Confront the situation and refuse to be part of it
- Refer the situation to an adult authority

(B) Possible Consequences:

Positive
- Increase respect and/or acceptance by others
- Increase in self-respect
- Increase in personal security
- Increase in physical safety
- Personal convenience

Negative
- Loss of respect and/or acceptance by others
- Loss of self-respect
- Increase in physical danger or injury
- Personal inconvenience
- Increase the probability of making same response again

MAJOR OUTCOME D: STUDENT WILL KNOW THAT THE INDIVIDUAL, HIS OR HER FAMILY, AND THE COMMUNITY HAVE INTERRELATED RESPONSIBILITIES FOR THE PREVENTION OF ALCOHOL AND DRUG ABUSE. PREVENTION

CONTENT	ACTIVITIES
Specific Outcome: 1. Evaluate the effectiveness of existing controls over the use and abuse of substances.	
1. The decision to use or not use a substance is a personal one. The personal decision is strongly influenced by the following sources of control: peer groups, family, church, school, media, substance producing industry, and the lawmaking and law enforcement systems. Substance use decisions are made in terms of perceived risks and gains. Sources of control exert their relative influences in terms of the individual's perception of the risk-gains for self. Risk should be defined as more than physical risk; risk has strong emotional overtones. Risks are taken for acceptance, economic reasons, cultural norms, stimulation and excitement, self-fulfillment. Certain substance use behaviors are tolerated by society and peer groups. Four types of prevention strategies have been identified as: (1) Coercion or threat of formal sanctions (2) Persuasion/Education (3) Elimination of Causes (4) Provision of Alternatives The four prevention strategies have been tried by existing sources of control in every community in varying degrees and with varying degrees of success. Our society has most often relied on the use of controls such as laws and regulations governing the use, sale, costs, and production of substances. Prevention programs will be minimally effective if parents, youth, and community groups do not share common prevention goals and agree on how these goals can be reached.	1A. Divide the class into eight study groups; one group for each source of control. Instruct each study group to identify both the methods of control used and the approaches to preventing substance abuse advocated by the source of control. A member from each study group should present the group's report and respond to questions and comments from the class and teacher. Generate a discussion of how possible combinations of the sources of control might be effective in preventing substance abuse in your community. B. Work with a small group of six students to research and develop a panel discussion in which each student is the "informed expert" on one of the following topics: ● Efforts in controlling the sale and distribution of alcohol and other drugs. ● Efforts at eliminating the causes of substance abuse in our society. ● Education as a method of persuading people not to use substances. ● Society's provision of alternative activities for meeting one's needs. ● Effectiveness of current alcohol and drug treatment and rehabilitation methods. ● Effect of media messages on adolescent use or non-use of substances. Allow each student to have six minutes to present his/her opening remarks during the first class presentation. Ask the remainder of the class to prepare questions for the "experts" in writing during the first presentation. Give the written questions to the appropriate expert(s) and allow them to respond during the next class meeting. Discuss and summarize the comments of the panel.

(CONTINUED ON NEXT PAGE)

CONTENT	ACTIVITIES

Personal control of substance use means that the person has assumed responsibility for his/her behavior.

The family is viewed by many authorities as potentially the most effective agent in influencing the substance use decisions of young people, but it is often the most difficult resource to enlist in substance abuse prevention.

The community's overall approach to substance abuse and its control often includes:

- Developing an informed public (attitudes and norms)
- Support for an effective law enforcement system
- Support for courts and laws that recognize the complex human issues that underlie substance use/abuse
- Provision of treatment and rehabilitation services
- Support for social and health agencies which provide services to families and individuals
- Support for physicians and clergy who counsel and/or refer people to services
- Support for and cooperation with thy school and other community agencies' efforts at primary prevention

CONTENT	ACTIVITIES

Specific Outcome: 2. Discuss the responsibilities of the community for the treatment and rehabilitation of substance abusers.

2. The community pays for the treatment and rehabilitation of chemically dependent persons.

   Medical and/or psychological care is provided for chemically dependent people in community supported agencies/organizations such as:

   - Free clinics, crisis centers, or hot lines
   - Marriage and family counseling services
   - Local councils on alcoholism/drug abuse
   - Local or regional alcohol/drug treatment centers
   - Alcoholics Anonymous, Al-Anon, and Alateen
   - Community mental health centers

2A. Students do research on treatment methods and facilities for chemically dependent persons. A small group of students should write a list of sources from which to obtain information about treatment methods and facilities for alcoholics and drug dependent people. The group divides up responsibility for the work. Types of sources include:

- Literature
- State and local departments of mental health
- State and local chemical dependency agencies
- Private alcoholism units
- State and local correctional systems
- Members of groups like AA, Al-Anon and Alateen
- Field trip to alcoholism/drug treatment unit to talk with staff and patients

Students draw up a list of questions they would like answered such as:

(1) What treatment methods exist?
(2) Which seem to be most effective and why?
(3) Have treatment methods changed over the years? If so, why?
(4) Are the most effective treatment methods in fact implemented? If not, why not?
(5) How much does it cost to treat and rehabilitate a client?
(6) What is the success rate for clients? How is success defined?

B. Invite a representative of a local alcohol/drug treatment center to speak to the class about the philosophy, type(s) of treatment offered, funding source, admittance procedure, in-patient and out-patient care provided at the facility, and cooperative arrangements with the local court system and other community agencies.

CONTENT	ACTIVITIES

Specific Outcome: 3. Suggest ways by which individuals can assume responsibility for the prevention of substance use and abuse.

3. The Task Force on Responsible Decisions About Alcohol[11] has stated that the skills and attitudes necessary to make responsible decisions can be identified and learned.

"If actual and potential alcohol misuse (abuse) is to be decreased, millions of Americans need to know what is expected of them; how their behaviors must change to become responsible non-users or users." (Interim Report Number 2)

In order to increase the opportunity to make responsible decisions about non-use or use of substances, people will need many skills and knowledges e.g. decision making skills, communication skills, inter- and intra-personal skills, skills at clarifying values, leisure activity skills, coping skills, and accurate knowledge about alcohol and other drugs.

The individual can take actions to reduce or prevent his/her own use, misuse, or abuse of substances.

The individual has a personal responsibility to help prevent substance abuse in his/her own community by:

- Getting in touch with his/her own attitudes about substances.
- Preparing oneself with facts about substances.
- Modeling constructive coping with one's own developmental concerns and personal problems.
- Involvement in and/or support for community programs of alternative activities.

Individuals will very likely be hosts and will have some responsibility for the control of substance use.

3A. Write or identify a situation where a young person is involved in the juvenile court system for violation of a substance law. Ask student to write an alternate life story without a legal violation. Include within the stories the social forces or agencies and the personal choice of behaviors which could have prevented the juvenile court situation.

B. As a class develop a list of actions that an individual can take to help prevent substance abuse in his/her community.

11. Task Force on Responsible Decisions About Alcohol. Interim Report Number 2. (Denver: Education Commission of the States, 1974).

CONTENT	ACTIVITIES
Specific Outcome: 4. Recommend community actions for the primary prevention of substance abuse.	
4. Primary prevention is the attempts made by individuals and/or communities to meet their needs without substance abuse. Communities should identify existing needs of its residents, its resources for meeting these needs and cooperatively develop and implement a plan of action to meet these needs. A community can develop services to meet youth and adult needs for new experiences, adventure, self-understanding and development, accomplishment, belonging, feeling important, discovering new abilities, and many other aspirations that many people turn to alcohol or drugs to fulfill.	4A. Discuss with the class the concept of primary prevention of substance abuse. As a class develop a definition of primary prevention. Identify ways that the school, family, church, local media, peer groups, and community organizations can assist in the primary prevention of substance abuse. B. Discuss with the class the following suggestions that Ernest P. Noble (director of NIAAA) has made to prevent or reduce alcohol abuse.[12] In the discussion ask students: Are the suggestions realistic? What other suggestions would you make? – "It might also be possible to reduce consumption and affect drinking patterns by changing the social or physical environment of drinking and altering societal institutions and customs. – "The alcohol beverage industry should stress prevention in its advertising and to establish nationwide prevention programs. – "The broadcast and film industry should re-evaluate media portrayals of drinking as an integral part of social custom." **On local level:** – "City planning and zoning boards could use their power to regulate the location and design of liquor outlets to reduce alcohol problems. – "Alcohol and tax agencies could control prices (raise them), hours, and conditions of sale of alcoholic beverages. – "Bartenders and liquor store clerks could restrict sales to intoxicated persons and seek to control excessive drinking."

12. Ernest P. Noble. "NIAAA Taking a Hard Look At Prevention Strategies." NIAAA Information and Feature Service. IFS No. 20. November 23, 1976, p. 1.

CONTENT	ACTIVITIES

Specific Outcome: 5. Discuss the influence of parental use and substance attitudes on their children's future substance use or non-use.

5. Parents affect the attitudes of their children toward alcohol and other drugs.

Blum (1972) identified several factors within the American family which contribute to high or low risk drug-taking behaviors of their children.[13] These factors included:

- Parental drug use behaviors
- Parental views of law and authority
- Child-rearing goals
- Parental acceptance of youthful self-expression
- Infant health habits

Most parents do not know how to effectively communicate with their children about their own attitudes and values related to substance use or non-use.

Significant others are those people in our lives to whom we give credibility and respect and care about.

In most instances parents are not seen by adolescents as significant others in their personal examination of alcohol/drug taking issues.

Parents must not give up their role of parent (especially nurturance and support functions), but they must realize that their significance does not exist just because they are parents.

13. Richard H. Blum and Associates. *Horatio Alger's Children: Role of the Family in the Origin and Prevention of Drug Risk.* (San Francisco: Jossey-Bass, 1972).

5A. Discuss the positive affects (primary prevention strategy applied at home) of parents listening for feelings and giving children positive feedback. Role play a parent listening for feeling while the child tells his/her problem.

B. Have students read and discuss in small groups the following letters to:

Dear Ann Landers:

"Our son was a bright, charming, creative child with a high IQ. He did poorly in school, got into all kinds of trouble, took drugs, and caused us many sleepless nights.
Finally my husband said to him, 'you are not going to ruin our lives. From now on you are responsible for yourself.
If you make it, fine. If you don't, you will have to suffer the consequences.'
From that day on we refused to give him one cent. By so doing we released him psychologically and put him in charge of his own life. . ."

Dear Ann Landers:

"What wisdom, consolation or advice can you give parents in their 50's who have worked hard to achieve the American dream, loved their children, and tried to give them the best world ever? We are also the unhappiest.
Many of our children are on drugs, unemployed, drop-outs, migrants, drifters, angry with the world, hostile toward us, and out of joint with society.
How much and for how long should parents pay in terms of self-recrimination, worry, disappointment, and financial support? How can we enjoy the years that are left to us now that we have more money, fewer business pressures, and still are in fairly good health?
It is heartbreaking to see our kids maladjusted, disoriented, and unable to cope. We can't help but feel we are to blame. After all, they are our sons and daughters. We raised them."

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CONTENT	ACTIVITIES
Many people realize that adolescents try to find ("test") a comfortable place between parental expectations and peer expectations. Behavior and values never take on real meaning for adolescents until they have survived this testing. Parents **cannot:** (1) Eliminate drug/alcohol situations from occurring (2) Prohibit young people from associating with peers. Parents **can** accept peer relationships and peer/parent testing as necessary developmental phenomena. Parents **can:** (1) Foster the growth of their child's self-concept and problem solving skills. (2) Communicate trust and respect to their children. (3) Communicate their attitudes and values related to substance issues. (4) Give their children postive feedback about their child's responsible decision making.	**Discuss:** The role of parent-child communications in the situations. Solicit answers to: – What conflicts in values seem to be involved? – What might the parents and children have done to prevent the situations from developing? – What community resources might have been of assistance in preventing the situations from occurring? – Why might the community resources not have been used?

CONTINUED

4 OF 7

CONTENT	ACTIVITIES

Specific Outcome: 6. Identify constructive aspects of an abstinent or responsible use life styles.

6. An abstinent or responsible use life style can allow people to constructively meet their needs.

   Drugs and alcohol are commonly used to facilitate interpersonal relations; the quality of the communications is a function of the substance effects.

   Abstinent and responsible users of substances have some measure of personal satisfaction from relating to others more effectively.

   Abstinent or responsible use life styles are behaviors based on the personal values people hold.

6A. **Stereotyped Life Styles:** Ask students to look at contradictions in their perceptions of people classified as "abstainers," and "social drinkers," or "problem drinkers" according to their non-use or use of alcohol. Discuss "stereotypes" and ask students to define understanding and accepting differences, tolerating differences, and adopting differences.

Differences: The teacher makes three separate columns on the blackboard, entitled "Behaviors," "Life Styles," and "Values." At the top of the board write Abstinent Person. For each column, students suggest characteristics of people who adopt an abstinent life style. Repeat with Responsible Drinker and Problem Drinker.

Behaviors	Life Style	Values
1. Avoids parties where alcohol served	1. Two-parent family	1. Honesty
2. Solves personal problems	2. Maintaining continuous employment	2. Loyalty to Country
3. Etc.	3. Etc.	3. Etc.

Discuss with the class: Are there basic differences between abstainers, social drinkers, and problem drinkers other than their behavior toward alcohol?

B. Invite two parents to talk about their non-use or responsible use of alcohol. Ask them to describe how their alcohol behaviors fit their life styles. Ask them to also discuss how they communicate their attitudes toward alcohol to their children.

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MAJOR OUTCOME E: STUDENT WILL KNOW PERSONALLY RELEVANT AND SATISFYING ALTERNATIVE BEHAVIORS TO ALCOHOL AND DRUG ABUSE. (ALTERNATIVES)

CONTENT	ACTIVITIES

Specific Outcome: 1. Assess one's own life style in relationship to meeting personal needs.

1. People make decisions about ways by which they can meet their needs. These decisions may not be significant in separate instances, but the cumulative effect of many such decisions establishes one's life style.

   Life styles are determined by decisions made on the basis of personal values.

   Life styles reflect the risk-taking behaviors of people.

   Risks are taken for acceptance, economic reasons, to conform to or to reject cultural norms, stimulation and excitement, and self-fulfillment.

   Observations about risk-taking:[14]

   - People differ on how much risk they like to take
   - People often do not have clear perceptions of themselves as risk-takers
   - A person's emotions influence his/her estimates of risks
   - For some people, something that is difficult to get is automatically more desirable
   - One is often willing to take great risks if the outcomes are highly valued.

   Alternatives to substance use/abuse work because they satisfy common needs. They generate pleasure and they offer positive experiences that make drugs and alcohol seem less interesting.

   Major health problems are related to our life styles.

   The current leading causes of death in the U.S. – heart disease, cancer, stroke, accidents, and diabetes – have all been linked to personal behavior: drinking, smoking, poor diet, obesity, lack of exercise, and unsuccessful coping with stress.

1A. **Expectations:** Ask students to write a brief description of him/herself five years from now, including: job, family, leisure time, goals, achievements, possessions (life style).

Personal Needs: Ask students to write a brief description of him/herself five years from now, indicating those personal needs and decisions which will most likely be influencing his/her life style.

With these two sets of information, ask each student to identify those personal actions that will involve the most risks and those aspects of their future life style that he/she most values.

B. **Personal Barometer of Being and Feeling:** Discuss with students the relevance of occasionally taking a look at your current feeling status, what is causing some unity to one's life and what is causing some disunity.

Reproduce the following scale and ask students to assess where they are presently on the scale. Discuss with students what non-chemical alternatives they can employ to bring oneself closer to the unity side or to maintain one's status.

14. *Road Notes. A Training Manual for People Helping People.* (Flint, Michigan: Genesee Intermediate School District, January, 1974), p. 79, Project TRIAD.

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CONTENT

ACTIVITIES

PERSONAL BAROMETER OF BEING AND FEELING

DISUNITY	UNITY		What actions should I take
Tension	1 2 3 4 5 6 7 8	Relaxation	
Anxiety	1 2 3 4 5 6 7 8	Calm	
Distress	1 2 3 4 5 6 7 8	Comfort	
Fear	1 2 3 4 5 6 7 8	Confidence	
Hostility	1 2 3 4 5 6 7 8	Warmth	
Loneliness	1 2 3 4 5 6 7 8	Loved	
Emptiness	1 2 3 4 5 6 7 8	Fulfillment	
Depression	1 2 3 4 5 6 7 8	Joy	
Despair	1 2 3 4 5 6 7 8	Serenity	

CONTENT	ACTIVITIES

Specific Outcome: 2. Choose alternatives to substance use which are compatible with personal interests and values.

2. Alternatives are not merely substitutes.

V.A. Dohner:[15]

"To be acceptable and attractive, any alternatives we offer must be realistic, attainable and meaningful. Any proposed alternative must assist people to find self-understanding, improved self-image, feeling of significance, expanded awareness of new experience which they seek through drugs. These alternatives must also meet other criteria:

(1) They must contribute to individual identity and independence;
(2) They must offer active participation and involvement;
(3) They must offer a chance for commitment;
(4) They must provide a feeling of identification with some larger body of experience; and
(5) Some of the alternatives must be in the realm of the non-cognitive and the intuitive."

Discovering and accepting ourselves is a mental health promoting alternative.

2A. Discuss with students the "alternatives concept" and criteria presented by V.A. Dohner. Ask students to list the types of alternative activities in which they engage. Discuss the individual activities lists as to their agreement with the criteria presented by Dohner.

B. Discuss with students the differences between drug and alcohol involvements and alternative involvements as presented in the following table:

Substance Involvements Are likely to result in –	**Alternative Involvements** Are likely to result in –
(1) Temporary high	(1) Continuing satisfaction
(2) Decreased self-esteem	(2) Increased self-esteem
(3) Dependency	(3) Independence
(4) Nothing lasting	(4) Building of resources
(5) Artifically induced state	(5) Natural state
(6) Decreased enjoyment of natural state	(6) Increased enjoyment of natural state
(7) Decreased relatedness to others	(7) Increased relatedness to others

5. Dohner, V. Alton, "Alternatives to Drugs - A New Approach to Drug Education," *Journal of Drug Education*, March, 1972.

CONTENT	ACTIVITIES
Specific Outcome: 3. Identify and analyze adult models for meeting needs constructively.	
3. Many adults use a wide variety of alternatives activities for fulfilling their emotional, social, intellectual, physical, and spiritual needs. Adult models are seen by young people in terms of desirable traits and personal competencies (e.g. ambitious, cheerful, dependable, truthful, loving, generous, self-controlled).	3A. Ask students to identify an adult who they think has it "pretty well together." After identifying the adult model ask students to write a brief response to each of the following questions: – How does this person behave when they experience disappointment or frustration? – How does the person give and receive love? – What kinds of activities does your adult model do for recreation? – How does the adult satisfy his/her social, intellectual, and spiritual needs? – Does your adult model seem to operate from some conscious plans for personal improvement? Each student should review his/her responses in terms of the appropriateness of the adult behavior. Criteria for this assessment might be that appropriate responses to needs bring satisfaction to the person and are acceptable to those around him/her.

CONTENT	ACTIVITIES

Specific Outcome: 4. Evaluate abstinence as a personal choice of life style.

4. Abstinence, not using alcohol or other mood altering substances, is a responsible choice of life style.

   Responsible drinking, using alcohol as an adjunct to other pleasurable activities, is a behavior accepted by our society.

4A. As a class develop a list of common activities in which they engage that might be difficult for them to abstain from doing, e.g.:

- Using salt and/or sugar
- Smoking tobacco
- Using the telephone
- Watching television
- Participating in recreational sports
- Drinking all beverages except water
- Driving a car

Ask students to select one or more activities and attempt to abstain from it (them) for one week. At the end of one week, ask each student to report to class on:

(1) Your success
(2) Your feelings about your success
(3) Your feelings during the period of abstinence; e.g., boredom, nervousness, anger, grouchiness, feelings towards others who were not abstaining.
(4) Your methods for abstaining

Discuss the relevancy of emotional influences (feelings) on the use, non-use, or abuse of substances.

B. Discuss with the class the abstinent life style advocated by some religions. Ask selected students to report on the abstinence norms and traditions of some religions.

C. As a class prepare a list of the advantages and the disadvantages of an abstinent life style.

CONTENT	ACTIVITIES

Specific Outcome: 5. Describe responsible hosting in regard to alcoholic beverages.

5. The social situation can either help or hinder responsible decisions about alcohol. Responsible serving of alcoholic beverages can make the individual's decisions easier.

   The host can have a party without serving alcoholic beverages. If the host does decide to serve alcoholic beverages he or she can:

   - Provide food when alcohol is served.
   - Provide other social activities as a primary focus when beverage alcohol is served.
   - Respect a guest's decisions to abstain.
   - Provide equally attractive and accessible non-alcoholic beverages when alcohol is served.
   - Serve or use alcohol only in environments conducive to pleasant and relaxed behavior.
   - Serve drinks that are diluted and do not urge that glasses be constantly full.
   - Recognize that drunkenness is neither healthy nor safe: do not excuse unacceptable behavior for that individual or others because of too much to drink.
   - Recognize a responsibility for health, safety, and pleasure of both drinking and non-drinking guests.
   - Make contingency arrangements for intoxication should it occur despite precautions i.e., transportation home, overnight accommodations, etc.

5A. As a class develop a list of responsible hosting practices.

B. Students write brief scenarios where a host is confronted with drinking issues at a party. Select scenarios and have students work in small groups with one scenario per group. Ask students to discuss:

   - What the host **would** do and why.
   - What the host **should** do and why.
   - If there is any discrepancy, why, and can it be overcome.
   - Whether a host has **other** responsibilities besides those raised by the scenarios.
   - What guests can do, if anything, about a **host** who is irresponsible.

   Groups report their conclusions to the class and respond to questions and comments.

   Example: You are having a big party after the Big Game and will be serving plenty of beer. You know that several kids will get drunk and want to drive home.

MAJOR OUTCOME F: STUDENT WILL BE ABLE TO EMPLOY DECISION MAKING SKILLS TO MAKE RESPONSIBLE DECISIONS RELATIVE TO PERSONAL ALCOHOL AND DRUG USE OR NON-USE. (DECISION MAKING)

CONTENT	ACTIVITIES

Specific Outcome: 1. Discuss the individual's right to make his/her own decision about substance non-use or use.

1. The decision to not use or to use substances is a personal matter; the individual must assume the responsibility for the consequences of his/her choice.

   Other people are often affected by one's decision to use or not use substances.

   Factors involved in making personal decisions may, in themselves be neither good or bad, but their effects may lead to sound or unsound decisions.

   Value judgments about substances and people who use/abuse substances strongly affect personal decisions about using or not using substances.

   Many decisions result from the individual's response to more subtle value pressures from family, peers, mass media. Such decisions are less likely to reflect the individual's own choice.

   Each person must weigh alternatives and consequences for himself/herself.

   Feelings in oneself and others need to be recognized and taken into account in decision making.

   People have decision making styles which are based on personal behavior patterns.

   Many people employ defense mechanisms such as rationalization, projection, and denial to justify their decisions to use or abuse substances.

1A. Discuss with students the steps in a decision making process and how people vary in personal decision making styles (sets of personal behaviors affect styles of decision making; e.g., independent, understanding, constructive, etc.). Ask students to complete a self-assessment of their decision making on an agree – disagree scale. Examples of items to assess might include:

- I usually try to think of as many alternatives as possible
- I try to consider how my decisions might affect others
- I need to solve my own problems by making my own decisions
- I have control over most decisions I make

B. Discuss the concept of "Risk – Gain tradeoffs" involved in substance use decisions. Some people perceive large gains to self (acceptance by peers, establishing one's identity, etc.) from using substances; while risks to self are perceived minimally or not at all. Other people perceive substance use behavior as high risk with low gains to self.

CONTENT	ACTIVITIES

Specific Outcome: 2. Identify social situations or conditions when individuals might be apt to use or abuse substances and will suggest ways to avoid or handle such occasions.

2. Every young person in our society will encounter situations which involve substance use.

Coping with substance use situations is directly related to how we feel about ourselves and our reasons for role experimentation.

A value judgment is a personal reaction to a statement or situation based on "feelings." These feelings help us decide whether something or someone is good or bad, acceptable or unacceptable.

Our own personal preferences and/or the standards set by a social group determine our value judgments about substance use and non-use.

Prediction and expectation heavily influence our choice of substance use/non-use behavior. When we make a conscious adjustment of our behavior, we do this with anticipated results.

The following factors directly influence predictions and expectations about substance use/non-use:

- The feelings one has toward or about another individual engaged in the substance use/non-use oneself is considering. (e.g. you expect others to feel toward you as you feel toward the original individual)
- The feeling one perceives others have toward or about another individual engaged in the use or non-use of substances.
- One's value system.
- One's own direct past experience with non-use/use of substances. (What kind of feedback did you get when you did this before?)
- The information received (feedback) during one's actual use/non-use.

2A. Students role play one or more scenarios in which a boyfriend or girlfriend is drinking excessively or using drugs in his or her date's company. After each role play, participants read their role profiles to class and discuss the feelings they had while role playing. Non-participants discuss how they might have acted or what they might have said had they been involved. Example role plays:

Date: You are 16-years-old and at a party with twenty-five friends. You've been going with your present date for five months. She has a habit of drinking too much at parties and then flirting with other boys. She's already had two beers and has just opened a third. What, if anything, do you do? (You've had two beers, too, but you think you can hold your liquor.)

Excessive Drinker: You are 16-years-old and at a party with twenty-five friends. You have dated this boy for about five months. You like to get "high" at these parties because you feel less shy with other people and it will just make you happy . . . and you don't mind making your boyfriend a little jealous by flirting with another boy or two. You're on your third beer now.

Teacher: Take notes of decisions both role players make. List the decisions on the board after the role play is ended. Ask the class what other decisions they would have made, what alternatives existed? What were the likely consequences of the suggested alternatives?

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CONTENT	ACTIVITIES

B. Ask students to study the following situations and discuss their suggested solutions. There are **no** correct answers.

"I really think Sue has more to drink than she can handle. What can I do without hurting her feelings?"

- Pretend not to notice
- Sober her up before the party ends
- Suggest leaving the party to take her home
- Insist she stop drinking
- Others

"I'm the only non-drinker at this party. What can I do so they won't make a fool out of me?"

- Make up a story about my health
- Say "no thanks" casually but firmly
- Take the drink and sip it slowly
- Take the drink and pour it into a flower pot
- Others

"I've never had a drink and I'd like to see what it's like!"

- Experiment at home when my parents are away
- Experiment with friends
- Ask my parents if I can drink with them
- Others

C. Repeat the form of 3B but modify the alternatives so that marijuana is the substance toward which the decisions must be made.

Level IV
Selected Resources

Pamphlets

"ABC's of Drinking And Driving". Greenfield, Mass.: Channing Bete Co., (Outcome No. C)

"Alcohol: A Family Affair". National PTA or Supt. of Government Documents, (Outcome No. A, D, E)

"The Drinking Question: Honest Answers to Questions Teenagers Ask About Drinking". U.S. Government Printing Office. (Outcome No. B)

"Drugs A Primer For Young People". Phoenix, Arizona, Do It Now Foundation. (Outcome No. B)

"Drugs And Youth". Drug Abuse Council. (Outcome No. D)

"Interim Report". No's. 1, 2, 3, & 4, Task Force On Responsible Decisions on Alcohol. Education Commission of the States. Denver, Colo. (Outcome No. D)

Wetherell, Jerome. *"People Do Drink And Drive"*. American Driver & Traffic Safety Education Assn., Washington, D.C. (Outcome No. C)

"Questions and Answers About Drug Abuse". Supt. of Doc. U.S. Government Printing Office. (Outcome No. B, E)

"You, Alcohol And Driving". Greenfield, Mass.: Channing Bete, Co. (Outcome No. C)

Books & Booklets

Brecher, Edward, *Licit and Illicit Drugs.* Little, Co. Society's attitudes towards use of and control of drugs.

Chemical Survival: A Primer for Western Men & Women. Phoenix, Arizona, Do It Now Foundation. (Outcome No. B)

Chemical Survival: A Primer for Western Men & Women. Phoenix, Arizona, Do It Now Foundation. (Outcome No. B)

Facts About Alcohol & Alcoholism. NIAAA, U.S. Government Printing Office. (Outcome No. B)

Finn, Peter & Platt, Judith. *Alcohol & Alcohol Safety: A Curriculum Manual for Senior High Level: A Teacher's Guide.* U.S. Government Printing Office. (Outcome No. A, F)

Fleming, Alice. *Alcohol, The Delightful Poison.* New York: Delacorte Press. History, traditions, and role of alcohol in American Life; includes misconceptions and attitudes. (Outcome No. A, B, D)

Frazer, Dan & Pawlak, Vic. *Alcohol, Facts Behind the Rumors Behind the Myths.* Phoenix, Arizona: Do It Now Foundation. (Outcome No. A, B)

Scoppettone, Sandra, *The Late Great Me,* New York: Bantam Books, (Outcome, No. A, C)

Summers, Marcia and others. *Our Chemical Culture.* (Outcome No. A, B)

Others

Dial A-L-C-O-H-O-L. NIAAA, a film series for high school on Alcohol Education. Four titles, teacher's manual and a student book. Available through Department of Public Instruction.

Finn, Peter & Lainsin, Jane. *Alcohol: Pleasures & Problems.* Cambridge, Mass. Abt Associates. Student book accompanying Dial A-L-C-O-H-O-L.

Chapter Four

This chapter includes the following types of teacher resources:

A. A glossary of terms related to alcohol and drug education
B. A guideline for the selection of audio-visual materials for use in alcohol and drug education
C. A bibliography of selected readings
D. A bibliography of selected curricula
E. A list of selected publications in the fields of alcoholism and drug abuse
F. A list of selected national organizations
G. A list of state and local organizations

The bibliographies and lists provided in this chapter are not intended to completely represent all of the resources available to teachers. There are several excellent audiovisual resources available to teachers which have not been cited in this guide. A list of recommended and not recommended films can be obtained from the Alcohol and Drug Education Program within the Department of Public Instruction.

GLOSSARY

1. **Alateen.** An organization for teen-agers whose mothers or fathers are alcoholics. Members meet to discuss how to deal with their parent(s) and be happy.

2. **Al-Anon.** A worldwide organization of wives and husbands of alcoholics. Members meet to discuss how to deal with their alcoholic husbands or wives.

3. **Alcoholic** is a person who is an excessive drinker. The person's dependence on alcohol has reached such a degree that it noticeably disturbs or interferes with his/her physical or mental health, interpersonal relations, and his/her satisfactory social and economic functioning.

4. **Alcholics Anonymous (AA).** A worldwide organization of recovering alcoholics. There are local groups in many towns. Members meet to discuss their problems related to alcohol so they can continue not to drink and to help others with drinking problems.

5. **Alternatives.** The various alternatives models assume that "when people possess the knowledge, motivation, and skills to create active and meaningful lives, the allure of drugs and alcohol is significantly reduced. Alternatives involve an assessment of individual needs (physical, recreational, sensory, emotional, interpersonal, social, intellectual, spiritual) and of personal and community resources. The alternatives may promote personal awareness, interpersonal relationships, self-reliance, creative and aesthetic experiences, philosophical explorations, social or political involvement, or religious experience.

   Alternatives are constructive and viable involvement in behaviors which provide greater needs satisfactions than substance use.

6. **Community Resources.** Those agencies and forces which affect children directly or indirectly and which an effective school program can tap for cooperative assistance although they are generally outside the control of school boards or school administrators.

7. **Controlled Substances.** Controlled substances are those placed on a schedule or in special categories to prevent, curtail, or limit their distribution and manufacture. Under the Controlled Substances Act of 1970 the Attorney General of the United States (on the recommendation of the Secretary of Health, Education, and Welfare) has the authority to place drugs into five schedules or categories, based on their relative potential for abuse, scientific evidence of the drug's pharmacological effect, the state of current scientific knowledge about the drug, and its history and current pattern of abuse.[1]

   The five schedules have different penalties for violations, with Schedule I the heaviest and Schedule V the mildest. Some drugs which are controlled are the opiates, amphetamines, hallucinogens, marijuana, and depressants.

8. **Decision Making.** Any action one chooses to take or not to take is the result of a decision making process. Decision making is a skill which must be learned. Becoming aware of this process, the opportunities to make decisions, and one's decision making style frees an individual to be and become what he or she chooses. It also brings the concept of individual responsibility for one's behavior very clearly into focus.

9. **Dependence.** Dependence is a state of periodic or chronic intoxication detrimental to the individual and to society, produced by the repeated consumption of a natural or synthetic drug. It consists of: (a) an overpowering desire to continue using the drug, (b) a tendency to increase the dose or the frequency of consumption, and (c) a psychological, and sometimes physical dependence on the drug's effects. The World Health Organization has substituted drug dependence of a certain type (opiate, alcohol, barbiturate) for what was called addiction.

9A. **Physical Dependence.** Physical dependence is the development of an altered physiological state that requires continued administration of a drug to prevent the appearance of a characteristic withdrawal or abstinence syndrome. The amount and frequency of drug use prior to development of tolerance and physical dependence may develop without simultaneous psychological dependence as in patients requiring large doses of analgesics for physical pain.

9B. **Psychological Dependence.** Psychological dependence refers to an emotional need to use periodically or chronically a drug to obtain pleasure or to avoid discomfort. The individual believes he is unable to get along in life without the agent. There is frequently the belief that the agent is an integral part of life. When the drug is unavailable the user may feel ill at ease, anxious, or irritable. At the same time, the individual may or may not be physically dependent on the drug.

1. Eric Scaps, Allen Cohen, Henry Ressink, *Balancing Head and Heart*, (Lafayette, Calif.: Prevention Materials Institute Press, 1975).

To state that a certain drug produces psychological dependence is naive and simplistic because the individual's free choice in using the drug is ignored. Also ignored are: (a) the variable and overlapping degrees of use by dependent and non-dependent users, (b) the fact that dependent persons use the drug to fulfill some unmet psychological need or as a people substitute; and (c) drugs may modify but do not compel a specific type of behavior as a consequence of their use. This does not deny that psychological changes produced by chronic drug use may increase the psychological dependency.

10. **Depressant.** Depressants are drugs which may reduce anxiety and excitement. They basically act to depress the activity of the central nervous system. Taken in small doses they temporarily ease tension in some people and induce sleep. Barbiturates, tranquilizers, and alcohol make up the largest groups of depressant drugs.

11. **Drug (Substance).** Any biologically active agent which when inhaled, ingested, or injected alters the physical or psychological functioning of the individual. Alcohol is a drug.

12. **Drug (Substance) Abuse** is variously defined as: (a) the use by self-administration of any drug in a manner that deviates from the accepted social and medical practices within a given community or society; (b) the habitual use by self-administration of any agent to the extent it interferes with the physical, psychological, vocational, or social functioning of the individual; or (c) the habitual use by self-administration of any agent for the sole purpose of altering the mood or emotions of the user.

13. **Drug (Substance) Use** refers to the consumption of any quantity of a substance for any purpose.

14. **Drug (Substance) Effects** refers to any physical or emotional changes produced by a drug. The modification of drug (substance) effects by physiological, social, and environmental factors is considerable. The effects are dependent on five factors: (A) individual dose response, (B) biological variability, (C) potency of the substance, (D) tolerance, and (E) mind set and setting.

    (A) Dose response refers to the fact that, as the amount of a substance in use is changed, there may be a change in the reaction of an individual. Other dose responses include therapeutic, toxic, or lethal: therapeutic refers to the amount of a drug that will aid in the solution of a medical problem; toxic means that the prescribed dose will have adverse effects on the body; and a lethal dose will result in death.

    (B) Biological variability in all organisms there is a substantial variability in biochemical response. This is particularly true with ingested drugs. Dose response curves vary widely between people. Some individuals are generally more sensitive to a drug than others. Some persons will show the desired effect at lower dosage levels and others, equally drug sensitive, will have more bad side effects at the set levels.

    (C) Potency of a drug is determined by the amount that must be given to obtain a particular response; the smaller the amount needed to achieve that result, the more potent the drug.

    (D) Tolerance refers to a condition in which repeated administration of a drug results in a gradually diminishing effect. To achieve the same result as previously, the dose must be increased. But increasing the dose also increases the unwanted side effects.

    (E) Mind set and setting is highly variable and involves the person's personality, the person's attitudes and moods, the setting (location, other people present), expected drug effects, past experience.

15. **Hallucination** is a false sensory perception.

16. **Hallucinogens.** Hallucinogens (also called psychedelics) are drugs which affect sensation, thinking, self-awareness, and emotion. Changes in time and space perception, delusions (false beliefs) and hallucinations (experiencing nonexisting sensations) may be mild or overwhelming, depending on dose and quality of the drug. Effects vary; the same person may have different reactions on different occasions.

    Many natural and synthetic hallucinogens are in use. LSD, a synthetic, is the most potent and best studied. Mescaline (from the peyote cactus), psilocybin (from the Mexican mushroom), morning glory seeds, DMT, DOM (STP), PMA, MDA, and others have somewhat similar effects.

17. **Influences.** Outside influences exert a strong impact on substance use/non-use behaviors. Three categories of influence (peer pressure, significant others, and institutional) should be considered in any substance education program.

17A. **Peer pressure** is social urging to behave in a way that is acceptable among people in one's own general age group. Peer pressure involves the need to be accepted, the need to have friends, and the need to check out our feelings and values with others. Understanding of the peer pressure placed on the individual by others is one of the best methods people have in coping with the pressure. The classroom can offer an opportunity to examine why people feel a need to apply peer pressure and how individuals feel when it is applied.

17B. **Significant others** are those people in one's life to whom one gives credibility and respect and toward whom one cares a great deal. People are significant others because of their role in one's life. The extent of the significance of these others (i.e. parents, teachers, ministers, employers) is determined by the credibility an individual assigns to them. This significance differs with each particular issue faced in one's life.

17C. **Institutional** influence. Institutions, such as the school system, church, and media, also influence one's choice of behavior. For example, school systems sanction values and behaviors and media advertisements sanction alcohol and drug taking behaviors and values.

18. **Intervention** means a substance abuse program providing services which are usually non-scheduled, short-term, and referral-oriented.

19. **Life coping.** The use or non-use of alcohol and other drugs reflect behavioral outcomes of a coping process. Young people are presented with the decision to use or not use substances as a part of their everyday experience in our society. Their decisions and behaviors reflect their skill at coping; their actions that solve problems or at least deal with them, reduce a danger or a threat, correct a harm, or achieve needs satisfaction. The life coping process begins with recognition of issues and problems. There must be personal **recognition** of an issue, problem, or opportunity and the need to deal with it. The recognition level requires skills of awareness, self-understanding, and understanding social situations. The second part of the coping process addresses the question: "What does this issue/problem mean to me?" The third part of the coping process involves making a **decision** to make an external or internal response.

20. **Life coping skills** are ways of dealing with the problems and challenges of living, changing, and growing. Examples of life coping skills are valuing, decision making, communicating, confronting, asserting, risking, experimenting, withdrawing, fantasizing, and understanding defense mechanisms.

21. **Maintenance**: Treatment of narcotic addicts with legally dispensed methadone or large enough doses of heroin to permit normal functioning to blunt the need for illegal narcotics.

22. **Marijuana.** Marijuana is a common plant with the biological name of cannabis sativa. The active (mind-affecting) ingredient is delta-9-tetra-hydrocannabinol, or THC. The flowering tops and leaves of the plant contain the highest THC concentration.

Hashish or "hash" is a dark brown resin from the tops of cannabis sativa. It is much stronger than crude marijuana since it contains more THC. "Hash oil" is a distillant of the marijuana plant with a concentration of THC of forty-eight percent or even higher. The effect on the user is more intense and the possibility of side effects is greater.

The effects of marijuana vary so widely that it can be either a stimulant or a depressant. THC is often considered a hallucinogen with some sedative properties. Most drug educators prefer to keep it in a separate category because of the debate that continues about its effects.

23. **Medicines** are drugs which are specifically developed to cure disease, prevent disease, or reduce their symptoms.

24. **Methadone.** Methadone is a synthetic narcotic used in the treatment of some heroin addicts. It relieves the physical craving for heroin and acts longer in the body than heroin. Used with proper supervision, methadone allows the addict to work and lead a relatively normal life.

Since methadone itself can cause physical dependence, it is under strict government regulation. Addicts admitted to methadone treatment are usually over eighteen and have a long history of dependence. Many programs provide for withdrawal from methadone maintenance, once rehabilitation has succeeded. Research is being done to develop longer acting methadone and to measure the effects of long-term use.

