Module 1

Center for the Application of Prevention Technologies

763-427-5310 or 800-782-1878

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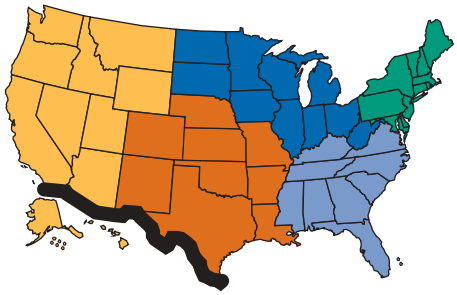
Regional Map



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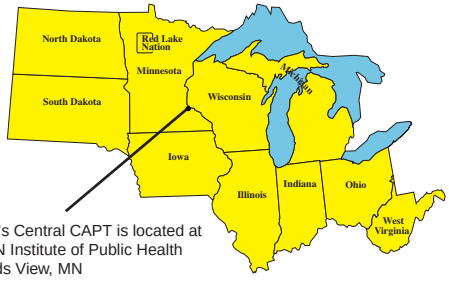
Central CAPT Region



CSAP's Central CAPT is located at the MN Institute of Public Health Mounds View, MN

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CAPT Mission Statement

To bring research to practice by assisting state/jurisdictions and community-based organizations in the application of the latest research-based knowledge to their substance abuse prevention program, practices, and policies.

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CAPT Core Prevention Services

- Repackage, transfer and replicate science-based prevention program models.
- Customize, repackage and transfer scientifically defensible prevention best practices.
- Customize, repackage and transfer scientifically defensible prevention promising approaches.

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WELCOME TO

Substance Abuse Prevention Specialist Training

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Expectations?

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Agenda

1. Introduction, History and Overview of Drugs and Prevention
2. Prevention Research
3. Prevention Program Planning
4. Evaluation
5. Using Human Development in Prevention
6. The Cultural Context and Ethics of Prevention
7. Prevention and the Media
8. Applying Prevention to the Community
9. Bringing it all Together

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Ground Rules

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Parking Lot

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Introduction

Why introduction and overview of drug prevention?

- To begin to get to know each other.
- To review history which allows us to build on our existing knowledge base and avoid ineffective and harmful practices.
- To provide an overview of the substance abuse prevention field toward an understanding of its evolution.

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Attitudes About Drugs

What attitudes about drugs did you grow up with?

How did those attitudes affect and influence your role as a prevention professional?

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Attitudes About Drugs

- No matter how knowledgeable or competent we become as prevention professionals, our work is invariably influenced by the attitudes we grew up with.
- It's important that we become aware of those attitudes.
- It is also important that we explore and challenge those attitudes which may be counterproductive.

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Viewpoints of Prevention

1. Read the *Viewpoint of Prevention* that was assigned to you. The worksheet may be found on p. 1.23 and p. 1.24.
2. Hold a group discussion representing your assigned viewpoint and express your viewpoint to the group.
3. Discuss the question: "What do you think is the best way to address the problem of drugs?"
4. You have 15 minutes.

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Viewpoints of Prevention

1. Did your group reach consensus?
2. How difficult was it to represent a different point of view?
3. What insights did you get from listening to other people, as well as to yourself?
4. Why do you think it's important for prevention professionals to be familiar with points of view that you may consider illogical, prejudiced, despicable, or absurd?

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Drugs of Abuse–

Classifications

- Central Nervous System Depressants
- Opiates/Opioids
- Central Nervous System Stimulants
- Hallucinogens
- Cannabinoids
- Inhalants
- Anabolic Steroids

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Central Nervous System Depressants

- Alcohol
- Sedative Hypnotics
  - Barbiturates (Seconal, Nembutal, Amytal)
  - Benzodiazepines (Valium, Xanax)
  - GHB and GBL (club drugs, date-rape drugs)
- Over-the-counter drugs
  - Nytol
  - Sominex

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Opiates/Opioids

- Heroin
- Morphine
- Codeine and Hyrodrocodone
- Methadone
- Demerol
- Percodan
- Vicodin
- Oxycontin

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Central Nervous System Stimulants

- Nicotine
- Caffeine
- Cocaine
- Crack Cocaine
- Amphetamines
- Nonamphetamine Stimulants
  - Ephedra