25. **Motives.** There are many reasons for contemporary substance use. Reasons most frequently offered range from the belief that "medicines" can solve all problems, to widespread access to various substances, "peer pressure," to the enjoyment of substance effects. Reasons for experimenting with substances (such as curiosity or peer pressure) may be different from the reasons people decide to use substances (such as social acceptance, enjoyment) and those reasons may be different from the reasons people continue to use substances regularly (such as emotional dependence or fear of withdrawal.

26. **Multimodality treatment.** A program offering more than one rehabilitative approach.

27. **Narcotic.** Narcotics are drugs that relieve pain and often induce sleep. The opiates, which are narcotics, include opium and drugs derived from opium, such as morphine, codeine, and heroin. Narcotics also include certain synthetic chemicals that have a morphine-like action, such as methadone.

28. **Overdose.** An "overdose" of drugs can be defined as an amount of drugs taken which causes an acute reaction to the user. A drug overdose can often be recognized even by a nonmedical observer because it often produces stupor or coma. Often there is a low breathing rate as well. Medical help is needed immediately. First aid measures that can be taken while waiting for medical help include artificial respiration to restore breathing.

29. **Prescription Drugs.** Those drugs, medications, and medical devices subject to regulations by a physician's prescription which are "habit forming," "toxic," "potentially harmful," or whose "method of use," are not safe except under the supervision of a physician.

30. **Prevention** means those organized efforts by individuals, schools, organizations, or agencies designed to deter or inhibit the development of substance abuse by individuals and the individual and social problems associated with substance abuse.

31. **Primary Prevention** is a constructive process designed to promote personal and social growth of the individual toward full human potential and thereby inhibit or reduce physical, mental, emotional, or social impairment which results in or from the abuse of chemical substances.

32. **Problem drinker.** A person whose drinking causes him or her a problem or causes problems for other people. The following have been suggested as criteria:

Anyone who needs to drink in order to get along or to cope with life.

Anyone who (by his/her definition) often drinks to a state of intoxication.

Anyone who goes to work intoxicated.

Anyone who is intoxicated while driving a car.

Anyone who (while intoxicated) has an injury requiring medical attention.

Anyone who has a conflict with the law as a consequence of being intoxicated.

Anyone who while intoxicated does something he/she says he/she would never do without alcohol.

33. **Psychoactive Drugs** are capable of changing mood, feelings, and thoughts by direct action on the central nervous system. These include various stimulants (nicotine, caffeine, cocaine, amphetamines); sedatives (alcohol, marijuana, barbiturates, tranquilizers); pain relievers (aspirin, narcotics); and mind-distorting agents (LSD, mescaline, marijuana).

34. **Rehabilitation** means the restoration of a client to the fullest physical, mental, social, vocational, and economic usefulness of which he or she is capable. Rehabilitation includes, but is not limited to, medical treatment, job counseling, occupational training, social and domestic rehabilitation, and education.

35. **Risk-taking** is an important element in the decision making process. One is willing to take great risks if a particular outcome is highly valued. Risk-taking is learned. Each person develops his/her own style of risk-taking and every person will take different amounts of risk on various decisions depending on the intended outcomes or the situations surrounding each decision.

36. **Self-concept** is the ongoing definition of ourselves and is the single most important element affecting human behavior. A young person who feels good about his or her self is more likely to take care of that self.

37. **Social drinker** is a person who drinks alcohol, but not so much that it causes problems for him/her or others.

38. **Stimulant.** Stimulants are drugs which increase alertness and activity. They include caffeine, cocaine, and amphetamines. Stimulants are often called "uppers" or "pep pills." Amphetamines are the most often abused stimulants.

39. **Substance** means all chemicals such as alcohol, spirits, wine, beer; controlled substances; prescription drugs; over-the-counter products; inhalants; and substances, other than food, used to affect the structure or any function of the body.

40. **Therapeutic communities.** Residential drug-abuse treatment centers where various forms of encounter groups and peer pressure are used to rehabilitate residents.

41. **Tolerance.** Tolerance is a physical condition which develops in users of certain drugs. When a person develops tolerance, he requires larger and larger amounts of the drug to produce the same effect.

42. **Treatment** means the broad range of planned and continuing in-patient, out-patient, and residential services including diagnostic evaluation, counseling, medical, psychiatric, psychological, social service care, and occupational services which may be extended to substance abusers and which is geared toward influencing the behavior of an individual to achieve a state of rehabilitation.

43. **Valuing.** Values are beliefs or preferences that guide people's actions. The process of valuing is a skill to be learned and utilized in making responsible decisions about use or non-use of substances. Values clarification requires students to examine their behavior and their values on the basis of three general criteria: choosing, prizing, acting. Students are asked to determine if they have **chosen** a course of action freely from several different alternatives after considering the consequences of each alternative. Do they **prize** their choice, in terms of being happy with the choice and affirming the choice publicly? And did they **act** on the choice, actually do something as a result of having made the choice, not only once but repeatedly. The behavior that reflects all of these criteria is based on real values.

44. **Volatile Substance.** Substances like model airplane glue, paint thinners, gasoline, and other volatile (breathable) solvents contain a variety of chemicals which can cause tissue damage or death when inhaled or ingested.

45. **Withdrawal.** A condition that results from discontinuance of the use of a drug on which the body has become physically dependent after extended heavy use.

B. Criteria For Chemical Abuse Related Films
(Alcohol and other drugs)

Films have become an increasingly attractive method of delivering chemical abuse related information. The Education Task Force of the Iowa Drug Abuse Authority encourages their use as one of many alternatives. In the area of chemical abuse education we have found that some films are productive in that they aid young people and adults in making decisions for their own lives which are growth producing. Some films reduce the chances for making sound decisions.

The following are some criteria for judging the merits of chemical abuse films. In evaluating a film, the reviewer may use the following rating scale to determine whether the film is appropriate for his/her intended audience.

	Strongly Disagree				Strongly Agree	
1. The film suits the purpose intended which is _____	1	2	3	4	5	N/A
2. The films suits the audience intended which is _____	1	2	3	4	5	N/A
The film contains the message that:						
3. The effect of a drug or alcohol is a function of the dosage, the method of administration, the frequency of use, the individual, and the environment.	1	2	3	4	5	N/A
4. The problems associated with alcohol and drug abuse are complex. There are no easy answers. No two substance users are alike.	1	2	3	4	5	N/A
5. Society needs to at least acknowledge an inconsistent position regarding the use of chemicals to alter an individual's mood. Some, tobacco and alcohol, are legal while others are illegal.	1	2	3	4	5	N/A
6. Drug and alcohol abuse are social problems, not just medical problems.	1	2	3	4	5	N/A
7. People can help to solve the drug and alcohol abuse problem by promoting the following conditions: better youth-adult communication, cooperation, and acceptance of differences.	1	2	3	4	5	N/A
8. The film promotes positive images and positive alternative activities rather than reinforcement of "how-to" techniques and exaggeration of negative effects.	1	2	3	4	5	N/A
9. The information in it is accurate from a scientific point of view.	1	2	3	4	5	N/A

(CONTINUED ON NEXT PAGE)

10. It is a contemporary film and is not out-of-date.	1	2	3	4	5	N/A
11. The film is well organized and understandable. Its message is clear.	1	2	3	4	5	N/A
12. It is entertaining and interesting.	1	2	3	4	5	N/A
13. The situations depicted are believable and realistic.	1	2	3	4	5	N/A
14. It is technically well produced (e.g. good color, sound, and picture quality).	1	2	3	4	5	N/A
15. Its length is appropriate for audience intended.	1	2	3	4	5	N/A

IF THE FILM DOES NOT RATE SCORES OF 4 OR 5 IN AT LEAST HALF OF THESE CATEGORIES, THE TASK FORCE RECOMMENDS THAT IT NOT BE SHOWN.

Alcohol & Health: Second Special Report to the U.S. Congress, Dept. of HEW, U.S. Government Printing Office, 1974.

Alternative Pursuits for Americas Third Century, National Institute on Drug Abuse, U.S. Government Printing Office, 1974.

Breacher, Edward. *Licit and Illicit Drugs.* Boston: Little, 1972.

Cornacchia, Harold and others. *Drugs In the Classroom, A Conceptual Model for School Programs.* St. Louis: C. V. Mosby, 1973.

Dohner, V. Alton. *Alternatives, One Approach to Drug Education.* American Vocational Association, Washington, D.C., 1973.

Doing Drug Education. The Role of the Teacher. National Institute of Drug Abuse, U.S. Government Printing Office, 1975.

The Drug Alternative. AAHPER, Washington, D.C., 1975.

Einstein, Stanley. *Beyond Drugs.* New York: Perganon Press Inc., 1975.

Facts About Alcohol & Alcoholism. NIAAA, Rockville, Maryland: DHEW Pub. No. (ADM) 74-31, 1974.

Fort, Joel. *Alcohol, Our Biggest Drug Problem.* New York: McGraw Hill, $6.95. This book deals with alcohol as a drug problem in all its aspects. The book covers abuses, treatment, prevention, and other factors, including ethnic drinking patterns.

———*American Drugstore A(Alcohol) to V(Valium).* Boston: Educational Associates, 1975.

Freed, Alvyn M. *T.A. for Kids.* Sacramento: Jalmar Press, 1974.

———*T.A. for Teens.*, 1976.

———*T.A. for Tots.*, 1973.

Hebeison, Ardyth. *Peer Program for Youth.* Minneapolis: Augsbuerg Press, 1973.

Hyde, Margaret O. *Alcohol: Drink or Drug.* New York: McGraw Hill, 1974. Discusses how various alcoholic beverages are made, social drinking and the danger signals of alcoholism.

———*Mind Drugs.* New York: McGraw Hill, 1974. $4.95. Up-to-date research information about specific drugs such as alcohol, marijuana, and heroin is presented.

Lyon, Harold C. *Learning to Feel – Feeling to Learn.* Columbus, Ohio: Charles E. Merrill, 1971.

Miles, Samuel. *Learning About Alcohol, A Resource Book for Teachers.* AAHPER, Washington, D.C., 1972.

Raths, Louis E.; Harmin, Merrill; Simon, Sidney. *Values and Teaching.* Columbus: Merrill, 1966. $3.95.

Resource Book for Drug Abuse Information. AAHPER, Washington, D.C., 1969.

Rosenthal, Mitchel S., M.D. and Mothnir, Ira. *Drugs, Parents & Children, The Three Way Connection.* Boston: Houghton Mifflin Co., 1972.

Samuels, Don and Mimi. *A Complete Handbook of Peer Counseling.* Miami, Florida: Fiesta Pub. Corp., 1975.

Schaps, Eric; Cohen, Allen; and Ressink, Henry. *Balancing Head and Heart: Sensible Ideas for the Prevention of Drug & Alcohol Abuse, Book 1: Prevention in Perspective.* Lafayette, California: Prevention Materials Institute Press, 1975.

———Slimon, Lee. *Balancing Head & Heart: Sensible Ideas for the Prevention of Drug & Alcohol Abuse, Book 2: Eleven Strategies.* Lafayette, California: Prevention Materials Institute Press, 1975.

———Adams, William; and Ressink, Henry. *Balancing Head & Heart: Implementation and Resources.* Vol. 3, Lafayette, California: Prevention Materials Institute Press, 1975.

Simon, Sidney and Kirschenbaum, Howard. *Readings in Values Clarification.* Minneapolis: Winston, 1973.

——Howe, Leland; and Kirschenbaum, Howard. *Values Clarification, A Handbook of Practical Strategies for Teachers and Students.* New York: Hart, 1972.

Smart, R. G. and Fejer, Diane. *Drug Education: Current Issues, Future Directions.* Ontario: Addiction Research Foundation, 1974.

Sumners, Marcia and others. *Our Chemical Culture.* Madison: Stash Press, 1975.

Weil, Andrew. *The Natural Mind.* Boston: Houghton Mifflin Co., 1973.

D. Selected Curricula and Related Resources

Alcohol Use and Traffic Safety. Maryland State Department of Public Instruction, Office of Curriculum Development, Baltimore, Maryland 21240. 1974. Vol I: A Curriculum Guide for Grades K–3, Vol. II: A Curriculum Guide for Grades 4–6, Vol. III: A Curriculum Guide for Grades 7–9, Vol. IV: A Curriculum Guide for Grades 10-12.

Bread and Butterflies. Agency for Educational Television. A classroom television series which reinforces career education in grades 4–6. Nine programs from the series are directly related to outcomes presented in this alcohol and drug education guide. Programs are shown on Iowa Public Broadcasting Network. Available on video tape from selected Area Education Media Centers.

Decision making and Drug Information. Drug Prevention Education, Cooperative Education Service Agency, Appleton, Wisconsin 54911. Teacher Activity Package Grades 2–6.

Drug Abuse Education Resource Guide. Indiana Department of Public Instruction, 1974.

Finn, Peter and Platt, Judith. *Alcohol and Alcohol Safety: A Curriculum Manual for Elementary Level.* Vol. I & II (Volume II is a Teacher's Activities Guide) U.S. Department of Transportation, 1972.

——*Alcohol and Alcohol Safety: A Curriculum Guide for Junior High Level.* Vol. I & II (Volume II is a Teacher's Activities Guide). These are available from Iowa Area Education Agency Media Centers or from Department of Public Instruction INFORMS on microfiche.

Focus on Mental Health. North Carolina Department of Public Instruction. Life Skills for Health: from booklets K–3, 4–6, 7–9, and 10–12. 1974.

Health Education: Drugs and Alcohol; An Annotated Bibliography. N.E.A., Available on microfiche from INFORMS, Department of Public Instruction. ED 104 841, 1975.

INFORMS. Iowa Department of Public Instruction. This service will conduct a computer search of ERIC (Educational Resources Information Center) on selected topics and provide microfiche copies.

Inside/Out. Agency for Educational Television. A classroom television series that helps elementary students to explore the emotional and social problems that confront them. Shown on Iowa Public Broadcasting Network. Available on video tape from selected Area Education Agency Media Centers.

A Reference Guide for Teachers on Emotional & Mental Health. Michigan Department of Education.

Self, Incorporated. Agency for Educational Television. A classroom television series that helps 11 to 13 year olds learn to cope with the emotional and social problems that confront them. Shown on Iowa Public Broadcasting Network; available on video cassette from Heartland Area Education Agency, Ankeny, Iowa.

Teaching About Drug Abuse. Illinois Interagency Drug Abuse Education Development Committee.

E. Selected Publications

Addictions. Alcoholism and Drug Addiction Research Foundation, Ed. Div. 33 Russell St., Toronto, Ontario, Canada. Articles on alcoholism and drug addiction and prevention education.

Current Health, The Continuing Guide to Health Education. Curriculum Innovations Highwood, Illinois.

Health Education. American Alliance Health, Physical Education and Recreation, 1201 16th St., Washington, D.C. Monthly $10. Available at college and university libraries. Physical Education and health teachers may have member's copies.

Intercom. Iowa Drug Abuse Authority, 615 E. 14th St., Des Moines, Iowa 50319.

The Journal. Addiction Research Foundation, Toronto, Canada 55S251. Newspaper; published monthly. Subscription rate $16 per year.

Journal of Alcohol and Drug Education. Alcohol and Drug Problems Association of North America, 3500 N. Logan, Lansing, Michigan 48914. Available by subscription, three issues per year. 3/year $4.

Journal of School Health. American School Health Association, Box 416, Kent, Ohio. September – June by membership. Available from State Mid-Library or college and university libraries. School health staff may have member's copies.

Listen, A Journal of Better Living. Pacific Press Publishing Association. Mountain View, California 94042.

National Drug Reporter. National Coordinating Council on Drug Education, 1211 Connecticut Avenue N.W., Washington, D.C.

Quarterly Journal of the Studies on Alcohol. Rutgers Center of Alcohol Studies, New Brunswick, New Jersey 08903. 9/yr. $20. Available at the State Medical Library in Des Moines and University of Iowa Medical Library.

The WORD. Iowa Division of Alcoholism, 508 10th Street, Des Moines, Iowa 50319.

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F. SELECTED ORGANIZATIONS: NATIONAL

ADDICTION RESEARCH FOUNDATION
33 Russell Street
Toronto, Canada 55S251

ADIRONDACK MOUNTAIN HUMANISTIC EDUCATION CENTER
Upper Jay, New York 12987

ALCOHOL & DRUG PROBLEMS ASSOCIATION OF NORTH AMERICA
1130 17th Street, N.W.
Washington, D.C. 20036

ALCOHOL SAFETY ACTION PROJECT
112 North Central Avenue
Suite 304
Phoenix, Arizona 85004

ALCOHOLICS ANONYMOUS WORLD SERVICE, INC.
P. O. Box 459
Grand Central Station
New York, New York 10017

AMERICAN ALLIANCE OF HEALTH, PHYSICAL EDUCATION & RECREATION (AAHPER)
1201 Sixteenth Street N.W.
Washington, D.C. 20036

AMERICAN COUNCIL OF ALCOHOL, INC.
119 Constitution Avenue, N.E.
Washington, D.C. 20002

AMERICAN MEDICAL ASSN.
535 North Dearborn Street
Chicago, Illinois 60610

AMERICAN PHARMACEUTICAL ASSN.
2213 Constitution Avenue, N.W.
Washington, D.C. 20037

AMERICAN SCHOOL HEALTH ASSN.
515 East Main Street
Kent, Ohio 44240

AMERICAN SOCIAL HEALTH ASSN.
Narcotic Advisory Committee
1740 Broadway
New York, New York 10019

BUREAU OF NARCOTICS AND DANGEROUS DRUGS
Department of Justice
1405 I Street, N.W.
Washington, D.C. 20226

CENTER FOR STUDIES OF NARCOTICS AND DRUG ABUSE
U.S. Public Health Services
5454 Wisconsin Avenue
Chevy Chase, Maryland 20203

CENTER OF ALCOHOL STUDIES
RUTGERS UNIVERSITY
Publications Division
New Brunswick, New York 08903

DEPARTMENT OF DRUG & ALCOHOL CONCERNS
United Methodist Church
1001 Maryland Avenue
Washington, D.C. 20002

DEPARTMENT OF HEALTH, EDUCATION AND WELFARE
Region V
300 South Wacker Drive
Chicago, Illinois 60606

DISTILLED SPIRITS COUNCIL OF U.S.
538 Pennsylvania Bldg.
Washington, D.C. 20004

DO IT NOW FOUNDATION
National Media Center
P. O. Box 5115
Phoenix, Arizona 85010

DRUG ABUSE COUNCIL
1828 L Street
Washington, D.C. 20036

EDUCATIONAL RESEARCH COUNCIL OF AMERICA
Rockefeller Building
Cleveland, Ohio 44113

FOOD AND DRUG ADMINISTRATION
U.S. Department of Health, Education
and Welfare
Washington, D.C. 20201

HEALTH EDUCATION COUNCIL
10 Downing Street
New York, New York 10014

JAYCEES: OPERATION THRESHOLD
Box 7
Tulsa, Oklahoma 74102

NARCOTIC ADDICTION CONTROL COMMISSION
Division of Research
Executive Park South
Albany, New York 12203

NATIONAL ALCOHOLIC BEVERAGE CONTROL ASSN., INC.
5454 Wisconsin Avenue
Chevy Chase, Maryland 20015

NATIONAL CLEARINGHOUSE FOR ALCOHOL
INFORMATION (NCALI)
P.O. Box 2345
Rockville, Maryland 20852

NATIONAL CONGRESS OF PARENTS & TEACHERS
Alcohol Education Project
700 North Rush Street
Chicago, Illinois 60611

NATIONAL COORDINATING COUNCIL ON DRUG ABUSE
EDUCATION AND INFORMATION, INC.
1211 Connecticut Avenue, N.W.
Washington, D.C. 20036

NATIONAL COUNCIL ON ALCOHOLISM, INC.
733 Third Avenue
New York, New York 10017

NATIONAL COUNCIL ON CRIME AND DELINQUENCY
44 East 23rd Street
New York, New York 10017

NATIONAL FAMILY COUNCIL ON DRUG ADDICTION
401 West End Avenue
New York, New York 10025

NATIONAL INSTITUTE FOR ALCOHOL ABUSE AND
ALCOHOL INFORMATION (NIAAA)
5600 Fishers Lane
Rockville, Maryland 20852

NATIONAL INSTITUTE OF DRUG ABUSE (NIDA)
11400 Rockville Pike
Rockville, Maryland 20852

NATIONAL INSTITUTE OF MENTAL HEALTH
Office of Communications
5454 Wisconsin Avenue
Chevy Chase, Maryland 20203

NATIONAL ORGANIZATION FOR REFORM OF
MARIJUANA LAWS (NORML)
2317 M Street, N.W.
Washington, D.C. 20037

NATIONAL SAFETY COUNCIL
425 Michigan Avenue
Chicago, Illinois 60611

PARENT TEACHER ASSOCIATION (PTA)
700 North Rush Street
Chicago, Illinois 60611

RUTGERS CENTER OF ALCOHOL STUDIES
Rutgers University
New Brunswick, New Jersey 08903

SIGNAL PRESS (WCTU)
1730 Chicago Press
Evanston, Illinois 60201

STASH
118 South Bedford
Madison, Wisconsin 53703

SUPERINTENDENT OF DOCUMENTS
Government Printing Office
Washington, D.C. 20402

TASK FORCE ON RESPONSIBLE DECISIONS ABOUT ALCOHOL
Education Commission of the State
300 Lincoln - Tower Street
Denver, Colorado 80203

UNITED NATIONS COMMISSION ON NARCOTIC DRUGS
United Nations Plaza
New York, New York 10017

U.S. DEPARTMENT OF HEALTH, EDUCATION AND WELFARE
Washington, D.C. 20201

U.S. OFFICE OF EDUCATION
National Training Center (Serving Iowa)
Region V Drug Education Training Resource Center
20th Floor
10 North LaSalle
Chicago, Illinois 60602

WORLD HEALTH ORGANIZATION
International Control Commission of Dangerous Drugs
3 United Nations
New York, New York 10017

G. SELECTED ORGANIZATIONS: STATE AND LOCAL

ALCOHOLICS ANONYMOUS
1400 Penn
Des Moines, Iowa 50316
515/266-9478

AREA EDUCATION AGENCY 13 DRUG EDUCATION PROJECT
Halverson Center
R.R. 1
Council Bluffs, Iowa 51501
712/366-0503

CNIR (Cooperative Network of Inservice Resource)
9 Westwood Drive
Marshalltown, Iowa 50158
800/542-7821

GRANTWOOD AEA (10) DRUG EDUCATION PROJECT
4401 6th Street, S.W.
Cedar Rapids, Iowa 52406
319/366-7601

IOWA BEER & LIQUOR CONTROL COMMISSION
Valley Bank Building
Des Moines, Iowa
515/281-5533

IOWA DEPARTMENT OF HEALTH INFORMATION AND EDUCATION
Lucas Building
Des Moines, Iowa 50319
515/281-5446

IOWA DEPARTMENT OF PUBLIC INSTRUCTION
Substance Education
Grimes State Office Building
Des Moines, Iowa 50319
515/281-3264

IOWA DEPARTMENT OF PUBLIC SAFETY
Lucas Building
Des Moines, Iowa 50319

1) Bureau of Criminal Investigation
515/281-5138

2) Highway Safety
515/281-3366

3) Narcotic and Drug Enforcement
515/281-3511

IOWA DIVISION ON ALCOHOLISM
508 10th Street
Des Moines, Iowa 50319
515/281-4417

IOWA DRUG ABUSE AUTHORITY
Liberty Building
Suite 230
418 6th Avenue
Des Moines, Iowa
515/281-3641

IOWA DRUG ABUSE INFORMATION CENTER
Cedar Rapids Public Library
428 3rd Avenue, S.E.
Cedar Rapids, Iowa 52401
319/398-5123

IOWA MEDICAL SOCIETY
1001 Grand Avenue
Des Moines, Iowa 50316
515/223-1401

IOWA MENTAL HEALTH AUTHORITY
University of Iowa
Iowa City, Iowa 52242
319/353-3901

IOWA PHARMACEUTICAL ASSOCIATION
302 Shops Building
Des Moines, Iowa
515/283-0169

IOWA PUBLIC BROADCASTING NETWORK
2801 Bell Avenue
Des Moines, Iowa 50321
515/281-4500

IOWA STATE TRAVELING LIBRARY
Historical Building (films)
Des Moines, Iowa 50319
515/281-5472

LAKELAND AREA EDUCATION AGENCY (3) DRUG
Education Project
Cylinder, Iowa 50528
712/424-3211

MISSISSIPPI BEND & DRUG EDUCATION PROJECT
Quint Cities Drug Abuse Council
310 West 2nd Street
Davenport, Iowa 52801
319/324-2168

NATIONAL COUNCIL ON ALCOHOLISM, Des Moines Area
606 Fleming Building
Des Moines, Iowa 50319
515/244-2297

Alcohol & Drug Education Guidelines: Scope & Sequence

Major Outcomes	At conclusion of: Level 1	At conclusion of: Level 2	At conclusion of: Level 3	At conclusion of: Level 4
A. Student will understand the basic factors in human behavior related to substance abuse: psychological, physiological and sociological.	1. List five need areas all people share (physical, intellectual, social, emotional, and spiritual). 2. Describe one's feelings about self and how these feelings affect one's behavior. 3. Describe how the actions of other people affect one's feelings. 4. Describe how belonging to a group affects one's feelings and behavior.	1. Identify ways in which people attempt to meet their needs by using substances. 2. Identify differences in family practices in the use of alcohol and other drugs. 3. Identify ways that peers might influence one's choice of substance use or non-use. 4. Describe advertising techniques used to promote the consumption of alcohol and other drugs.	1. Describe methods used by adolescents to satisfy their needs. 2. Identify examples of peer influence on decisions to use or not use substances. 3. Identify the influence of the family on decisions to use or not use substances. 4. Identify the roles of mass media and advertising in influencing decisions about substance use or non-use. 5. Identify the internal (self) controls which a person can apply to decisions about substance use or non-use.	1. Interpret reasons why people use and abuse substances. 2. Analyze the influence of peers on adolescents' decisions to use or not use substances. 3. Analyze the influence of adult models on adolescents' decisions to use or not use substances. 4. Identify the social norms for the use of alcohol and other substances and the influences these norms have on individual decisions about use or non-use. 5. Discuss personal characteristics which may precede alcohol and drug abuse. 6. Analyze the impact of the alcohol and drug industries on the use of substances. 7. Discuss the factors which influence alcohol and drug effects.
B. Student will know impartial scientific facts about alcohol and other drugs.	1. Explain the purpose of medicines. 2. Describe the role of parents, pharmacists and other health professionals in dispensing medicines. 3. List home and school rules for using medicines, poisons, and other substances. 4. Identify harmful household products (substances).	1. Describe the effects of alcohol and commonly misused drugs on body systems. 2. Give examples of substances classified as stimulants, depressants, hallucinogens, narcotics, and volatile substances. 3. Explain medical uses of commonly used drugs. 4. Give examples of the role that drugs have played in improving the quality of health. 5. Describe the differences between the terms: a) substance used and abuse and b) prescription and nonprescription drugs. 6. Define the term alcoholism. 7. Explain the statement that alcohol is the major drug of abuse in the United States. 8. Describe antidotes and emergency procedures to counteract the toxic effects of ingested poisons in household products.	1. Classify substances according to their physiological and psychological effects. 2. Discuss the concepts of drug allergies and drug side-effects. 3. Identify the differences between prescription and nonprescription drugs. 4. Describe the risks in using alcohol in combination with other drugs. 5. Describe antidotes and emergency procedures to counteract the toxic effects of ingested substances. 6. Describe ways in which intoxification changes the behavior of a driver and interferes with the operation of vehicle. 7. Discuss the differences between prevention and treatment of substance abuse. 8. Interpret the terms alcoholic, problem drinker, social drinker, and abstainer. 9. Relate drug research to life expectancy.	1. Classify alcohol and other drugs according to their effects on the mind and body. 2. Identify beneficial and harmful effects of alcohol and other drugs on the body. 3. Analyze and interpret the accuracy of drug and alcohol information from all sources. 4. Evaluate common alcohol and drug myths. 5. Describe procedures for being an informed consumer of prescription and nonprescription drugs. 6. Identify procedures to help in drug and alcohol emergencies and crises. 7. Evaluate the effects of alcohol and other drugs upon driving behaviors and performance.
C. Student will know the probable consequences of any alcohol and drug use to the individual, to the family, and to the community.	1. Give examples of how misuse of medicines or household substances will very likely result in physical harm.	1. Explain how the misuse of medicines, alcohol, and nonprescription drugs might result in physical harm to oneself. 2. Know that there are legal controls for the use or possession of alcohol and most drugs. 3. Describe the possible harm to self from "taking a dare" involving the use of known and unknown substances. 4. Identify the possible benefits of using alcohol and other drugs.	1. Identify the problem associated with the use of alcohol and other drugs for the individual, family, and community. 2. Identify certain risks or dangers of alcohol use to which teen-agers are uniquely susceptible. 3. Explain how laws govern the personal use, sale and possession of alcohol and drugs. 4. Describe the relationship of drug abuse to illegal drug traffic, crime, and delinquency.	1. Discuss the detrimental effects of drug and alcohol dependency to the individual, the family, and the community. 2. Demonstrate a knowledge of the laws and regulations concerning the use, sale, possession of alcohol in Iowa and the possible consequences of violating these laws. 3. Demonstrate a knowledge of the laws and regulations concerning the use, sale, and possession of "controlled substances" in Iowa and the possible consequences of violating these laws. 4. Demonstrate a knowledge of the consequences of driving while under the influence of alcohol (and other drugs); both immediate and long range. 5. Describe the possible consequences of one's responses toward a person whose behavior has been changed to alcohol or drugs.
D. Student will know that the individual, his/her family, and the community have interrelated responsibilities for the prevention of alcohol and drug abuse.	1. Describe the ways, rules, regulations, and laws helping protect one's health and safety; particularly those related to medicines and poisons. 2. Identify and respect persons who help protect and maintain one's health and safety. 3. Identify dangerous situations involving medicines and poisons and appropriate responses to the situations.	1. List ways society tries to prevent individuals from becoming abusers of alcohol and drugs. 2. Explain the role of laws, rules, and regulations in the prevention of substance abuse. 3. Identify ways to prevent oneself from misusing or abusing alcohol and drugs. 4. Identify personal attitudes related to substance use and to substance abuse. 5. Identify the community services available to help with alcohol and drug problems.	1. Explain how the use and abuse of substances might be prevented by controls that exist in society. 2. Identify local efforts at preventing substance abuse. 3. Discuss ways by which peers, siblings and older youth can influence the non-use of substances by junior high school students. 4. Analyze the contributions of the family in the primary prevention of substance abuse. 5. Discuss personal value positions on the use and abuse of substances. 6. Describe how to use agencies which offer assistance to people with mental health, substance abuse, and family problems.	1. Evaluate the effectiveness of existing controls over the use, misuse, and abuse of substances. 2. Discuss the responsibilities of the community for the treatment and rehabilitation of substance abusers. 3. Suggest ways by which individuals can assume responsibility for the prevention of substance use and abuse. 4. Recommend community actions for the primary prevention of substance abuse. 5. Discuss the influence of parental substance use and substance attitudes on their children's future substance use or non-use. 6. Identify constructive aspects of an abstinent or responsible use life styles.
E. Student will know personally relevant and satisfying alternative behaviors to substance abuse.	1. Identify ways in which people behave in order to meet their needs. 2. Identify appropriate responses to feelings. 3. Identify an adult he/she can talk with. 4. Recognize personal interests.	1. Identify ways by which people meet their needs without using substances (the alternatives concept). 2. Identify alternative activities afforded through community agencies and programs. 3. Identify alternative activities afforded within the school environment.	1. Identify several alternative behaviors one can employ to satisfy one's needs without using substances. 2. Identify settings in the home, school, and community as possible resources for satisfying some needs. 3. Discuss abstinence as a choice of life style.	1. Assess one's own life style in relationship to meeting personal needs. 2. Choose alternatives to substance use which are compatible with personal interests and values. 3. Identify and analyze adult models for meeting needs constructively. 4. Evaluate abstinence as a personal choice of life style. 5. Describe responsible hosting in regards to alcoholic beverages.
F. Student will be able to employ decision making skills to make responsible decisions relative to personal alcohol and drug use or non-use.	1. Demonstrate the use of a problem solving process. 2. Identify a safe behavior in situations which involve medicines and poisons.	1. Demonstrate the decision making process in relationship to the use of medicines, alcohol, and other drugs. 2. List the reasons why a person might or might not make the decisions to use alcoholic beverages. 3. Describe the application of a problem solving process as a non-chemical method of dealing with personal problems.	1. Apply the decision making process to situations involving alcohol and other drugs.	1. Discuss the individual's right to make his/her own decision about substance non-use or use. 2. Identify situations or conditions when individuals might be apt to use or abuse substances and will apply the decision making process in selecting an appropriate behavior.

STATEMENT OF JOHN TAPSCOTT, EXECUTIVE DIRECTOR, NATIONAL COUNCIL ON ALCOHOLISM, DES MOINES AREA, DES MOINES, IOWA

In dealing with and treating the chemically dependent juvenile, the practice of pulling that individual from the family unit and focusing all energy on the dependent person alone has proven ineffective.

Juveniles with chemical dependency problems are often pointed out within a dysfunctional family unit and labeled as being "the problem". While in reality that person may be chemically dependent, the fact remains that other members of the family unit may be equally dysfunctional due to the overall effect of chemical dependency on the family unit.

As the chemically dependent individual progresses through stages of the illness, the ability to relate honestly to self and others is greatly diminished. Relationships deteriorate as communication becomes less open and honest. Trust levels decrease and may become non-existent. Due to changes in self perception and feelings of self worth, a chemically dependent juvenile may come to feel set apart from the rest of the family unit. These feelings may be reinforced as the other family members find their own attitudes and feelings change towards that individual.

In short, alcoholism and other chemical dependencies are family illnesses and must be treated as such.

We have started a pilot project (The Student Assistance Program) at a private school, whereby students who have chronic discipline problems are referred, along with their parents, to our program.

These students are under threat of suspensi[illegible]or have already been suspended pending involvement in an evaluation proce[illegible]by our counselors, and appropriate referrals to service providers are then made.

This program is in its infancy, operating for only 2 months, but some interesting statistics are beginning to show.

Seventy-seven percent of the students referred to the Student Assistance Program were having problems due to alcohol/drug abuse, either their own or their parents.

Ninety percent of all alcohol and other drug related cases show a marked deterioration in family relationships. Eighty percent of the students with dependency problems have at least one alcoholic parent.

Contrary to what one might have expected, 84.6 percent of the total referrals were families and 80 percent of those with chemical dependency problems were females.

An even greater need for expanded services is seen in those cases involving an alcoholic parent, where the parent has not sought treatment for his or her alcoholism.

On the basis of our figures, there is also a strong indication that in such cases girls have the most difficulty in coping with an alcoholic parent. They are also the most likely to develop chemical dependency problems at an early age.

The idea of prevention is a familiar one—stopping a problem before it starts. The saying that an ounce of prevention is worth a pound of cure is true—especially for alcohol/drug problems. The money appropriated for treatment compared to prevention reflects the lack of priority given to the whole area of prevention.

At the present time our education coordinator acts as a resource person to classroom teachers. She has presented a program, "Alcohol, Drugs or Alternatives!" to approximately 15,000 classroom students in the Des Moines area within the past 24 months. Not only is cognitive information about substance abuse considered; but emphasis is placed on clarifying values, decisionmaking skills, self-awareness, the the alternatives concept.

As an outgrowth of our present substance abuse prevention/education program, we are in the process of setting up a pilot project for the 78–79 school year. This will involve selected groups of parents, teachers, and K–6th grade students in three schools. We will meet on a regular basis for the entire school year.

1. For parents, prevention means raising children to become responsible, caring, and thinking adults. Our pilot project will use the manual, "A Family Response to the Drug Problem". We will meet with parents in a group setting with a facilitator. Improving communication skills will be an objective.

2. For school systems and teachers, prevention means providing content—facts about substances and substance abuse. It also means providing experiences whereby a student is allowed to clarify his or her own values. The teachers in our pilot project will use the booklet, "Beyond the Three R's". Being able to identify students who come from homes where a parent is a substance abuser will be an objective for the teachers' group.

3. These children have a 45 to 50 percent greater chance of becoming substance abusers themselves. They show generally more disturbed behavior, more trouble in school, poor school records, and yes—trouble with the law. Prevention at an early age with this group of children is of utmost importance. We cannot stress this strongly enough. Problems of these children, even at a very early age will not

remedy themselves. Because of substance abuse in the family, the problems will get worse and the support within the family will diminish. Therefore, the child goes on to greater problems and possible delinquency.

We would urge the committee to consider specific recommendations regarding prevention of chemical substance abuse.

1. Increase appropriations for prevention, bringing prevention into a more equitable position with treatment spending.
2. Reevaluate existing legislation relative to substance abuse education in the educational system.
3. Have input in teacher training relative to developing skills necessary to implement an effective alcohol and drug education program.
4. Have input in teacher training relative to early identification of high risk young people.
5. Provide training of those skills necessary to focus prevention activities for high risk groups, such as children of substance abusers.
6. The banning of alcoholic beverage advertising on television. Not only do these prime time commercials reflect sexist sterotypes, but they unrealistically distort the truth by equating alcohol consumption with friendship, fun, popularity, and other positive good feelings that have nothing to do with alcohol use. Public Service Announcements, which are realistic, informative, and educational, are shown at non-prime times such as midnight or later.
7. Require that federally supoprted programs outline specific family involvement in treating the chemically dependent person.

STATEMENT OF HAROLD A. MULFORD, PH. D., PROFESSOR AND DIRECTOR OF ALCOHOL STUDIES, DEPARTMENT OF PSYCHIATRY, COLLEGE OF MEDICINE, UNIVERSITY OF IOWA, DES MOINES, IOWA

Unfortunately hard scientific data regarding the causes and remedies for alcohol abuse are scarce. On balance, the existing body of verified knowledge is more negative than positive. Any statement about the problem, confined strictly to hard data would therefore be short and largely negative. The first part of this statement regarding the current status of Iowa's alcoholism programs will stick to hard data. The second part is more personal opinion.

The alcoholism disease remains undefined and the cause, the cure and the preventive remain a mystery. Although there is no "technological fix" for alcoholism, like for example the vaccine for polio, still treatment centers continue to proliferate acting as though they have a technological solution. Unfortunately, the more rigorously science scrutinizes the treatments the more negative the results. A study by the Institute of Psychiatry in London reported in the May 1977 Journal of Studies on Alcohol found that a control group of alcoholic patients who received one year of treatment including six weeks hospitalization (more if needed) obtained results virtually identical with those of an experimental group that received only three hours of advice by the center staff. About one third of each group "improved". The study confirms similar findings of two earlier studies, one in Wisconsin and one in Boston. The recent report by the Rand Corporation evaluating 44 NIAAA funded alcoholism centers across the nation found "remission" rates to be independent of type of treatment. In fact, the study found a remission rate of 55 percent for patients who received no treatment, or only "minimal treatment." This compares with 73 percent for those who received full treatment.

Currently Iowa has a network of approximately 75 community alcoholism service centers, more than a dozen inpatient treatment centers and 16 halfway houses for alcoholics. The effects of the expanding prevention and rehabilitation programs have not been rigorously investigated. Claims of 60 to 70 percent "success" must, be judged against the Rand Corporation findings of 55 percent "success" for untreated alcoholics seen in similar centers across the nation.

The recent unprecedented increase in per-capita sales of absolute alchool in the state (they have nearly doubled in 20 years), plus the fact that the annual rate of increase has been accelerating, would suggest that prevention efforts have not entirely achieved their goal.

Regardless of the unknown success rates of Iowa's rehabilitation programs measured in terms of consumer benefits, the Iowa Division on Alcoholism Quarterly Monitoring Reports do document trends in cost effectiveness measured in terms of number of alcoholics served and total expenditures. For the period covered by the quarterly report ending, March 1976 through the quarter ending,

June 1977 (the most recent report available to this investigator) total expenditures for all centers rose 39 percent while client intakes declined 27 percent. Expenditures per-new client intake per-quarter almost doubled (91 percent). This is shown in the accompanying graphs and table.

To go above the documented facts to consider their interpretations, their causes and what needs to be done is to enter the murky waters of opinion speculation, emotions, politics and of course controversy. In the absence of hard data on the causes of the trends in cost effectiveness, we can only note some associated events and speculate about their effects.