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Hallucinogens

- PCP
- LSD
- Peyote
- Psilocybin
- MDMA
- Ketamine

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Cannabinoids

- Marijuana
- Hashish
- Hashish oil
- Charas
- Ganja
- Bhang

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Inhalants

- Volatile Solvents
  - Gasoline
  - Paint thinner
- Aerosols and
  - Household cleaning products
  - Model cement glue
- Gases
  - Butane
  - Nitrous Oxide
- Volatile Nitrites
  - Amyl nitrite (poppers)

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Steroids

- Depo-Testosterone
- Durabolin
- Danocrine
- Halotestin

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Setting Guidelines for Substance Use and Nonuse

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Healthful Use of Substances

Examples:

- Appropriate use of prescribed medications
- Occasional, moderate and legal use of alcohol
- Abstinence from alcohol use for personal, religious or health reasons

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Substance Use/Abuse Problems

Examples:

- Impaired or intoxicated driving
- Family, group, or team tension due to use
- Underage drinking and other legal problems
- Chemical dependency
- Harm to developing fetus
- Smoking or use of smokeless tobacco

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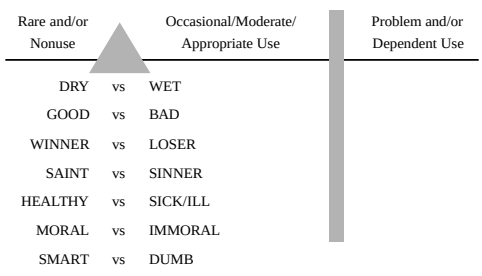
Continuum of Alcohol Nonuse and Use



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What Can We Say

1. Abstinence is a safe and acceptable lifelong decision that many young people are choosing.
2. We do not want you to use alcohol before you are legally allowed to do so, and we do not want you to use illegal drugs at all.
3. Abstinence can be a lifelong decision. However, when you are an adult and if you choose to use alcohol, we want you to know how to do so legally, safely and appropriately.

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Benefits of Nonuse for Adolescents

1. The risks of experiencing alcohol-related problems are greatly reduced.
2. Life skills can develop fully.
3. Performance in many areas is best when free of the influences of alcohol or other drugs.
4. Physical, emotional, social and spiritual development can occur normally and naturally.
5. Relationships can develop honestly and be based on mutual interests.

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SITUATIONS WORKSHEET

Situations that involve actual or intended use of alcohol, tobacco and other drugs are described below. For each situation, choose the **words** that you feel best describe the use. Choose no more than three words per situation. You will be asked to share your responses in a small group.

Healthy	**Wise**	**Legal**	**Appropriate**	**Responsible**	**Low Risk**	**Good**	**Necessary**
Unhealthy	**Foolish**	**Illegal**	**Inappropriate**	**Irresponsible**	**High Risk**	**Bad**	**Unnecessary**

1. A women who is four months pregnant has a glass of wine to relax after a particularly stressful day at work. _____
2. A 15-year-old boy uses steroids to help increase muscle mass. _____
3. A person enjoys watching the evening news and having a drink before going to bed. _____
4. A 16 year-old girl has a glass of wine with the family at home. _____
5. A person has a couple of beers nightly to help get to sleep. _____
6. Two team members share a 12 pack after their softball game. _____
7. A teacher joins several parents at a local bar after a ball game. _____
8. A person likes to have a beer after mowing the lawn on a hot day. _____
9. Wine is served to school-aged young people as part of a religious ceremony. _____
10. A person enjoys sharing a joint on a weekend with friends. _____
11. Parents make beer available to everyone attending their child's high school graduation party. _____
12. After their shift on Friday, several members of a crew gather for a few drinks at a nearby bar. _____
13. To conclude their date, a couple returns to his place to share a few drinks. _____
14. A person lights up a cigarette without asking nonsmokers if it bothers them. _____
15. Two parents have a beer with the youth team they coach, as the team celebrates with soft drinks after a win. _____
16. Parents include a cooler with beer for a family boating trip. _____

Discussion Questions:

1. Was it easy to choose words that describe each situation?
2. What were the criteria or guidelines that you used to decide whether the use was appropriate, inappropriate, etc.?