Beginning in January 1975, the state tightened its control of the local community centers which previously had been largely locally controlled and locally funded. The Federal Government, under authority of PL91–616, obligates the state to establish a State Alcoholism Authority and develop a State Alcoholism Plan as a condition for receiving federal funds. The state central office which had been operating on a budget of approximately $60,000 a year in 1973–1974 has since had a budget approximating $400,000.

It would appear that an undue share of the Federal funds meant to help alcoholics is instead going into program administration. The 1976 Iowa State Alcoholism Plan budgets only $459,526 of the $715,002 Federal Formula grant funds to the treatment centers. Out of this each center is expected to employ a "data coordinator" to help with the required paperwork. And the monitoring reports show at the local center level little more than half of staff time is given to direct services to alcoholics.

While one can appreciate the State Alcoholism Division's desire to develop a well organized, well administered, tightly controlled, "service delivery system", this means for helping alcoholics has tended to become an end in itself. This confusion of means and ends is seen in the statement implementation of Standard Operating Procedures established by the Joint Commission on the Accreditation of Hospitals (JCAH). JCAH officials and the Iowa State Division acknowledge that there is no evidence that implementing the standards means either that more alcoholics will be served or that the services will be more effective (see enclosed letter signed by Peter Brandon of the State Division).

Reading through the standards they appear quite reasonable. And there is no hard data showing what their effects are. However, there is evidence of certain ways in which this added regimentations of both the center staff and their clients, has been, and will likely continue to be, counter productive to the original goal of contacting and helping alcoholics.

We observed, first, that in several centers, staff morale was effected. Some counselors who felt that they had been hired to serve alcoholics found themselves devoting ever more time to completing forms to serve the system. Some quit in frustration and left the field.

Second, the implementation of the standards diverted center staff attention and effort from serving alcoholics to preparing for JCAH evaluation and accreditation. During the fall and winter of 1976, admissions to the Oakdale State Treatment Center declined noticeably. When an Oakdale staff member called several local centers to inquire why their referral to Oakdale had declined, they said they were too busy preparing for accreditation to see alcoholics.

In the long run, center staff will likely adjust to the regimentation. In fact, many may come to appreciate the orderliness and the scheduling of appointments to fit their own convenience. Some may even come to prefer setting in the office completing forms to the challenge of going out to contact and help alcoholics.

There will always be many alcoholics, however, who will not, or cannot, adjust to the regimentation. For example, the director of the Iowa City Center, interpreted the JCAH requirements to mean that the alcoholic should, in his words "learn some respect for a 50-minute counseling hour." In addition alcoholics are required to sign an appointment form to come in later for their 50-minute counseling session. Such regimentation subtley discourages many alcoholics who could otherwise be encouraged to enter treatment by a more flexible, personal welcome. The practical effect of these procedures is to screen out alcoholics who are "not ready for help". However, to serve only those who are "ready" is to serve only those who are so far advanced in the natural maturing out process they don't need much help. This sidesteps the bulk of the problem. This, we believe, will be a continuing and growing problem as the center's procedures gradually become more uniform and more rigid as the regimentation feeds on itself.

Part of the rationale for shifting control of the centers to the state was the "need for greater accountability". Granting the need for accountability, one

must question the economics, if not the wisdom, of the shift from local to state control. Several local centers could abscond with their entire budget for the year and the loss to the taxpayer would not equal what the state central authority spends to police them.

Granted that JCAH accreditation was necessary for third-party (Blue Cross) payments, I expect that third-party payments will lead to even more regimentation, standardization and more paperwork. The center's activities will become even more irrelevant to the alcoholic's needs, admissions will fail to grow, or even continue their decline, and unit costs will continue to rise. Just as a center that specializes in one type of therapy is inclined to favor those alcoholics who happen to fit that treatment so all centers will now have a financial incentive to favor the alcoholics who have insurance. Centers will also have a monetary incentive to retain the alcoholic in treatment for as long as the insurance will pay for it—whether the alcoholic needs it or not. This will likely happen despite the evidence cited earlier that, on the average, shorter treatments are just as beneficial to the alcoholic as much longer ones. In summary, the hard data are not available to specify the connection between the laws that called for the establishment of the alcoholism programs, the way the laws were inplemented and the ultimate benefit to those the laws were intended to help.

My own observation has led to the conclusion that unit costs have increased, and will continue to grow because regimentation once established tends to feed on itself. Form replaces substance; activity is substituted for results; program administrators' need for orgaization, accountability and respectability, (e.g., JCAH accreditation) takes precedence over the alcoholics' needs for flexibility and understanding.

We have records from one center in Iowa that remains locally funded, locally controlled and highly cost effective. It is located in Washington, Iowa. The Washington County Board of Supervisors funds a "general practice" counselor and an assistant to help people, many of whom turn out to be alcoholics. Administration, what little is needed, is handled by the county auditor. Simple records of client services are maintained by the counselor and submitted to the supervisors as well as to a three-member advisory committee. Johnson County similarly funds a "generalist" counselor through Court Services and with similar cost-effective results. Their helping approach is very personal, individualized, simple and common sense. The counselor offers no specialized therapy. Rather he reaches out to contact alcoholics and help them make maximum use of available community resources to solve their own individual problems.

It is very much a "self-help" approach for the alcoholic as well as the community. The counselor does nothing for the alcoholic he can get the alcoholic to do for himself. He does nothing for the alcoholic he can get another agency in the community to do. As a "generalist", he serves the entire range of persons with drinking problems not just those that fit a special treatment. He helps them attend to the whole spectrum of diverse problems that they usually have—not merely the simgle problem that happens to fit the counselor's favorite treatment speciality.

The counselor works with the community as much as with the alcoholic. He mobilizes and coordinates existing community services for the alcoholic. He also acts as a catalyst to assist his client to obtain maximum benefit from each service. This tends to maximize community involvement in developing improved ways of coping with problems of alcohol abuse. There are beneficial prevention spin offs as the community becomes more involved and better educated.

In many ways this community self-help program is an extension of the AA approach. Indeed AA is one of the major resources employed by the community counselor. The counseling itself is a form of "peer counseling", but it is only an incidental part of helping the alcoholic sort his problems and obtain the specific services he needs to solve them. In addition the counselor does what AA is reluctant to do. He engages in aggressive outreach to contact alcoholics mainly through the other community agencies. He also more aggressively follows up on them and provides a long-term continuum of help and psychological support.

Rather than following standard operating procedures arbitrarily laid down by "experts" in a far-off central office—50-minute hours, appointment cards, etc.—the general counselor and the alcoholic decide together, what his specific problems and needs are, and how best to use existing community resources.

The greater efficiency of such a general practice counselor, as compared with other centers is impressive. The annual unit cost per new client is about $100 for the Washington Center. This is approximately one-eighth that of the state average last year. This hardly equals hospital treatment center costs for one day. The Washington Center's effectiveness has not been scientifically evaluated. However,

all of the treatment evaluation research to date, would lead us to hypothesize that the approach is no less effective than other treatments. The large degree of public support of the center is some indication that the community is satisfied that it earns its keep.

Of course the center serves juveniles with an alcohol problem the same way as anyone else. Currently, some 18% of the Washington Center case load of over 100 cases are 20 years or younger. This is three times the state average. In fact, it has been demonstrated that this general counselor approach, because of its outreach work, reaches alcoholics earlier in their drinking careers. This allows for secondary prevention. In addition the counselor works with the schools by encouraging them to establish their own alcohol prevention/education programs, which is consistent with the "self help" principle.

To be of most benefit to juveniles, such a center would ideally employ a counselor who had a special ability to relate to them. This would be in keeping with the very personal "peer counseling concept" that characterizes this kind of community center. We know of no special institution or special treatment modality that is of any particular value to juveniles with drinking problems.

Most juveniles who encounter drinking problems—expecially the "spree" drinkers will mature out as they take on the responsibilities of adulthood. Still there is a small hard core who have already come to rely heavily upon alcohol as a way of life. This has been at the expense of learning more socially acceptable ways of coping with everyday problems. It is this 3 or 4% of the juveniles who are most in need of help to prevent years of alcoholic drinking. They need help to learn to cope without alcohol. Theoretically, this can best be accomplished by a "general practice" community counselor working with the juvenile problem drinker on his own turf in his own home community context rather than in the artificial world of an institution.

In the absence of a technological fix we suggest that the central concept of a formal program to rehabilitate problem drinkers, juvenile or adult, should be "self-help" at both the community level and the individual level.

STATEMENT OF GARY RIEDMANN, DIRECTOR, DEPARTMENT OF SUBSTANCE ABUSE, STATE OF IOWA, DES MOINES, IOWA

ALCOHOL ABUSE AND JUVENILES IN IOWA

I. Extent, nature and levels of alcohol abuse problem among juveniles

Alcohol abuse appears to be a significant problem among Iowa juveniles, both in rural and urban areas. In 1974, a study was completed on the incidence and prevalence of alcohol and drug abuse in Iowa with funding from the Iowa Drug Abuse Authority, the Iowa Division on Alcoholism and the Iowa Crime Commission. In 1976, a less comprehensive form of this study was completed, which mostly confirmed the results of the 1974 study in regards to alcohol abuse. Taken primarily from this 1974 study, the major indicators of an alcohol problem among Iowa youth are as follows:

In both the 1974 and 1976 studies, the median age for first drug use remained at 14. In the 1974 study, however, the earliest reported use of any drug was the use of alcohol at age 9, while in the 1976 study, experimental use of alcohol was reported at age 6, with regular use reported by age 10.

Of those surveyed in 1974, 11 percent who reported experiencing alcohol-related problems were 17 or younger.

Some 17,000 (projected) adolescents 14–17 manifest a heavy drinking pattern. Almost half (47 percent) of youth in this age range report being regular (at least once a month) or heavy (every day) drinkers.

Thirty-nine percent of youth 14–17 perceive themselves as regular drinkers, and 22.6 percent of youth in this age category worry about their drinking.

Seventy percent of 14–17 year olds report drinking more than previously. (The study indicates that this may be a logical maturation process, but deserves watching.)

Sixteen percent of 14–17 year olds reported having had a family problem relating to drinking.

Of "street drug" users, 90 percent indicated alcohol as the first drug used.

Although national statistics show that between 2–3 percent of persons treated for alcohol problems (in alcohol programs) are 19 or younger, Iowa has no breakdown by age at the current time. Statistics do indicate that the mediam age, however, of persons entering alcohol programs has decreased from approximately

39 in 1975 to 36 in 1977. Realizing the importance of knowing the age of clients in treatment, however, the Iowa alcohol program reporting system will soon be including are breakdowns. Currently drug abuse programs alread, report by age.

Through reports from these drug abuse programs, we know that many drug clients name alcohol as a secondary drug of abuse. Of 497 persons 17 and under admitted to Iowa drug programs in 1976, 87 named alcohol as a second drug of abuse, while others listed it as a third drug.

An example of the alcohol abuse problem among juveniles is shown in the experiences of the Ames-based Youth and Shelter Services which has found that 26 percent of the youth it works with have alcohol as a presenting problem. Program staff report alcohol problems have steadily increased in numbers over the past several years and the program reports more teenage alcoholics for which proper facilities are not readily available.

II. Link between alcohol abuse and juvenile justice system

Recognizing that there is currently a lack of data regarding alcohol use and abuse by juveniles who may become involved with Iowa's juvenile justice system, the Iowa Department of Substance Abuse is currently involved in a study of this problem. Although the results from a survey conducted with juveniles (mainly 14–16) in Iowa juvenile institutions (such as the Eldora Training School) and in group homes have not yet been tabulated, preliminary results show some general trends:

There appears to be a direct correlation between youth with alcohol problems and their placement outside their homes in juvenile institutions or group homes. As compared to youth in the general population, the percentage of youth in juvenile institutions or group homes who have ever used alcohol appears to double or triple the general population figure.

The age when alcohol was first used is young, generally under 13 years of age.

Many of the juveniles report at least one parent being a moderate to heavy drinker.

Administrators of juvenile institutions and group homes estimate that between 25 percent to 75 percent of their youth have or have had a problem with alcohol.

III. Treatment

Problems surrounding the treatment of juveniles with alcohol problems center around two primary issues: referral into the treatment system from the juvenile justice system, and actual treatment services provided specifically for juveniles.

The previously mentioned juvenile justice/substance abuse study indicated two major concerns. First, many juvenile programs do not have the necessary screening processes to determine whether the young people with whom they deal have hidden alcohol or other drug problems. Some of these programs are not equipped to deal with substance abusing young people, and do not accept persons with known alcohol or other drug problems. There is a need for alternative programming to deal with youth not accepted by these programs and a need for more comprehensive training of the staff in juvenile institutions to prepare them for helping with substance abuse problems.

Secondly, there is a need for earlier identification and diversion programming for persons experiencing problems with alcohol. When any juvenile is involved in an alcohol-related legal problem or crisis situation, he/she should be referred to an appropriate helping source rather than placed in jail to detoxify or returned home unhelped.

Although these are major concerns discovered in the Iowa Department of Substance Abuse juvenile justice/substance abuse project, others may surface when the data compilation and analysis are complete by this summer. Through this project, it is hoped that we can better foster cooperation between juvenile social service personnel and substance abuse prevention and treatment services.

The second issue involved in treatment is the actual availability of treatment services aimed at and serving the specific needs of young persons. There are currently nearly forty programs in the state which are treating alcohol abusers through inpatient, outpatient, and/or residential/intermediate care. Though most of these programs are dealing with some juvenile alcohol abusers, as they voluntarily come or are referred for treatment, the only alcohol program aimed only at youth is Gordon Chemical Dependency Center in Sioux City. In addition Powell III in Des Moines has a special focus on youth besides its other programs, and ADASI in Des Moines has a residential facility expecially for juveniles. Other programs are finding an increased need for residential services for youth, such as the Siouxland Council on Alcoholism in Sioux City which found that its residential/intermediate care facility for women was filling up almost entirely with teenaged girls.

Many more programs are likely to be confronted with significant numbers of juveniles seeking treatment due to a major change made in Iowa law January 1, 1978, regarding juvenile alcoholism treatment. Previously juveniles treated for alcohol problems must have had their parent's consent. Since juveniles can now receive treatment without the knowledge and/or consent of their parents or guardians, it is possible that numbers or juveniles seeking treatment may increase significantly, thereby increasing the demand for youth-oriented services.

In light of the growing necessity for alcoholism services aimed at youth, the Iowa Department of Substance Abuse, as well as its funding agencies—the National Institute on Alcohol Abuse and Alcoholism and the National Institute on Drug Abuse—has established youth programming as a priority.

IV. Prevention

The Iowa Department of Substance Abuse considers prevention of alcohol and other drug abuse problems before they become problems as a top priority. Current funding and programmatic efforts in this area currently take three primary approaches.

First, the department currently funds a number of substance abuse education/prevention projects aimed primarily at school-aged children. Not only are there a number of individuals within substance abuse treatment programs who provide education/prevention services, but there are separate programs operating independently or as part of area education agencies which emphasize values clarification, decision-making, and self-awareness. These programs work with students, teachers, administrators, as well as with parent groups and are attempting to help youth develop the ability to face life's problems and stresses without depending on alcohol or other drugs. A major focus of several of these programs is peer programming, which trains small groups of youth to become good listeners and sources of help and referral for peers who may come to them with substance abuse or other problems before they would consider seeking help from an adult or any established program.

A second substance abuse prevention effort by the Iowa Department of Substance Abuse is the support of intervention and alternatives programming. As indicated in the surveys mentioned earlier, many youths who have already used alcohol are worried about their drinking. These individuals are more likely to contact hotline-type programs where they can be anonymous, especially when they may not feel that their problem is that serious. These intervention programs can help provide information to these individuals and refer them to other sources of help more appropriate to their particular problem. In addition, these intervention programs are also important in substance abuse prevention to help youth deal with problems such as loneliness, peer pressure, and other situations that could lead to the abuse of alcohol or other drugs.

Another facet of many of these intervention programs is the provision of alternatives programming. Realizing that much of alcohol abuse is done because of the lack of other more constructive recreational alternatives, especially in small Iowa communities, intervention programs attempt to get "uninvolved" youth into activities that interest them and give them "natural highs" instead of getting drunk or high on other drugs. These alternatives might include involvement in art, music, helping others, or many other possibilities. An especially innovative example is an Ames program which involves young people in the creation of electronic music, photography, and other creative exercises.

A third prevention effort comes through the Department's support of the Alcohol and Drug Education program of the State Department of Public Instruction. In addition to directly funding one of the two persons involved in this program, the department has helped fund specific projects such as recent school surveys on alcohol and drug abuse and the printing of substance abuse education guidelines.

Prevention needs: Currently education/prevention services are scattered and not available to all Iowans. Much of this has been due to lack of adequate funding available from State and Federal sources for prevention programming and training. Prevention programs run into problems because they have not been able to adequately document the positive results of their services due to the abstract nature. The irony, however, is that they need funding in order to make comprehensive evaluations of their services, yet limited funding is available because they cannot sufficiently document their successes. Despite that in Iowa, as on a national level, prevention is considered a top priority, tightening federal and state dollars for substance abuse have forced administrators to allocate funding primarily to treatment programs just to maintain a subsistence level. Before education/prevention services can adequately hope to address the needs of potentially

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substance abusing young people in Iowa, more funding specifically for prevention activities must be made available.

SUMMARY

In summary, it is imperative that the Federal Government provide assistance to help reduce alcohol abuse problems among young persons. This assistance needs to come in two primary areas:

(1) Funding—In order for substance abuse programs to adequately address the specific problems of alcohol abuse among juveniles, federal funding must be provided to assist programs in establishing these separate components, whether it be juvenile residential/intermediate care facilities or youth-specific outpatient services. Funding also is crucial in the area of training for youth related alcoholism services. Especially, funding must be specifically allocated to support prevention programming. If we are to really keep young persons from having problems in the first place, we must have the funding to set up comprehensive prevention programs that prepare the students before they are confronted by alcohol. In addition, we must provide the funding to allow prevention efforts to receive the evaluation and research that they desperately need in order to maintain their credibility and to justify their continued financial support.

(2) Interagency Cooperation—Federal agencies involved in funding and programming for youth programs must cooperate closely to provide the necessary youth programming for present and potential young alcohol abusers. The following are areas of necessary cooperation:

(*a*) Various federal agencies provide funding for alcohol related services but not in a coordinated fashion. Funding policies and mechanisms must be established to coordinate the funding provided in states.

(*b*) The Department of Substance Abuse received Federal funds to develop a statewide comprehensive plan to describe needs, services and priorities. The lack of information on available federal funds for alcohol creates the possibility of poor planning and duplication of services.

(*c*) Coordination should be developed on state and local levels for comprehensive health services being provided.

(*d*) Federal agencies involved in providing funds should coordinate their efforts in providing similar services (NIDA, NIAAA, LEAA).

ADDITIONAL MATERIAL SUBMITTED FOR THE RECORD

Office of the Governor
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DES MOINES, IOWA 50319

ROBERT D. RAY
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FRED S. BRINKLEY, JR.
DRUG ABUSE AUTHORITY
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December 18, 1974

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FOR IMMEDIATE RELEASE

Des Moines

The Iowa Drug Abuse Authority (IDAA) released preliminary findings today resulting from a 4-month incidence and prevalence study of drug use and abuse in Iowa which began in April, 1974, and ended in September, 1974. According to Mr. Fred Brinkley, Jr., Director of IDAA, the total cost of the study was approximately $71,000.00; the costs being shared by the Iowa Crime Commission, the State Alcoholism Authority (OPP), and the Iowa Drug Abuse Authority.

Brinkley stated that this study represented the most intensive effort ever conducted in Iowa to examine the drug use and abuse patterns of Iowans. The study, according to Brinkley, was carried out by Resource Planning Corporation (RPC) of Miami, Florida; Washington, D.C.; and New York, New York. This was the thirteenth such state-wide study carried out by RPC. Brinkley stated that the study was conducted under the direction of Dr. Carl D. Chambers, Ph.D., Executive Vice President of RPC, and coordinated by IDAA Deputy Director, Mr. Leslie G. Brody.

The study consisted of five (5) separate but interrelated assessments of drug use and abuse in Iowa: (1) a general

population interview study of 2,000 male and female persons over the age of 13; (2) interviews within 280 rural families; (3) special interviews with 264 active members of the illicit drug subculture in 8 major urban cities across the state (Des Moines, Dubuque, Davenport/Quad Cities, Sioux City, Iowa City, Council Bluffs, Waterloo/Cedar Falls, and Cedar Rapids); (4) special interviews with 130 homeless alcoholics from the Sioux City, Council Bluffs, Des Moines, Waterloo, Dubuque, Cedar Rapids, and Davenport areas; and lastly, a census survey within all formal treatment programs for substance abusers, all Mental Health Institutions, all hospital emergency rooms and medical examiners offices and all city, county, and state jails, reformatories and prisons.

According to Brinkley, Dr. Carl D. Chambers and Dr. Harvey Siegal, Ph.D., RPC senior scientist, alcohol assessments, will be in Des Moines from December 18-20, 1974, to brief Governor Ray on the preliminary findings of this study, and will meet with administrative and planning staff of the Iowa Drug Abuse Authority, the Alcohol Commission and Iowa Crime Commission. Chambers and Siegal will conclude their visit to Des Moines by debriefing the Iowa Drug Abuse Authority State Advisory Council members at their December 20, 1974, meeting.

Chambers stated that the general population studies undertaken in Iowa "...focused on the prevalence, frequency, and situational context of the use and misuse of both legal psychoactive drugs and illicit drugs. In addition, the general assessments also centered upon the population's attitudes toward various types of drug abuse and abusers, and upon the accuracy of the population's beliefs regarding the adverse effect of certain forms of drug use and abuse."

Chambers stressed that "...the figures generated by these, or any other general population assessment based on a sampling methodology, represent estimations of drug-taking in Iowa and are more appropriately viewed as problem indicators rather than "absolute" numbers of persons involved." Chambers went on to say that "General population surveys offer an appropriate foundation upon which problem identification and long range intervention strategies can be formulated for the management of current and potential drug taking behaviors which exist within a given geographical region."

In regards to General Drug Use in Iowa, Brinkley stated that "The Incidence and Prevalence Study suggests that of the 2,076,100 persons age 14 years and above who have used medications, 40.3% have used them to cure or prevent serious illness; 85.8% have used them to relieve headaches, backaches or muscular pain; 19.3% have used them to help get to sleep; 10.7% have used them to lose or to control weight; 7.5% have used them to relieve a tired feeling or to pep up; and 23.3% have used drugs to calm down or to relieve nervous tension."

According to Chambers "The general use of psychoactive medications to sedate, stimulate and to tranquilize oneself among Iowa residents, does not differ significantly from the aggregate findings derived from RPC state-wide surveys conducted with similar methodologies and instrumentation in Indiana, Minnesota, North Dakota, South Dakota, Utah, Arizona, New York, New Jersey, Delaware, South Carolina, Mississippi, and Florida."

In comparing results from the general population survey, the study among rural families and a special survey among families in the town of Ida Grove, Chambers stated that "The use of psychoactive medications to get to sleep, to pep one up and to cope with stress and tension, probably increased in direct proportion to population density."

The study indicated that regarding prescription drug use, residents of Iowa are most likely to experience problems associated with the relaxants/minor tranquilizers, the non-controlled narcotics, and the barbiturates. The studies also point to relatively high rates of apparent medicine "sharing" and the high rates at which these prescription drugs are being taken other than as prescribed. Brinkley pointed out the potential dangers of self-medication without professional guidance, especially when these drugs are mixed with alcohol.

In regards to over-the-counter drug use, Chambers stated that "The prevalence and current use of over-the-counter psychoactive drugs in Iowa should receive some consideration by drug abuse intervention planners." Chambers attributes at least part of this prevalence to heavy mass media advertising of these products coupled with less money to buy more potent street drugs and the general acceptance of adolescents to experiment with euphoria producing drugs.

In the area of illicit drug use, the surveys conducted within the general population of Iowa indicate both the total prevalence and current use of marijuana are the highest of all the illegal drugs. Within the State, 166,000 persons or 8.0% of the population

age 14 years and above are projected to have smoked marijuana on at least one occasion, and of those, some 96,400 persons are believed to have done so within the past six months (February, 1974 - July, 1974). The data collected suggests that some 68,600 persons or 3.3% of everyone age 14 and above are current and/or regular users of marijuana. Chambers stated that the current/regular users of marijuana in Iowa can be characterized as follows: more than four-fifths are under age 25, two-thirds are males, one-third are students and, while all classes are significantly represented, the greatest overrepresentations occur in the lower socioeconomic classes.

Brinkley pointed out that probably the most significant single finding involving current/regular use of marijuana, as indicated in this study, is that 31.0% of all such users are fully employed non-students. Very few of these employed "smokers", however, use the drug while on the job. The overwhelming majority of marijuana use occurs in the privacy of one's own home or at parties. Brinkley went on to say that, while some 90% of all marijuana smokers were found to also drink alcohol, an overwhelming majority do not purport the use of any other illicit drug.

Chambers went on to say that since approximately one-third of the total population of Iowa does not believe marijuana smoking to be any more harmful than drinking alcohol, and some 14.3% do not believe there is anything wrong with smoking marijuana if it is done so in moderation, the State of Iowa finds itself in a most difficult position. According to Chambers, if the current statutes remain as they are, almost 70,000 people are at immediate risk for arrest and punishment for engaging in what they perceive to be a

relatively harmless social recreational activity. "On the other hand," continued Chambers, "to remove the statutes pertaining to marijuana would probably produce at least temporary increases in involvement with this drug by a minimum of 300% and possibly as much as 900%."

Brinkley said that reduction of the penality for the possession of small amounts of marijuana, and not the total removal of statutes relating to marijuana, may offer the best alternative given the present situation which criminalizes the user. He also agreed with Chambers that Iowa would indeed face a substantial increase in the use of the drug with the removal of all penalizing statutes with regard to the use of the drug.

He also said that though the scientific research regarding the short and long term health and psychological effects of marijuana use on the user has been somewhat inconclusive, new evidence is emerging which warrants further examination. Brinkley went on to say that the current/regular use of marijuana users appears similar to what has been found typical in other states of comparable size and composition, as well as in the nation as a whole.

In contrast with the relatively high levels of marijuana use within the State of Iowa, the study indicates that the use of other illicit drugs is relatively low. Less than one percent of the base population are projected as regular users of any of these drugs, and much of the usage reported seems to be within an experimental or social/recreational context.

Based on the general population survey, the following minimal involvements with illicit drugs are reported:

Drug	Estimated Number of Persons Who Ever Used The Drug	Estimated Number of Persons Who Are Current/Regular Users Of The Drug
Marijuana	166,000	68,600
Cocaine	41,000	5,500
"Speed"	39,000	8,900
LSD	22,500	1,700
Other Psychedelics	27,400	1,000
Inhalants	12,900	600
Heroin	5,500	1,100

These estimations must be considered as the minimal number of persons involved with these "illicit" drugs since the information came from residents in permanent households whose drug use had not made them dysfunctional, had not resulted in their being arrested and sent to prisons nor had resulted in their being hospitalized at the time the study was being conducted.

The illicit street or subculture study suggests that "involved" or hidden users are best characterized as young poly-drug users with a median age of 22.3 years. Chambers went on to say that the data suggests the two most prevalent patterns of consumption among active involved drug abusers in Iowa are people who smoke marijuana but do not use any other drugs (excluding alcohol) for their euphoric effects and people who smoke marijuana and also use amphetamines.

Chambers also indicated that large numbers of active involved drug abusers are unaware of the treatment services available in their communities and if they do know the programs, at best they have very mixed feelings about the services being delivered. This would suggest that Iowa programs established for drug abusers need to stress outreach and aggressive case finding approaches as well as significant public information campaigns regarding the services offered by drug treatment programs.

The study indicated that the greatest number of persons (61.0%) would turn first to their family physician or to a psychiatrist for the solution of any drug problems. Clergymen (17.2%) are the second most frequently indicated by respondents as someone people would turn to for problems of a drug nature. Also, 16.0% indicated that they would turn to drug problem specialists (counselors) and 16.2% to formal treatment program/clinics, for any assistance for drug problems.

Since "drug problems" appear to be detected earliest within the family and since family members would prefer to enlist the aid of their family physician or clergyman, Brinkley pointed out that Iowa needs to consider how best to equip the family to function in early drug abuse problem detection and to assist general practitioners and physicians in family medicine as well as the clergy in meaningful intervention once a drug problem is referred to them.

The Iowa study suggests that some 36,100 persons have a drug related problem in the family, on the job or with the police. These 36,100 persons represent 3.3% of all the people age 14 and above who have ever used a prescription drug or any of the illicit drugs. The data indicates that as one begins to become heavily involved with drugs,

personal and social problems occur first within the family, secondly with the law and finally, one begins to experience problems within their occupational roles.

The survey was also designed to produce other indices of the "costs" of misusing or abusing drugs. The data suggest some 232,500 persons have experienced some adverse psychological or physiological reaction from taking drugs and 51,400 have experienced more than two such adverse reactions. These 232,500 persons represent 21.0% of all the people who have ever taken one of the prescription drugs or even used one of the illicit drugs. In addition, some 11,000 persons are believed to have received some form of formal treatment and some 81,500 have received some form of counseling for drug use problems.

Although the newly created State Alcoholism Commission has not had an opportunity to fully analyze the alcohol data collected in this study, some preliminary findings are worth noting. According to the study results, a projected 52% of the population of Iowa aged 14 and above, report consuming some alcoholic beverage more often than once a month. The proportion of regular drinkers in Iowa falls midway between statistics representing neighboring states where similar research was conducted. Generally, the use of alcoholic beverages appear to be an established norm in the State of Iowa. Almost three-fourths (73%) of the state's population reported drinking some alcohol in the last year. A somewhat small proportion of Iowa's population, aged 14 and above, can also be considered "regular drinkers" in that they drink at least once a month.

Siegal, the scientist responsible for the alcohol sections of the study, stated that in regards to heavy drinkers, the following can be stated:

- Some four-fifths (83%) of those who are heavy drinkers are male.

- The 18 to 24 year age group are most likely to be over-represented.

- An estimated 17,000 adolescents between the ages of 14 and 17 manifest a heavy drinking pattern. Of significance, the studies did show a correlation between how much parents drink and the drinking behavior of their children. For examples, parents who drink heavily are most likely to have children who also drink heavily.

- The use of other psychoactive substances is common in the heavy drinking population.

- Some 13% report regular use of illicit drugs.

- Some 40% are heavy smokers (of tobacco)

The prevalence of alcohol problems in Iowa is similar to that found in the neighboring states of North Dakota, South Dakota, Minnesota and Indiana. The statistics in Iowa, however, suggest a higher proportion of Iowans who drink regularly or used to drink regularly and report alcohol related problems. In Iowa, 18% of those interviewed reported having alcohol related problems while the average for all these state studies is 14%.

In regards to the homeless alcoholics, the study pointed out that respondents generally felt that the number of young people and Indians falling into this category is increasing. Respondents also stated that more drugs are available, more drinking is being done, and fewer jobs are available. Siegal emphasized that males tend to predominate this respondent group; over 90% were male, 85% were white, 8% were black and some 7% were American Indians. The size of this homeless population in Iowa is projected to be approximately 1,000 persons.

The study also pointed out that the majority of the state's population do possess a fairly enlightened outlook on alcohol and alcohol-related problems, however, specific knowledge about alcohol and alcoholism is lacking. Brinkley emphasized that the data clearly reveals that a significant proportion of those experiencing difficulty with alcohol fall into the younger age brackets thus making it imperative for appropriate agencies to explore the development of meaningful alcohol education curriculum to be provided at early educational levels.

In regard to treatment, the survey revealed that the problem drinker in Iowa is typically an employed male, in the most productive years of his life. This data implies that recruitment into treatment should be through the major foci of the problem drinker's lives. This would mean encouraging the expansion of programs attempting to reach the problem drinker on the job. In those areas in which there are not any such programs, their development should be facilitated by appropriate agencies.

The attitudes and knowledge concerning the effects of drugs, drug users, and the laws which relate to controlling drug use examined in the study are of special note. In relation to alcohol or drug education being needed in the school, 87.2% of the respondents felt it was; interestingly 80.2% of those surveyed felt that smoking marijuana in moderation was wrong while 32.4% of the respondents felt that smoking marijuana is no more harmful than drinking alcohol. In regards to marijuana use leading to stronger drug use, 66.2% of the respondents felt this phenomena occurs.

Forty-six point two per cent of those surveyed did not feel that s trict and harsh punishment of drug abusers keep others from using drugs and 30.4% felt that the current penalties for possession of marijuana for personal use should be reduced to an offense punishable by a fine. As for local court systems, only 28.5% of those surveyed

felt that an adequate job was being done by local courts in the sentencing of persons arrested and convicted of drug selling offenses. It is interesting to note that while 42.5% of the population believe that strict and harsh punishment of users is a deterant against drug abuse, 82.1% of the population believe that education is the best way of preventing drug abuse.

Brinkley stated that the data obtained from this study combined with the data base displayed in the IDAA 1973/74 Comprehensive State Plan for Drug Abuse Prevention and the current update of that data suggest that

- the current treatment delivery system in Iowa should be evaluated with specific reference to its effectiveness and appropriateness for engaging and addressing the needs of young multiple drug users.

- a major campaign of aggressive early case finding warrants consideration to deal with the apparent large numbers of persons between the ages of 14 and 17 who are already heavy consumers of alcohol and who are current/regular users of marijuana and other hallucinogens.

- a campaign to counteract the popular attitude of the normalacy of chemically coping with general living situations needs to be examined. It appears, says Brinkley that those who are most susceptible to the acceptance of such coping aids are probably the least likely to accept the inherrent physical and psychological dangers in long term or indiscriminate use of psychoactive preparations.

- preventative drug education should be provided during elementary school if it is going to have any significant impact.

- the family, family physicians and the clergy appear to be the best "first line of defense" for dealing with drug abuse problems.

- in spite of the somewhat geographic isolation from major drug centers, most drugs seem to be available most of the time in most

parts of Iowa.

- Cocaine use would appear to be the current "emerging" drug in Iowa thus requiring a major informational/education effort in that most of the street respondents believed cocaine to be a social drug no more harmful than marijuana.

- in general, the quality of illicit drugs in Iowa is quite low and frequently mislabeled in the market place. The findings represent the initial analysis of the study. Several more months will be needed by the involved agencies to make a comprehensive analysis of the complete study, Brinkley said. For the first time, our agencies and their staff are faced with the unique problem of having too much, rather than too little information to work with. As the data is further analyzed, additional information relating to the problem and our response to the problem will be released to the public.

Incidence & Prevalence Studies of Substance Use & Abuse in Iowa

1974 - 1976

HIGHLIGHTS

IOWA DRUG ABUSE AUTHORITY

INCIDENCE AND PREVALENCE STUDIES

OF

SUBSTANCE USE AND ABUSE

IN

IOWA

1974 - 1976

HIGHLIGHTS

IOWA DRUG ABUSE AUTHORITY

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The Iowa Drug Abuse Authority wishes to acknowledge the efforts of Dr. Carl Chambers of the Resource Planning Corporation for his direction of most of the research which was used in the formulation of this document.

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This abstract of the incidence and prevalence of substance use and abuse in Iowa is based on the findings of the 1974 incidence and prevalence study and its 1976 update, as well as Client Oriented Data Acquisition Process (CODAP) program reporting forms. The incidence and prevalence studies were conducted by the Resource Planning Corporation as consultants for the Iowa Drug Abuse Authority (IDAA) in cooperation with the Iowa Crime Commission. The studies are extensive and contained in several volumes. Therefore, IDAA felt an abstract which contained pertinent facts regarding the current substance abuse problem in the state would be valuable.

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Section I. METHODOLOGY

URBAN STUDY

Two thousand Iowans aged 14 or above were selected from the non-farm residency population across the state and interviewed in the 1974 study. These same persons, whenever possible, were recontacted in 1976 for the update study. This table describes the mailed and returned questionnaire distribution:

1974 Interview Population		1976 Mail Population*	1976 Completed Questionnaire Returns**	
			N	Rate
Ages 14-17	441	340	111	33%
18-24	518	370	116	31%
25-34	513	410	172	42%
35-49	216	173	87	50%
50+	267	214	86	40%
Total	2,000	1,507	572	38%

* Includes those who were willing for their name and address to be recorded at time of the 1974 interview. Approximately 25% of the total population did not want to be so identified.

** Includes only those who completed at least 80% of the questionnaire.

RURAL STUDY

Two hundred eighty rural families residing on farms in twelve predominately rural counties of Iowa were interviewed in this portion of the 1974 study. Each family selected had to have at least one child age 14 or above living in the home. A total of 864 persons were interviewed. The same persons were recontacted whenever possible for the 1976 update. This table describes the mailed and returned questionnaire distribution:

1974 Interviewed Population		1976 Mailed Population	1976 Completed Questionnaire Returns*	
Ages 14-17, 18-24, 25-34	403	403	122, 34, 11	167 (41%)
35-49, 50+	461	461	115, 56	171 (37%)
Total	864	864		338 (39%)

* Includes only those who completed at least 80% of the questionnaire.

SUBCULTURE STUDY

This study was undertaken in 1974 and again in 1976 to provide descriptive data relative to the nature and structure of the substance using within that population of Iowans whose drug use remains basically hidden and illicit. This group is commonly referred to as the "street" users. Face-to-face interviews were conducted by interviewers who were familiar with the communities. The same instrument was utilized in both studies. Data was collected from 307 active drug users who were distributed in these eight Iowa localities:

	No.	Percent
Davenport/Quad Cities	66	21%
Iowa City	20	7%
Cedar Rapids	29	9%
Waterloo	41	13%
Cedar Falls	25	8%
Des Moines	74	24%
Council Bluffs	20	7%
Sioux City	32	10%
Total	307	100%

Section II. SUMMARY OF THE INCIDENCE & PREVALENCE OF SUBSTANCE USE IN IOWA IN 1976

GENERAL POPULATION STUDY

The general population study in 1976 had a geographic control to allow comparisons between the rural and urban populations. Rural population refers to those Iowans residing on farms.

Over-the-Counter (OTC) Drug Use

General consumption patterns

Drug	Most Frequent User	Sex	Age Group	% of Sample
Sleeping Aid	Rural	Male & Female	25-34	25% (each)
Tranquilizers	Rural	Female	18-24	12%
Stimulants	Urban	Female	14-17	22%
	Rural	Female	14-17	21%
Cough Suppressants	Urban	Female	14-17	55%
Analgesics (Non-Aspirin)	Urban	Female	18-24	52%
	Urban	Female	18-24	38%

High Frequency* User Distribution

	Urban Cohort	Rural Cohort
Sleeping Aids	<1%	<1%
Tranquilizers	0%	0%
Stimulants	1%	<1%
Analgesics	1%	<1%
Cough Suppressants	2%	1%

*Daily for at least one week.

Prescription Drug Use

General Consumption Patterns

Drug	Most Frequent User	Sex	Age Group	% of Sample
Sedatives	Rural	Male	14-17	15%
Tranquilizers	Urban	Female	25-34	23%
	Urban	Female	35-49	22%
Diet Pills	Urban	Female	18-24	17%
Pep Pills	Rural	Male	14-17	15%
	Urban	Male	14-17	12%
Analgesics	Urban	Female	18-24	31%

High Frequency User Distribution

	Urban Cohort	Rural Cohort
Sedatives	<1%	<1%
Tranquilizers	1%	1%
Diet Pills	<1%	0%
Pep Pills	1%	0%
Analgesics	1%	<1%

Illicit Drug Use

Prevalence of Urban Use by Age & Sex

Sex/Age	N	Marijuana Hashish	L.S.D./Other Hallucinogens	Heroin	Cocaine
Males 14-17	49	35%	10%	4%	8%
18-24	62	21	6	3	8
25-34	80	6	1	0	1
35-49	38	0	0	0	0
50+	46	0	0	0	0
Females					
14-17	62	26%	2%	3%	5%
18-24	54	15	2	0	6
25-34	92	3	0	1	1
35-49	49	2	0	2	4
50+	40	0	0	0	0
Total Males	275	13%	2%	1%	4%
Total Females	297	9%	1%	1%	3%
Total 1976	572	10%	1%	1%	3%

Prevalence of Rural Use by Age & Sex

Sex/Age	N	Marijuana Hashish	L.S.D./Other Hallucinogens	Heroin	Cocaine
Males 14-17	52	23%	13%	12%	12%
18-24	17	24	12	6	12
25-34	3	0	0	0	0
35-49	36	0	0	0	0
50+	28	0	0	0	0
Females					
14-17	70	9%	0%	1%	1%
18-24	17	6	0	0	0
25-34	8	0	0	0	0
35-49	79	0	0	0	0
50+		28	0	0	0
Total Males	136	12%	1%	5%	6%
Total Females	202	3%	0%	<1%	<1%
Total 1976	338	7%	1%	2%	3%

Generalizations Urban & Rural*

- Urban dwellers more frequently use marijuana than rural dwellers, but rural dwellers may use the other drugs more frequently.
- Males, regardless of place of residence are more frequent users of all illegal drugs than females.
- The most frequent using sex/age/urbanicity cohort for each illegal drug is as follows:

  (1) Marijuana/Hashish - Urban Males 14-17 (35%)
  (2) L.S.D./Other Hallucinogens - Rural Males 14-17 (13%)
  (3) Heroin - Rural Males 14-17 (12%)
  (4) Cocaine - Rural Males 14-17 (12%) & 18-24 (12%)

* The high prevalence of use of LSD, heroin and cocaine reported by rural respondents is surprising. One possible explanation is that these drugs are just beginning to be widely diffused into the rural areas and experimentation is high.

Alcohol

Prevalence of Alcohol Use by Sex and Age

Urban

	Daily	Almost Daily	3-4 Times Week	1-2 Times Week
Males 14-17	0%	4%	14%	18%
18-24	3	0	13	35
25-34	5	6	15	23
35-49	3	13	5	16
50+	4	9	4	2
Total Males	3	6	11	20
Females				
14-17	0%	2%	4%	13%
18-24	0	0	4	20
25-34	0		2	20
35-49	0	0	0	18
50+	2	0	0	2
Total Females	<1	<1	2	16

Rural

	Daily	Almost Daily	3-4 Times Week	1-2 Times Week
Males				
14-17	0%	0%	7%	23%
18-24	0	6	18	53
25-34	0	0	0	33
35-49	0	6	14	28
50+	4	4	4	14
Total Males	1	3	10	26
Females				
14-17	0%	0%	3%	11%
18-24	0	0	6	24
25-34	13	0	0	0
35-49	1	0	4	11
50+	0	0	3	11

DRUG SUBCULTURE

Drug Use

Distribution of drug first used

	Number	Percent
Alcohol	279	91
Marijuana	20	7
Amphetamines	4	1
Hashish	1	<1
Other Sedatives	2	1
L.S.D.	1	<1
Total	307	100

Drugs of Choice

Rank Order of Preference

First Choice		First or Second Choice	
1. Marijuana	(44%)	1. Marijuana	(36%)
2. Alcohol	(16%)	2. Alcohol	(20%)
3. Cocaine	(10%)	3. Cocaine	(10%)
4. Amphetamines	(8%)	4. Amphetamines	(8%)
5. Heroin	(8%)	5. Hashish	(8%)

Drugs Actually Used in Last 60 Days	Drugs Actually Used in Last 7 Days.
(a) Marijuana	(a) Marijuana
(b) Amphetamines	(b) Amphetamines
(c) Hashish	(c) Cocaine
(d) Cocaine	(d) Hashish

Mean Number of Drugs Used

	1974	1976
Used last 60 days	2.7	3.6
Used last 7 days	1.8	2.4

Hard Drug Subculture*

Consumption patterns of "hard" drug users during last 60 days.

	Number	Percent
Alcohol	27	73%
Marijuana	29	78%
Hashish	12	32%
Barbiturates	9	24%
Methaqualone	2	5%
Other Sedatives	3	8%
L.S.D.	4	11%
Other Psychotogens	2	5%
Cocaine	14	38%
Amphetamines	7	19%
Other Stimulants	-	-
Heroin	28	76%
Other Narcotics	7	19%

* This includes persons who use heroin or other narcotics on a regular basis (either daily or several times a week), and those who are regular users of cocaine and have concurrent involvement with narcotics and/or sedatives.

Overdose/adverse reactions among "hard" drug users.

Drug	Total Persons
Heroin	17
L.S.D.	3
Morphine	1
Codeine	1
Heroin/Stimulants	1
Heroin/L.S.D.	1

The "Soft" Drug Subculture

Consumption patterns of "soft" drug users in last 60 days.

Drug	Number	Percent
Alcohol	250	93
Marijuana	252	93
Hashish	84	31
Barbiturates	35	13
Methaqualone	1	<1
Other Sedatives	18	7
L.S.D.	55	20
Other Psychotogens	33	12
Cocaine	68	25
Amphetamines	123	46
Other Stimulants	10	4
Heroin	9	3
Other Narcotics	10	4
Solvents/Inhalants	10	4

Overdose/adverse reactions among "soft" drug users.

Drug	Number	Percent
L.S.D.	39	14
Other Psychotogens	17	6
Barbiturates	16	6
Amphetamines	14	5
Heroin	10	4
Cocaine	6	2
Heroin/L.S.D.	2	1
Heroin/Barbiturates	1	1
Heroin/Cocaine	1	1
L.S.D./Amphetamines	1	1
L.S.D./Sedatives	3	1
L.S.D./Marijuana	1	1
L.S.D./Other Psychotogens	1	1
Amphetamines/Other Psychotogens	2	1
Amphetamines/Sedatives	4	1
Cocaine/L.S.D.	1	1

Criminality Among Drug Users

Characteristics of those persons for whom criminal activities are their primary means for support.

	"Hard" Drug Users	"Soft" Drug Users
1976	a. 65% Support Themselves By Crimes	a. 12% Support Themselves By Crimes
	b. Crimes Committed 1. Drug Sales (62%) 2. Shoplifting (21%) 3. Prostitution (17%)	b. Crimes Committed 1. Drug Sales (87%) 2. Shoplifting (13%)
	c. 32% Were Arrested In Last 60 Days	c. 39% Were Arrested In Last 60 Days

Section III. GENERAL COMPARISON SUMMARY OF THE 1974 INCIDENCE AND PREVALENCE STUDY AND 1976 RESURVEY

GENERAL POPULATION

Over the Counter Medications

Basic consumption patterns between the 1974 survey and the 1976 resurvey remained stable except for a single increase indicated in the consumption of cough suppressants and non-aspirin analgesics.

Prescription Medications

Comparisons between the 1974 survey and the 1976 resurvey show slight increases in the consumption of sedatives and non-aspirin analgesics, and a significant increase in the consumption of minor tranquilizers (>5%). All other comparisons indicate a stable consumption pattern.

Illegal Drugs

The prevalence of marijuana use during the last six months (5%) and the last month (3%) did not change between 1974 and 1976.

The prevalence of L.S.D. or other hallucinogen use during the last six months and the last month may have decreased from 1% to less than 1% between 1974 and 1976.

The prevalence of heroin use and cocaine use has probably remained stable between 1974 and 1976 (1% and less for use the last six months and last month).

SUBCULTURE

Generalizations in Regard to the Active Drug Using Subculture

Alcohol is the principal onset drug for both studies.

Marijuana is the principal drug of choice for both studies.

The rank order of drugs preferred and those actually used is remarkably similar and stable for both studies (excludes alcohol).

The polydrug pattern (the use of multiple drugs concurrently) appears to be increasing.

Criminality among "soft" drug users does not appear to be increasing but probably is among "hard" drug users. Drug sales remain the primary criminal activity of both types of drug users. It must be noted that 32% of all criminal "hard" drug users and 39% of all criminal "soft" drug users had been arrested during the 60 days prior to interview but were still "on the streets" and still "dealing."

Although the median age of onset is the same for both 1974 and 1976 (age 14) the earliest ages of onset appear to be decreasing. For example, in 1974 the earliest age of onset was 9 while among those interviewed in 1976 several began experimenting with alcohol around the age of 6 and daily use was reported as early as age 10. The earliest onset age for drug use other than alcohol was 9 with regular use being reported by age 10.

Drug Quality and Availability

While heroin (usually Mexican) seems to be available most of the time in most localities at a fairly consistent price, the quality of the drug is inconsistent over time and from locale to locale.

Cocaine would appear to be more available than heroin but with wide variations in price and quality. Much more so than with heroin, the price of cocaine appears to be directly related to the quality of the drug.

Marijuana continues to be available to anyone anywhere. It would appear there has been a marked increase in the availability of "imported" marijuana with a greater potency than the locals.

Among stimulants, pharmaceutical amphetamines appear less available, pharmaceutical non-amphetamine stimulants are more available, and illicitly manufactured amphetamines are readily available everywhere.

The availability and use of sedatives appears to have declined significantly. A decline in the popularity of methaqualone was most obvious.

The availability and use of L.S.D. and most other psychotogens appear to have declined significantly. The growing and consuming of psychedelic mushrooms may be the exception to this observation. A decline in the popularity of phencyclydine (PCP) was most obvious.

The availability of illicit methadone appears to have all but disappeared.

The use of amylnitrate ("poppers") appears to be increasing in popularity.

ATTITUDES COMPARISON

Both the original study and the resurvey accumulated comparative urban/rural data on several attitudinal questions. These comparisons are presented below:

Where would you first seek help if you or a member of your family was to have a drug/alcohol problem?

	1976		1974
	Rural (338)	Urban (572)	Urban (2,000)
Family Physician	35%	36%	21%
Family Clergyman	9%	10%	17%
Local Hospital	1%	1%	6%
Local Treatment Program	11%	14%	16%
Local Mental Health Center	2%	3%	16%

The local treatment program is now considered the second choice among respondents.

What do you consider the best way of preventing drug abuse?

	1976	
	Rural (338)	Urban (572)
Stricter law enforcement	33%	29%
More treatment programs	6%	5%
More educational programs	48%	48%
Other/No Data	13%	17%

Education is still viewed as the best preventive measure.

The penalty for "first time" possession of marijuana should be reduced to an offense punishable by a fine.

	1974		1976	
	Rural (864)	Urban (2,000)	Rural (338)	Urban (572)
Agree	21%	30%	33%	37%
Disagree	66%	50%	43%	41%
Not Sure	13%	19%	24%	21%

Some of those respondents who in 1974 felt the penalty for marijuana possession should not be reduced to a fine have apparently changed their minds or are unsure.

A lot of people need drugs to cope with stress.

	1974		1976	
	Rural (864)	Urban (2,000)	Rural (338)	Urban (572)
Agree	49%	49%	15%	18%
Disagree	42%	42%	66%	66%
Not Sure	9%	9%	19%	15%

A significant number of respondents now feel drugs are not the answer to stress.

Section IV. TREATMENT PROGRAM CLIENT PROFILE

A 25% random sample of the CODAP admission reporting sheets sent to IDAA by drug treatment programs provided statistical data on clients for 1975 and 1976. Program surveys provided the statistical data for 1973 and 1974. A client profile for each year from 1973 through the first six months of 1976 was drawn up for this data and is displayed below.

	1973	1974	1975	1976
Age:	Under 26 (85%)	21	20.7	21.2
Sex:	Male (61%)	Male (62%)	Male (59.6%)	Male (58.9%)
Race:	White (85%)	White (97%)	White (88.6%)	White (90.5%)
Education:	Some high school or graduate (77%)	Undetermined	11.1 Years	10.7 Years
Employment:	Employed (37%)	Employed (39%)	Employed (31.4%)	Employed (29.2%)
Legal Status:	Undetermined	Undecermined	Voluntary (70.3%)	Voluntary (75%)
Drugs of Choice:	Opiates Marijuana Polydrug Stimulants Hallucinogens Alcohol Barbiturates	Marijuana Opiates Alcohol Barbiturates Amphetamines Hallucinogens Solvents Cocaine	Marijuana Amphetamines Alcohol Hallucinogens Heroin Barbiturates Cocaine Solvents	Marijuana Amphetamines Alcohol Hallucinogens Heroin Barbiturates Sedatives Cocaine Solvents
Polydrug Use: (more than 1 drug used concurrently)	% Undetermined	30%	75%	82.6%

The typical program client as defined above has not changed significantly since 1973 with the exception of the prevalence of polydrug use and the shift in preference from opiates to amphetamines as the primary drug of choice among the clients. Over 82% of the clients entering drug abuse treatment today are polydrug users.

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Preliminary Report

THE IOWA STATE-WIDE YOUTH NEEDS ASSESSMENT SURVEY

by

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Under the sponsorship of the State Office for Planning and Programming and the Iowa Crime Commission

For the past two years technical assistance from the Community Youth Program Project of Iowa State University's Sociology Department has been provided to state agencies and communities of Iowa to enhance their capacity to conduct effective planning, program design and implementation, and feedback evaluation relative to youth development and delinquency prevention. Such technical assistance has focused on designing and implementing a state-wide survey that assesses the needs of youth and the design and implementation of a procedure for planning and programming community-based youth development and prevention programs. A major objective of this project is to develop at the state and local levels rational and empirically based program planning and development.

In the fall of 1976 a large sample of adolescents throughout the state of Iowa participated in a youth needs assessment survey.

The survey instrument consisted of the following types of measures:

1. A series of demographic items (age, sex, grade level, residence area, etc.), permitting a "sorting out" of results as they reflect the needs, interests and experiences of particular groups of youth;

2. A Needs and Problems checklist containing 63 items in the areas of youth employment, medical and legal services, school-related needs and problems, neighborhood-based problems, and parent/family problems. Youth were given the opportunity to indicate those areas in which they experienced needs or problems and to indicate the frequency and seriousness with which they experienced particular needs or problems.

3. A set of questions intended to measure youth familiarity with a variety of local organizations and agencies offering services to youth.

CONTINUED

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4. A series of questions comprising "Impact Scales," which are tied to a set of tested theoretical propositions about youth development and delinquency prevention. The survey measures perceptions of: 1) access to socially desirable roles; 2) positiveness by friends, family, and teachers, i.e., positive and negative labeling; and 3) substantial personal control over the direction of their own lives as integrated members of the community, i.e., alienation.

In the summer of 1976 youth service providers throughout the state responded to a mail-back Youth Service Agency Needs Assessment instrument. This instrument was designed to collect descriptive information about youth service providers' perceptions of youth needs and problems in a given community. The items included in this instrument ask agency personnel to respond to the same list of needs and problems which appear in the Youth Needs Assessment. There can therefore be a comparison of perceptions of youths and agency personnel as to the needs of youth.

Sample of Iowa Public School Districts*

The sample consisted of youngsters who were attending grades seven through twelve in the public schools of Iowa. Within a sampled school district a minimum sample size of 25 children per grade level were sampled from each of the six grade levels. Resources limited the study to a selected sample of 30 school districts or a total of 4,500 children. Twenty-eight school districts participated in the study. The actual number of students represented in the study is

*The Iowa Public School sample for the state-wide youth needs assessment survey was selected through sample procedures conducted by the Statistical Laboratory of the Department of Statistics, Iowa State University, Ames, Iowa.

3,947 which is 88 percent of the selected sample population. In the fall of 1976, the time the data was collected, Iowa had approximately 298,000 children attending public junior and senior high schools. Therefore the number of youths participating in the study represents a little over one percent of the total state junior and senior high school student population.

A self-weighting sample of students (that is, a sample in which each student has an equal probability of being chosen) was selected as follows:

1) Thirty school districts were selected with probabilities proportioned to their sizes based on their official total enrollment in grades seven through twelve during the 1975-1976 school year as reported to the Iowa Department of Public Instruction.

2) Within the selected school districts, one classroom (a required class for purposes of eliminating biases), was selected at random.

This sampling procedure could be expected to yield about 150 sample students in each of the 30 sample school districts depending upon how closely the actual enrollment agreed with the official reported enrollment. Within a sample school, the 150 sample students would be distributed over the six grade levels in proportion to their enrollment.

In order to assure a wide geographic distribution of school districts in the sample the districts were arranged in order geographically and sampled systematically. The districts were first grouped into the 15 area community college regions; within each region, the counties were ordered in a geographic manner; and within counties, the districts

were ordered alphabetically. Districts having classes with less than 25 students were combined with neighboring districts.

Within the school districts selected, if there existed an alternative learning center for those children with behavioral problems, the populations of those centers were also surveyed.

Administration of the Youth Needs Assessment Survey

The surveying of classrooms took place during November of 1976. The Questionnaire Administrators were Iowa State University students who had been thoroughly trained in the administration of the survey instrument. In the majority of classes, no school personnel were present in the classroom during the survey session.

The role of the questionnaire administrators was to explain the study to the students, and help students with reading difficulties.

The survey was self-administered, confidential, and voluntary. Students had forty to sixty minutes to complete the survey, depending on the length of their regular classroom period.

On the respective dates of administration, absentee rates were low: two or less absentees per classroom. No attempt was made to survey the absent students.

Since the survey was voluntary students could refuse to participate. However, refusal rates were very low: less than 1 percent of the students.

Sample of Youth Service Providers of Iowa

In June and July, 1976, 386 youth service agencies and 123 school counselors were mailed the survey packet (total of 509). Twenty-eight

percent of the youth service providers and 42 percent of the school counselors returned the survey by the designated six week period. A follow-up letter and survey was sent to the youth services agencies that did not return the material. Altogether 240 out of 509 surveys were returned, which represents 47 percent of the original sample.

The categories of agencies included in the study are:

1. Licensed Child Care Facilities
2. Referral Agencies
3. Drug and Alcohol Treatment Facilities
4. Probation Offices
5. Alternative School
6. Diversion Resources
7. Detention Facilities
8. Police Liaison Programs and Juvenile Bureaus.

The surveys were mailed to Agency Directors, however in many cases the Director assigned another staff person to complete the instrument.

Data Processing

Coding, key punching, and computer analysis were completed at the University of Iowa and Iowa State University Computer Centers.

The following tables present a portion of the relevant findings in terms of frequencies and percentages of the Iowa State-Wide Youth Needs Assessment Survey.

Presentation of Data

The following presents summaries of portions of the state-wide youth needs assessment and youth service agency needs assessment findings.

State-Wide Youth Needs Assessment

The demographic information depicts the following profile of the state-wide youth sample. There is nearly an equal number of males and females (a few more males) in the sample. The age range goes from 11 to 19 with most of the sample falling in the 13 to 17 range. There is a substantially large percentage of 15, 16 and 17 year olds. The vast majority of the sample is caucasian (93%), three percent of the sample is black. There is just about equal numbers of subjects in the 7th through 12th grade levels. "Father" was identified as "head of the family" by most of this sample (79.6%). The largest percentage occupational category for family head fell in the "skilled manual" area (25%), with substantial proportions identified as "administrative" (14.2%), "sales workers" (13%), and "machine operators" (14%). A significant percentage of family heads were high school graduates (44%). Twenty-five percent of the family heads had some college or college level training or finished a college program. The State Office for Planning and Programming area analysis shows that the sample was well distributed throughout the state (only areas 12 and 14 are not represented). There are significantly large percentages of the sample represented in Area 11 (18.3%) and Area 13 (12.8%).

The Youth Needs Checklist can best be understood by identifying consensus problem areas, that is, problems or needs presented in the survey in which there were a significantly large proportion of youth subjects agreeing that these were issues of personal concern to them. These problems or needs of youth can be identified as first order problems, that is, 30 percent or more

of the sample stated these were problems to them; second order problems, that is, 25 to 29% of the sample related these were problems to them; and third order problems, that is, 20 to 24% of the sample identified these were problems to them. If we cluster analyze consensus items, several problem and need categories become evident. The World of Work is a problem area identified by our youthful sample. Referring to the Youth Needs Checklist, items 4 and 6 are first order problems, item one is a second order problem, and items 3, 5 and 10 are third order problems. The youngsters are concerned about jobs not being available to them, no way to find out about jobs, jobs having no future, and lack of training for jobs. Over 50 percent of the group identifying these problems stated that they were "very often" to "sometimes" problems. About 50% stating these were not serious areas; but significant proportions (30 percent or more) stated they are "somewhat" problem areas.

Teachers and Schools is the second major problem area identified by the subjects. Items 17, 21, 24, 58, 60, 61 and 63 are first order problems. Note the intensity of items 24, 60 and 63; approximately 50 percent of the sample identify these as personal problems. Students see as major problems "no say in the running of their schools," "no say of school free time," and "no say in their school lunch programs." Second order teacher and school problems are items 20 and 22. A third order school problem is item 62. The subjects choose items indicating school personnel lack of understanding or an interest in students, lack of interesting and relevant classes, and student lack of power in effecting school programs and functions. All these problems tended to be frequent and serious for the sample of youths. Sixty to 70 plus percent of those identifying these school and teacher items as problems remarked that these were "very often" or "sometimes" problems and they were "very serious" or "somewhat serious" problems.

Police and Youth arises as a third problem area identified by the sample. A first order problem was item 33 stating that police are not interested in helping kids (29.5%). Second order problem items were 30, 32 and 37, while third order problem items were 31 and 36. Those identifying these as problems saw them as frequent and serious issues (60 to 70 plus percent stating they were "very often" or "sometimes" problems, and 70 to 80 plus percent stating they were very or somewhat serious problems to them). Significant proportion of the sample is concerned over police in interested in youngsters, police over-reacting, police corruption, police not helping youth and police being unfair to male youth.

Parents and Adult Response to Youth is a fourth problem area identified by the subjects. A first order problem is item 46 that states parents do not understand kids' problems (43.2%). Most of those identifying this as a problem felt it was very or sometimes frequent (70%) and very or somewhat serious (65%). Third order problems were item 40 indicating a problem of no confidence in going to adults with problems (24.0%) and item 41 stating that parents are not interacting with their children enough (21.2%). Again, these were seen as frequent and serious problems by those responding to these items.

A fifth problem area identified by the sample was that of Neighborhood. A first order problem was item 49 identifying stealing and vandalism in subjects neighborhoods (42.8%). A third order problem was item 47 stating neighbors do not know or care about each other (23.5%). Both items show frequency and seriousness of problems to be significantly high. This is an interesting and perplexing reaction of youngsters that surely needs more study.

Recreation and Transportation is the last problem area identified by the subjects. Five first order problems arise, these are items 51, 52, 53, 54 and 55. Note that over half of the sample feel there is not enough things

to do (53.5%) and entertainment is too costly for kids (52.6%). Also significant proportions of the sample felt that recreational and educational centers are not available at leisure time and transportation is unavailable to get to leisure time pursuits. All these items were frequent (80% of those responding to the items) and serious (70% of those responding to the items).

Youth Responses to Agencies

Six agencies with statutory responsibility to service youth were presented to the youth subjects. The subjects were asked if they knew about the agency and if they did they were to respond to a series of questions relating to ease of finding the agency, peer image, did they know what services were provided, did they think the agency would keep information confidential, are personnel easy to talk to and can they easily obtain help at the agency.

The subjects were asked if they sought or received help from the agency. The agencies were: State Department of Social Services, probation department, school guidance counselors, mental health center, police department and Job Service of Iowa.

In regard to the state agencies--Department of Social Services, Job Service of Iowa and the area agency mental health center--small percentages of subjects know about them (though more stated they know about Job Service of Iowa). Those that did know about these agencies were not clear about their knowledge of the agencies. Though these agencies, in the subjects perceptions, were not hard to get to and confidentiality was not a problem, significant proportions did not know about peer image, did not know if employees were easy to talk to and were unsure if they could get help from an agency person.

Perceptions toward probation and police were somewhat clearer, though significant percentages of the responding sample responded to the "don't know" category regarding ease of getting people to talk to and difficulty in getting someone to help. Responses toward probation indicated that a significant proportion of the responding subjects thought peer image was negative, knew what kinds of things probation officers do, and felt confidentiality was not a problem. The police department, in the eyes of the responding subjects, was easy to get to and did not have a good peer image. About the same percentage of subjects felt confidentiality was a problem (31.1%) than was not a problem (33%) with police. The responding sample was also diversified on the issue of police being easy to talk to. Twenty-eight percent responded "sometimes," 30.9 percent indicated "no," and 28.5 percent marked "don't know."

Responses toward school guidance counselors tended to be positive. However, note that significant proportions of the responding sample rated peer image halfway ("sometimes good") and rated ease to talk to school counselors halfway ("sometimes easy to talk to").

Few of the subjects experienced the Department of Social Services, probation and the mental health center. Significant proportions of subjects experienced the police (29.7%) and Job Service of Iowa (19.8%). Most of the sample experienced school guidance counselors (66.1%).

Self-Reported Delinquency Inventory

The state-wide sample of youth were asked to report their own behavioral patterns regarding 19 deviant acts. These ranged from minor infractions (giving a fake excuse to a teacher) to status offenses (running away) to felonies (breaking and entering). As would be expected, many of the youngsters did not engage in any of the deviant acts. However, an item analysis points

out some interesting patterns. Significant percentages of the subjects did engage once-in-awhile in minor infractions such as giving fake excuses to teachers (30.4% responding "one or twice") and taking little things of $5 or less (32.2% responding "once or twice"). Significant percentages occur in the "once or twice" category for "taken something from a locker" (20.3%), "damaged property" (23.7%), and "skipped school" (22.7%). Though small percentages occur in the extent of "marijuana used" categories, larger proportions of subjects do report marijuana used "several times" (7.7%) and "very often" (11.1%) compared to the other infraction behaviors.

The most significant finding pertains to alcohol use. A significant proportion of the sample used alcoholic beverages "once or twice (23.8%), and the largest percentages than any of the other infractions occur in the "several times" category (20.6%) and the "very often" category (15%). Alcohol use by minors appears to be a prominent behavioral occurrence.

State-Wide Youth Service Agency Needs Assessment

In conjunction with the state-wide youth needs assessment, those who provide services to youth were asked to assess youth needs in their area of service. These youth agency personnel were asked to respond to the same items that were on the youth questionnaire. The instructions asked them to estimate percentage of all youth in their service area having the need or problem and the degree of seriousness.

The youth service providers identified more crucial youth problem areas than the adolescent subjects. Several of these problem areas corresponded to the youth sample consensus areas. Again, we can cluster analyze first, second, and third order problems (this time by the mean percent of the estimates of extent of problem in the service area) to formulate problem and need categories. We can also determine over and under estimation of

youth service providers perceptions of youth problems by comparing the youth and service provider data results.

The service providers agree with the youth sample that the World of Work is a major problem area for youngsters. First order problems are items 1, 2, 3, 4, 6 and 10. No jobs available for kids, no jobs with futures, no job training, are a concern. The service providers overestimated these needs in their areas and perceive the need or more serious than the youth.

Drugs and Youth are first order problems and serious problems in the eyes of service providers. The service providers sample highly overestimate the problem (item 11, youth: 12%--service providers 30%; item 12, youth 2.3%--service providers 36%).

Sex Education is another high estimated youth problem area (items 15 and 16). These items were also highly overestimated in terms of youth need and service provider estimate of youth falling into this need category.

Teacher and Schools were identified as a need area by the service providers, though they underestimated the extent of the problem (items 17, 20, 21, 23 and 24). Service providers highly underestimated the "lack of interest by school personnel" (item 17) and "lack of student input in schools" (item 24) problems, while they overestimated the "lack of alternative school programs" issue (item 23).

School Counselors occurs as a third order problem (items 28 and 29). Not enough counselors and counselors not having useful information for youth are considered more of a problem in the eyes of service providers than youth.

Parents and Adult Response to Youth are first order problems (items 40, 41, 42, 44 and 46). This problem area appears to be the highest priority issue (service providers felt that over half of the youth in their area

suffer from "parents not spending enough time with their kids"). The service providers overestimated the problem and felt it a more serious problem than the youth sample (though both samples felt this is a serious problem area).

Neighborhood was identified as a problem area (item 47). The service providers overestimated the extent of "people not caring for each other" problem (item 47) and underestimated the "having things stolen or destroyed in neighborhood" problem (item 49).

Like the youth sample, the service providers see many kids falling into the Recreation and Transportation need category (items 51, 52, 53 and 54). The youth sample sees this as more of a problem than the service provider sample, especially the need for convenient transportation issue (item 54).

It should be noted that Medical Treatment for Youth is viewed as a much bigger problem in the perceptions of service providers than youth (items 13 and 14).

A major differentiation between the youth and service provider samples is the issue of Police and Youth (items 30, 31, 32, 33, 36 and 37). The youth sample considers police interaction with adolescents a major and serious problem. The service providers greatly underestimated the frequency and seriousness of this youth problem.

Summary

The findings of a portion of the state-wide youth needs assessment (sample of 3,947 seventh through twelfth graders) and the state-wide youth service agency needs assessment (sample of 240 youth service providers) can be summarized as follows:

1. The state-wide youth sample can be described as: equally split between male and female, mostly from the 13-17 age range, mostly caucasian,

with predominently fathers as head of the family working in mostly skilled manual or administrative or sales or machine operator careers, with a large percentage of family heads completing high school, and sample subjects residing in all areas of the state.

2. Cluster analysis of consensus of problems items on the Youth Needs Checklist determined several major problem areas. These are: 1) the world of work, 2) teachers and schools, 3) police and youth, 4) parents and adult response to youth, 5) neighborhood, and 6) recreation and transportation.

3. Cluster analysis of the youth service providers needs assessment shows some of the same problem areas being identified. These are: 1) the world of work; 2) teachers and schools, 3) parents and adult response to youth, 4) neighborhood, and 5) recreation and transportation. Except for the teacher - school items, the service providers overestimated the frequency of these problems. Problem areas identified more by service providers than youth were: 1) drugs and youth, 2) sex education, 3) school counselors, and 4) medical treatment for youth. A major difference between the youth and service provider samples was the police and youth problem area. The adolescents identified this as a major problem to them, while the service providers indicated few youngsters have problems with police in their service area. The service providers greatly underestimated the frequency and seriousness of this youth problem.

4. A small proportion of youth subjects knew about the Department of Social Service, Job Service of Iowa and the area mental health center. Those that did really did not have a clear picture of these agencies. Probation and police were clearer to the youth subjects. The subjects felt that neither probation nor police had a good image with their peer group. Most of all the youth knew about school guidance counselors and identified these counselors in a positive way. Few of the youth had sought or obtained

services from the Department of Social Services, probation and the mental health center. More had experienced police and Job Service of Iowa. Most all the sample obtained assistance from school guidance counselors.

5. Most of the youth sample reported they "never" engaged in the deviant acts listed in the survey. However, significant proportions of youngsters had "once or twice" given fake excuses to teachers, taken little things, taken things from others lockers, damaged property and skipped school. A significant finding was to extensive use of alcohol reported by the youngsters. Alcohol use by minors is a prominent occurrence.

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DEMOGRAPHIC INFORMATION

PERTAINING TO YOUTH NEEDS ASSESSMENT

SAMPLE

BREAKDOWN OF SAMPLE

BY SEX

	FREQUENCY	PERCENT
MALE	2012	51.3%
FEMALE	1913	48.7
TOTAL	3925	100.0
NO RESPONSE	22	

BREAKDOWN OF SAMPLE

BY AGE

	FREQUENCY	PERCENT
9 years old	0	0%
10 years old	0	0
11 years old	5	0.1
12 years old	372	9.5
13 years old	628	16.0
14 years old	575	14.6
15 years old	679	17.3
16 years old	681	17.3
17 years old	715	18.2
18 years old	248	6.3
19 years old	23	0.6
TOTAL	3926	99.9
NO RESPONSE	21	

BREAKDOWN OF SAMPLE

BY

EDUCATION LEVEL OF FAMILY HEAD

	FREQUENCY	PERCENT
GRADE SCHOOL	75	2.0%
JUNIOR HIGH	405	10.6
SOME HIGH SCHOOL	477	12.5
HIGH SCHOOL GRADUATE	1670	43.6
1-3 yrs C or SPECIAL TRAINING	529	13.8
4 yr COLLEGE GRADUATE	439	11.5
GRADUATE SCHOOL	235	6.1
TOTAL	3830	100.1
NO RESPONSE	117	

BREAKDOWN OF SAMPLE

BY OPP AREA

	FREQUENCY	PERCENT
AREA 1 DECORAH	183	4.7%
AREA 2 MASON CITY	381	9.7
AREA 3 SPENCER	112	2.9
AREA 4 SIOUX CITY	289	7.4
AREA 5 FORT DODGE	157	4.0
AREA 6 MARSHALLTOWN	157	4.0
AREA 7 WATERLOO	226	5.8
AREA 8 DUBUQUE	290	7.4
AREA 9 DAVENPORT	153	3.9
AREA 10 CEDAR RAPIDS	459	11.7
AREA 11 DES MOINES	724	18.5
AREA 12 CARROLL	0	0
AREA 13 COUNCIL BLUFFS	505	12.9
AREA 14 CRESTON	0	0
AREA 15 OTTUMWA	112	2.9
AREA 16 BURLINGTON	176	4.5
TOTAL	3924	100.3
NO RESPONSE	23	

BREAKDOWN OF SAMPLE

BY ETHNICITY

	FREQUENCY	PERCENT
WHITE	3591	92.9%
BLACK	114	3.0
CHICANO	32	0.8
AM. INDIAN	46	1.2
ASIAN	9	0.2
OTHER	72	1.9
TOTAL	3864	100.0
NO RESPONSE	83	

BREAKDOWN OF SAMPLE

BY GRADE

	FREQUENCY	PERCENT
7th grade	645	16.4%
8th grade	641	16.3
9th grade	613	15.6
10th grade	678	17.3
11th grade	684	17.4
12th grade	665	16.9
OTHER	4	0.1
TOTAL	3930	100.0
NO RESPONSE	17	

BREAKDOWN OF SAMPLE

BY

WHO IS HEAD OF FAMILY

	FREQUENCY	PERCENT
FATHER	3113	79.6%
STEPFATHER	217	5.5
MOTHER	461	11.8
STEPMOTHER	0	0
FOSTER FATHER	20	0.5
FOSTER MOTHER	5	0.1
OTHER RELATIVE	25	0.6
OTHER	72	1.8
TOTAL	3913	99.9
NO RESPONSE	34	

BREAKDOWN OF SAMPLE

BY

OCCUPATION OF FAMILY HEAD

	FREQUENCY	PERCENT
HIGH EXECUTIVES	252	6.9%
BUSINESS MANAGER	283	7.7
ADMINISTRATIVE	521	14.2
SALES WORKERS	465	12.7
SKILLED MANUAL	907	24.7
MACHINE OPERATORS	497	13.5
UNSKILLED EMPLOYEES	130	3.5
STUDENTS	8	0.2
HOUSEWIVES	8	0.2
RETIRED	52	1.4
UNEMPLOYED	111	3.0
FARMER	436	11.9
DISABLED	3	0.1
TOTAL	3673	100.0
UNCODABLE	274	

Youth Needs Checklist Items
Indicating Personal Experience of, Frequency of,
and Seriousness of the Need or Problem

Need or Problem	% of entire youth sample responding "yes" to that item: Yes	% of those responding "yes" who indicated frequency to be: Very Often	Some-times	Once/ Twice	% of those responding "yes" who described that need or problem as: Very Serious	Some-what	Not Serious
1. Looked for work but found that there were no jobs available.	29.1 (1131)	21.2 (248)	34.3 (401)	44.5 (521)	10.1 (119)	36.0 (425)	53.9 (637)
2. A need for counseling about jobs.	11.1 (428)	12.1 (57)	35.5 (167)	52.4 (247)	8.3 (44)	29.6 (157)	62.1 (329)
3. Unable to find a job for the summer.	20.6 (799)	24.5 (199)	37.0 (301)	38.5 (313)	16.6 (139)	32.3 (270)	51.0 (426)
4. Unable to get a job because of your age.	34.1 (1325)	31.7 (412)	26.0 (338)	42.4 (551)	18.3 (234)	29.4 (376)	52.2 (667)
5. No way to find out about what jobs are available.	22.3 (865)	27.5 (232)	40.7 (343)	31.8 (268)	16.6 (144)	39.1 (340)	44.3 (385)
6. The only jobs available have no future.	30.7 (1199)	30.8 (355)	32.8 (378)	36.3 (418)	16.9 (195)	32.6 (377)	50.6 (585)
7. Police record keeping you from getting or keeping a job.	2.4 (95)	29.3 (34)	23.3 (27)	47.4 (55)	18.3 (32)	18.9 (33)	62.9 (110)
8. Your sex keeping you from getting or keeping a job.	3.1 (123)	16.2 (26)	33.1 (53)	50.6 (81)	10.4 (20)	24.9 (48)	64.8 (125)
9. Your race or ethnic background keeping you from getting or keeping a job.	1.6 (64)	30.2 (29)	28.1 (27)	41.7 (40)	16.8 (23)	18.2 (25)	65.0 (89)
10. No specific training for jobs.	22.8 (890)	16.1 (131)	38.5 (314)	45.5 (371)	12.4 (104)	35.6 (298)	51.9 (434)
11. Being hassled by other kids to use or buy drugs.	11.6 (454)	28.5 (131)	31.6 (145)	39.9 (183)	20.6 (101)	23.0 (113)	56.4 (277)
12. Needing drug counseling and education.	2.2 (87)	21.9 (23)	38.1 (40)	40.0 (42)	19.1 (29)	15.8 (24)	65.1 (99)

Youth Needs Checklist Items
Indicating Personal Experience of, Frequency of,
and Seriousness of the Need or Problem (Cont.)

Need or Problem	% of entire youth sample responding "yes" to that item: Yes	% of those responding "yes" who indicated frequency to be: Very Often	Some-times	Once/ Twice	% of those responding "yes" who described that need or problem as: Very Serious	Some-what	Not Serious
13. Medical care or treatment costing too much.	7.6 (299)	26.2 (78)	43.0 (128)	30.9 (92)	28.6 (98)	32.7 (112)	38.8 (133)
14. Too hard to get medical treatment by yourself.	6.7 (261)	18.7 (47)	42.9 (108)	38.5 (97)	23.8 (68)	32.5 (93)	43.7 (125)
15. A need for counseling about pregnancy and abortion.	4.1 (158)	12.6 (22)	27.6 (48)	59.8 (104)	29.9 (64)	24.8 (53)	45.3 (97)
16. A need for counseling about sex and birth control.	7.8 (303)	16.2 (50)	39.2 (121)	44.7 (138)	24.8 (87)	30.8 (108)	44.4 (156)
17. Teachers not understanding kids.	44.9 (1749)	34.7 (622)	40.7 (730)	24.6 (442)	28.0 (496)	41.9 (742)	30.1 (532)
18. Being physically hurt by other kids in school.	13.1 (511)	16.0 (86)	33.4 (179)	50.6 (271)	15.0 (84)	31.4 (176)	53.6 (300)
19. Being physically hurt by teachers when they discipline you.	7.4 (287)	17.0 (51)	30.7 (92)	52.3 (157)	19.3 (63)	30.4 (99)	50.3 (164)
20. Not enough different kinds of classes or courses at school.	29.6 (1156)	31.5 (348)	40.5 (447)	28.1 (310)	23.1 (261)	44.3 (502)	32.6 (369)
21. Not enough classes or courses which are useful or really important.	30.7 (1198)	33.6 (382)	41.9 (476)	24.5 (278)	31.5 (369)	42.5 (498)	26.0 (304)
22. Teachers not interested in you.	26.7 (1039)	22.7 (227)	41.0 (411)	36.3 (364)	23.7 (236)	35.8 (357)	40.5 (403)
23. A lack of alternative school programs like vocational training schools, GED, continuing education programs, or Free School.	12.9 (502)	34.1 (160)	39.9 (187)	26.0 (122)	32.4 (166)	36.3 (186)	31.4 (161)

Youth Needs Survey 1976
Checklist Items, Page 3

Youth Needs Checklist Items
Indicating Personal Experience of, Frequency of,
and Seriousness of the Need or Problem (Cont.)