Suggested Guidelines

1. The use of alcohol is a personal choice. No one should be pressured to drink or not to drink, or made to feel uneasy or embarrassed because of a personal choice.
2. Alcohol use is not essential for the enjoyment of family or social events or for celebrating success.
3. Illegal drug use has specific health, legal and ethical risks and should be avoided and discouraged.
4. There are times when it is important for everyone to abstain from alcohol or other drug use.
5. Use of alcohol that leads to impairment or intoxication is unhealthy, risky and should be avoided and discouraged.

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Suggested Guidelines (cont'd)

6. Tobacco use has significant risks and should be avoided and discouraged.
7. Medications should only be used as prescribed or according to directions.
8. There are personal limits of moderation for anyone who chooses to use alcohol.
9. There are ways to minimize health and safety risks when serving alcohol.
10. Avoid situations where someone else's alcohol, tobacco or other drug use may put you at risk.

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Suggested Guidelines Worksheet

As individuals, parents and families, our risk for developing a substance abuse problem is directly related to our ability to establish and follow guidelines for safe, legal and appropriate use or nonuse of alcohol and other drugs. Listed below are some suggestions for setting both personal and group guidelines. Please read through the information in **bold** type and then you will be asked to discuss the questions in a small group.

Suggested Guidelines

1. **The use of alcohol is a personal choice. No one should be pressured to drink or not to drink, or made to feel uneasy or embarrassed because of a personal choice.**

   a) In what kinds of situations do adults feel pressure to use or not use alcohol?
   b) Is the pressure any different for young people?
   c) How might a family history of alcoholism influence personal choices?

2. **Alcohol use is not essential for the enjoyment of family or social events or for celebrating success.**

   a) What does "not essential" mean?
   b) Do you agree with this guideline? Why or why not?

3. **Illegal drug use has specific health, legal and ethical risks and should be avoided and discouraged.**

   Examples include:
   - Dosage is unpredictable
   - Purity is unpredictable
   - Criminal record

   a) What drugs are illegal?
   b) What are their risks?
   c) Is it ever appropriate to use an illegal drug?

4. There are times when it is important for everyone to abstain from alcohol or other drug use.

Examples include:

- when recovering from chemical dependency;
- when the alcohol or other drug use is illegal;
- when pregnant or nursing;
- when operating equipment—motor vehicles, motorcycles, boats, tools, firearms, etc.;
- when swimming, skiing, climbing, or doing other risky physical activities;
- when at work or studying;
- when performing in athletics or fine arts; and
- when taking certain medications.

a) What effects of alcohol make this guideline important?
b) Do you agree that people should abstain at these times?
c) What would you say to someone who is pregnant and drinking? Pregnant and smoking? Using steroids? Swimming and drinking? Smoking marijuana while studying? Drinking and about to drive? Under the legal drinking age?
d) Are there other times when it is important to abstain?

5. Use of alcohol that leads to impairment or intoxication is unhealthy, risky and should be avoided and discouraged.

a) What level of drinking is socially acceptable? Is drunkenness ever socially acceptable?
b) Are there circumstances in which excessive drinking is tolerated in your community?
c) Do you think people generally agree with this standard?
d) Should drunkenness be considered irresponsible? Indicative of personal problems? A normal part of life? Humorous?
e) Is there anything wrong with laughing at people who are drunk?

6. Tobacco use has significant risks and should be avoided and discouraged.

a) Are you comfortable asking someone to refrain from smoking in your presence?
b) Do you think people believe that using smokeless tobacco is low risk behavior?

7. Medications should only be used as prescribed or according to directions.

a) Do you think people ever share prescription medications?

8. There are personal limits of moderation for everyone who chooses to use alcohol.

Factors that influence the effects of alcohol include:

- gender;
- weight;
- time between drinks;
- strength and number of drinks;
- food intake;
- age;
- emotional state.

a) How do these factors influence personal limits?
b) What are the gender differences that can affect personal limits of moderation?
c) How can you help someone establish personal limits of moderation?