Need or Problem	% of entire youth sample responding "yes" to that item: Yes	% of those responding "yes" who indicated frequency to be: Very Often	Some-times	Once/ Twice	% of those responding "yes" who described that need or problem as: Very Serious	Some-what	Not Serious
24. Students not having any say in how schools are run.	49.8 (1942)	41.9 (789)	37.2 (701)	20.9 (393)	35.7 (670)	41.3 (774)	23.0 (432)
25. Being expelled or suspended from school.	11.5 (447)	15.3 (69)	22.6 (102)	62.1 (280)	16.7 (79)	32.1 (152)	51.2 (242)
26. Racial discrimination in school courses and programs.	3.9 (151)	24.4 (39)	46.2 (74)	29.4 (47)	26.0 (51)	30.1 (59)	43.9 (86)
27. Sex discrimination in school courses and programs.	8.1 (317)	18.6 (60)	33.4 (108)	48.0 (155)	18.8 (67)	31.4 (112)	49.9 (178)
28. Not enough school counselors.	15.4 (601)	25.5 (139)	42.5 (232)	32.1 (175)	20.5 (122)	41.4 (247)	38.1 (227)
29. When you go to school counselors, they don't have useful information.	18.3 (710)	26.8 (184)	38.8 (266)	34.4 (236)	22.7 (159)	36.7 (257)	40.6 (284)
30. Police treating things more seriously than they should.	25.1 (979)	37.6 (356)	33.7 (319)	28.6 (271)	38.6 (370)	34.8 (333)	26.6 (255)
31. Police being dishonest and crooked.	19.8 (768)	39.1 (291)	32.1 (239)	28.9 (215)	47.0 (355)	32.0 (242)	21.0 (159)
32. Police not being around when you need them.	26.7 (1040)	27.4 (276)	36.2 (365)	36.5 (368)	35.8 (356)	38.2 (380)	26.0 (259)
33. Police not being really interested in helping kids.	29.5 (1144)	38.3 (426)	35.9 (399)	25.8 (287)	42.7 (478)	36.1 (404)	21.2 (237)
34. Racial prejudice on the part of the police.	8.0 (300)	32.6 (102)	41.2 (129)	26.2 (82)	37.1 (126)	32.1 (109)	30.9 (105)
35. Being picked on or hassled by the police.	15.1 (589)	28.2 (163)	30.3 (175)	41.5 (240)	30.8 (186)	31.3 (189)	37.8 (228)

Youth Needs Survey 1976
Checklist Items, Page 4

Youth Needs Checklist Items
Indicating Personal Experience of, Frequency of,
and Seriousness of the Need or Problem (Cont.)

Need or Problem	% of entire youth sample responding "yes" to that item: Yes	% of those responding "yes" who indicated frequency to be: Very Often	Some-times	Once/ Twice	% of those responding "yes" who described that need or problem as: Very Serious	Some-what	Not Serious
36. Police being more strict with boys than girls.	20.8 (810)	35.0 (272)	36.0 (280)	29.0 (225)	29.0 (227)	37.7 (295)	33.2 (260)
37. Friends getting arrested.	26.7 (1040)	18.0 (181)	35.2 (354)	46.8 (471)	23.3 (232)	40.5 (404)	36.2 (361)
38. Problems getting legal help, that is in getting a lawyer to help you.	4.0 (155)	24.4 (39)	33.7 (54)	41.9 (67)	31.3 (60)	27.1 (52)	41.7 (80)
39. Courts being unfair.	7.8 (303)	34.0 (101)	32.3 (96)	33.7 (100)	42.9 (139)	28.4 (92)	28.7 (93)
40. No adult you can talk over problems with.	24.0 (937)	36.1 (330)	41.1 (376)	22.8 (208)	32.8 (304)	38.9 (361)	28.3 (263)
41. Parents not spending enough time with their kids.	21.2 (824)	35.9 (290)	42.0 (339)	22.1 (178)	34.0 (280)	33.4 (275)	32.6 (268)
42. Parents not providing good supervision or control.	8.4 (327)	41.1 (131)	32.6 (104)	26.3 (84)	35.2 (122)	27.1 (94)	37.8 (131)
43. Parents not giving their kids necessary things such as food, a place to live, and medical care.	3.8 (149)	50.3 (72)	30.1 (43)	19.6 (28)	34.1 (58)	22.4 (38)	43.5 (74)
44. Parents' lack of interest in their kids.	11.8 (462)	28.8 (134)	39.5 (184)	31.8 (148)	28.8 (141)	32.0 (157)	39.2 (192)
45. Parents physically hurting their children when angry.	12.5 (489)	18.6 (93)	42.4 (212)	39.0 (195)	24.9 (128)	31.8 (164)	43.3 (223)
46. Parents not understanding kids' problems.	43.2 (1683)	29.2 (481)	40.3 (663)	30.5 (503)	28.0 (458)	36.8 (602)	35.2 (576)
47. People in your neighborhood not knowing or caring about each other.	23.5 (916)	33.4 (299)	41.9 (375)	24.8 (222)	20.6 (188)	38.4 (350)	41.0 (374)

Youth Needs Checklist Items
Indicating Personal Experience of, Frequency of,
and Seriousness of the Need or Problem (Cont.)

Need or Problem	% of entire youth sample responding "yes" to that item: Yes	% of those responding "yes" who indicated frequency to be: Very Often	Some-times	Once/ Twice	% of those responding "yes" who described that need or problem as: Very Serious	Some-what	Not Serious
48. Different racial groups not getting along and fighting with each other.	13.1 (511)	27.1 (135)	40.5 (202)	32.5 (162)	28.3 (147)	39.1 (203)	32.6 (169)
49. Having things stolen or destroyed in your neighborhood.	42.8 (1668)	16.0 (262)	38.9 (637)	45.1 (740)	26.1 (424)	41.4 (672)	32.6 (529)
50. Street fights and gangs in your neighborhood.	7.8 (305)	24.8 (75)	36.3 (110)	38.9 (118)	23.1 (75)	33.2 (108)	43.7 (142)
51. Not enough different kinds of things to do.	53.5 (2090)	47.9 (965)	38.5 (776)	13.6 (275)	34.2 (689)	35.6 (719)	30.2 (609)
52. Entertainment and other kinds of things costing too much.	52.6 (2054)	49.0 (968)	36.8 (727)	14.2 (281)	37.2 (732)	37.3 (730)	25.6 (504)
53. Recreation, school or community centers not being open when you want them to be.	31.1 (1210)	29.6 (349)	47.1 (556)	23.4 (276)	22.7 (265)	38.2 (445)	39.1 (456)
54. Need for convenient transportation.	32.1 (1249)	40.3 (492)	42.1 (514)	17.7 (216)	26.9 (328)	39.9 (487)	33.3 (406)
55. Entertainment and recreation centers not available.	37.1 (1444)	45.5 (633)	37.1 (516)	17.5 (243)	34.0 (472)	37.3 (518)	28.8 (400)
56. No place for runaways to get help.	13.8 (534)	40.5 (204)	33.9 (171)	25.6 (129)	47.2 (250)	31.1 (165)	21.7 (115)
57. No place besides jail to hold arrested kids.	15.7 (607)	41.8 (231)	33.3 (184)	25.0 (138)	42.5 (248)	33.0 (193)	24.5 (143)
58. Students not having enough to say at school about scheduling of classes.	35.6 (1323)	35.9 (459)	39.5 (505)	24.7 (316)	31.4 (405)	40.4 (521)	28.2 (363)

Youth Needs Checklist Items
Indicating Personal Experience of, Frequency of,
and Seriousness of the Need or Problem (Cont.)

Need or Problem	% of entire youth sample responding "yes" to that item: Yes	% of those responding "yes" who indicated frequency to be: Very Often	Some times	Once/ Twice	% of those responding "yes" who described that need or problem as: Very Serious	Some what	Not Serious
59. Before and after school activities (like sports, drama club, etc.) need more students running them.	19.3 (717)	24.4 (166)	51.9 (353)	23.7 (161)	18.3 (127)	42.7 (296)	39.0 (270)
60. Students not having enough say about their free time between classes.	47.6 (1775)	46.8 (796)	34.5 (588)	18.7 (318)	38.7 (654)	34.3 (580)	27.0 (456)
61. Students not having enough say about class subjects.	35.2 (1310)	35.7 (455)	42.0 (535)	22.4 (285)	33.7 (426)	40.1 (506)	26.2 (331)
62. School codes of conduct (like dress codes, manners, etc.) are determined without enough say from students.	23.3 (870)	35.3 (297)	41.9 (353)	22.8 (192)	28.5 (244)	39.6 (339)	31.8 (272)
63. Students not being able to help plan the lunch room program (menu's, conduct, time, etc.).	48.8 (1818)	59.0 (1033)	26.0 (455)	15.1 (264)	33.4 (593)	32.3 (572)	34.3 (608)
64. Counselors not understanding kids.							
65. Principals not understanding kids.							

Youth Needs Survey
Agency Items

DEPARTMENT OF SOCIAL SERVICES

Youth Responses to Agency-Related Questions

Item	Yes	Some-times	No	Don't Know	Total
Do you know anything about this agency or organization? Percent answering "yes": 20. (Number answering "yes" = 761					
Of the 761 providing information on this agency, percent responding:	9.3	19.8	46.6	24.3	100%
1. Is it difficult to get there?	(68)	(144)	(340)	(177)	(729)
2. Do they have a good "image" with kids you know, i.e., do kids think it's an OK place to go for help?	19.8 (145)	28.4 (208)	18.6 (136)	33.2 (243)	100% (732)
3. Do you know what kinds of things they will do if you go there?	31.3 (228)	19.2 (140)	28.5 (208)	21.0 (153)	100% (729)
4. Do you think the agency would tell anyone about your problems if you went there?	12.1 (88)	10.7 (78)	60.2 (438)	16.9 (123)	99.9% (727)
5. Are the people there easy to talk to?	25.1 (183)	20.5 (149)	9.5 (69)	44.9 (327)	100% (728)
6. Is it difficult to get someone there to help you?	9.0 (66)	16.1 (118)	37.2 (272)	37.6 (275)	99.9% (731)

Youth Responses about Personal Experience with This Agency

Item	% Yes	(N)
Have you personally sought or received help from this agency or organization?	8.2	288

Youth Needs Survey
Agency Items

PROBATION DEPARTMENT

Youth Responses to Agency-Related Questions

Item	Yes	Some-times	No	Don't Know	Total
Do you know anything about this agency or organization? Percent answering "yes": 27.6 (Number answering "yes" = 1014					
Of the 1014 providing information on this agency, percent responding:	6.5	14.1	52.1	27.3	100%
1. Is it difficult to get there?	(64)	(139)	(512)	(268)	(983)
2. Do they have a good "image" with kids you know, i.e., do kids think it's an OK place to go for help?	15.3 (151)	28.3 (279)	37.0 (365)	19.5 (192)	100% (987)
3. Do you know what kinds of things they will do if you go there?	38.3 (374)	17.6 (172)	26.6 (260)	17.5 (171)	100% (977)
4. Do you think the agency would tell anyone about your problems if you went there?	17.7 (174)	12.1 (119)	53.6 (527)	16.7 (164)	100.1% (984)
5. Are the people there easy to talk to?	19.1 (188)	25.6 (252)	16.8 (165)	38.5 (378)	100% (983)
6. Is it difficult to get someone there to help you?	9.3 (92)	16.8 (166)	37.6 (372)	36.3 (359)	100% (989)

Youth Responses about Personal Experience with This Agency

Item	% Yes	(N)
Have you personally sought or received help from this agency or organization?	9.1	323

Youth Needs Survey
Agency Items

SCHOOL COUNSELORS/GUIDANCE COUNSELORS

Youth Responses to Agency-Related Questions

Item	Yes	Some-times	No	Don't Know	Total
Do you know anything about this agency or organization? Percent answering "yes": 80.4 (Number answering "yes" = 3052					
Of the 3052 providing information on this agency, percent responding:	6.2	29.6	57.4	6.8	100%
1. Is it difficult to get there?	(189)	(898)	(1741)	(207)	(3035)
2. Do they have a good "image" with kids you know, i.e., do kids think it's an OK place to go for help?	44.2 (1341)	34.0 (1031)	12.8 (387)	9.1 (275)	100.1% (3034)
3. Do you know what kinds of things they will do if you go there?	49.2 (1485)	24.5 (738)	16.7 (504)	9.6 (289)	100% (3016)
4. Do you think the agency would tell anyone about your problems if you went there?	11.5 (347)	10.1 (304)	67.4 (2034)	11.1 (334)	100.1% (3019)
5. Are the people there easy to talk to?	47.5 (1439)	36.7 (1110)	10.6 (322)	5.2 (157)	100% (3028)
6. Is it difficult to get someone there to help you?	8.7 (264)	19.4 (588)	64.0 (1944)	7.9 (241)	100% (3037)

Youth Responses about Personal Experience with This Agency

Item	% Yes	(N)
Have you personally sought or received help from this agency or organization?	66.1	2449

Youth Needs Survey
Agency Items

MENTAL HEALTH CENTER

Youth Responses to Agency-Related Questions

Item	Yes	Some-times	No	Don't Know	Total
Do you know anything about this agency or organization? Percent answering "yes": 19.0 (Number answering "yes" = 669					
Of the 669 providing information on this agency, percent responding:	9.5	17.5	50.8	22.3	100.1%
1. Is it difficult to get there?	(62)	(115)	(333)	(146)	(656)
2. Do they have a good "image" with kids you know, i.e., do kids think it's an OK place to go for help?	24.1 (157)	21.5 (140)	28.4 (185)	26.0 (169)	100% (651)
3. Do you know what kinds of things they will do if you go there?	39.0 (255)	16.1 (105)	25.1 (164)	19.9 (130)	100.1% (654)
4. Do you think the agency would tell anyone about your problems if you went there?	13.9 (91)	12.4 (81)	56.2 (367)	17.5 (114)	100% (653)
5. Are the people there easy to talk to?	26.6 (174)	23.6 (154)	8.4 (55)	41.3 (270)	99.9% (653)
6. Is it difficult to get someone there to help you?	6.2 (40)	17.1 (111)	38.4 (249)	38.4 (249)	100.1% (649)

Youth Responses about Personal Experience with This Agency

Item	% Yes	(N)
Have you personally sought or received help from this agency or organization?	7.3	249

Youth Needs Survey
Agency Items

POLICE DEPARTMENT

Youth Responses to Agency-Related Questions

Item	Yes	Some-times	No	Don't Know	Total
Do you know anything about this agency or organization? Percent answering "yes": 68.4 (Number answering "yes" = 2581					
Of the 2581 providing information on this agency, percent responding:	4.5	8.2	80.2	7.1	100%
1. Is it difficult to get there?	(116)	(210)	(2058)	(182)	(2566)
2. Do they have a good "image" with kids you know, i.e., do kids think it's an OK place to go for help?	10.4 (267)	28.5 (730)	49.8 (1275)	11.3 (290)	100% (2562)
3. Do you know what kinds of things they will do if you go there?	37.7 (967)	19.8 (508)	27.3 (700)	15.1 (388)	99.9% (2563)
4. Do you think the agency would tell anyone about your problems if you went there?	31.1 (795)	16.8 (431)	33.0 (844)	19.1 (489)	100% (2559)
5. Are the people there easy to talk to?	12.2 (312)	28.4 (723)	30.9 (787)	28.5 (727)	100% (2549)
6. Is it difficult to get someone there to help you?	16.3 (417)	23.3 (597)	33.6 (859)	26.8 (686)	100% (2559)

Youth Responses about Personal Experience with This Agency

Item	% Yes	(N)
Have you personally sought or received help from this agency or organization?	29.7	1073

Youth Needs Survey
Agency Items

IOWA EMPLOYMENT SERVICE/JOB SERVICE OF IOWA

Youth Responses to Agency-Related Questions

Item	Yes	Some-times	No	Don't Know	Total
Do you know anything about this agency or organization? Percent answering "yes": 30.4 (Number answering "yes" = 1051					
Of the 1051 providing information on this agency, percent responding:	11.8	14.5	65.7	8.0	100%
1. Is it difficult to get there?	(122)	(149)	(677)	(82)	(1030)
2. Do they have a good "image" with kids you know, i.e., do kids think it's an OK place to go for help?	38.8 (398)	28.0 (288)	11.6 (119)	21.6 (222)	100% (1027)
3. Do you know what kinds of things they will do if you go there?	57.9 (594)	16.9 (173)	15.3 (157)	9.9 (102)	100% (1026)
4. Do you think the agency would tell anyone about your problems if you went there?	12.6 (129)	11.9 (121)	51.6 (527)	23.9 (244)	100% (1021)
5. Are the people there easy to talk to?	37.4 (381)	27.7 (283)	9.0 (92)	25.9 (264)	100% (1020)
6. Is it difficult to get someone there to help you?	11.9 (122)	26.4 (271)	40.0 (410)	21.7 (222)	100% (1025)

Youth Responses about Personal Experience with This Agency

Item	% Yes	(N)
Have you personally sought or received help from this agency or organization?	19.8	678

SELF-REPORTED DELINQUENCY

DELINQUENT ACT	NEVER	ONCE OR TWICE	SEVERAL TIMES	VERY OFTEN	TOTAL
GIVEN TEACHER A FAKE EXCUSE	55.5 (2057)	30.4 (1126)	9.8 (363)	4.3 (161)	100% (3707)
TAKEN LITTLE THINGS	57.7 (2136)	32.2 (1192)	7.1 (264)	3.0 (110)	100% (3702)
BROKEN INTO A PLACE	86.9 (3237)	10.7 (398)	1.8 (66)	0.6 (24)	100% (3725)
TAKEN CAR FOR A DRIVE WITHOUT PERMISSION	89.8 (3343)	7.5 (281)	1.9 (70)	0.8 (28)	100% (3722)
TAKEN SOMETHING FROM A LOCKER	75.8 (2820)	20.3 (754)	2.9 (108)	1.1 (40)	100.1% (3722)
DAMAGED PROPERTY	68.8 (2557)	23.7 (880)	5.4 (202)	2.1 (78)	100% (3717)
BEAT UP OTHER KIDS	81.2 (3021)	14.4 (535)	2.6 (95)	1.8 (68)	100% (3719)
PARTICIPATED IN GANG FIGHTS	86.5 (3208)	9.5 (353)	2.3 (84)	1.7 (63)	100% (3708)
TAKEN SOMETHING WORTH 50 DOLLARS OR MORE	89.0 (3302)	8.0 (298)	1.7 (62)	1.3 (50)	100% (3712)
RUN AWAY FROM HOME	88.7 (3294)	8.7 (324)	1.6 (61)	0.9 (33)	99.9% (3712)
TAKEN SOMETHING WORTH 5-50 DOLLARS	82.0 (3047)	14.0 (519)	2.6 (98)	1.3 (50)	99.9% (3714)
USED FORCE TO GET MONEY	93.1 (3445)	5.1 (187)	1.0 (37)	0.9 (33)	100.1% (3702)
USED MARIJUANA	71.4 (2648)	9.8 (364)	7.7 (287)	11.1 (410)	100% (3709)
SOLD MARIJUANA	87.6 (3239)	6.1 (227)	3.2 (119)	3.0 (112)	99.9 (3697)
SKIPPED SCHOOL	64.5 (2385)	22.7 (841)	8.1 (301)	4.7 (173)	100% (3700)
SNIFFED GLUE	91.2 (3374)	6.3 (234)	1.4 (50)	1.1 (41)	100% (3699)
USED HARD DRUGS	90.9 (3365)	4.9 (183)	2.6 (98)	1.5 (54)	99.9% (3700)
SOLD HARD DRUGS	95.7 (3540)	2.1 (77)	1.1 (39)	1.2 (43)	100.1% (3699)
USED ALCOHOL	40.6 (1504)	23.8 (881)	20.6 (763)	15.0 (556)	100% (3704)

TABLE 16

Comparison of Responses to the Youth Needs Checklist as Used in the Youth Needs Survey and in the Community Resources Survey

Need or Problem	YOUTH NEEDS SURVEY: Youth responses about which problems on the checklist have been experienced personally and the seriousness of the need or problem for them.		COMMUNITY RESOURCES SURVEY YOUTH SERVICE PROVIDERS: Director and Caseworker estimates of percent of youth with specified needs and problems and estimates of the seriousness of the problem for youth in the community.	
	Percent of youth claiming the need or problem (N)**	Seriousness: Mean Score of total claiming the need* (N)	Estimates of Extent: Mean Percent≠ (N)	Estimates of Seriousness: Mean Score* (N)
1. Looked for work but found that there were no jobs available.	29.1 (1131)	1.56 (1181)	44.80 (214)	2.32 (234)
2. Need for counseling about jobs.	11.1 (428)	1.46 (530)	43.19 (204)	1.92 (232)
3. Unable to find summer jobs.	20.6 (799)	1.66 (835)	43.50 (211)	2.34 (233)
4. Unable to get a job because of their age.	34.1 (1325)	1.66 (1277)	36.47 (210)	2.09 (234)
5. No way to find out about what jobs are available.	22.3 (865)	1.72 (869)	21.00 (196)	1.48 (225)
6. The only jobs available to youth have no future.	30.7 (1199)	1.66 (1157)	40.10 (193)	1.92 (222)

* Mean Seriousness Score is based on the rating: 1 = Not Serious; 2 = Somewhat Serious; 3 = Very Serious. The closer the estimate is to 3, the more serious the need was considered to be by the respondents. In this case, all the scores are added together and divided by the number responding.

** The number in parentheses is the absolute frequency.

≠ "Mean Percent" is the average estimate of all respondents; i.e., all the estimates, given as percents, were summed and divided by the number responding to the item.

TABLE 16

Comparison of Responses to the Youth Needs Checklist
as Used in the Youth Needs Survey and in the Community Resources Survey

Need or Problem	YOUTH SERVICE PROVIDERS: YOUTH			DIRECTORS AND CASEWORKERS		
		Percent of youth claiming the need or problem	Seriousness: Mean Score of total claiming the need		Estimates of Extent: Mean Percent	Estimates of Seriousness: Mean Score
7. Police record keeping youth from getting or keeping a job.		2.4 (95)	1.55 (175)		9.60 (187)	1.35 (223)
8. A youth's sex keeping him/her from getting or keeping a job.		3.1 (123)	1.46 (193)		7.87 (179)	1.19 (221)
9. A youth's race or ethnic background keeping him/her from getting or keeping a job.		1.6 (64)	1.52 (137)		5.71 (182)	1.26 (217)
10. No specific training for jobs.		22.8 (890)	1.61 (836)		41.56 (203)	2.01 (231)
11. Being hassled by other kids to use or buy drugs.		11.6 (454)	1.64 (491)		30.36 (186)	2.02 (213)
12. Need for drug counseling and education.		2.2 (87)	1.54 (152)		35.98 (192)	2.04 (218)
13. Medical care or treatment costing too much.		7.6 (299)	1.90 (343)		19.94 (180)	1.70 (217)
14. Too hard to get medical treatment without parents.		6.7 (261)	1.80 (286)		18.45 (174)	1.57 (210)
15. A need for counseling about pregnancy and abortion.		4.1 (158)	1.85 (214)		23.22 (186)	1.74 (220)

TABLE 16

Comparison of Responses to the Youth Needs Checklist
as Used in the Youth Needs Survey and in the Community Resources Survey

Need or Problem	YOUTH SERVICES PROVIDERS: YOUTH			DIRECTORS AND CASEWORKERS		
		Percent of youth claiming the need or problem	Seriousness: Mean Score of total claiming the need		Estimates of Extent: Mean Percent	Estimates of Seriousness: Mean Score
16. A need for counseling about sex and birth control.		7.8 (303)	1.80 (351)		39.51 (190)	1.98 (221)
17. Teachers, counselors, or school principals not understanding kids.		44.9 (1749)	1.98 (1770)		25.92 (186)	1.81 (217)
18. Youth being physically hurt by other kids in school.		13.1 (511)	1.61 (560)		2.37 (165)	1.10 (208)
19. Youth being physically hurt by teachers when disciplined.		7.4 (287)	1.69 (326)		9.21 (173)	1.44 (213)
20. Not enough different kinds of classes or courses at school.		29.6 (1156)	1.91 (1132)		22.26 (182)	1.60 (218)
21. Not enough classes or courses which are useful or really important.		30.7 (1198)	2.06 (1171)		27.68 (182)	1.78 (216)
22. Teachers not interested in youth.		26.7 (1039)	1.83 (996)		17.46 (178)	1.57 (215)
23. A lack of alternative school programs like vocational training schools, GED, continuing education programs, or free schools.		12.9 (502)	2.01 (513)		21.08 (182)	1.71 (219)

TABLE 16

Comparison of Responses to the Youth Needs Checklist
as Used in the Youth Needs Survey and in the Community Resources Survey

Need or Problem	YOUTH SERVICE PROVIDERS: YOUTH		DIRECTORS AND CASEWORKERS	
	Percent of youth claiming the need or problem	Seriousness: Mean Score of total claiming the need	Estimates of Extent: Mean Percent	Estimates of Seriousness: Mean Score
24. Students not having any say in how schools are run.	49.8 (1942)	2.13 (1876)	27.15 (175)	1.50 (212)
25. Youth being expelled or suspended from school.	11.5 (447)	1.66 (473)	12.21 (183)	1.70 (221)
26. Racial discrimination in school courses and programs.	3.9 (151)	1.82 (196)	5.36 (169)	1.18 (211)
27. Sex discrimination in school courses and programs.	8.1 (317)	1.69 (357)	8.45 (168)	1.23 (209)
28. Not enough school counselors.	15.4 (601)	1.82 (596)	23.22 (178)	1.74 (215)
29. School counselors not having useful information for youth.	18.3 (710)	1.82 (700)	24.60 (180)	1.73 (212)
30. Police treating things more seriously than they should.	25.1 (979)	2.12 (958)	10.23 (175)	1.31 (211)
31. Police being dishonest and crooked.	19.8 (768)	2.26 (756)	6.64 (161)	1.22 (202)
32. Police not being around when youth need them.	26.7 (1040)	2.10 (995)	10.60 (166)	1.38 (207)
33. Police not being really interested in helping kids.	29.5 (1144)	2.22 (1119)	13.09 (167)	1.44 (206)

TABLE 16

Comparison of Responses to the Youth Needs Checklist
as Used in the Youth Needs Survey and in the Community Resources Survey

Need or Problem	YOUTH SERVICE PROVIDERS: YOUTH		DIRECTORS AND CASEWORKERS	
	Percent of youth claiming the need or problem	Seriousness: Mean Score of total claiming the need	Estimates of Extent: Mean Percent	Estimates of Seriousness: Mean Score
34. Racial prejudice on the part of the police.	8.0 (300)	2.06 (340)	6.42 (162)	1.29 (202)
35. Youth being picked on or hassled by the police.	15.1 (589)	1.93 (603)	9.33 (169)	1.35 (210)
36. Police being more strict with boys than with girls.	20.8 (810)	1.96 (782)	10.45 (167)	1.24 (204)
37. Friends getting arrested.	26.7 (1040)	1.87 (997)	9.87 (162)	1.29 (203)
38. Problems getting legal help.	4.0 (155)	1.90 (192)	12.19 (176)	1.49 (215)
39. Courts being unfair to youth.	7.8 (303)	2.14 (324)	6.28 (167)	1.24 (209)
40. No adult with whom youth can talk over their problems.	24.0 (937)	2.04 (928)	20.84 (183)	1.78 (215)
41. Parents not spending enough time with their kids.	21.2 (824)	2.01 (823)	50.45 (195)	2.46 (226)
42. Parents not providing good supervision or control.	8.4 (327)	1.97 (347)	48.42 (196)	2.48 (227)

TABLE 16

Comparison of Responses to the Youth Needs Checklist
as Used in the Youth Needs Survey and in the Community Resources Survey

Need or Problem	YOUTH SERVICE PROVIDERS: YOUTH Respondents (N)	YOUTH: Percent of youth claiming the need or problem	YOUTH: Seriousness: Mean Score of total claiming the need	DIRECTORS AND CASEWORKERS: Respondents (N)	DIRECTORS AND CASEWORKERS: Estimates of Extent: Mean Percent	DIRECTORS AND CASEWORKERS: Estimates of Seriousness: Mean Score
43. Parents not giving their kids necessary things such as food, a place to live, and medical care.		3.8 (149)	1.91 (170)		13.25 (187)	1.69 (217)
44. Parents' lack of interest in their kids.		11.8 (462)	1.90 (490)		35.18 (191)	2.25 (221)
45. Parents physically hurting their children when angry.		12.5 (489)	1.82 (515)		11.86 (176)	1.84 (212)
46. Parents not understanding kids' problems.		43.2 (1683)	1.93 (1636)		40.74 (192)	2.26 (220)
47. People in their neighborhoods not knowing or caring about each other.		23.5 (916)	1.80 (912)		34.68 (180)	1.89 (211)
48. Different racial groups not getting along and fighting with each other.		13.1 (511)	1.96 (519)		9.92 (171)	1.35 (206)
49. Having things stolen or destroyed in their neighborhoods.		42.8 (1668)	1.94 (1625)		19.91 (175)	1.80 (213)
50. Street fights and gangs in their neighborhood.		7.8 (305)	1.79 (325)		8.60 (166)	1.28 (209)

TABLE 16

Comparison of Responses to the Youth Needs Checklist
as Used in the Youth Needs Survey and in the Community Resources Survey

Need or Problem	YOUTH SERVICE PROVIDERS: YOUTH Respondents (N)	YOUTH: Percent of youth claiming the need or problem	YOUTH: Seriousness: Mean Score of total claiming the need	DIRECTORS AND CASEWORKERS: Respondents (N)	DIRECTORS AND CASEWORKERS: Estimates of Extent: Mean Percent	DIRECTORS AND CASEWORKERS: Estimates of Seriousness: Mean Score
51. Not enough different kinds of things to do.		53.5 (2090)	2.04 (2017)		33.53 (188)	1.95 (221)
52. Entertainment and other recreational things costing too much.		52.6 (2054)	2.12 (1966)		34.22 (187)	1.92 (219)
53. Recreation, school, or community centers not being open when they need to be.		31.1 (1210)	1.84 (1166)		31.14 (178)	1.82 (213)
54. Need for convenient transportation.		32.1 (1249)	1.94 (1221)		24.48 (172)	1.60 (214)
55. Entertainment & recreation centers not available.		37.1 (1444)	2.05 (1390)			
56. No place for runaways to get help.		13.8 (534)	2.26 (530)			
57. No place besides jail to hold arrested kids.		15.7 (607)	2.18 (584)			
58. Students not having enough say at school about scheduling of classes.		35.6 (1323)	2.03 (1289)			

TABLE 16

Comparison of Responses to the Youth Needs Checklist
as Used in the Youth Needs Survey and in the Community Resources Survey

Need or Problem	YOUTH			YOUTH SERVICE PROVIDERS DIRECTORS AND CASEWORKERS		
	Respondents (N)	Percent of youth claiming the need or problem	Seriousness: Mean Score of total claiming the need	Respondents (N)	Estimates of Extent: Mean Percent	Estimates of Seriousness: Mean Scor
59. Before & after school activities (like sports, drama club, etc.) need more students running them.		19.3 (717)	1.79 (693)			
60. Students not having enough say about their free time between classes.		47.6 (1775)	2.12 (1690)			
61. Students not having enough say about class subjects.		35.2 (1310)	2.08 (1263)			
62. School codes of conduct (i.e. dress codes, manners, etc.) are determined without enough say from students.		23.3 (870)	1.97 (855)			
63. Students not being able to help plan the lunch room program (menus, conduct, time, etc.).		48.8 (1818)	1.99 (1773)			
64. Counselors not understanding kids.						
65. Principals not understanding kids.						

OMB8557-4025

STUDENTS' QUESTIONNAIRE

The Community Youth Program Project of Iowa State University is conducting a youth survey to find out the needs and problems of youth in Iowa. We are interested in your opinion on a number of possible youth needs and problems. We think you will find the following questions interesting to answer. In order for the survey to be of any value, it is very important that you be honest in answering the questions. This is not a test, and there are no right or wrong answers. The information which is gathered from all of the surveys will be compiled by Iowa State University and will be used to assist state and local youth agencies in better planning and delivering services to youth. Participation in the survey is voluntary.

Your name will not appear any place on this questionnaire. Feel free to answer exactly the way you feel, for no one in this school will ever see the answers. When the group is finished we will collect the questionnaires. They will be taken directly to the University for tabulation.

Remember: This is a questionnaire of your opinions and not a test. The only "right" answer is what YOU believe to be true. Most of the questions can be answered by putting a circle around a number. For example:

	Strongly Disagree	Disagree	Agree	Strongly Agree
I like my friends	1	2	3	(4)

The number 4 in the example has been circled to show that the reader strongly agrees with the statement.

Try to work quickly, without spending too much time on any single question. Answer the questions in order and please answer all of them. If you do not understand what to do after you read the instructions, raise your hand. We want everyone to have a clear understanding of what we are asking you to do. By asking for clarification you are assisting others in gaining this understanding.

Please quickly look at the questions. Would you be willing to participate in this survey? (Circle one)

YES 1
NO 2

We appreciate your willingness to participate in this survey. Thank you.

Martin G. Miller, Ph.D., Project Director
Barbara Burger Sink, Research Coordinator
Community Youth Program Project

Department of Sociology
Iowa State University
Ames, Iowa 50011

Now let's begin with the questions.

1. How old are you? (circle one number) 9 10 11 12 13 14 15 16 17 18 19

2. What is your sex? (circle one)
   - Male 1
   - Female 2

3. To what ethnic group do you belong? (circle one)
   - White/Anglo 1
   - Black/Negro 2
   - Hispanic (Spanish, Mexican, Chicano, Puerto Rican) 3
   - American Indian 4
   - Asian/Pacific Islander 5
   - Other (specify) _____ . . . 6

4. What grade are you in now? (circle one)
   - 7th 1
   - 8th 2
   - 9th 3
   - 10th 4
   - 11th 5
   - 12th 6
   - Other (specify)_____ . . . 7

5. How long have you lived in your present house? (circle one)
   - Less than one year 1
   - One or two years 2
   - Three or four years 3
   - More than four years 4

6. Which of the following best describes where you live? (circle one)
   - House (one family only) 1
   - House (more than one family) 2
   - Apartment (private bathroom) 3
   - Apartment (shared bathroom) 4
   - Mobile or trailer home 5
   - Hotel or Motel 6
   - Other (explain)_____ 7

7. Who is the head of your family? (circle one number only)
   - Father 1
   - Stepfather 2
   - Foster Father 3
   - Mother 4
   - Stepmother 5
   - Foster Mother 6
   - Other Relative 7
   - Other (explain) _____ 8

8. Is the head of your family?
   A. Employed 1
      Unemployed 2
      Retired 3
   B. <u>If employed</u>, what kind of job does the head of your family have? (write in)_____
      <u>(If unemployed or retired)</u> What kind of job did the head of your family have when he/she was working? (write in)_____
   C. Briefly describe what the head of your family does at work._____

9. How far did the head of your family go in school? (circle the highest level of education completed)

Grade School	1
Junior high/Middle school	2
Some high school	3
High school graduate	4
1-3 years college or business school or special training	5
4 year college graduate	6
Graduate school or professional training (doctor, lawyer, Ph.D., etc.)	7

10. A. With which of the following adults, 18 years of age or older, are you living? (circle yes or no for each)

	Yes	No
Mother	1	0
Father	1	0
Stepmother	1	0
Stepfather	1	0
Foster Mother	1	0
Foster Father	1	0
Grandmother(s)	1	0
Grandfather(s)	1	0
Aunt(s)	1	0
Uncle(s)	1	0
Brother(s) (18 or older)	1	0
Sister(s) (18 or older)	1	0
Husband or wife (18 or older)	1	0
Boy Friend or Girl Friend (18 or older)	1	0
Other (please explain) _____	1	0

10. B. In the past year, what changes have happened in your family? Have any of the persons listed below moved in or out of your family?

(If the person has not moved in or out, circle the number under Not Moved. If the person has moved in or out, circle the appropriate response. If the person has died, circle Moved Out, and if the person was born, circle Moved In.)

	Not Moved	Moved In	Moved Out
Mother	0	1	2
Father	0	1	2
Stepmother	0	1	2
Stepfather	0	1	2
Foster Mother	0	1	2
Foster Father	0	1	2
Grandmother(s)	0	1	2
Grandfather(s)	0	1	2
Aunt(s)	0	1	2
Uncle(s)	0	1	2
Brother(s) (18 or older)	0	1	2
Sister(s) (18 or older)	0	1	2
Brother(s) (17 or younger)	0	1	2
Sister(s) (17 or younger)	0	1	2
Husband or wife (18 or older)	0	1	2
Boy Friend or Girl Friend (18 or older)	0	1	2
Other (please explain) _____	0	1	2

11. Counting yourself, how many children or youth under 18 live in your house?

Write in the number _____.

12. A. What is the name of the town or city that you live in?

(write in the name)

B. If you do not live in a town or city, name the nearest town or city to your home.

(write in the name)

In this next section, we would like to find out something about the kinds of needs and problems you have. Please look at each of the possible problems or needs on the list below. For each one, we would like to know if you have ever had that need or problem. It is not likely that you will have had all of the problems or needs listed. If you have not had that problem or need, circle 0 under No in the first column and go on to the next one. If you have had that problem or need, we would like to know How Often and How Serious it is for you personally. Please circle the number of the appropriate response for each of your answers.

Problem or Need	Has this ever been a problem for you personally? Yes	No	IF YES, HOW OFTEN? Once or Twice	Sometimes	Very Often	HOW SERIOUS? Not Serious	Somewhat Serious	Very Serious
13. Looked for work, but found that there were no jobs available.	1	0	1	2	3	1	2	3
14. A need for counselling about jobs.	1	0	1	2	3	1	2	3
15. Unable to find a job for the summer	1	0	1	2	3	1	2	3
16. Unable to get a job because of your age.	1	0	1	2	3	1	2	3
17. No way to find out about what jobs are open or available.	1	0	1	2	3	1	2	3

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Problem or Need	Has this ever been a problem for you personally? Yes	No	IF YES, HOW OFTEN? Once or Twice	Sometimes	Very Often	HOW SERIOUS? Not Serious	Somewhat Serious	Very Serious
18. The only jobs available have no future.	1	0	1	2	3	1	2	3
19. Police record keeping you from getting a job.	1	0	1	2	3	1	2	3
20. Your sex keeping you from getting or keeping a job.	1	0	1	2	3	1	2	3
21. Your race or ethnic background keeping you from getting or keeping a job.	1	0	1	2	3	1	2	3
22. No specific training for jobs.	1	0	1	2	3	1	2	3
23. Being hassled by other kids to use or buy drugs.	1	0	1	2	3	1	2	3
24. Needing drug counselling and education.	1	0	1	2	3	1	2	3
25. Medical care or treatment costing too much.	1	0	1	2	3	1	2	3
26. Too hard to get medical treatment by yourself.	1	0	1	2	3	1	2	3
27. A need for counselling about pregnancy and abortion.	1	0	1	2	3	1	2	3

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	Problem or Need	Has this ever been a problem for you personally? Yes	No	IF YES, HOW OFTEN? Once or Twice	Sometimes	Very Often	HOW SERIOUS? Not Serious	Somewhat Serious	Very Serious
28.	A need for counselling about sex and birth control.	1	0	1	2	3	1	2	3
29.	Teachers, counselors or principals not understanding kids.	1	0	1	2	3	1	2	3
30.	Being physically hurt by other kids in school.	1	0	1	2	3	1	2	3
31.	Being physically hurt by teachers when they are disciplining you.	1	0	1	2	3	1	2	3
32.	Not enough different kinds of classes or courses at school.	1	0	1	2	3	1	2	3
33.	Not enough classes or courses which are useful or really important.	1	0	1	2	3	1	2	3
34.	Teachers not interested in you.	1	0	1	2	3	1	2	3
35.	A lack of alternative school programs like vocational training schools, GED, continuing education programs, or Free Schools.	1	0	1	2	3	1	2	3

	Problem or Need	Has this ever been a problem for you personally? Yes	No	IF YES, HOW OFTEN? Once or Twice	Sometimes	Very Often	HOW SERIOUS? Not Serious	Somewhat Serious	Very Serious
36.	Students not having any say in how schools are run.	1	0	1	2	3	1	2	3
37.	Being expelled or suspended from school.	1	0	1	2	3	1	2	3
38.	Racial discrimination in school courses & programs.	1	0	1	2	3	1	2	3
39.	Sex discrimination in school courses and programs.	1	0	1	2	3	1	2	3
40.	Not enough school counselors.	1	0	1	2	3	1	2	3
41.	When you go to school counselors they don't have useful information.	1	0	1	2	3	1	2	3
42.	Police treating things more seriously than they should.	1	0	1	2	3	1	2	3
43.	Police being dishonest & crooked.	1	0	1	2	3	1	2	3
44.	Police not being around when you need them.	1	0	1	2	3	1	2	3
45.	Police not being really interested in helping kids.	1	0	1	2	3	1	2	3

C2

	Problem or Need	Has this ever been a problem for you personally? Yes	No	IF YES, HOW OFTEN? Once or Twice	Some-times	Very Often	HOW SERIOUS? Not Serious	Somewhat Serious	Very Serious
46.	Racial prejudice on the part of the police	1	0	1	2	3	1	2	3
47.	Being picked on or hassled by the police	1	0	1	2	3	1	2	3
48.	Police being more strict with boys than girls.	1	0	1	2	3	1	2	3
49.	Friends getting arrested.	1	0	1	2	3	1	2	3
50.	Problems getting legal help, that is in getting a lawyer to help you	1	0	1	2	3	1	2	3
51.	Courts being unfair.	1	0	1	2	3	1	2	3
52.	No adult you can talk over problems with.	1	0	1	2	3	1	2	3
53.	Parents not spending enough time with their kids.	1	0	1	2	3	1	2	3
54.	Parents not providing good supervision or control.	1	0	1	2	3	1	2	3
55.	Parents not giving their kids necessary things such as food, a place to live and medical care.	1	0	1	2	3	1	2	3

	Problem or Need	Has this ever been a problem for you personally? Yes	No	IF YES, HOW OFTEN? Once or Twice	Some-times	Very Often	HOW SERIOUS? Not Serious	Somewhat Serious	Very Serious
56.	Parents' lack of interest in their kids.	1	0	1	2	3	1	2	3
57.	Parents physically hurting their children when angry.	1	0	1	2	3	1	2	3
58.	Parents not understanding kids' problems.	1	0	1	2	3	1	2	3
59.	People in your neighborhood not knowing or caring about each other.	1	0	1	2	3	1	2	3
60.	Different racial groups not getting along & fighting with each other.	1	0	1	2	3	1	2	3
61.	Having things stolen or destroyed in your neighborhood.	1	0	1	2	3	1	2	3
62.	Street fights & gangs in your neighborhood.	1	0	1	2	3	1	2	3
63.	Not enough different kinds of things to do.	1	0	1	2	3	1	2	3
64.	Entertainment and other recreational things costing too much.	1	0	1	2	3	1	2	3

C3

Problem or Need	Has this ever been a problem for you personally? Yes	No	IF YES, HOW OFTEN? Once or Twice	Sometimes	Very Often	HOW SERIOUS? Not Serious	Somewhat Serious	Very Serious
65. Recreation, school or community centers not being open when you want them to be.	1	0	1	2	3	1	2	3
66. Need for convenient transportation.	1	0	1	2	3	1	2	3
67. Entertainment & recreation centers not available.	1	0	1	2	3	1	2	3
68. No place for runaways to get help.	1	0	1	2	3	1	2	3
69. No place besides jail to hold arrested kids.	1	0	1	2	3	1	2	3
70. Students not having enough say at school about scheduling of classes.	1	0	1	2	3	1	2	3
71. Before & after school activities (like sports, drama club, etc.) need more students running them.	1	0	1	2	3	1	2	3
72. Students not having enough say about their free time between classes.	1	0	1	2	3	1	2	3
73. Students not having enough say about class subjects.	1	0	1	2	3	1	2	3

Problem or Need	personally? Yes	No	IF YES, HOW OFTEN? Once or Twice	Sometimes	Very Often	HOW SERIOUS? Not Serious	Somewhat Serious	Very Serious
74. School codes of conduct (like dress codes, manners, etc.) are determined without enough say from students.	1	0	1	2	3	1	2	3
75. Students not being able to help plan the lunch room program (menu's, conduct, time, etc.).	1	0	1	2	3	1	2	3
76. Other (please specify)_____	1	0	1	2	3	1	2	3

77. We are interested in your opinions or beliefs about some of the persons, agencies, or organizations where you might sometimes think of going for help. Please rate each of the persons, agencies and organizations listed below in terms of each of the descriptions given. If you do not know anything about a particular person, agency, or organization, simply circle "No" number to the question "Do you know anything about this agency or organization?" and skip to the next organization. Otherwise answer all the questions in that section.

A. DEPARTMENT OF SOCIAL SERVICES

Do you know anything about this agency? (circle Yes or No)

YES 1
NO 0

If NO, skip to part B.

DEPARTMENT OF SOCIAL SERVICES (continued)

If YES:

(circle one)

	Yes	Sometimes	No	Don't Know
1. Is it difficult to find a way to get to this agency?	1	2	3	4
2. Do they have a good "image" with kids you know, i.e., do kids think it's an OK place to go for help?	1	2	3	4
3. Do you know what kind of things they will do if you go there?	1	2	3	4
4. Do you think the agency would tell anyone about your problems if you didn't want them to tell?	1	2	3	4
5. Are the people there easy to talk to?	1	2	3	4
6. Is it difficult to get someone to help you there?	1	2	3	4

0
2

B. PROBATION DEPARTMENT

Do you know anything about this agency? (circle Yes or No)

YES 1
NO 0

If NO, skip on to part C.

IF YES:

	Yes	Sometimes	No	Don't Know
1. Is it difficult to find a way to get to this agency?	1	2	3	4
2. Do they have a good "image" with kids you know., i.e., do kids think it's an OK place to go for help?	1	2	3	4
3. Do you know what kind of things they will do if you go there?	1	2	3	4
4. Do you think the agency would tell anyone about your problems if you didn't want them to tell?	1	2	3	4
5. Are the people there easy to talk to?	1	2	3	4
6. Is it difficult to get someone to help you there?	1	2	3	4

0
3

C. SCHOOL COUNSELORS/GUIDANCE COUNSELORS

Do you know anything about these counselors? (circle Yes or No)

YES 1
NO. 0

If NO, skip to part D.

IF YES:

(circle one)

	Yes	Sometimes	No	Don't Know
1. Is it difficult to get an appointment	1	2	3	4
2. Do they have a good "image" with kids you know, i.e., do kids think it's an OK place to go for help?	1	2	3	4
3. Do you know what kind of things they will do if you go to them?	1	2	3	4
4. Do you think the counselors would tell anyone about your problems if you didn't want them to tell?	1	2	3	4
5. Are the counselors easy to talk to?	1	2	3	4
6. Is it difficult to get a counselor to help you?	1	2	3	4

C4

D. MENTAL HEALTH CENTER

0
4

Do you know anything about this agency? (circle Yes or No)

YES 1
NO 0

If NO, skip to part E.

IF YES:

	Yes	Sometimes	No	Don't Know
1. Is it difficult to find a way to get to this agency?	1	2	3	4
2. Do they have a good "image" with kids you know, i.e., do kids think it's an OK place to go for help?	1	2	3	4
3. Do you know what kind of things they will do if you go there?	1	2	3	4

MENTAL HEALTH CENTER (continued)

	Yes	Sometimes	No	Don't Know
4. Do you think the agency would tell anyone about your problems if you didn't want them to?	1	2	3	4
5. Are the people there easy to talk to?	1	2	3	4
6. Is it difficult to get someone to help you there?	1	2	3	4

E. POLICE DEPARTMENT

0
5

Do you know anything about this agency? (circle Yes or No)

YES 1
NO 0

If NO, skip to part F.

IF YES:	Yes	Sometimes	No	Don't Know
1. Is it difficult to find a way to get to this agency?	1	2	3	4
2. Do they have a good "image" with kids you know, i.e., do kids think it's an OK place to go for help?	1	2	3	4
3. Do you know what kind of things they will do if you go there?	1	2	3	4
4. Do you think the agency would tell anyone about your problems if you didn't want them to tell?	1	2	3	4
5. Are the people there easy to talk to?	1	2	3	4
6. Is it difficult to get someone to help you there?	1	2	3	4

0
6

F. IOWA EMPLOYMENT SERVICE/JOB SERVICE OF IOWA

Do you know anything about this agency? (circle Yes or No)

YES 1
NO 0

If NO, skip to question 78.

IOWA EMPLOYMENT SERVICE/JOB SERVICE OF IOWA (continued)

IF YES:	Yes	Sometimes	No	Don't Know
1. Is it difficult to find away to get to this agency?	1	2	3	4
2. Do they have a good "image" with kids you know, i.e., do kids think it's an OK place to go for help?	1	2	3	4
3. Do you know what kind of things they will do if you go there?	1	2	3	4
4. Do you think the agency would tell anyone about your problems if you didn't want them to tell?	1	2	3	4
5. Are the people there easy to talk to?	1	2	3	4
6. Is it difficult to get someone to help you there?	1	2	3	4

78. We are interested in finding out how many of the persons, agencies or organizations you just described you actually have had personal experience with regarding some need or problem. If you have personally sought or received help from any of the persons, agencies or organizations listed below, please circle Yes. If not, circle No.

Persons, Agencies, or Organizations	YES	NO
1. Department of Social Services	1	0
2. Probation Department	1	0
3. School Counselor/Guidance Counselor	1	0
4. Mental Health Center	1	0
5. Police Department	1	0
6. Iowa Employment Service/Job Service of Iowa	1	0

79. Now, we would like to have your answers to a series of statements about yourself. Remember that we are interested in your opinions and that there are no right or wrong answers. Please indicate whether you STRONGLY AGREE, AGREE, DISAGREE, or STRONGLY DISAGREE by circling the number that is your opinion. Circle only one number for each statement to indicate your answer. If you have any questions or don't understand a word, please ask someone in charge.

	STRONGLY DISAGREE	DISAGREE	AGREE	STRONGLY AGREE
1. It is sometimes necessary to lie on a job application to get the job you want.	1	2	3	4
2. If one wants to get good grades in school, he will have to cheat sometimes.	1	2	3	4
3. It's OK to lie if you are protecting a friend in trouble.	1	2	3	4
4. One can make it in school without having to cheat on exams. . . .	1	2	3	4
5. One should always tell the truth, regardless of what one's friends think of him.	1	2	3	4
6. If one wants to have nice things he has to be willing to break the rules or laws to get them. . . .	1	2	3	4
7. Most teachers, principals, and counselors don't really care about most kids.	1	2	3	4
8. It's hard to know who to trust these days.	1	2	3	4
9. I often feel lonely.	1	2	3	4
10. A kid has to live for today and can't worry about what might happen to him tomorrow.	1	2	3	4
11. It is easier for other people to decide what is right than it is for me.	1	2	3	4
12. The chances for me and my friends making it in life are getting worse, not better.	1	2	3	4
13. My friends don't seem to like me as much as they did in the past. . .	1	2	3	

	STRONGLY DISAGREE	DISAGREE	AGREE	STRONGLY AGREE
14. I often feel awkward and out of place.	1	2	3	4
15. It's not worth planning for anything in the future because I really don't know what is going to happen these days. . . .	1	2	3	4
16. I sometimes feel like nobody cares about me anymore.	1	2	3	4
17. I often feel like it's not worth even trying to change things in my life.	1	2	3	4
18. One problem with the world today is that most people don't believe in anything.	1	2	3	4
19. It seems that it is harder to know how to act today than it used to be.	1	2	3	4
20. My friends seem to change their minds about things more often than in the past.	1	2	3	4
21. Everything changes so quickly these days that I often have trouble deciding which are the right rules to follow.	1	2	3	4
22. People were better off in the old days when everyone knew just how he was expected to act. . . .	1	2	3	4

C5

80. Now we would like to ask a few questions about your hopes for the future in terms of education and jobs.

How far would you like to go in school? _____ (write in)

	(circle)
1. What do you think your chances are for getting this much education? Good, fair or poor?	Poor . . . . 1 Fair . . . . 2 Good 3
2. What are the chances you will drop out or be forced to quit school before completing high school? Good, fair, or poor?	Poor . . . . 1 Fair . . . . 2 Good 3

		(circle)
3.	When/If you have completed high school, what are the chances teachers will remember you as a good student? Good, fair, or poor?	Poor . . . . 1 Fair . . . . 2 Good 3
4.	Would you say that most, some, or none of your friends will enter a college of a university?	None . . . . 1 Some . . . . 2 Most 3
5.	Some people say that every person in the United States has an equal chance to get an education. Other people say that some persons have a better chance to get an education than do others. What about you? Do you have a better, equal, or worse chance than others to get an education?	Worse Chance . . . 1 Equal Chance . . . 2 Better Chance . . 3

81. What kind of job would you like to have as an adult?_____ (write in)

		(circle)
1.	What do you think your chances are of ever getting that kind of job? Good, fair, or poor?	Poor . . . . 1 Fair . . . . 2 Good 3
2.	What are the chances of a young person in this city getting a good paying, honest job? Good, fair, or poor?	Poor . . . . 1 Fair . . . . 2 Good 3
3.	How good are your chances of getting any job as an adult you felt was a good, steady, dependable one? Good, fair, or poor?	Poor . . . . 1 Fair . . . . 2 Good 3
4.	How good are your chances of getting a job as an adult that really pays well? Good, fair, or poor?	Poor . . . . 1 Fair . . . . 2 Good 3
5.	How good do you think your chances are for getting ahead and being successful in your future job? Good, fair, or poor?	Poor . . . . 1 Fair . . . . 2 Good 3

		(circle)
6.	Some people say that every person in the United States has an equal chance to get the job he wants. Others say that some persons have a better chance to get the jobs they want. How about you? Do you have a better, equal, or worse chance than do others to get the job you want?	Worse chance . . . . 1 Equal Chance . . . . 2 Better Chance . . . 3

Now we would like to ask about your relations with your parents, teachers, and friends. Please look at the following sets of words and think about your relationships at home. How do you think your parents see you on the following set of words? Select (circle) the number for each set of words that you feel best describes how your parents see you. For example, on the first set of words if you think they see you as somewhat cooperative you would probably circle the number 3. If you think they see you as very cooperative you would probably circle number 1. If you think they see you as somewhat troublesome, you would probably circle 5 or 6. Remember, for each set of words, circle the number that best represents how you think your parents see you.

82.	Cooperative	1	2	3	4	5	6	7	Troublesome
	Bad	1	2	3	4	5	6	7	Good
	Conforming (obeys rules)	1	2	3	4	5	6	7	Deviant (breaks rules)
	Delinquent (breaks laws)	1	2	3	4	5	6	7	Law Abiding (obeys laws)
	Obedient	1	2	3	4	5	6	7	Disobedient
	Polite	1	2	3	4	5	6	7	Rude

83. Thinking about your teachers and using the same set of words, how do you think your teachers would describe you?

Cooperative	1	2	3	4	5	6	7	Troublesome
Bad	1	2	3	4	5	6	7	Good
Conforming (obeys rules)	1	2	3	4	5	6	7	Deviant (breaks rules)

Delinquent (breaks laws)	1	2	3	4	5	6	7	Law Abiding (obeys laws)
Obedient	1	2	3	4	5	6	7	Disobedient
Polite	1	2	3	4	5	6	7	Rude

84. Using the same set of words, how do you think your friends would describe you?

Cooperative	1	2	3	4	5	6	7	Troublesome
Bad	1	2	3	4	5	6	7	Good
Conforming (obeys rules)	1	2	3	4	5	6	7	Deviant (breaks rules)
Delinquent (breaks laws)	1	2	3	4	5	6	7	Law Abiding (obeys laws)
Obedient	1	2	3	4	5	6	7	Disobedient
Polite	1	2	3	4	5	6	7	Rude

85. The next series of questions deals with rules and regulations. Recent studies suggest that everyone breaks some rules and regulations during his lifetime. Some break them regularly, others less often. Some are more serious and others less serious. There are a number of rules and laws which typically apply to youth. Below are a number of statements regarding these laws and rules.

Please read each item and then respond to the question: In the last two months, how often have you . . .

Circle the number of the answer you choose for each item. Remember, all your answers will be kept secret.

	NEVER	ONCE OR TWICE	SEVERAL TIMES	VERY OFTEN
1. Given a teacher a fake excuse for being absent	1	2	3	4
2. Taken little things (worth $5 or less) that didn't belong to you. . .	1	2	3	4

	NEVER	ONCE OR TWICE	SEVERAL TIMES	VERY OFTEN
3. Broken into a place that is locked just to look around.	1	2	3	4
4. Taken a car for a drive without the owner's permission	1	2	3	4
5. Taken something from a kid's locker without asking him	1	2	3	4
6. Damaged public or private property just for fun	1	2	3	4
7. Beat up on other kids or adults just for the heck of it.	1	2	3	4
8. Participated in gang fights	1	2	3	4
9. Taken something worth $50 or more that didn't belong to you	1	2	3	4
10. Run away from home.	1	2	3	4
11. Taken something worth between $5 and $50 that didn't belong to you.	1	2	3	4
12. Used force (strong arm methods) to get money from another person.	1	2	3	4
13. Used marijuana	1	2	3	4
14. Sold marijuana	1	2	3	4
15. Skipped school without a legitimate excuse.	1	2	3	4
16. Sniffed glue or inhaled toxic (dangerous) fumes.	1	2	3	4
17. Used hard drugs.	1	2	3	4
18. Sold hard drugs.	1	2	3	4
19. Used alcohol	1	2	3	4

86. Now we would like to have you answer some questions about yourself. Please read through the statements below and circle the number of the answer for each statement that best describes how you feel about yourself.

	NEVER	SOME-TIMES	OFTEN	ALWAYS
1. You feel that you are a person of worth, at least equal with others	1	2	3	4
2. You feel that other people see you as having good qualities	1	2	3	4

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	NEVER	SOMETIMES	OFTEN	ALWAYS
3. All in all, you are inclined to feel that you are a failure.	1	2	3	4
4. You are able to do things as well as most people	1	2	3	4
5. You feel you do not have much to be proud of	1	2	3	4
6. You take a positive attitude (think good about) toward yourself	1	2	3	4
7. You feel satisfied with yourself	1	2	3	4
8. You wish you could have more respect for yourself	1	2	3	4
9. You feel useless	1	2	3	4
10. You feel you are no good at all.	1	2	3	4

87. The next set of statements have to do with your group of friends. Again, please read through the statements below and circle the number of the response for each item that best describes your friendship group. If you have any questions about the statements, please ask for help.

	NO	DON'T KNOW	YES
1. The kids in my group would think less of a person if he/she were to get in trouble with the law.	1	2	3
2. Getting into trouble in my group is a way of gaining respect.	1	2	3
3. The members of my group feel that laws are good and should be obeyed	1	2	3
4. The kids in my group get into trouble at home, in school, and in the city.	1	2	3
5. Kids that get into trouble a lot feel very uncomfortable in my group	1	2	3
6. When I choose a group of friends I choose kids that are not afraid to have a little fun even if it means breaking the law	1	2	3
7. Kids who get into trouble with the law are "put down" in my group.	1	2	3
8. If you haven't gotten into some kind of trouble the kids in my group think you are "chicken" or something.	1	2	3

88. In the following set of items, we would like you to answer some questions about your parents. Read each statement and circle the number of the answer which best describes how your parents respond to you.

	NEVER	SOMETIMES	OFTEN	ALWAYS
1. Your parents would help you if you were to get into serious trouble.	1	2	3	4
2. Your parents find fault with you even when you don't deserve it	1	2	3	4
3. Your parents really care about you.	1	2	3	4
4. Your parents are dissatisfied (unhappy) with the things you do.	1	2	3	4
5. Your parents blame you for all their problems.	1	2	3	4

89. For the final set of items, circle 1 for Yes or 0 for No.

	YES	NO
1. Do you believe that most problems will solve themselves if you just don't fool with them?	1	0
2. Are you often blamed for things that just aren't your fault?	1	0
3. Do you feel that most of the time it doesn't pay to try hard because things never turn out right anyway?	1	0
4. Do you feel that most of the time parents listen to what their children have to say?	1	0
5. When you get punished does it usually seem it's for no good reason at all?	1	0
6. Most of the time do you find it hard to change a friend's opinion (mind)?	1	0
7. Do you feel that it's nearly impossible to change your parents' minds about anything?	1	0
8. Do you feel that when you do something wrong there's very little you can do to make it right?	1	0
9. Do you believe that most kids are just born good at sports?	1	0
10. Do you feel that one of the best ways to handle most problems is just not to think about them?	1	0

		YES	NO
11.	Do you feel that when a kid your age decides to hit you, there is little you can do to stop him or her?	1	0
12.	Have you felt that when people were mean to you it was usually for no reason at all?	1	0
13.	Most of the time, do you feel that you can change what might happen tomorrow by what you do today?	1	0
14.	Do you believe that when bad things are going to happen they just are going to happen no matter what you try to do to stop them?	1	0
15.	Most of the time do you find it useless to try to get your own way at home?	1	0
16.	Do you feel that when somebody your age wants to be your enemy there is little you can do to change matters? . . .	1	0
17.	Do you usually feel that you have little to say about what you get to eat at home?	1	0
18.	Do you feel that when someone doesn't like you there is little you can do about it?	1	0
19.	Do you usually feel that it's almost useless to try in school because most other children are just plain smarter than you?	1	0
20.	Are you the kind of person who believes that planning ahead makes things turn out better?	1	0
21.	Most of the time, do you feel that you have little to say about what your family decides to do?	1	0

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Thank you for your willingness to participate in this youth survey.

ANNUAL UPDATE TO THE IOWA STATE PLAN FOR ALCOHOLISM 1978

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IOWA CITIZENS ADVISORY COUNCIL

The Iowa Legislature passed H.F. 594 (Appendix 1) during the 67th General Assembly. The bill merges the Iowa Division on Alcoholism and the Iowa Drug Abuse Authority into a Department of Substance Abuse. By Executive Order, Governor Robert D. Ray delayed the merger of the agencies to January 1, 1978.

Under the provisions of the bill, the Director is appointed by the Governor with approval by the Senate. There is a nine member Commission appointed by the Governor which establish policies governing the performance of the Department. There will be a nine member State Advisory Council appointed by the Governor to advise the Director in administering the provisions of the new law.

Until the new Advisory Council is appointed, the present Advisory Council shall remain in effect. The structure, duties and composition remains unchanged as it is specified in Chapter 125, 1977 Code of Iowa.

The membership, professions and terms of office are as follows:

ONE YEAR TERM

William J, Beck
Farmer
1405 East Quarry
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Phone: (319) 342-2791

**Don E. Perkins
Resource Manager
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Stanley Lawrence Saxton, Jr.,
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TWO YEAR TERM

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THREE YEAR TERM

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James R. Rowen
Associate Commissioner and Acting Deputy Commissioner
Department of Social Services
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Des Moines, Iowa - 50319
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*Chairman

**Vice Chairman

The membership is fairly representative as far as ethnic and minorities. There will be one vacancy on the Citizens' Advisory Council on Alcoholism to be preferably filled by a woman.

The following is an accounting of the Advisory Council meetings held in Des Moines, Iowa, and actions:

December 3, 1976, met, re-elected Reverend Robert Hedges as Chairman and prepared three recommendations to the Commission on Alcoholism.

1. The Council recommended an adequately funded state alcoholism program of $3.6 million as requested by the Division to the State Comptroller.
2. The Council recommended that an appropriate work program for alcoholics coming out of treatment be developed, administered locally and funded at a minimum level of $1 million.
3. The Council commended the Commission for their activities and urged them to adopt the proposed Code of Ethics.

The Commission adopted the first and third recommendations. The second was not endorsed because there was existing programming through Job Service, Vocational Rehabilitation and other community resources.

April 14, 1977, the Council met, received a legislative update from the Director and began developing operating rules and procedures at the request of the Governor. The Council reiterated its priority for the year would be in education and prevention efforts.

May 12, 1977, the Council met to discuss directions in education and prevention. Four recommendations were developed for the Commission:

1. That the Commission fund the Department of Public Instruction at the requested $44,000 for FY '78.
2. That the Commission make extensive efforts to bolster communications between the Department of Public Instruction and Iowa Division on Alcoholism.
3. That there be long-range, systematic increase of prevention efforts.
4. That there be an increase in prevention efforts directed toward the medical, legal and clergy professions.

The Commission funded Department of Public Instruction for $40,000 for FY '78. The other recommendations were filed for further consideration.

SUMMARY OF ACTIVITIES AND ACCOMPLISHMENTS OF FISCAL YEAR 1977 GOALS

FY ' 77 GOAL: To have accreditation of all contracting alcoholism service centers by the Joint Commission on Accreditation of Hospitals within one year.

The Iowa Division on Alcoholism entered into a contract with the Joint Commission on Accreditation of Hospitals (JCAH) for survey of all Iowa contracting alcoholism service centers. The surveys were to be conducted based on the schedule the Division was to submit to JCAH.

To begin preparation the alcoholism service centers for the accreditation process, the Iowa Division on Alcoholism conducted two three-day workshops, one in Sioux City for the centers in the western part of the state, and Iowa City for the eastern programs. The workshops were conducted by consultants to the Division and Division staff. The JCAH Manual was reviewed step by step and the required documentation for each item was discussed.

Following the workshops, the Division technical assistance staff provided ongoing assistance. After the alcoholism service centers had had several months to prepare the documentation, onsite pre-surveys were conducted. The results of the pre-surveys assisted in determining the readiness of the agency for the actual survey by JCAH.

Prior to the surveys, considerable technical assistance was provided by Division staff. There was inter-program exchange of ideas and methods to upgrade documentation.

A workshop was held in Des Moines for all programs preparing for accreditation. The program staff brought all documentation materials to the meeting. Division staff and contracted consultants reviewed step-by-step all the agencies' materials. The workshop provided program staff to further exchange ideas and methods.

For those agencies which did not participate in the first preparatory workshops, a makeup session was conducted in Des Moines. Division staff provided onsite assistance to enable several programs to be surveyed.

Two alcoholism service centers had applied for and received JCAH accreditation prior to the Division's involvement. Surveys for the first group of centers, thirteen (13) agencies, determined ready for accreditation began the first week in May, 1977, and were completed in mid-June. A second group, six (6) centers, are scheduled for surveys in September, 1977. The remaining six (6) not scheduled for surveys are continuing the documentation process and upgrading the environmental factors associated with accreditation.

The Iowa Division on Alcoholism brought in an outside team to evaluate the functions and responsibilities of the Division and staff. Their report was filed with the Commission and the Governor.

FY '77 GOAL: To upgrade the qualifications of alcoholism service center counselors to include credentialing in one year.

A counselor credentialing workshop was held in August, 1976. An ad hoc committee of counselors working in the field participated and developed draft guidelines. The guidelines were presented to the Commission on Alcoholism in September. With the Commission endorsement, the committee continued to refine the guidelines to include a mix of education and training alternatives, procedures and appeal processes.

A case management seminar for counselors was conducted by Iowa Division on Alcoholism and Program Evaluation Training Project Staff from Superior, Wisconsin. Improved case management was reflected during the pre-surveys and JCAH surveys.

Regional training sessions designed to follow up on case management, counseling techniques - individual and group - outreach, and utilization of other supportive services were conducted by Division staff.

Iowa's 6th Annual Summer School was held in August, 1976. The week-long session involved a wide range of persons involved in alcoholism - program staff, board members, students, correction officers and social workers.

The 7th Annual Summer School, jointly sponsored by Iowa Division on Alcoholism and Iowa Drug Abuse Authority was held August 15-19, 1977. Topics included law enforcement, occupa-

tional programming, insurance, medical community, prevention, education and community motivation.

Peer Counselor Training for high school teams sponsored by the Department of Public Instruction, under contract with the Division, ran concurrently with the Summer School.

FY '77 GOAL: To establish a State Employees Assistance Program and private employees occupational programming in industries within one year.

Governor Robert D. Ray has recommended that State of Iowa departments establish policies on Employees Assistance Program. To date, five (5) departments have done so and fifty (50) employees have been referred.

The National Council on Alcoholism received continued support from the Division for their Employee Assistance Program in the Greater Des Moines area. The program has assisted fifty-one (51) companies, private and governmental agencies, in developing Employee Assistance Programs which cover 37,000 employees. The National Council has provided other alcoholism service center assistance in developing occupational program.

FY '77 GOAL: Through mass media and the 454 school districts to educate the public about alcohol and alcoholism.

With the cooperation of National Institute on Alcohol Abuse and Alcoholism (NIAAA), the Division distributed public

Service announcement spots to the local television stations. At the end of each spot, the name, address and telephone number of the local alcoholism service centers was listed for viewers who sought additional information about alcohol and alcoholism.

The Department of Public Instruction, under contract with the Division, completed and publishes a curriculum guide for grades kindergarten through twelfth on alcohol and other drugs.

The Department of Public Instruction staff presented the curriculum guide at Area Education Agencies workshops and University of Iowa course on alcohol and drug abuse. Additionally, Department of Public Instruction staff served as technical assistant to Area Education Agencies to increase their capabilities of providing information and special services to the schools in their areas.

Buena Vista College, Storm Lake, Iowa, submitted a proposal for a January Interim Course in Alcohol Education to be held January, 1977. The Iowa Commission on Alcoholism funded the course at a cost of $780 with the stipulations that provision be made for students to become acquainted with Alcoholics Anonymous and all course materials be made available to other colleges in Iowa.

The course was held, stipulations were met and students indicated a desire to see instruction in this area offered again. Buena Vista College is beginning plans for staff and freshman training in the area of alcohol abuse education.

Upon request the Prevention Coordinator conducted an initial week of alcohol education for selected classes of high school students at Albia High School, Albia, Iowa. This instruction, including development and administration of a student survey, was used as a lead-in activity for the local alcoholism service center to establish an ongoing relationship with the schools in the catchment area.

Results were development of an "after hours" peer group of students at Albia High School and the survey is being used to initiate alcohol education activities in the five counties covered by the SIEDA Alcoholism Center, Ottumwa, Iowa.

An Alcohol Education Task Force was formed by the Office of Student Affairs, Iowa State University, Ames, Iowa. One of the results of the Task Force was the identified need of an Alcohol Education Programmer so that Iowa State University could make a concerted effort with the alcohol education needs of the students.

The Division partially supported the position of the Alcohol Education Programmer through the Ames alcoholism service center, Iowa State University supported the balance of expenses. The Alcohol Education Programmer is housed in the Office of Student Life on the campus.

FY '77 GOAL: To increase the number of affiliate agreements with community hospitals for medical detoxification and accept all alcoholics for admission

on a twenty-four hour basis by twenty-five (25) more hospitals.

The alcoholism service centers did not reach the goal of twenty-five (25) more affiliate agreements with community hospitals to provide twenty-four hour medical detoxification services. The alcoholism agencies did strengthen existing affiliate agreements as a part of preparation for Joint Commission on Accreditation of Hospitals accreditation survey.

The affiliate agreements are more detailed, specify the responsibilities of the alcoholism centers and the hospitals, the screening and evaluation of persons admitted to hospitals, and the fiscal responsibilities of the parties involved.

FY '77 GOAL: Coordination of Planning and Funding Resources - To involve three additional resources within one year in the planning and funding of Iowa alcoholism programs.

Procedures were established for the alcoholism service centers to purchase Food Stamps on behalf of qualified clients in residential units. This resource reduced cash dispersements from the agencies' budgets for food. Use of Food Stamps is optional for the client as well as the service center.

The Division initiated steps for better relationships and referrals between community alcoholism service centers and the Rehabilitation and Education Services Branch (Vocational Re-

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habilitation) of the Department of Public Instruction. A joint plan was developed by the Division and Vocational Rehabilitation. Two (2) alcoholism service centers were selected based on the availability of Vocational Rehabilitation counselors in the area served by the alcoholism center and the willingness of the agencies to participate.

Follow-up reports indicate that one (1) alcoholism service center developed a contract with Vocational Rehabilitation and has regular referrals between Vocational Rehabilitation and alcoholism counselors. The other alcoholism service center referred clients to Vocational Rehabilitation counselors, however, due to the Vocational Rehabilitation caseload, little was accomplished.

It is the responsibility of each service center to refer clients to Vocational Rehabilitation based upon a needs assessments and individual treatment plans.

A proposal was submitted by the Division to Veterans Administration. The proposal would have provided for outpatient counseling for qualified veterans in three (3) outpatient alcoholism service centers. The Veterans Administration response was they did not have funds for this type of demonstration programming.

The Division continued joint planning with the Iowa Department of Social Services on Title XX. Division staff served on the State Title XX Advisory Council. The Division maintained a statewide Title XX contract for two years. The decision

was made that for Year III, the alcoholism service centers would contract directly with the Department of Social Services for Title XX reimbursement for outpatient counseling.

In accordance with P.L. 93-641, the National Health Planning and Development Act, the Division has cooperated with the three (3) Health Systems Agencies (HSAs) which cover Iowa's ninety-nine counties. Division staff participated in a Data Resource Workshop for the staffs of the three HSAs. Division staff and several alcoholism service centers staff served on the Technical Review Committee of the Iowa HSA's Substance Abuse Component, Health Status Plan.

Drafts of the Iowa HSA's and Health Planning Council of the Midlands' (HSA) alcoholism components will be reviewed and commented on by the Division.

The State Health Planning and Development Agency (SHPDA) consulted the Division during A-95 reviews of grants submitted by alcoholism service centers to National Institute on Alcohol Abuse and Alcoholism.

A proposal to provide third-party reimbursement for residential care and outpatient counseling was prepared by the Division and submitted to Blue Cross of Iowa. Due to the National Institute on Alcohol Abuse and Alcoholism and Blue Cross Association contract to develop a model benefit package for alcoholism services, Blue Cross of Iowa decided to wait the outcome of Phase I of the Blue Cross Association project.

Blue Cross Assocation selected Blue Cross of Iowa as one of the three (3) Plans to market the three-year model benefits. One of the criteria for selection of the Plan was interest and cooperation by the State Alcoholism Authority.

Blue Cross of Iowa has designated a Project Coordinator. A task force of representatives from the various Blue Cross departments will be appointed. A staff member from Iowa Division on Alcoholism will serve on the task force to provide technical assistance.

Blue Cross of Iowa and the Division will enter into a written Memorandum of Understanding which outlines the roles and expectations of each agency. A draft of the Memorandum has been prepared.

FY '77 GOAL; To hold quarterly regional Management by Objectives Workshops on administration and fiscal aspects of alcoholism programming.

Due to the schedules of workshops planned by other agencies, the decision was made to encourage staff of the alcoholism service centers to attend and participate in those workshops.

Level I - Basic Detoxification - was held at Schoitz Hospital in Waterloo, Iowa. Subjects covered were the medical/psychiatric aspects of detoxification; law and the detox center; alcoholism and poly-drug use and abuse; and social services and the detox center.

Level II Workshop covered advanced training in administration and supervision; law and the detox center; medical aspects and special needs problems.

Level III Workshop was emphasis on development of worker skills in management, administration and evaluation.

Levels I, II and III were supported by Midwestern Area Alcohol Education and Training Program through the Rochester Center Continuing Education and Extension, University of Minnesota.

A week-long workshop was held in Des Moines for alcoholism service centers staff. Alcoholism program administration, grant writing, personnel supervision, decision making and treatment planning were covered. The workshop was put on by the Alcohol Education and Training, Wichita State University, through Midwestern Area Alcohol Education and Training Program sponsorship.

For all the above mentioned workshops, the Division served as the facilitator, to inform the alcoholism service centers staff about the sessions and encouraged participation.

FY '77 GOAL: To conduct four regional follow-up workshops on the Division monitoring and evaluation systems by October 1, 1977.

The Division was advised that the National Institute on Alcohol Abuse and Alcoholism was going to make changes in the

forms used in the monitoring system. In that the Division uses identical forms, the decision was made to delay the regional workshops until the new forms were approved and distributed.

Regional workshops were held in March to prepare the alcoholism service centers staff for the changeover to the new forms effective April 1, 1977.

Technical assistance was provided to alcoholism service centers on the interpretation of the output reports, training new data coordinators and counselors on the completion of the reports as well as follow-up training for data coordinators and program administrators.

A special meeting was held in conjunction with an Iowa Commission on Alcoholism monthly meeting on the interpretation and use of the data in the output reports.

GOALS FOR FISCAL YEAR 1978

Input into the State Plan Update Goals is derived in several ways. The monthly Commission on Alcoholism meetings are open public meetings. Citizens concerned about alcohol abuse and alcoholism prevention, education and treatment programs and services address their issues. The discussions and decisions provide the State Authority with policies and directions which are reflected in the Goals.

The State Advisory Council decided to primarily direct their attention to prevention and education. The Council's actions are considered in developing the goals and activities to meet their concerns.

Alcoholism service center board members, staff and State Alcoholism Authority staff are involved in local planning on Department of Social Services District Advisory Councils, Sub-Area Councils of the Health Systems Agencies, State Health Planning and Development Agency, mental health and drug abuse agencies. Participation with the other agencies' planning provides greater coordinator of services and efficient utilization of available funding.

Due to the merger of the Iowa Division on Alcoholism and Iowa Drug Abuse Authority, submission of comprehensive regional plans have been deferred. Regional Plans, based on the requirements of H.F. 594, will be submitted in the Spring, 1978.

The goals for FY '78 are presented in priority order as a continuation of the Iowa Master State Plan for Alcoholism. The continued ranking of the priorities reflects the Division on Alcoholism in view of the needs which have evolved from an operational statewide program and not necessarily in terms of the responsibility or needs based on population patterns, minority densities, or low income status. Rather, the emphasis is placed on reaching all types of persons regardless of income status, race, profession or urban or rural residency since it is known that alcohol related problems and alcoholism are not inherent in any particular group but are found in every segment of society.

CONTINUING INTO FY '78 GOAL: To have at least fifty percent (50%) of the alcoholism service centers which have not been surveyed by Joint Commission on Accreditation of Hospitals to be scheduled for survey and meet JCAH accreditation by the end of the third quarter of FY '78.

As of October, 1977, six contracting alcoholism service centers had not been scheduled for JCAH survey. Documentation in preparation for survey is in the process at the six centers. In one instance, the agency must relocate its' facility to meet the environmental standard.

It will be the responsibility of the alcoholism service centers which have achieved Joint Commission on Accreditation of Hospitals accreditation to continue to meet the standards and be reaccredited. Having applied for JCAH accreditation or being accredited are requirements of the facilities to be eligible for contracting with Blue Cross of Iowa, a Plan which is participating in the National Institute on Alcohol Abuse and Alcoholism/Blue Cross Association Model Benefit Study.

Currently nine alcoholism service centers have received JCAH accreditation, six have not received a report back.

Funds for pre-survey and JCAH survey costs were withheld by the Division on FY '77 contracts to the alcoholism service centers ($2000.00 per agency). The Division on Alcoholism entered into a direct contract with JCAH for the surveys and paid JCAH directly for services conducted.

CONTINUING INTO FY '78 GOAL: To develop the procedures for credentialing alcoholism service center counselors in one year.

A task force has been formed to develop procedures for credentialing counselors. The task force is composed of counselors and directors from several treatment programs in the State.

The task force is taking into account the need to acknowledge previous experience of alcoholism field workers in developing the standards for certification of counselors.

The task force members are volunteers. Any costs associated by the credentialing process are included in the Division staff and support costs budget.

It is anticipated that the technical aspects of application, certificiation, duration and appeals hearings will be completed by the task force and rules governing the credentialing process will be submitted to the Commission for approval. The target date set for completion of the rules is June 30, 1978.

CONTINUING INTO FY '78 GOAL: To establish a State Employee Assistance Program and private industries employees programs in one year.

H.F. 594 mandates the Director to develop education and treatment programs for state and local governments and private business and industry employees (Chapter 125.10(12). One staff member will have the primary responsibility to assist state departments in developing and implementing their employee programs.

On the local level, the staff member will coordinate efforts on the part of alcoholism service centers staff in implementing employee programs similar to the National Council on Alcoholism Employee Assistance Program with local governments and private business and industry.

The Division will continue to support the National Council on Alcoholism Employee Assistance Program component. The program encompasses the Greater Des Moines area. The National

Council on Alcoholism provides screening, evaluation and referral to the appropriate treatment program or other agency to meet the employee needs.

The costs of implementing the State Employees Assistance Program are included in the Division's staff and support budget. The National Council on Alcoholism has been awarded $58,400.00 based on the Iowa fiscal year.

CONTINUING INTO FY '78 GOAL: To develop public awareness and information on alcohol abuse and alcoholism particularly as it relates to youth, women, minorities and special target groups in each of the sixteen regions in the state.

This goal is to be implemented in several facets.

To develop public awareness on alcohol abuse, alcoholism and other substance abuse, a public information campaign will be held during Substance Abuse Week in January, 1978. The planning for the week's activities has been initial.

Services for youth are to be primarily directed toward education. The curriculum guide for alcohol education for grades kindergarten through twelfth has been completed. Area Education Agency staff will receive training on the use of the guide in the Fall, 1977. Implementation of the Guide in the public schools will follow the training sessions.

Peer counseling training sponsored by Grantwood Area Education Agency and the Department of Public Instruction will have trained one hundred and fifty-seven youths. The trained youths provide information and referral services to their peers who are experiencing difficulties with alcohol or whose parents, through their abuse of alcohol, are creating family conflicts. The students act as facilitators in "rap groups" and provide training in their local communities.

The Division support for the peer counseling training will be $3500.00 Grant Wood Area Education Agency and $2700.00 Department of Public Instruction.

To address the specific needs of minorities there are several programs specifically directed toward reaching and providing services to this target group. The Inner Urban Alcohol Program, Des Moines, Iowa, provides a youth prevention component as well as outreach and treatment services for adults.

An alternative source of funding for the program has been developed to enable the agency to expand the services.

The Minority Alcoholism Action Project, Waterloo, Iowa, provides education, outreach and treatment services to persons in the city. The agency has received an additional source of funds to expand the level of services available.