9. There are ways to minimize health and safety risks when serving alcohol.

Examples include:

- Emphasize friendship, conversation and other activities rather than drinking;
- Offer a variety of attractive nonalcoholic drinks that are easily available;
- Provide a variety of foods;
- Serve all drinks to guests rather than having an open bar;
- Inform guests whether or not beverages such as punch contain alcohol;
- Stay alert and assume responsibility for helping a guest who may have had too much to drink;
- Create an environment that allows guests to feel comfortable making a personal choice about alcohol use or nonuse.

a) How can nonalcoholic drinks be made to appear attractive?
b) What kinds of activities can reduce the emphasis on alcohol use?
c) What steps can be taken to help guests feel comfortable?
d) Should the person(s) holding social events be responsible for seeing that alcohol, if used, is used legally, moderately and safely?

10. Avoid situations where someone else's alcohol, tobacco or other drug use may put you at risk.

Examples include:

- Not riding with an impaired or intoxicated driver;
- Using seat belts at all times to protect both drinkers and non-drinkers against being injured or killed in an alcohol-related crash;
- Exercising caution in unfamiliar environments;
- Recognizing and avoiding high risk sexual situations.

10. (cont'd)

a) *What common situations where alcohol, and other drugs are used may put you or a family member at risk?*
b) *What actions can you take to advise your child or young people about risky situations regarding alcohol?*
c) *Are you comfortable telling an impaired driver that you will not ride with him/her?*
d) *Do you always wear a seat belt and insist that family members do the same?*

The need for guidelines about alcohol and other drug use is clear and the responsibility for establishing and following them is shared by all of us. Parents, teachers, clergy, law enforcement, coaches and other adults all have a role to play. We can affirm the right of adults to drink alcohol safely and wisely. We can share our concerns with those who drink or use other drugs illegally or inappropriately. We can support those who choose not to drink. We can be compassionate to those whose lives have been affected by alcoholism and other drug-related problems. Lastly, we can encourage discussions about alcohol use and be role models for healthy and appropriate choices about whether, when and how to drink.

Personal Guidelines Worksheet

What are your personal guidelines for choices about alcohol, tobacco and other drug use? Use the space below to describe your personal guidelines.

We have found it to be helpful to make a personal commitment to follow one's personal guidelines and discuss them with a close friend, spouse, or family member.

Who will you talk to about your guidelines?

When will you talk with this person?

Family Guidelines Worksheet

What guidelines about alcohol, tobacco and other drug use do you want to establish with your family? Use the space below to describe your family guidelines.

We have found it to be helpful to make a commitment to discuss family guidelines with other family members.

Who will you include in your guidelines discussion?

When will you have the discussion?

VIDEO:

SEE IT SAY IT,

SIX STEPS

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Gateway Drugs

- Gateway drugs are the most common drugs of first use among youth– (tobacco and alcohol and in some communities inhalants and marijuana)
- Effective prevention professionals need to be familiar with which substances are being abused in their communities
- Gateway drugs claim more lives than all other drugs combined

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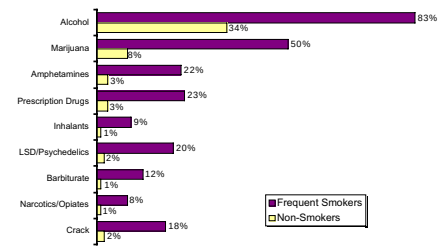
Frequent Smokers and Non-Smokers

Any substance Use in Past 30 Days

2001 Minnesota Student Survey

12th Grade Students



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Discussion Questions

1. How has the history of drugs in America contributed to current attitudes about drugs?
2. Why do you think some drugs are seen as more acceptable, while others are considered unacceptable in our society?
3. Why do you think our efforts at prevention have not eliminated drug use by adolescents?

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Supply Reduction

Any method used to reduce the availability of drugs. Examples: confiscation of drug shipments, destruction of crops, criminal penalties for possession and distribution

Demand Reduction

Any method used to reduce the demand for drugs. Examples: assessment and treatment services, prevention curricula in schools, sobriety support services

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A Timeline of Prevention

1. Read the worksheet, *A Timeline of Prevention*, found on p. 1.38-1.39.
2. Answer the following questions:
   - Which philosophies of prevention have been prominent in our history?
   - Do you feel we have or have not learned from our mistakes?
   - How have our attitudes toward drugs affected alcohol and other drug policies?