The American Indian Community Center, Des Moines, Iowa, provides education, outreach and outpatient services to that population in the Greater Des Moines area.

The projected use of funds from the Iowa Division on Alcoholism for the minority programs is:

	STATE FUNDS	FORMULA GRANT FUNDS	TOTAL
Inner Urban Alcoholism Program - Des Moines, Iowa	$10,000	$20,000	$30,000
Minority Alcoholism Action Program - Waterloo, Iowa	- 0 -	$40,000	$40,000
American Indian Community Center - Des Moines, Iowa	$37,000	- 0 -	$37,000

Alcoholism service centers in Davenport and Burlington have staff members who are bilingual. The staff provides counseling services to the clients who are from Spanish speaking populations in the respective regions.

The program designed to reach and treat the elderly in the Mid-Eastern Community Council on Alcoholism's region in Iowa City is continuing. The program is being supported with local funding.

Efforts will continue to provide education training to law enforcement personnel, clergy and other helping professions. With the adoption of the Uniform Act in Iowa, eight specific training sessions for peace officers on alcohol education, alcoholism and the resources available to assist the officers in carrying out their duties will be held during the third quarter of the state's fiscal year.

CONTINUING INTO FY '78 GOAL: To continue planning and funding treatment and re-

habilitation with three other resoucres.

The Iowa Division on Alcoholism maintained a Title XX State contract with the Department of Social Services for two years. It was mutually agreed by the two state agencies that for Year III, the alcoholism service centers would enter into individual contracts with the Department for Title XX reimbursement for outpatient counseling. Individual contracts will enable the centers to also contract for "Mini-Title XX" funds appropriated by the Iowa legislature to supplement the federal Title XX allocation.

Residential rehabilitation and treatment programs which are approved are eligible to purchase Food Stamps on behalf of qualified clients. The USDA Food Stamp program is administered by the Iowa Department of Social Services.

Blue Cross of Iowa has been selected as one of three Plans for the Blue Cross Association/National Institute on Alcohol Abuse and Alcoholism Model Benefit Program. Blue Cross of Iowa will contract with alcoholism service centers that have applied for or receive Joint Commission on Accreditation of Hospitals accreditation. The benefits for enrolled clients will be:

* Thirty (30) days of intermediate inpatient or intermediate day/night care.
* Thirty (30) visits of outpatient care.
* Fifteen (15) visits of family therapy.
* Sixty (60) visits of outpatient care in lifetime reserve.

The lack of coverage for groups which enroll will be:

* Full service (100%)
* 80-20 co-insurance (80%)
* 60-40 co-insurance (60%)

To assist Blue Cross of Iowa with the implementation of the Model Benefits, the Division and Blue Cross will enter into a Memorandum of Understanding which will outline roles and expectations of the two parties. The Division will provide technical assistance on education, marketing, identification of prospective enrollees and administrative/contractual roles.

The National Health Planning and Resources Development Act (P.L. 93-641) includes planning for alcoholism services. The Iowa Division on Alcoholism has and will continue to monitor and work with the three Health Systems Agencies covering the Iowa alcoholism programs to assure there is proper coordination.

Expenditures for this goal are included in some of the agency staff and support costs.

CONTINUING INTO FY '78 GOAL: To expand the data monitoring system to include drug abuse programs by June 30, 1978.

The Iowa Division on Alcoholism and the Iowa Drug Abuse Authority are to be merged into a Department of Substance Abuse on January 1, 1978. The Division has had a comprehensive

data monitoring system for all contracting alcoholism service centers since July, 1975. The system can provide the same data information for drug programs as well as alcoholism programs. Output reports on client activity, source of referrals to and during treatment, client characteristics, and program efficiency are some of the information from the systems. The reports are used by the local agencies as a management tool and internal evaluation of the program. At the state level the reports are used in planning and evaluating services.

Adding drug programs to the data system will enable the new Department of Substance Abuse to have consistent information on all programs.

The data system costs for alcoholism programs is estimated at $38,400. The additional costs for adding drug abuse programs would depend on the number of programs, client flow and any computer programming modifications which may be required. Therefore, a full cost estimate is not available, however, drug abuse funds would cover any additional expenditures.

FY '78 GOAL: To increase the awareness and need for alcoholism programs for women, alcoholism service centers will conduct a seminar on alcoholism and women in its respective region.

The Iowa Division on Alcoholism data monitoring system indicates that only 13.5% of the persons seeking treatment

are women. A greater emphasis needs to be placed on reaching and treating alcohol abusers and alcoholic women. It will be the responsibility of the alcoholism service centers in each of the sixteen regions to conduct at least one seminar on women and alcoholism. In regions with more than one alcoholism service center, it will be a jointly sponsored seminar.

The seminar agenda is to be developed based on local needs and resources. The Division staff will provide technical assistance as requested to the alcoholism service centers in developing the seminars.

The seminars would be self-supporting by using registration fees for participants. The fees would cover conference rooms, meals, and honorariums, if any, for featured speakers.

FY '78 GOAL: To establish baseline data on the magnitude of alcohol abuse and alcoholism in Iowa through a year long incidence and prevelance study.

The Division will recommend to the rulemaking body that it incorporate the implementation of an incidence and prevelance study of alcohol abuse and alcoholism in Iowa. The study would provide the baseline data for long-range planning for alcoholism services. It would identify the degree or extent that Iowans experience problems with alcohol abuse and alcoholism in any particular population groups.

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The data would be used for long-range planning in the direction of prevention and education services, delivery of treatment and rehabilitation and the expansion of existing services or development of new activities.

The estimated costs for the incidence and prevelance study is $50,000. The proposed study and costs estimates are Appendix II.

EVALUATION

The Iowa Division on Alcoholism monitoring system provides statistics on client activity in each program, profile of client characteristics, source of referrals into and out of intreatment, program efficiency and maintenance of sobriety at intake and follow-up. The state cumulative quarterly report ending March, 1977, is Appendix III. Due to the revised forms effective April, 1977, the computer program is being rewritten and the quarterly report ending June, 1977, has been delayed.

The data system is used in evaluating the state alcoholism program. The evaluation addresses client flow, services, referrals, staff-client ratioes, cost efficiency and effectiveness program by program and the state as a whole.

The monitoring evaluation assures agency compliance that the mandated comprehensive alcoholism services are being delivered.

Attainment of the goals of the State Plan are monitored internally by the Division. Staff assignments and responsibilities are determined according to goal achievement.

CONTINUED

6 OF 7

ASSURANCE OF COMPLIANCE WITH THE DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE REGULATION UNDER TITLE VI OF THE CIVIL RIGHTS ACT OF 1964

DIVISION ON ALCOHOLISM (hereinafter called the "Applicant")
(Name of Applicant)

HEREBY AGREES THAT it will comply with title VI of the Civil Rights Act of 1964 (P.L. 88-352) and all requirements imposed by or pursuant to the Regulation of the Department of Health, Education, and Welfare (45 CFR Part 80) issued pursuant to that title, to the end that, in accordance with title VI of that Act and the Regulation, no person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department; and HEREBY GIVES ASSURANCE THAT it will immediately take any measures necessary to effectuate this agreement.

If any real property or structure thereon is provided or improved with the aid of Federal financial assistance extended to the Applicant by the Department, this assurance shall obligate the Applicant, or in the case of any transfer of such property, any transferee, for the period during which the real property or structure is used for a purpose for which the Federal financial assistance is extended or for another purpose involving the provision of similar services or benefits. If any personal property is so provided, this assurance shall obligate the Applicant for the period during which it retains ownership or possession of the property. In all other cases, this assurance shall obligate the Applicant for the period during which the Federal financial assistance is extended to it by the Department.

THIS ASSURANCE is given in consideration of and for the purpose of obtaining any and all Federal grants, loans, contracts, property, discounts or other Federal financial assistance extended after the date hereof to the Applicant by the Department, including installment payments after such date on account of applications for Federal financial assistance which were approved before such date. The Applicant recognizes and agrees that such Federal financial assistance will be extended in reliance on the representations and agreements made in this assurance, and that the United States shall have the right to seek judicial enforcement of this assurance. This assurance is binding on the Applicant, its successors, transferees, and assignees, and the person or persons whose signatures appear below are authorized to sign this assurance on behalf of the Applicant.

Dated October 14, 1977 IOWA DIVISION ON ALCOHOLISM
(Applicant)

By [signature]
(President, Chairman of Board, or comparable authorized official)

508 Tenth Street

Des Moines, Iowa - 50319
(Applicant's mailing address)

HEW-441
(12-64)

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
PUBLIC HEALTH SERVICE

STATE HEALTH PLAN BUDGET

STATE: IOWA — FISCAL YEAR: 1978
AGENCY: IOWA DIVISION ON ALCOHOLISM
☒ INITIAL
☐ REVISION NO. 10/5/77

FUND SOURCE	TITLE V–SOC. SECURITY ACT SEC. 503 MCH (A)	SEC. 504 CC (B)	PUBLIC HEALTH SERVICE ACT, AS AMENDED SEC. 314(a) PLANNING (C)	SEC. 314(d) PUBLIC HEALTH (D)	SEC. 314(d) MENTAL HEALTH (E)	SEC. 303(a) ALCOHOL (F)	SEC. 304(a) M H CONST. (G)	SEC. 306(c) HOSP. ADMIN. (H)	(I)
1. STATE PUBLIC						951,782			
2. LOCAL PUBLIC									
3. PRIVATE NON-PROFIT									
4. SUB-TOTALS						951,782			
5. FEDERAL — FINANCIAL ASSISTANCE — FUND A									
FEDERAL — FINANCIAL ASSISTANCE — FUND B						730,919			
FEDERAL — DIRECT ASSISTANCE									
6. PREVIOUS FISCAL YEAR (s) CARRYOVER A.		A.							
PREVIOUS FISCAL YEAR (s) CARRYOVER B.		B.							
7. TOTALS						1,682,701			
8. NON FEDERAL SHARE REQUIREMENTS						1,242,330			
9. MAINTENANCE OF EFFORT									
10. AMOUNT OF MATCHING PROPOSED BY STATE									
11. DIRECT COMMUNITY SERVICES									
12. TOTAL HEALTH FUNDS BUDGETED						951,782			

STATE FUNDS BUDGETED TO OTHER AGENCIES

PURPOSE	STATE PUBLIC AGENCIES	LOCAL PUBLIC AGENCIES	NON-PROFIT
13. PUBLIC HEALTH			
14. MENTAL HEALTH			

REMARKS:

PROGRAM DIRECTOR (Name and Title)
Jeff Voskans, Director

AGENCY HEAD (Signature) [signature] DATE 10/5/77
TITLE DIRECTOR

OFFICE OF GOVERNOR [signature] DATE 10-17-77
TITLE adm. asst.

PHS-6133-2 (Formerly HSM-561-2)
9-73

FORM APPROVED
O.M.B. NO. 68-R1222

APPENDIX I

H.F. 594

HOUSE FILE 594

AN ACT

RELATING TO SUBSTANCE ABUSE BY CREATING AN IOWA DEPARTMENT OF SUBSTANCE ABUSE, PRESCRIBING THE STRUCTURE, POWERS AND DUTIES OF THE DEPARTMENT, APPLYING THE FUNDING FORMULA FOR ALCOHOLISM PROGRAMS IN CHAPTER ONE HUNDRED TWENTY-FIVE (125) OF THE CODE TO ALL SUBSTANCE ABUSE PROGRAMS, PROVIDING FOR THE LICENSING OF TREATMENT FACILITIES BY THE DEPARTMENT, MAKING PROVISIONS OF CHAPTER ONE HUNDRED TWENTY-FIVE (125) OF THE CODE RELATING TO THE TREATMENT AND COMMITMENT OF ALCOHOLICS, AND PERSONS INCAPACITATED BY ALCOHOL APPLICABLE TO PERSONS WHO ABUSE ANY CHEMICAL SUBSTANCE, REPEALING CHAPTERS TWO HUNDRED TWENTY-FOUR (224) AND TWO HUNDRED TWENTY-FOUR A (224A) OF THE CODE AND PROVIDING A PENALTY.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF IOWA:

Section 1. NEW SECTION. DECLARATION OF POLICY. It is the policy of this state:

1. That substance abusers and persons suffering from chemical dependency be afforded the opportunity to receive quality treatment and directed into rehabilitation services which will help them resume a socially acceptable and productive role in society.

2. To encourage substance abuse education and prevention efforts and to insure that such efforts are coordinated to provide a high quality of services without unnecessary duplication.

3. To insure that substance abuse programs are being operated by individuals who are qualified in their field whether through formal education or through employment or personal experience.

This section is effective January 1, 1978.

Sec. 2. Section one hundred twenty-five point two (125.2),

Code 1977, is amended by striking subsections one (1), three (3), five (5), and eleven (11) and inserting in lieu thereof the following:

1. "Chemical dependency" means an addiction or dependency, either physical or psychological, on a chemical substance. Persons who take medically prescribed drugs shall not be considered chemically dependent if the drug is medically prescribed and the intake is proportionate to the medical need.

3. "Chemical substance" means alcohol, wine, spirits and beer as defined in chapter one hundred twenty-three (123) of the Code and drugs as defined in section two hundred three A point two (203A.2), subsection three (3) of the Code, which when used improperly could result in chemical dependency.

5. "Substance abuser" means a person who habitually lacks self-control as to the use of chemical substances or uses chemical substances to the extent that his or her health is substantially impaired or endangered or that his or her social or economic function is substantially disrupted.

Sec. 3. Section one hundred twenty-five point two (125.2), subsections two (2), four (4), six (6), seven (7), eight (8), and ten (10), Code 1977, are amended to read as follows:

2. "Facility" means a hospital, institution, detoxification center, or installation providing care, maintenance and treatment for ~~alcoholics~~ substance abusers and ~~approved~~ licensed by the ~~director~~ department under section 125.13.

4. "Department" means the ~~state~~ Iowa department of ~~health~~ substance abuse.

6. "Director" means the director of the Iowa ~~division on alcoholism~~ department of substance abuse.

7. "Commission" means the ~~Iowa~~ commission on ~~alcoholism~~ substance abuse within the ~~division~~ department.

8. "Incapacitated by ~~alcohol~~ a chemical substance" means that a person, as a result of the use of ~~alcohol~~ a chemical substance, is unconscious or has his or her judgment otherwise

so impaired that he or she is incapable of realizing and making a rational decision with respect to ~~his~~ the need for treatment.

10. "Intoxicated person" means a person whose mental or physical functioning is substantially impaired as a result of the use of ~~alcohol~~ a chemical substance.

Sec. 4. Section one hundred twenty-five point three (125.3), Code 1977, is amended to read as follows:

125.3 ESTABLISHED. There is established ~~within~~ the ~~state~~ Iowa department of ~~health-a-division-on-alcoholism~~ substance abuse which shall develop, implement and administer a comprehensive ~~alcoholism~~ substance abuse program pursuant to sections 125.1 to 125.26. There is established within the ~~division~~ department a commission on ~~alcoholism~~ substance abuse to establish policies governing the performance of the ~~division~~ department in the discharge of duties imposed on it by this chapter. The commission shall consist of nine members appointed by the governor. Appointments shall be made on the basis of interest in and knowledge of ~~alcoholism~~ substance abuse, however two of the members shall be persons who, in their regular work, have direct contact with substance abuse clients. All members shall be eligible electors of the state of Iowa ~~and-no-more-than-five-members-shall-belong to-the-same-political-party.--No-member-shall-be-a-director of-a-local-or-regional-alcoholism-center~~.

Sec. 5. Section one hundred twenty-five point five (125.5), Code 1977, is amended to read as follows:

125.5 MEETINGS. The commission shall organize annually and shall select from its membership a ~~chairman~~ chairperson and a vice ~~chairman~~ chairperson. The commission shall meet at least six times a year. Other meetings shall be called by the ~~chairman~~ chairperson or upon written request of a majority of the members of the commission. The ~~chairman~~ chairperson shall preside at all meetings or in ~~his~~ the chairperson's absence the vice ~~chairman~~ chairperson shall preside. Five members of the commission shall constitute

a quorum but the concurrence of a majority of the commission shall be required to determine any matter relating to its duties.

Sec. 6. Section one hundred twenty-five point six (125.6), Code 1977, is amended to read as follows:

125.6 COMPENSATION. Each member of the ~~Iowa~~ commission on ~~alcoholism~~ substance abuse shall receive forty dollars per day for each day spent in performance of the duties of the commission. Each member shall also receive ~~his~~ actual necessary expenses incurred in the performance of his or her duties.

Sec. 7. Section one hundred twenty-five point seven (125.7), Code 1977, is amended by adding the following new subsection:

NEW SUBSECTION. Consider and approve or disapprove all applications for a license and all cases involving the renewal, denial, suspension or revocation of a license.

Sec. 8. Section one hundred twenty-five point seven (125.7), subsections two (2), four (4), five (5) and eight (8), Code 1977, are amended to read as follows:

2. Approve the comprehensive ~~alcoholism~~ substance abuse program, and the funding therefore, developed by the ~~division~~ department pursuant to sections 125.1 to 125.26.

4. Establish policies governing the performance of the director in the discharge of ~~his~~ the director's duties.

5. Advise or make recommendations to the governor and the general assembly relative to ~~alcoholism~~ substance abuse treatment, intervention and education and prevention programs in this state.

8. Submit to the governor and the general assembly an annual report covering the activities of the ~~division~~ department.

Sec. 9. Section one hundred twenty-five point eight (125.8), Code 1977, is amended by striking the section and inserting in lieu thereof the following:

125.8 DIRECTOR APPOINTED. The director of the department

shall be appointed by the governor for a four-year term with the approval of two-thirds of the members of the senate. The director shall be a qualified person who has training or experience in handling substance abuse problems and the ability to organize and otherwise supervise delivery systems providing treatment, intervention and education and prevention services to persons suffering from substance abuse problems. The director shall serve as secretary to the commission.

Sec. 10. Section one hundred twenty-five point nine (125.9), subsections one (1), two (2), four (4) and six (6), Code 1977, are amended to read as follows:

1. Plan, establish and maintain treatment, intervention and education and prevention programs as necessary or desirable in accordance with the comprehensive ~~alcoholism~~ substance abuse program.

2. Make contracts necessary or incidental to the performance of ~~his~~ the duties and the execution of ~~his~~ the powers of the director, including contracts with public and private agencies, organizations and individuals to pay them for services rendered or furnished to ~~alcoholics~~ substance abusers or intoxicated persons.

4. Co-ordinate the activities of the ~~division~~ department and co-operate with ~~alcoholism~~ substance abuse programs in this and other states, and make contracts and other joint or co-operative arrangements with state, local or private agencies in this and other states for the treatment of ~~alcoholics~~ substance abusers and intoxicated persons and for the common advancement of ~~alcoholism~~ substance abuse programs.

6. Employ a deputy director who shall be exempt from the merit system and shall serve at the pleasure of the director. The director may employ other staff necessary to carry out the duties assigned to ~~him~~ the director.

Sec. 11. Section one hundred twenty-five point nine (125.9), Code 1977, is amended by adding the following new subsections after subsection four (4):

NEW SUBSECTION. Require that a written report, in

reasonable detail, be submitted to the director at any time by any agency of this state or of any of its political subdivisions in respect to any substance abuse prevention function, or program for the benefit of persons who are or have been involved in substance abuse, which is being conducted by the agency.

NEW SUBSECTION. Submit to the governor a written report of the pertinent facts at any time the director concludes that any agency of this state or of any of its political subdivisions is conducting any substance abuse prevention function, or program for the benefit of persons who are or have been involved in substance abuse in a manner not consistent with or which impairs achievement of the objectives of the state plan to combat substance abuse, and has failed to effect appropriate changes in the function or program.

Sec. 12. Section one hundred twenty-five point ten (125.10), Code 1977, is amended to read as follows:

125.10 DUTIES OF DIRECTOR. The director shall:

1. Prepare and submit a state plan subject to approval by the commission and in accordance with the provisions of title XLII, United States Code, section 4573. The state plan shall designate the ~~division~~ department as the sole agency for supervision of the administration of the plan and ~~may~~ shall provide for the appointment of a citizens advisory council on ~~alcoholism~~ substance abuse.

2. Develop, encourage, and foster state-wide, regional and local plans and programs for the prevention of ~~alcoholism~~ substance abuse and the treatment of ~~alcoholics~~ substance abusers and intoxicated persons in co-operation with public and private agencies, organizations and individuals, and provide technical assistance and consultation services for these purposes.

3. Co-ordinate the efforts and enlist the assistance of all public and private agencies, organizations and individuals interested in the prevention of ~~alcoholism~~ substance abuse and the treatment of ~~alcoholics~~ substance abusers and

intoxicated persons.

4. Co-operate with the department of social services in establishing and conducting programs to provide treatment for ~~alcoholics~~ substance abusers and intoxicated persons.

5. Co-operate with the department of public instruction, boards of education, schools, police departments, courts and other public and private agencies, organizations and individuals in establishing programs for the prevention of ~~alcoholism~~ substance abuse and the treatment of ~~alcoholics~~ substance abusers and intoxicated persons, and in preparing curriculum materials thereon for use at all levels of school education.

6. Prepare, publish, evaluate and disseminate educational material dealing with the nature and effects of ~~alcohol~~ chemical substances.

7. Develop and implement, as an integral part of treatment programs, an educational program for use in the treatment of ~~alcoholics~~ substance abusers and intoxicated persons, which program shall include the dissemination of information concerning the nature and effects of ~~alcohol~~ chemical substances.

8. Organize and implement, in co-operation with local treatment programs, training programs for all persons engaged in treatment of ~~alcoholics~~ substance abusers and intoxicated persons.

9. Sponsor and implement~~, in co-operation with local treatment programs,~~ research in cooperation with local treatment programs into the causes and nature of ~~alcoholism~~ substance abuse and treatment of ~~alcoholics~~ substance abusers and intoxicated persons, and serve as a clearing house for information relating to ~~alcoholism~~ substance abuse.

10. Specify uniform methods for keeping statistical information by public and private agencies, organizations and individuals, and collect and make available relevant statistical information, including number of persons treated, frequency of admission and readmission, and frequency and

duration of treatment.

11. Develop and implement, with the counsel and approval of the commission, a compehensive plan for treatment of ~~alcoholics~~ substance abusers and intoxicated persons, said plan to be co-ordinated with health systems agencies.

12. Assist in the development of, and co-operate with, ~~alcohol~~ substance abuse education and treatment programs for employees of state and local governments and businesses and industries in the state.

13. Utilize the support and assistance of interested persons in the community, particularly recovered ~~alcoholics~~ substance abusers, to encourage ~~alcoholics~~ substance abusers to voluntarily undergo treatment.

14. Co-operate with the commissioner of public safety in establishing and conducting programs designed to deal with the problem of persons operating motor vehicles while intoxicated.

15. Encourage general hospitals and other appropriate health facilities to admit without discrimination ~~alcoholics~~ substance abusers and intoxicated persons and to provide them with adequate and appropriate treatment, and may negotiate and implement contracts with hospitals and other appropriate health facilities with adequate detoxification facilities.

16. Encourage all health and disability insurance programs to include ~~alcoholism~~ substance abuse as a covered illness.

17. Review all state health, welfare, education and treatment ~~plans~~ proposals to be submitted for federal funding under federal legislation, and advise the governor on provisions to be included relating to ~~alcoholism~~ substance abuse and substance abusers and intoxicated persons.

Sec. 13. Section one hundred twenty-five point eleven (125.11), Code 1977, is amended by striking the section and inserting in lieu thereof the following:

125.11 STATE ADVISORY COUNCIL--MEMBERSHIP.

1. There is established within the department a state advisory council which shall be composed of nine members and

which shall advise the director in administering this chapter. The governor shall appoint the members of the advisory council, who shall serve at the pleasure of the governor, and shall designate the chairperson of the advisory council. The director or a designee shall serve as the advisory council's secretary. The advisory council shall be entirely advisory in character and may not exercise administrative authority.

2. Members of the substance abuse advisory council shall, to the extent practicable, be drawn from different geographical areas of the state, and shall provide representation for:

a. Nongovernmental organizations concerned directly or indirectly with substance abuse such as local citizen groups, employee groups, national groups, labor and management, and other provider, consumer, and consumer advocate groups.

b. Public agencies concerned directly or indirectly with substance abuse, such as local elected officials or representatives of health and mental health agencies, welfare agencies, and law enforcement agencies.

c. The minority, poverty, and major population groups which are significantly affected by the problems of substance abuse.

d. At least one representative of the state health coordinating council.

3. Members of the council shall serve without compensation but shall receive reimbursement for travel and other necessary expenses actually incurred in the performance of their duties.

Sec. 14. Section one hundred twenty-five point twelve (125.12), Code 1977, is amended to read as follows:

125.12 COMPREHENSIVE PROGRAM FOR TREATMENT--REGIONAL FACILITIES.

1. The commission shall establish a comprehensive and co-ordinated program for the treatment of ~~alcoholics~~ substance abusers and intoxicated persons. Subject to the approval of the ~~commissioner~~ commission, the director shall divide the state into appropriate regions for the conduct of the program and establish standards for the development of the

program on the regional level. In establishing the regions, consideration shall be given to city and county lines, population concentrations and existing ~~alcoholism~~ substance abuse treatment services. In determining the regions, the director shall not be required to follow the regional map as prepared by the office for planning and programming.

2. The program of the commission shall include:

a. Emergency treatment provided by a facility affiliated with or part of the medical service of a general hospital.

b. Inpatient treatment.

c. Intermediate treatment.

d. Outpatient and follow-up treatment and rehabilitation.

e. Prevention and education.

3. The director shall provide for adequate and appropriate treatment for ~~alcoholics~~ substance abusers and intoxicated persons admitted under sections 125.16 to 125.19. Treatment shall not be provided at a correctional institution except for inmates.

4. The director shall maintain, supervise and control all facilities operated by ~~him~~ the director pursuant to this chapter. The administrator of each facility shall make an ~~annual~~ a report of the activities of the facility to the ~~director~~ commission in the form and manner the ~~director~~ commission specifies.

5. All appropriate public and private resources shall be co-ordinated with and utilized in the program if possible.

6. The director shall prepare, publish and distribute annually a list of all facilities.

7. The director may contract for the use of a facility if the director, subject to the policies of the commission and pursuant to section 125.27, considers this to be an effective and economical course to follow.

Sec. 15. Section one hundred twenty-five point thirteen (125.13), Code 1977, is amended by striking the section and inserting in lieu thereof the following:

125.13 PROGRAMS LICENSED--EXCEPTIONS.

1. Except as provided in subsection two (2) of this section, a person may not maintain or conduct any chemical substitutes or antagonists program, residential program or nonresidential outpatient program, the primary purpose of which is the treatment and rehabilitation of substance abusers without having first obtained a written license for the program from the department.

2. The licensing requirements of this Act, except the requirements imposed by section twenty-four (24) of this Act, shall not apply to any of the following:

a. Hospitals providing any care or treatment to substance abusers required on January 1, 1978, by other provisions of law to be licensed.

b. Any practitioner of medicine and surgery or osteopathic medicine and surgery, in his or her private practice. However, a program shall not be exempted from licensing by the commission by virtue of its utilization of the services of a medical practitioner in its operation.

c. Private institutions conducted by and for persons who adhere to the faith of any well recognized church or religious denomination for the purpose of providing care, treatment, counseling, or rehabilitation to substance abusers and who rely solely on prayer or other spiritual means for healing in the practice of religion of such church or denomination.

d. Facilities, institutions, or programs which, in the discretion of the department, provide services which are only informational or educational in nature.

e. Alcoholics anonymous.

Sec. 16. Chapter one hundred twenty-five (125), Code 1977, is amended by adding sections seventeen (17) through twenty-four (24) of this Act after section one hundred twenty-five point thirteen (125.13) of the Code.

Sec. 17. NEW SECTION. LICENSES--RENEWAL--FEES. The commission shall meet to consider all cases involving issuance, denial, suspension, or revocation of a license. Upon approval of an application for licensing by the commission, a license

shall be issued by the department. Licenses shall expire one year from the date of issuance and shall be renewed upon timely application made in the same manner as for original issuance of a license unless notice of nonrenewal is given to the licensee at least thirty days prior to the expiration of the license. The department shall not charge a fee for licensing or renewal.

Sec. 18. NEW SECTION. INSPECTION OF LICENSEES. The department shall at least annually inspect the facilities and review the procedures utilized by each licensed program. The examination and review may include case record audits and interviews with staff and patients, consistent with the confidentiality safeguards of state and federal law.

Sec. 19. NEW SECTION. TRANSFER OF LICENSE OR CHANGE OF LOCATION PROHIBITED. A license issued under this chapter may not be transferred, and the location of the physical facilities occupied or utilized by any program licensed under this chapter shall not be changed without the prior written consent of the commission.

Sec. 20. NEW SECTION. LICENSE SUSPENSION OR REVOCATION. Violation of any of the requirements or restrictions of this chapter or of any of the rules properly established pursuant to this chapter is cause for suspension, revocation or refusal to renew a license. The director shall at the earliest time feasible notify a licensee whose license the commission is considering suspending or revoking and shall inform the licensee what changes must be made in the licensee's operation to avoid such action. The licensee shall be given a reasonable time for compliance, as determined by the director, after receiving such notice or a notice that the commission does not intend to renew the license. When the licensee believes compliance has been achieved, or if the licensee considers the proposed suspension, revocation or refusal to renew unjustified, the licensee may submit pertinent information to the commission who shall expeditiously make a decision in the matter and notify the licensee of the decision.

Sec. 21. NEW SECTION. HEARING BEFORE COMMISSION. If a licensee under this chapter makes a written request for a hearing within thirty days of suspension, revocation or refusal to renew a license, a hearing before the commission shall be expeditiously arranged. If the role of a commission member is inconsistent with the member's job role or function, or if any commission member feels unable for any reason to disinterestedly weigh the merits of the case before the commission, the member shall not participate in the hearing and shall not be entitled to vote on the case. The commission shall issue a written statement of its findings within thirty days after conclusion of the hearing upholding or reversing the proposed suspension, revocation or refusal to renew a license. No action involving suspension, revocation or refusal to renew a license shall be taken by the commission unless a quorum of five of the nine members are present at the meeting. A copy of the decision shall be promptly transmitted to the affected licensee who may, if aggrieved by the decision, seek judicial review of the actions of the commission in accordance with the terms of the Iowa administrative procedure Act.

Sec. 22. NEW SECTION. REISSUANCE OR REINSTATEMENT. After suspension, revocation or refusal to renew a license pursuant to this chapter, the affected licensee shall not have the license reissued or reinstated within one year of the effective date of the suspension, revocation or expiration upon refusal to renew, unless by order of the commission. After that time, proof of compliance with the requirements and restrictions of this chapter and the rules established pursuant to this chapter must be presented to the commission prior to reinstatement or reissuance of a license.

Sec. 23. NEW SECTION. RULES. The commission shall establish rules pursuant to chapter seventeen A (17A) of the Code requiring facilities to use reasonable accounting and reimbursement systems which recognize relevant cost-related factors for substance abuse patients. A facility shall not

be licensed nor shall any payment be made under this chapter to a facility which fails to comply with those rules or which does not permit inspection by the department or examination of all records, including financial records, methods of administration, general and special dietary programs, the disbursement of drugs and methods of supply, and any other records the commission deems relevant to the establishment of such a system. However, rules issued pursuant to this paragraph shall not apply to any facility referred to in section fifteen (15), subsection two (2) or section thirty-six (36) of this Act.

Sec. 24. NEW SECTION. CHEMICAL SUBSTITUTES AND ANTAGONISTS PROGRAMS. The commission shall have exclusive power in this state to approve and license chemical substitutes and antagonists programs, and monitor chemical substitutes and antagonists programs in this state to insure that the programs are operating within the rules established pursuant to this chapter and the commission shall be obliged to grant such approval and license if the requirements of the rules are met and no state funding is requested.

The department may:

1. Continuously study and evaluate chemical substitutes and antagonists programs in this state and annually report to the governor and the general assembly on the effectiveness and needs of the programs.

2. Provide advice, consultation, and technical assistance to chemical substitutes and antagonists programs.

3. In its discretion, approve local agencies or bodies to assist it in carrying out the provisions of this chapter.

Sec. 25. Section one hundred twenty-five point fifteen (125.15), Code 1977, is amended to read as follows:

125.15 ACCEPTANCE FOR TREATMENT--RULES. The commission shall adopt and may amend and repeal rules for acceptance of persons into the treatment program, subject to the provisions of chapter 17A, considering available treatment resources and facilities, for the purpose of early and

effective treatment of ~~alcoholics~~ substance abusers and intoxicated persons. In establishing the rules the commission shall be guided by the following standards:

1. If possible a patient shall be treated on a voluntary rather than an involuntary basis.

2. A patient shall be initially assigned or transferred to outpatient or intermediate treatment, unless ~~he~~ the patient is found to require inpatient treatment.

3. A person shall not be denied treatment solely because ~~he~~ the person has withdrawn from treatment against medical advice on a prior occasion or because ~~he~~ the person has relapsed after earlier treatment.

4. An individualized treatment plan shall be prepared and maintained on a current basis for each patient.

5. Provision shall be made for a continuum of co-ordinated treatment services, so that a person who leaves a facility or a form of treatment will have available and may utilize other appropriate treatment.

Sec. 26. Section one hundred twenty-five point sixteen (125.16), Code 1977, is amended to read as follows:

125.16 VOLUNTARY TREATMENT OF ~~ALCOHOLICS~~ SUBSTANCE ABUSERS.

1. ~~An alcoholic~~ A substance abuser may apply for voluntary treatment or rehabilitation services directly to a facility or to a licensed physician and surgeon or osteopathic physician and surgeon. If the proposed patient is a minor or an incompetent person, ~~his~~ a parent, a legal guardian or other legal representative may make the application. The licensed physician and surgeon or osteopathic physician and surgeon or any employee or person acting under his or her direction or supervision, or the facility shall not report or disclose the name of the person or the fact that treatment was requested or has been undertaken to any law enforcement officer or law enforcement agency; nor shall such information be admissible as evidence in any court, grand jury, or administrative proceeding unless authorized by the person seeking treatment. If the person seeking such treatment or rehabilitation is

a minor who has personally made application for treatment, the fact that the minor sought treatment or rehabilitation or is receiving treatment or rehabilitation services shall not be reported or disclosed to the parents or legal guardian of such minor without the minor's consent, and the minor may give legal consent to receive such treatment and rehabilitation.

2. Subject to rules adopted by the commission, the administrator in charge of a facility may determine who shall be admitted for treatment or rehabilitation. If a person is refused admission, the administrator, subject to rules adopted by the commission, shall refer the person to another facility for treatment if possible and appropriate.

3. A substance abuser seeking treatment or rehabilitation and who is either addicted or dependent on a chemical substance shall first be examined and evaluated by a licensed physician and surgeon or osteopathic physician and surgeon who shall prescribe a proper course of treatment and medication, if needed. The licensed physician and surgeon or osteopathic physician and surgeon may further prescribe a course of treatment or rehabilitation and authorize another licensed physician and surgeon or osteopathic physician and surgeon or facility to provide the prescribed treatment or rehabilitation services. Treatment or rehabilitation services may be provided to a person individually or in a group. Any facility providing or engaging in such treatment or rehabilitation shall not report or disclose to a law enforcement officer or law enforcement agency the name of any person receiving or engaged in such treatment or rehabilitation; nor shall any person receiving or participating in such treatment or rehabilitation report or disclose the name of any other person engaged in or receiving such treatment or rehabilitation or that such program is in existence, to a law enforcement officer or law enforcement agency. Such information shall not be admitted in evidence in any court, grand jury, or administrative proceeding. However, any person

engaged in or receiving such treatment or rehabilitation may authorize the disclosure of his or her name and individual participation.

~~3~~ 4. If a patient receiving inpatient care leaves a facility, ~~he~~ the patient shall be encouraged to consent to appropriate outpatient or intermediate treatment. If it appears to the administrator in charge of the facility that the patient is ~~an alcoholic~~ a substance abuser who requires help, the director may arrange for assistance in obtaining supportive services and residential facilities.

~~4~~ 5. If a patient leaves a facility, with or against the advice of the administrator in charge of the facility, the director may make reasonable provisions for ~~his~~ the patient's transportation to another facility or to ~~his~~ the patient's home. If ~~he~~ the patient has no home ~~he~~ the patient shall be assisted in obtaining shelter. If ~~he~~ the patient is a minor or an incompetent person the request for discharge from an inpatient facility shall be made by a parent, legal guardian or other legal representative or by the minor or incompetent if ~~he~~ the patient was the original applicant.

6. Any person who reports or discloses the name of a person receiving treatment or rehabilitation services to a law enforcement officer or law enforcement agency or any person receiving treatment or rehabilitation services who discloses the name of any other person receiving treatment or rehabilitation services without the written consent of the person in violation of the provisions of this section shall upon conviction be guilty of a simple misdemeanor.

Sec. 27. Section one hundred twenty-five point seventeen (125.17), subsections one (1) and two (2), Code 1977, are amended to read as follows:

1. An intoxicated person may come voluntarily to a facility for emergency treatment. A person who appears to be intoxicated or incapacitated by ~~alcohol~~ a chemical substance in a public place and in need of help ~~may~~ shall be taken to a facility by a peace officer. If the person refuses the

proffered help, ~~he~~ the person may be arrested and charged with intoxication.

2. If no facility is readily available the person may be taken to an emergency medical service customarily used for incapacitated persons. The peace officer in detaining the person and in taking ~~him~~ the person to a facility, in taking ~~him~~ the person into protective custody and shall make every reasonable effort to protect ~~his~~ the person's health and safety. In taking the person into protective custody, the detaining officer may take reasonable steps ~~to protect himself~~ for self-protection. A taking into protective custody under this section is not an arrest and no entry or other record shall be made to indicate that the person who is taken into protective custody has been arrested or charged with a crime.

Sec. 28. Section one hundred twenty-five point seventeen (125.17), subsection four (4), Code 1977, is amended by striking the section and inserting in lieu thereof the following:

4. A person who is found to be intoxicated or incapacitated by a chemical substance after examination by a qualified health professional shall be required to remain at the facility until the qualified health professional determines that the person is not likely to inflict physical self harm or inflict physical harm on others. If the person is detained longer than twenty-four hours the qualified health professional shall examine him or her at least once every twelve hours to determine if further detention is necessary. The qualified health professional shall enter a written order for the person to be detained in custody. Such order shall state the circumstances under which the person was taken into custody and the grounds supporting the finding or probable cause to believe that he or she is sufficiently impaired or incapacitated by a chemical substance to cause physical injury to himself or herself or others if released. The order shall be filed in the district court of the area in which the person

is detained.

Sec. 29. Section one hundred twenty-five point eighteen (125.18), subsection one (1), Code 1977, is amended to read as follows:

1. An intoxicated person who has threatened, attempted, or inflicted physical self harm ~~on himself~~ or threatened, attempted or inflicted physical harm on another and is likely to inflict physical self harm ~~on himself~~ or is likely to physically harm another unless committed, or who is incapacitated by ~~alcohol~~ a chemical substance, may be committed to a facility for emergency treatment. A refusal to undergo treatment does not constitute evidence of lack of judgment as to the need for treatment.

Sec. 30. Section one hundred twenty-five point nineteen (125.19), subsections one (1), two (2), and five (5) and subsection nine (9), paragraphs a and b, Code 1977, are amended to read as follows:

1. A person may be committed to the custody of ~~the division~~ a facility by the district court upon the petition of ~~his~~ the person's spouse or guardian, a relative, the certifying physician, or the administrator in charge of a facility. The petition shall allege that the person is ~~an alcoholic~~ a substance abuser who habitually lacks self-control as to the use of ~~alcoholic beverages~~ chemical substances, and (a) that ~~he~~ the person has threatened, attempted or inflicted physical harm on another and that ~~he~~ the person is likely to inflict physical self harm ~~on himself~~ or inflict physical harm on another unless committed; or (b) that ~~he~~ the person is incapacitated by ~~alcohol~~ a chemical substance. A refusal to undergo treatment does not constitute evidence of lack of judgment as to the need for treatment. The petition shall be accompanied by a certificate of a licensed physician who has examined the person within two days before submission of the petition, unless the person whose commitment is sought has refused to submit to a medical examination or was unavailable for examination, in which case the fact of refusal or unavailability shall be alleged in the petition. The certificate shall set forth the physician's findings in support of the allegations of the petition. A physician employed by the admitting facility or the ~~division~~ department is not eligible to be the certifying physician.

2. Upon the filing of the petition, the court shall fix a date for a hearing no later than ten days after the date the petition was filed. If a judicial hospitalization referee has been appointed under section two hundred twenty-nine point twenty-one (229.21) of the Code for the county in which the petition is filed, the clerk of the district court shall immediately notify the referee of the filing of the petition and the referee shall thereupon discharge all of the duties imposed upon judges of the district court by this section. A copy of the petition and the notice of hearing shall be served in the manner of an original notice on the person whose commitment is sought and upon a parent or legal guardian if the person is a minor. A copy of the petition and the notice of hearing shall be mailed or delivered in the manner provided for motions in civil cases to the petitioner, the next of kin of the person other than the petitioner, the administrator of the facility to which the person has been committed for emergency care, and any other person the court believes should receive copies. A petition shall have attached a copy of the certificate specified in this section.

5. A person committed under this section shall remain in the custody of ~~the division~~ a facility for treatment for a period of thirty days unless sooner discharged. This section shall not be construed to require the ~~division~~ department to pay the cost of any medication or procedure provided the person during that period which is not necessary or appropriate to the specific objectives of detoxification and treatment of ~~alcoholism~~ substance abuse. At the end of the thirty-day period, ~~he~~ the person shall be discharged automatically unless the director before expiration of the period petitions the court for an order for ~~his~~ the person's recommitment upon

the grounds set forth in subsection 1 for a further period not to exceed ninety days.

a. In case of ~~an alcoholic~~ a substance abuser committed under subsection 1, paragraph "a", that ~~he~~ the person is no longer ~~an alcoholic~~ a substance abuser or the likelihood no longer exists.

b. In case of ~~an alcoholic~~ a substance abuser committed under subsection 1, paragraph "b", that the incapacity no longer exists, that further treatment will not be likely to bring about significant improvement in the person's condition, or that treatment is no longer adequate or appropriate.

Sec. 31. Section one hundred twenty-five point twenty (125.20), subsection two (2), Code 1977, is amended to read as follows:

2. Notwithstanding subsection 1, the director may make available information from patients' records for purposes of research into the causes and treatment of ~~alcoholism~~ substance abuse. Information under this subsection shall not be published in a way that discloses patients' names or other identifying information.

Sec. 32. Section one hundred twenty-five point twenty (125.20), Code 1977, is amended by adding the following new subsection:

NEW SUBSECTION. Notwithstanding the provisions of subsection one (1) of this section a patient's records may be disclosed to medical personnel in a medical emergency with or without the patient's consent.

Sec. 33. Section one hundred twenty-five point twenty-one (125.21), subsection two (2), Code 1977, is amended to read as follows:

2. Neither mail nor other communication to or from a patient in a facility may be intercepted, read or censored, except that the commission may adopt reasonable rules regarding the use of telephones by patients in facilities and the delivery of ~~controlled~~ chemical substances ~~and other intoxicants~~.

Sec. 34. Section one hundred twenty-five point twenty-two (125.22), Code 1977, is amended to read as follows:

125.22 COMPOSITION OF FACILITIES BOARDS--TREATMENT PLANS FURNISHED.

1. In addition to other requirements established by this chapter, ~~no~~ a facility shall not be ~~approved~~ licensed pursuant to section ~~125.13~~ fifteen (15) of this Act unless it is either a political subdivision, a licensed hospital or a community mental health center operating under chapter 230A, or it is organized under the Iowa nonprofit corporation Act appearing as chapter 504A. In the latter case, one-third of the membership of the board of directors shall be representatives of such government units providing funds to the facility for treatment of ~~alcoholism~~ substance abuse.

2. A local governmental unit which is providing funds to a facility for treatment of ~~alcoholism~~ substance abuse may request from the facility a treatment program plan prior to authorizing payment of any claims filed by the facility. The governing body of the local governmental unit may review the plan, but shall not impose on the facility any requirement conflicting with the comprehensive treatment program requirements of section 125.28.

Sec. 35. Section one hundred twenty-five point twenty-three (125.23), subsection three (3), Code 1977, is amended to read as follows:

3. Nothing in this chapter affects any law, ordinance, resolution or rule against drunken driving, driving under the influence of alcohol or other chemical substance, or other similar offense involving the operation of a vehicle, aircraft, boat, machinery or other equipment, or regarding the sale, purchase, dispensing, possessing or use of alcoholic beverages or beer at stated times and places or by a particular class of persons or regarding the sale, purchase, possession or use of another chemical substance.

Sec. 36. Section one hundred twenty-five point twenty-six (125.26), Code 1977, is amended to read as follows:

125.26 FUNDING AT MENTAL HEALTH INSTITUTES. Chapter 230 shall govern the determination of the costs and payment for treatment provided to ~~alcoholics~~ substance abusers in a mental health institute under the department of social services, except that the charges shall not constitute a lien on any real estate owned by persons legally liable for support of the ~~alcoholic~~ substance abuser and the daily per diem shall be billed at twenty-five percent. Beginning July 1, ~~1976~~ 1977, the superintendent of a state hospital shall total only those expenditures which can be attributed to the cost of providing inpatient treatment to ~~alcoholics and intoxicated persons~~ substance abusers for purposes of determining the daily per diem. The provisions of section 125.31 shall govern the determination of who is legally liable for the cost of care, maintenance, and treatment of ~~an alcoholic~~ a substance abuser and of the amount for which the person is liable.

Sec. 37. Section one hundred twenty-five point twenty-seven (125.27), Code 1977, is amended to read as follows:

125.27 CONTRACT FOR CARE--RULES ADOPTED. The director may, consistent with the comprehensive ~~alcoholism~~ substance abuse program, enter into written agreements with a facility as defined in section 125.2 to pay for seventy-five percent of the cost of the care, maintenance and treatment of an ~~alcoholic~~ a substance abuser. Such contracts shall be for a period of no more than one year. The commission shall review and evaluate at least once each year all such agreements and determine whether or not they shall be continued.

The contract may be in such form and contain provisions as agreed upon by the parties. Such contract shall provide that the facility shall admit and treat ~~alcoholics~~ substance abusers regardless of where they have residence. If one payment for care, maintenance, and treatment is not made by the patient or those legally liable therefor within thirty days after discharge the payment shall be made by the ~~division~~ department directly to the facility. Payments shall be made each month and shall be based upon the facility's average

daily per patient charge. Provisions of this section shall not pertain to patients treated at the mental health institutes.

If the appropriation to the ~~commission~~ department is insufficient to meet the requirements of this section, the ~~commission~~ department shall request a transfer of funds and section 8.39 shall apply.

Contracting facilities shall deliver to each patient upon discharge a statement of the costs of the care, maintenance and treatment for which that patient is liable, and shall retain a carbon copy or other similar copy of that statement for a period of not less than one year after the date of discharge of the patient to whom the statement refers. Every payment received by a contracting facility from or on behalf of a patient, whether received before or after costs have been billed to the ~~division~~ department or to a county, shall be identified by the facility as to patient and invoice or statement, and shall be reported to the ~~division~~ department. A contracting facility shall allow as a credit against a future billing to the ~~division~~ department or to a county, payments received during each month from or on behalf of a patient whose care, maintenance and treatment theretofore has been billed to and paid by the ~~division~~ department or a county. Failure by a contracting facility to comply with this paragraph, or with rules promulgated pursuant to section ~~125.43, subsection 4,~~ twenty-three (23) of this Act shall constitute grounds for nonrenewal of the contract.

Sec. 38. Section one hundred twenty-five point twenty-eight (125.28), subsection one (1), Code 1977, is amended to read as follows:

1. Except as provided in section 125.26, each county shall pay for the remaining twenty-five percent of the cost of the care, maintenance, and treatment under this chapter of residents of that county from the county mental health and institutions fund as provided in section ~~444~~.12. The commission shall establish guidelines for use by the counties

in estimating the amount of expense which the county will incur each year. The facility shall certify to the county of residence once each month twenty-five percent of the unpaid cost of the care, maintenance, and treatment of ~~an alcoholic~~ a substance abuser. Such county shall pay the cost so certified to the facility from its county mental health and institutions fund. However, the approval of the board of supervisors shall be required before payment is made by a county for costs incurred which exceed a total of five hundred dollars for one year for treatment provided to any one ~~alcoholic or intoxicated person~~ substance abuser, except that such approval is not required for the cost of treatment provided to ~~an alcoholic or intoxicated person~~ a substance abuser who is committed pursuant to section 125.18 and 125.19. A facility may, upon approval of the board of supervisors, submit to a county a billing for the aggregate amount of all care, maintenance, and treatment of ~~alcoholics~~ substance abusers who are residents of that county for each month. The board of supervisors may demand an itemization of such billings at any time or may audit the same.

Sec. 39. Section one hundred twenty-five point twenty-nine (125.29), Code 1977, is amended to read as follows:

125.29 COUNTY OF RESIDENCE DETERMINED. The facility shall, when ~~an alcoholic~~ a substance abuser is admitted, or as soon thereafter as it receives the proper information, determine and enter upon its records the Iowa county of residence of ~~such alcoholic~~ the substance abuser, or that the person resides in some other state or country, or that the person is unclassified with respect to residence.

Sec. 40. Section one hundred twenty-five point thirty (125.30), Code 1977, is amended to read as follows:

125.30 DISPUTES OVER PAYMENT. In the event any county to which certification of the cost of care, maintenance, and treatment of ~~an alcoholic~~ a substance abuser is made, disputes that such ~~alcoholic~~ substance abuser has ~~his~~ residence in that county, it shall immediately notify the facility that

such dispute exists. The director shall immediately investigate the facts and determine in which county the patient has residence. The director shall certify ~~his~~ the determination to the county, if any, wherein it is found the patient has residence and to the facility. A county certified by the director to be the county of residence shall reimburse the facility as provided in this chapter. If the director finds that the residence of ~~an alcoholic~~ a substance abuser at the time of admission was in another state or country or that the person is unclassified with respect to residence, then the ~~division~~ department shall pay for that portion of ~~his~~ the patient's care, maintenance, and treatment that ~~his~~ the patient's county of residence would have been liable to pay. For purposes of this section, a "facility" does not include a mental health institute under the control of the department of social services.

Sec. 41. Section one hundred twenty-five point thirty-one (125.31), unnumbered paragraph one (1), Code 1977, is amended to read as follows:

The ~~alcoholic~~ substance abuser and any person, firm, corporation, or insurance company bound by contract to provide support, hospitalization, or medical services for the ~~alcoholic~~ substance abuser shall be legally liable to the county of the ~~alcoholic's~~ substance abuser's residence for twenty-five percent of the total amount and to the ~~division~~ department for seventy-five percent of the total amount of the cost of providing care, maintenance, and treatment for the ~~alcoholic~~ substance abuser while a voluntary or committed patient in a facility, except when the state pays the total cost of care in which case liability of one hundred percent shall be to the state. Nothing in this section shall prohibit any individual from paying any portion of the cost of treatment.

Sec. 42. Section one hundred twenty-five point thirty-three (125.33), Code 1977, is amended to read as follows:

125.33 COUNTY AUDITOR TO KEEP ACCOUNTS. The auditor of each county shall keep an accurate account of the total cost

to the county of the care, maintenance, and treatment of any ~~alcoholic~~ substance abuser and shall keep an index of the names of the ~~alcoholics~~ substance abusers for whose benefit county funds are expended pursuant to section 125.28 for those services. The index shall be used only for audit purposes by the state or county and shall not be considered a public record.

Sec. 43. Section one hundred twenty-five point thirty-four (125.34), Code 1977, is amended to read as follows:

125.34 COLLECTION OF CLAIMS BY BOARD OF SUPERVISORS. The board of supervisors shall collect the total amount of all such liabilities as they become due, from those persons whom the board has found, under section 125.28, subsection 2, are able to pay. The board shall direct the county attorney to proceed with the collection of such liabilities as a part of the duties of that office. The county shall be entitled to keep the total amount of all such liabilities collected. The county attorney, with the consent of the board of supervisors, may execute an agreement providing for the acceptance of a lesser amount owed by an ~~alcoholic~~ a substance abuser, his or her spouse, or estate to the county. The execution of such agreement may provide that the same is in satisfaction of all moneys owed the county.

Sec. 44. Chapter one hundred twenty-five (125), Code 1977, is amended by adding the following new sections after section one hundred twenty-five point thirty-six (125.36):

NEW SECTION. USE OF FUNDS. The director shall not be required to distribute or guarantee funds:

1. To any program which does not meet licensing standards,

2. To any program providing unnecessary, duplicative or overlapping services within the same geographical area, or

3. To any program which has adequate resources at its disposal.

This section is effective January 1, 1978.

NEW SECTION. AUDITS. All licensed substance abuse programs shall be subject to regular audit by the auditor of state

or to special audits requested by the director.

This section is effective January 1, 1978.

NEW SECTION. FUTURE STATUS OF DEPARTMENT. The provisions of chapter one hundred twenty-five (125) of the Code are repealed effective July 1, 1982. The first session of the Sixty-ninth General Assembly meeting in the year 1981 shall review the activities and performance of the department and shall not later than July 1, 1981 make a determination concerning the status and duties of the department.

This section is effective January 1, 1978.

Sec. 45. Section two hundred twenty-nine point twenty-one (229.21), subsection one (1), Code 1977, is amended to read as follows:

1. As soon as practicable after the adoption of this Act the judges in each judicial district shall meet and shall determine, individually for each county in the district, whether it appears that one or more district judges will be sufficiently accessible in that county to make it feasible for them to perform at all times the duties prescribed by sections 229.7 to 229.20 and by ~~chapter 224~~ section thirty (30) of this Act. If the judges find that accessibility of district court judges in any county is not sufficient for this purpose, the chief judge of the district shall appoint in that county a judicial hospitalization referee. The judges in any district may at any time review their determination, previously made under this subsection with respect to any county in the district, and pursuant to that review may authorize appointment of a judicial hospitalization referee, or abolish the office, in that county.

Sec. 46. The governor shall make the initial appointments to the commission and the advisory council for terms for commencing July 1, 1977. The provisions of sections six (6) and thirteen (13) of this Act shall apply to the payment of per diem and expenses to commission and advisory council members as if the provisions of sections six (6) and thirteen (13) of this Act were in effect on July 1, 1977. The

provisions of this section shall be effective July 1, 1977.

Sec. 47. Chapters two hundred twenty-four (224) and two hundred twenty-four A (224A) and sections one hundred twenty-five point one (125.1) and one hundred twenty-five point fourteen (125.14), Code 1977, are repealed.

Sec. 48. Sections one hundred twenty-five point thirty-seven (125.37) through one hundred twenty-five point forty-two (125.42), Code 1977, are repealed. Notwithstanding subsection one (1) of section four point one (4.1) of the Code, the repeal of section one hundred twenty-five point forty-two (125.42) of the Code shall not operate to repeal the provisions of chapter one hundred twenty-five (125) of the Code as they existed before the effective date of this section and as they are amended by this Act.

Sec. 49.

1. Sections two (2) through forty-three (43), sections forty-five (45), forty-seven (47) and sections fifty (50) through fifty-two (52) of this Act are effective January 1, 1978.

2. Section forty-eight (48) of this Act is effective July 1, 1977.

Sec. 50. The governor may by executive order delay the implementation of sections thirty-six (36) through forty-three (43) of this Act until July 1, 1978 if the governor finds that delayed implementation of sections thirty-six (36) through forty-three (43) of this Act would allow the state and local substance abuse programs the opportunity to solve any administrative and fiscal problems which may occur as the result of implementation of the funding formula for substance abuse programs contained in sections thirty-six (36) through forty-three (43) of this Act. If the implementation of sections thirty-six (36) through forty-three (43) of this Act is delayed pursuant to this section, the provisions of sections one hundred twenty-five point twenty-six (125.26) through one hundred twenty-five point thirty-four (125.34) of the Code shall continue to be in force as

they existed prior to January 1, 1978 until sections thirty-six (36) through forty-three (43) of this Act are implemented by the governor on July 1, 1978.

Sec. 51. The Code editor shall place sections seventeen (17) through twenty-four (24) of this Act following section one hundred twenty-five point thirteen (125.13) of the Code and shall renumber all sections in chapter one hundred twenty-five (125) of the Code and correct internal references in chapter one hundred twenty-five (125) of the Code in accordance with this Act.

Sec. 52. The Code editor shall change all references to the word "division" in chapter one hundred twenty-five (125) of the Code to the word "department".

DALE M. COCHRAN
Speaker of the House

ARTHUR A. NEU
President of the Senate

I hereby certify that this bill originated in the House and is known as House File 594, Sixty-seventh General Assembly.

DAVID L. WRAY
Chief Clerk of the House

Approved _____, 1977

ROBERT D. RAY
Governor

APPENDIX II

Center for Business and Behavioral Research
University of Northern Iowa
Cedar Falls, Iowa

Contracting Agency: Iowa Divison of Alcoholism
Des Moines, Iowa

Type of Study: Statewide household survey utilizing an interview schedule.

Location of Study: State of Iowa

Purpose of Study: To determine the incidence and prevalence of alcoholism in Iowa.

Methods and Procedures:

Research Instrument--
A survey interview schedule will be developed jointly by representatives of the Contracting Agency and the Center for Business and Behavioral Research. The schedule will be designed so that the average interview will not exceed sixty minutes.

Sampling--
A multi-level area probability sampling plan will be used in selecting 600 sampling units (households) from the state of Iowa.

Data Collection Techniques--
The interview schedule will be administered by trained interviewers using recognized household interviewing techniques.

Written Report--One Hundred Fifty copies of a final report will be prepared and presented to the Contracting Agency at the end of the study.

Monthly Progress Reports: The Center will present to the Contracting Agency monthly progress reports during the duration of the study.

Time Factor: The Center will agree to begin work under this project not later than thirty (30) days after a formal Agreement has been signed by all parties. The final written report will be presented to the Contracting Agency within 18 months after a formal Agreement has been signed by all parties.

Agreement: The Contracting Agency is required to enter into a formal agreement with the Center before any phase of the proposed study can begin.

Termination Provision: The Contracting Agency has the option of terminating the proposed study at any time. Should the Contracting Agency terminate the study, said agency shall pay to the Center all costs incurred in the execution of the study up to and including the date of termination.

Costs: The total cost of the study is $53,479 (see Appendix for proposed budget).

Date of Proposal: October 12, 1977.

Equal Opportunity Employer: The Center for Business and Behavioral Research is an equal opportunity employer and in the performance of all contracts complies with Title 49, Code of Federal Regulations.

Prepared by:

Robert E. Kramer
Associate Director

	Proposed Budget
Wages, Salaries and Benefits	
Principal Investigators	$13,789
Graduate Research Assistant	4,341
Research Assistants	3,600
Secretaries	3,343
Field Interviewers	6,870
Materials, Supplies and Services	
Consultants	500
Postage, telephone and supplies	900
Data processing, computer time	2,500
Duplicating and printing	2,100
Travel and Related Expenses	2,679
Other	
Lodging and subsistence for field interviewers	3,944
Subtotal	44,566
Institutional Indirect Costs (20% of subtotal)	8,913
TOTAL	$53,479

APPENDIX III

03/01/77 RUN DATE-05/12/77 PAGE NO. 30
S22SA090 I O W A A L C O H O L I S M T R E A T M E N T M O N I T O R I N G S Y S T E M

PROFILE OF ATC CLIENT CASELOAD

REPORT NUMBER - IA PERIOD ENDING - MARCH 1977

	REPORT MONTH												TWELVE MONTH TOTAL	MONTHLY AVERAGE
	APR	MAY	JUNE	JULY	AUG	SEPT	OCT	NOV	DEC	JAN	FEB	1977 MAR		
TOTALS 999														
INITIAL CONTACTS	732	949	970	940	907	905	876	827	833	987	944	1,030	11,060	923
INTAKES	747	811	751	683	625	680	612	595	569	701	694	750	8,168	681
TOTAL TERMINATIONS	57	82	120	238	336	235	337	307	439	473	750	568	3,944	329
TREATMENT COMPLETED	8	6	11	35	42	65	140	87	164	166	287	206	1,217	101
PREINTAKES SERVED	99	103	172	232	265	246	258	271	361	284	309	406		251
ACTIVE CLIENTS	2,003	2,327	2,532	2,429	2,655	2,669	2,899	3,030	3,042	3,245	3,256	3,322		2,784
90-DAY CASELOAD	3,022	3,565	4,146	4,595	4,997	5,061	5,291	5,431	5,596	5,947	6,184	6,337		5,016
FTE STAFF-DIRECT	219.0	206.6	229.4	218.6	167.6	191.6	204.9	205.6	233.0	240.1	232.4	265.7		217.9
FTE STAFF-INDIRECT	214.1	204.5	218.6	191.5	176.0	164.7	164.0	146.5	150.3	151.2	141.9	164.4		174.0

TOTAL EXPENDITURES LAST QUARTER $1,544,992 DATE CENTER ENTERED I-D-A- SYSTEM

AVERAGE EXPENDITURES PER PERSON SERVED PER MONTH 2ND QTR/76- $244 3RD QTR/76- $184 4TH QTR/76- $150 1ST QTR/77- $143

AVERAGE NUMBER PERSONS SERVED PER MONTH PER FTE STAFF 2ND QTR/76- 5.6 3RD QTR/76- 7.6 4TH QTR/76- 8.9 1ST QTR/77- 9.1

TREATMENT CENTER - TOTALS
STATE -
REGION -

PERIOD ENDING- MARCH 1977

REPORT III A - CLIENT INTAKE CHARACTERISTICS

CHARACTERISTIC	TOTAL STATE	2ND QTR 1976	3RD QTR 1976	4TH QTR 1976	1ST QTR 1977	TWELVE MONTH	ALL ATC CENTERS
NUMBER OF INTAKES		2,309	1,988	1,776	2,095	0	8,168
MEAN AGE	28.8	36.9	36.7	36.4	36.5	.0	36.7
PERCENT MALE	48.6%	86.1%	87.4%	85.1%	87.4%	.0%	86.5%
ETHNICITY							
WHITE	98.6%	91.7%	92.4%	91.6%	91.4%	.0%	91.8%
BLACK	1.2%	4.1%	3.7%	3.9%	3.6%	.0%	3.9%
SPANISH DESCENT	.1%	1.8%	2.2%	2.2%	2.4%	.0%	2.3%
AMERICAN INDIAN	* %	1.9%	1.5%	1.9%	1.6%	.0%	1.8%
ALASKAN NATIVE	* %	.0%	.2%	.0%	.0%	.0%	.0%
ASIAN DESCENT	* %	.0%	.0%	.2%	.0%	.0%	.1%
OTHER	.1%	.4%	.2%	.1%	.1%	.0%	.2%
MEDIAN SCHOOL YEARS	12.2	12.2	12.2	12.3	12.3	.0	12.2
MARITAL STATUS							
MARRIED	66.8%	36.1%	35.3%	36.7%	39.1%	.0%	36.8%
DIVORCED/SEPARATED	8.9%	31.4%	31.0%	31.5%	30.3%	.0%	31.0%
SINGLE/WIDOWED	24.3%	32.5%	33.7%	31.8%	30.6%	.0%	32.2%
PERCENT UNEMPLOYED	3.8%	35.5%	33.0%	33.4%	32.6%	.0%	33.7%
PERCENT IN WORK FORCE	77.0%	82.8%	83.2%	82.9%	86.2%	.0%	83.8%
PERCENT HAD PRIOR TREATMENT	**	29.2%	27.2%	28.3%	27.4%	.0%	28.0%
MEAN INCOME LAST YEAR	* 7,157	* 8,714	* 9,149	* 9,373	* 9,818	* 0	* 9,251
YEARS HEAVY DRINKING	**	11.7	11.5	11.3	11.1	.0	11.4
YEARS LIVING IN COMMUNITY	**	14.7	15.2	14.7	16.0	.0	15.2
ALCOHOL CONSUMED/DAY (OZS.)	**	4.0	4.0	4.0	3.7	.0	3.9
OCCUPATION							
PROFESSIONAL	20.5%	7.0%	8.9%	8.0%	7.7%	.0%	7.9%
SALES AND CLERICAL	20.5%	7.3%	6.5%	7.5%	6.8%	.0%	7.0%
CRAFTSMAN	25.2%	31.5%	32.3%	32.5%	31.9%	.0%	32.0%
LABORERS	16.2%	26.7%	24.2%	24.6%	28.2%	.0%	26.0%
SERVICE	13.2%	8.2%	9.0%	8.4%	8.2%	.0%	8.5%
STUDENT	*** %	8.9%	9.3%	9.8%	8.0%	.0%	8.9%
HOUSEWIFE	*** %	10.4%	9.9%	9.2%	9.1%	.0%	9.7%
NONE	4.4%	.0%	.0%	.0%	.0%	.0%	.0%

* - DATA NOT AVAILABLE ** - DOES NOT APPLY *** - PERCENT INCLUDED UNDER HEADING NONE

TREATMENT CENTER - TOTALS
STATE -
REGION -

PERIOD ENDING - MARCH 1977

REPORT III C - SOURCE OF REFERRAL - CENTER CONTACTS

	2ND QTR 1976	3RD QTR 1976	4TH QTR 1976	1ST QTR 1977	TWELVE MONTH	ALL ATC CENTERS
NUMBER OF CONTACTS	2,828	2,742	2,512	2,929	11,011	11,011
PERCENT DISTRIBUTION						
HOSPITALS , CMHC S , MD S	9.3%	9.0%	8.8%	8.9%	9.0%	9.0%
A A	3.0%	3.3%	3.3%	2.5%	3.0%	3.0%
OTHER ALCOHOLISM PROGRAMS	3.9%	4.2%	4.7%	5.4%	4.6%	4.6%
VOC. REHAB SOCIAL OR COMMUNITY	5.3%	4.0%	7.3%	6.7%	5.8%	5.8%
COURTS - DRIVING RELATED	15.9%	19.7%	18.5%	20.8%	18.8%	18.8%
COURTS NOT DRIVING RELATED	10.3%	9.7%	8.1%	7.7%	9.0%	9.0%
POLICE	10.2%	12.2%	9.7%	7.0%	9.8%	9.8%
EMPLOYER	2.6%	3.1%	4.3%	6.2%	4.1%	4.1%
SELF	23.6%	19.9%	19.1%	18.2%	20.2%	20.2%
FAMILY , FRIENDS	11.7%	11.6%	12.4%	11.4%	11.7%	11.7%
OTHER , UNKNOWN	3.6%	2.8%	3.3%	4.7%	3.6%	3.6%

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TREATMENT CENTER - TOTALS
STATE -
REGION -

PERIOD-ENDING MARCH 1977

REPORT III D - INPATIENT SERVICES

AVERAGE DAYS PER CLIENT PER MONTH

	2ND QTR 1976	3RD QTR 1976	4TH QTR 1976	1ST QTR 1977	TWELVE MONTH	ALL CENTERS
EMERGENCY / DETOX CARE	2.2	2.0	2.8	2.0	2.2	2.2
INPATIENT - HOSPITAL	6.8	7.1	7.9	8.2	7.5	7.5
PARTIAL HOSPITAL - INTERMEDIATE	6.1	6.9	.0	.0	6.3	6.3
QUARTERWAY HOUSE - INPT. REHAB.	16.0	13.5	15.1	17.5	15.8	15.8
HALFWAY HOUSE - TRANS. RESIDENCE	19.8	19.5	20.8	21.2	20.2	20.2
RESIDENTIAL CARE	27.0	27.5	22.6	28.3	26.4	26.4
DROP-IN UNIT	.0	.0	4.6	.0	4.6	4.6

AVERAGE NUMBER OF CLIENTS PER MONTH

	2ND QTR 1976	3RD QTR 1976	4TH QTR 1976	1ST QTR 1977	TWELVE MONTH	ALL CENTERS
EMERGENCY / DETOX CARE	359.0	329.3	272.0	261.3	305.4	305.4
INPATIENT - HOSPITAL	309.7	341.7	296.3	322.7	317.6	317.6
PARTIAL HOSPITAL - INTERMEDIATE	24.0	10.3	.0	.0	8.6	8.6
QUARTERWAY HOUSE - INPT. REHAB.	18.0	18.7	32.0	37.3	26.5	26.5
HALFWAY HOUSE - TRANS. RESIDENCE	444.3	341.7	301.0	307.7	348.7	348.7
RESIDENTIAL CARE	10.7	10.3	6.3	3.3	7.7	7.7
DROP-IN UNIT	.0	.0	2.3	.0	.6	.6

REPORT III E - OUTPATIENT SERVICES

AVERAGE CLIENT HOURS PER MONTH

	2ND QTR 1976	3RD QTR 1976	4TH QTR 1976	1ST QTR 1977	TWELVE MONTH	ALL CENTERS
EMERGENCY / DETOX CARE	20	3	28	2		16
MEDICAL MAINTENANCE	2	2	1	2		2
INDIVIDUAL COUNSELING	2	2	2	2		2
INDIVIDUAL THERAPY	2	3	3	2		2
GROUP COUNSELING	4	5	5	6		5
GROUP THERAPY	4	5	4	4		4
FAMILY COUNSELING / THERAPY	2	2	2	2		2
VOCATIONAL REHABILITATION	2	1	57	3		12
SOC., OCC., REC. THERAPY	6	7	5	5		6
FAMILY / COLLATERAL SERVICES	3	3	4	4		3
CASE CONSULTATION	1	1	1	1		1

TREATMENT CENTER - ALL CENTERS PERIOD ENDING - MARCH 1977

REPORT III E - OUTPATIENT SERVICES (CONT D.)

AVERAGE NUMBER OF CLIENTS PER MONTH

	2ND QTR 1976	3RD QTR 1976	4TH QTR 1976	1ST QTR 1977	TWELVE MONTH	ALL CENTERS
EMERGENCY / DETOX CARE	2	1	2	/ 2		2
MEDICAL MAINTENANCE	60	37	47	77		55
INDIVIDUAL COUNSELING	2,354	2,264	2,363	2,426		2,352
INDIVIDUAL THERAPY	27	8	12	23		18
GROUP COUNSELING	547	522	570	633		568
GROUP THERAPY	9	16	54	62		35
FAMILY COUNSELING / THERAPY	193	199	188	169		187
VOCATIONAL REHABILITATION	1	1	1	2		1
SOC., OCC., REC. THERAPY	25	11	16	7		15
FAMILY / COLLATERAL SERVICES	503	457	460	489		477
CASE CONSULTATION	583	556	625	700		616
% CLIENTS TAKING ANTABUSE	13.2%	10.9%	10.1%	9.5%		10.9%

TREATMENT CENTER - TOTALS
STATE -
REGION -

PERIOD ENDING - MARCH 1977

REPORT III F - REFERRALS OUT OF CENTER

DURING TREATMENT

	2ND QTR 1976	3RD QTR 1976	4TH QTR 1976	1ST QTR 1977	TWELVE MONTH	ALL CENTERS
NUMBER OF REFERRALS	4,037	3,752	3,299	3,108	0	14,196
PERCENT DISTRIBUTION						
HOSPITALS CMHCS M.D.	008.8%	008.7%	007.8%	008.0%	000.0%	008.4%
A.A.	075.9%	076.3%	075.5%	080.1%	000.0%	076.8%
OTHER ALCOHOLISM PROGRAMS	001.6%	002.3%	002.5%	006.0%	000.0%	003.0%
VOC. REHAB., SOCIAL OR COMMUNITY	006.8%	007.0%	007.5%	000.0%	000.0%	005.5%
POLICE	003.6%	004.1%	001.8%	001.2%	000.0%	002.8%
EMPLOYER	000.5%	000.7%	001.4%	001.5%	000.0%	001.0%
OTHER, UNKNOWN	002.7%	001.0%	003.5%	003.2%	000.0%	002.6%

TREATMENT CENTER - TOTALS
STATE -
REGION -

PERIOD ENDING - MARCH 1977

REPORT IIIG - SOURCE OF CENTER FUNDS

	2ND QTR 1976	3RD QTR 1976	4TH QTR 1976	1ST QTR 1977	TWELVE MONTH	ALL CENTERS
LOCAL GOVERNMENT	11.5%	19.1%	17.9%	15.0%	.0%	15.7%
STATE GOVERNMENT	17.8%	20.9%	18.7%	24.5%	.0%	20.4%
FEDERAL STAFFING GRANT	6.5%	8.0%	4.8%	4.5%	.0%	6.0%
OTHER FEDERAL FUNDS	8.4%	4.9%	2.4%	3.4%	.0%	4.9%
PATIENT FUNDS	4.1%	4.7%	4.1%	5.2%	.0%	4.5%
PRIVATE INSURANCE	9.6%	11.0%	11.9%	13.8%	.0%	11.5%
MEDICARE AND MEDICAID	1.6%	.7%	2.3%	3.5%	.0%	2.0%
STATE - LOCAL GOVERNMENT FEES	30.6%	25.1%	30.9%	24.9%	.0%	28.0%
PUBLIC ASSISTANCE / OTHER SERVICE	6.8%	3.2%	5.3%	3.5%	.0%	4.7%
FUND RAISING	.0%	1.3%	.1%	.2%	.0%	.4%
OTHER	3.1%	1.1%	1.8%	1.5%	.0%	1.9%
TOTAL GOVERNMENT FUNDS	44.2%	52.9%	43.8%	47.4%	.0%	47.0%
TOTAL SERVICE FEES	52.7%	44.7%	54.5%	50.9%	.0%	50.7%
TOTAL OTHER SERVICES	3.1%	2.4%	1.9%	1.7%	.0%	2.3%

TREATMENT CENTER - TOTALS
STATE -
REGION -

PERIOD ENDING - MARCH 1977

REPORT III H UNIT COSTS FOR CLIENT SERVICES

	2ND QTR 1976	3RD QTR 1976	4TH QTR 1976	1ST QTR 1977	TWELVE MONTH	ALL CENTERS
MEAN MONTHLY EXPENDITURE PER CLIENT	$164	$152	$141	$140	$0	$149
COST PER INPATIENT EMER/DETOX DAY	$102	$127	$75	$106	$0	$102
COST PER INPATIENT HOSPITAL DAY	$42	$38	$41	$45	$0	$42
COST PER PARTIAL HOSPITAL DAY	$99	$98	$0	$0	$0	$93
COST PER QUARTERWAY HOUSE DAY	$22	$11	$11	$7	$0	$12
COST PER HALFWAY HOUSE DAY	$17	$20	$18	$18	$0	$18
COST PER RESIDENTIAL CARE DAY	$100	$29	$51	$48	$0	$58
COST PER DROP-IN DAY	*	*	$244	*	$0	$1,083
COST PER OUTPATIENT VISIT	$19	$18	$18	$17	$0	$18
COST PER OUTPATIENT HOUR	$20	$18	$16	$15	$0	$17

* EXPENSE AND/OR DIRECT HOURS REPORTED WITHOUT SERVICES.
** SERVICES REPORTED WITHOUT EXPENSE AND/OR DIRECT HOURS.

TREATMENT CENTER - TOTALS
STATE -
REGION - 0

PERIOD ENDING - MARCH 1977

REPORT III/M - CLIENT CHANGES

	NUMBER OF CLIENTS	AT INTAKE	60 DAYS AFTER INTAKE	180 DAYS AFTER INTAKE
ABSOLUTE ALCOHOL CONSUMED / DAY (OZS.)	928	3.4	.5	.7
IMPAIRMENT (0-33)	931	8.9	1.6	2.1
DAYS DRANK LAST MONTH	932	14.5	3.6	4.3
DAYS WORKED LAST MONTH	893	14.1	14.1	15.3
INCOME EARNED LAST MONTH	885	$ 511	$ 579	$ 561
UNEMPLOYED (PER CENT)	780	21.9%	13.0%	17.3%
ABSTAINED (PER CENT)	932	12.6%	63.6%	59.7%

APPENDIX IV

ALLOCATIONS TO COMMUNITY ALCOHOLISM SERVICE CENTERS FOR FY '78
BY
THE IOWA COMMISSION ON ALCOHOLISM

Agency Name	Community	Formula Funds	State	Title XX	Total
Northeast Iowa Mental Health Center	Decorah	$ 32,750	$ 15,000	$23,250	$ 71,000
Alcoholism Coordinating Center	Mason City	30,000	48,000	21,600	99,600
Northwest Iowa Alcoholism Treatment Unit	Spirit Lake	26,500	15,000	22,500	64,000
Siouxland Council on Alcoholism	Sioux City	61,850	100,000	21,150	183,000
The Midwest Iowa Alcohol And Drug Abuse Center	Onawa	33,000	5,000	- 0 -	38,000
North Central Alcoholism Research Foundation	Fort Dodge	40,000	28,000	31,950	99,950
Alcoholism Treatment Unit of Central Iowa	Marshalltown	42,890	- 0 -	- 0 -	42,890
Northeast Council on Alcoholism	Waterloo	40,000	58,750	23,250	122,000
Minority Alcoholism Action Program	Waterloo	40,000	- 0 -	- 0 -	40,000
Tri-County Citizens' Committee on Alcohol and Drug Abuse	Dubuque	24,215	80,000	- 0 -	104,215
Scott County Alcoholism Research Foundation	Davenport	42,089	80,000	24,862	146,951
New Directions, Inc.	Clinton	38,000	30,000	- 0 -	68,000
Citizens' Committee on Alcohol and Drug Abuse	Cedar Rapids	37,500	40,000	37,500	115,000
Mid-Eastern Community Council on Alcoholism	Iowa City	25,000	30,700	- 0 -	55,700
Lakeside Foundation	Cedar Rapids	18,000	- 0 -	- 0 -	18,000
Central Iowa Alcoholism Center	Des Moines	100,000	98,000	60,000	258,000
Regional Alcoholism Center, Inc.	Ames	- 0 -	73,000	- 0 -	73,000
National Council on Alcoholism	Des Moines	58,480	- 0 -	- 0 -	58,480
Native American Project on Alcoholism	Des Moines	37,000	- 0 -	- 0 -	37,000
Inner Urban Alcohol Program	Des Moines	10,000	20,000	- 0 -	30,000
Central Iowa Foundation on Alcoholism	Newton	- 0 -	34,500	- 0 -	34,500
Area XII Alcoholism and Drug Treatment Unit	Jefferson	20,000	34,241	21,750	75,991

ALLOCATIONS cont'd
Page 2

Agency Name	Community	Formula Funds	State	Title XX	Total
River Bluffs Alcoholism Service Center	Council Bluffs	$ 34,000	$ 30,500	$22,500	$ 87,000
Alcohol Assistance Agency	Atlantic	32,750	10,000	17,250	60,000
Southern Iowa Economic Development Association Alcoholism Project	Ottumwa	30,000	45,000	30,187	105,187
Southeast Iowa Council on Alcohol and Drug Problems	Burlington	109,450	24,300	17,250	151,000
Mental Health Institute	Independence	12,000	- 0 -	- 0 -	12,000
Department of Public Instruction	Des Moines	40,000	- 0 -	- 0 -	40,000

APPENDIX V

IOWA DIVISION ON ALCOHOLISM

BUDGET

ADMINISTRATION

	STATE	FEDERAL	TOTAL
DIRECTOR	16,203	12,371	28,574
ASST. DIRECTOR	10,696	8,648	19,344
SECRETARY II	4,997	3,999	8,996
FRINGE BENEFITS	3,979	5,036	9,015
TRAVEL	6,000		6,000
OFFICE SUPPLIES & EXPENSE	2,000		2,000
PRINTING & BINDING	1,000		1,000
TELEPHONE	1,500		1,500
DUES	625		625
	47,000	30,054	77,054

STATE	47,000
FEDERAL	30,054
	77,054

DEVELOPMENT AND TRAINING OPERATIONS

SALARIES	
Prevention Coordinator	$ 14,794.00
Health Planner II	17,550.00
Accountant II	13,624.00
Technical Assistant	14,233.00
Technical Assistant	14,233.00
Analyst/Programmer	14,794.00
Secretary I	7,956.00
Clerk Steno III	8,268.00
Clerk II	6,318.00
FRINGE BENEFITS	17,704.00
STATE TRAVEL	7,000.00
SUPPLIES	12,000.00
Office Supplies Other Supplies Publications Printing & Binding	
TELEPHONE & TELEGRAPH	6,000.00
EQUIPMENT	500.00
OFFICE SPACE	8,500.00
STAFF DEVELOPMENT & TRAINING	8,000.00
ADVISORY COUNCIL TRAVEL	1,500.00
	$172,974.00
INCIDENCE & PREVELANCE STUDY	50,000.00
TREATMENT CENTERS	439,491.00
STATE DATA PROCESSING	38,400.00
ADMINISTRATION-BROUGHT FORTH	30,054.00
	$730,919.00

END