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Evolution and Training of the Prevention Discipline

- Scientific Theory Base
- Verified Methods
- Accountability for Service Effectiveness
- Academic Coursework or Degree
- Formal Training or Internship
- Code of Ethics
- Certification or Licensure

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Building Blocks for Successful Prevention Programs

- The program is based on sound theory and uses practices grounded in research.
- The program is systematically planned and assessed.
- The program is facilitated by knowledgeable and competent staff.
- The program is sensitive to participants from a variety of backgrounds and cultures, and it uses a code of ethics.
- The program is developmentally appropriate.
- The program incorporates the media.
- The program is evaluated.

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Introduction

Why introduction and overview of drugs and prevention?

- To get to know each other a little better
- Looking at history allows us to build on our existing knowledge base and avoid duplicating ineffective and harmful practices
- An overview of the prevention field explains where we have been and where we need to go

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Questions and Discussion
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Viewpoints of Prevention

Represent your viewpoint faithfully in the discussion. You can be flexible—you can even change your mind—but be sure that you at least put forth the point of view described below.

1. The Moral Crusader

You fervently believe that alcoholism and other drug dependence is a sin. People who lapse into addiction are morally flawed and will no doubt go to hell unless they are reformed. It's clear that people who are strong will resist the temptations of drugs and will follow the righteous path.

The key to prevention is warning and redeeming: warning people not to be tempted by the evil of drugs and redeeming those who have fallen under the spell and wish to rejoin society.
The question you want answered: If it's bad to use drugs—and it's obviously bad—why shouldn't we try to get everyone on the straight and narrow and throw the ones who refuse in prison?

2. The Socioeconomic and Ethnic Chauvinist

Everything you've seen leads you to believe that alcoholism and other drug dependence is a malady of the poor and nonwhite. These people use drugs to escape from their miserable existences and continue the cycle of their poverty. They use drugs because they don't know any better and they perpetuate their travails by becoming dependent.

The key to prevention is isolation: keeping addiction in the ghettos and not letting it spread to the middle and upper classes.
The question you want answered: What's wrong with doing a little triage—cutting off the people who have willingly sold themselves out and trying to protect the rest of us?

3. The Doctor

Addiction is clearly a disease. People who are drunk, high or otherwise under the influence of drugs need to be cleansed of the substance within them. You no more tolerate the resistance of the addicted patient than you would tolerate the resistance of a tubercular patient.

The key to prevention is removal: getting drugs out of patients and getting drugs out of society.
The question you want answered: Why don't we just set up treatment facilities around the country and help those afflicted?

4. The Scare Monger

People just don't understand the consequences of using drugs. You can overdose, you can become a drunk, you can get in a fatal car accident, lose your mind and so on. If people only realized what horrible things could befall them if they used drugs, they'd keep far away.

The key to prevention is fear: showing people as graphically as possible the lurid consequences of drug use.
The question you want answered: Why should we hold back on showing people just how horrible using drugs is?

5. The Educator

We live in an enlightened age in which knowledge is power. If people use drugs, it's only because they're not familiar with them. Once they know what all the drugs are, how they affect the mind and body and some of the history behind different kinds of drugs, they won't be interested in trying them.

The key to prevention is knowledge: giving people as much information as possible about drugs and drug use.
The question you want answered: Why shouldn't we trust people's innate intelligence and give them all the facts so they can make a safe and healthy decision about drugs?

6. The Blamer

The reason we're in such a sorry state is because some people aren't pulling their weight. Parents are bringing up their kids too leniently. Schools aren't setting good examples. Television, movies and music are replete with unhealthy role models. And politicians are bought off by the big tobacco and alcohol corporations.

The key to prevention is accountability: making sure that everyone toes the line about the harmfulness of drugs. **The question you want answered:** Why can't we get tougher laws that will hold parents, schools, media and politicians to their commitments about drug abuse?

Historical Overview of Prevention

Alcoholic beverages have been a part of the Nation's past since the landing of the Pilgrims. According to *Alcohol and Public Policy: Beyond the Shadow of Prohibition*, a publication commissioned by the National Institute on Alcohol Abuse and Alcoholism (NIAAA) and prepared by the National Academy of Sciences, the colonists brought with them from Europe a high regard for alcoholic beverages, which were considered an important part of their diet. Drinking was pervasive because alcohol was regarded primarily as a healthy substance with preventive and curative powers, not as an intoxicant. Alcohol was also believed to be conducive to social as well as personal health. It played an essential role in rituals of conviviality and collective activity, such as barn raisings. While drunkenness was condemned and punished, it was viewed only as an abuse of a God-given gift.

The first temperance movement began in the early 1800's in response to dramatic increases in production and consumption of alcoholic beverages, which also coincided with rapid demographic changes. Agitation against ardent spirits and the public disorder they spawned gradually increased during the 1820's In addition, inspired by the writings of Benjamin Rush, the concept that alcohol was addicting and that this addiction was capable of corrupting the mind and the body, took hold. The American Society of Temperance, created in 1826 by clergymen, spread the anti-drinking gospel. By 1835, out of a total population of 13 million citizens, 1.5 million had taken the pledge to refrain from distilled spirits. The first wave of the temperance movement (1825 to 1855) resulted in dramatic reductions in the consumption of distilled spirits, although beer drinking increased sharply after 1850.

The second wave of the temperance movement occurred in the late 1800's with the emergence of the Women's Christian Temperance Movement, which, unlike the first wave, embraced the concept of prohibition. It was marked both by the recruitment of women into the movement and the mobilization to close down saloons. The movement set out to remove the destructive substance, and the industries that promoted its use, from the country. The movement held that while some drinkers may escape problems of alcohol use, even moderate drinkers flirted with danger.

The culmination of this second wave was the passage of the 18th Amendment and the Volstead Act, which took effect in 1920. While Prohibition was successful in reducing per capita consumption and some problems related to drinking, its social turmoil resulted in its repeal in 1933.

Since the repeal of Prohibition, the dominant view of alcohol problems has been that alcoholism is the principal problem. With its focus on treatment, the rise of the alcoholism movement depoliticized alcohol problems as the object of attention, as the alcoholic was considered a deviant from the predominant styles of life of either abstinence or "normal" drinking. The alcoholism movement is based on the belief that chronic or addictive drinking is limited to a few, highly susceptible individuals suffering from the disease of alcoholism.

The disease concept of alcoholism focuses on individual vulnerability, be it genetic, biochemical, psychological or social/cultural in nature. Under this view, if the collective problems of each alcoholic are solved, it follows that society's alcohol problem will be solved.

Nevertheless, the pre-Prohibition view of alcohol as a special commodity has persisted in American society and is an accepted legacy of alcohol control policies. Following Repeal, all States restricted the sale of alcoholic beverages in one way or another in order to prevent or reduce certain alcohol problems. In general, however, alcohol control policies disappeared from the public agenda as both the alcoholism movement and the alcoholic beverage industry embraced the view, "the fault is in the man and not in the bottle."

This view of alcoholism problems has also been the dominant force in contemporary alcohol problem prevention. Until recently, the principal prevention strategies focused on education and early treatment. Within this view, education is intended to inform society about the disease and to teach people about the early warning signs so that they can initiate treatment as soon as possible. Efforts focus on "high-risk" populations and attempt to correct a suspect process or flaw in the individual, such as low self-esteem or lack of social skills. The belief is that the success of education and treatment efforts in solving each alcoholic's problem will solve society's alcohol problem as well.

Contemporary alcohol problem prevention began in the 1970's as new information on the nature, magnitude and incidence of alcohol problems raised public awareness that alcohol can be problematic when used by any drinker, depending upon the situation. There was a renewed emphasis on the diverse consequences of alcohol use—particularly trauma associated with drinking/driving, fires and violence, as well as long-term health consequences.

The history of nonmedical drug use and the development of policies in response to drug use, also extends back to the early settlement of the country. Like alcohol, the classification of certain drugs as legal or illegal has changed over time. These changes sometimes had racial and class overtones. According to Mosher and Yanagisako, for example, Prohibition was in part a response to the drinking practices of European immigrants, who became the new lower class. Cocaine and opium were legal during the 19th century and were favored drugs among the middle and upper classes. Cocaine became illegal after it became associated with African Americans following Reconstruction. Opium was first restricted in California in 1875 when it became associated with Chinese immigrant workers. Marijuana was legal until the 1930's, when it became associated with Mexicans. LSD, legal in the 1950's, became illegal in 1967 when it became associated with the counterculture.

By the end of the 19th century, concern had grown over the indiscriminate use of these drugs, especially the addicting patent medicines. Cocaine, opium and morphine were common ingredients in various potions sold over the counter. Until 1903, cocaine was an ingredient of Coca-Cola®. Heroin, which was isolated in 1868, was hailed as a non-addicting

treatment for morphine addiction and alcoholism. States began to enact control and prescription laws, and in 1906 Congress passed the Pure Food and Drug Act. It was designed to control opiate addiction by requiring labels on the amount of drugs contained in products, including opium, morphine and heroin. It also required accurate labeling of products containing alcohol, marijuana and cocaine.

The Harrison Act (1914) imposed a system of taxes on opium and coca products with registration and record-keeping requirements in an effort to control their sale or distribution. However, it did not prohibit the legal supply of certain drugs, especially opiates.

Current drug laws are rooted in the 1970 Controlled Substances Act. Under this measure, drugs are classified according to their medical use, their potential for abuse and their likelihood of producing dependence. The act contains provisions for adding drugs to the schedule and rescheduling drugs. It also establishes maximum penalties for the criminal manufacture or distribution of scheduled drugs.

Increases in per capita alcohol consumption as well as increased use of illegal drugs during the 1960's raised public concern regarding alcohol and other drug problems. Prevention issues gained prominence on the national level with the creation of the National Institute on Alcohol Abuse and Alcoholism (NIAAA) in 1971 and the National Institute on Drug Abuse (NIDA) in 1974. In addition to mandates for research and the management of national programs for treatment, both Institutes included prevention components.

To further prevention initiatives at the federal level, the Anti-Drug Abuse Act of 1986 created the U.S. Office for Substance Abuse Prevention (OSAP), which consolidated alcohol and other drug prevention activities under the Alcohol, Drug Abuse and Mental Health Administration (ADAMHA). The ADAMHA block grant mandate called for states to set aside 20 percent of the alcohol and drug funds for prevention. In a 1992 reorganization, OSAP was changed to the Center for Substance Abuse Prevention (CSAP), part of the new Substance Abuse and Mental Health Services Administration (SAMHSA), retaining its major program areas, while the research institutes of NIAAA and NIDA transferred to NIH.

The Office of National Drug Control Policy (ONDCP) was established by the Anti-Drug Abuse Act of 1988. Its primary objective was to develop a drug control policy that included roles for the public and private sectors to "restore order and security to American neighborhoods, to dismantle drug trafficking organizations, to help people break the habit of drug use, and to prevent those who have never used illegal drugs from starting." In early 1992, underage alcohol use was included among the drugs to be addressed by ONDCP.

Although federal, state and local governments play a substantial role in promoting prevention agendas, much of the activity takes place at grassroots community levels. In addition to funding from CSAP's "Community Partnerships" grant program, groups receive support from private sources, such as the Robert Wood Johnson "Fighting Back" program.

Although alcohol and other drug problems continue to plague the nation at intolerably high levels, progress is being made. National surveys document a decline in illicit drug use and a leveling off of alcohol consumption. And indicators of problem levels, such as alcohol-involved traffic crashes, show significant declines.

UPDATE:
In the 1990's, despite the best efforts of the Federal, State, and Local governments, drug abuse continued to pose serious threats to the health and to the social and economic stability of American communities. However, two hopeful trends have been occurring. The knowledge gained through prevention research (e.g. the results of demonstration projects and program evaluations) has led to the development of formal theories, "best practices," and "promising approaches." And, in the late 1990's, policies, laws, and norms were changed to influence the incidence and prevalence of drug use: Tobacco companies were forced to stop unethical advertising campaigns geared toward teenagers, and many communities increased the price of alcohol and tobacco through excise taxes and passed ordinances prohibiting billboard advertisements by the alcohol industry.

References:
A Promising Future: Alcohol and other Drug Problem Prevention Services Improvement. CSAP Prevention Monograph 10 (1992) BK191

Substance Abuse and Mental Health Services Administration. *Summary of Findings from the 2000 National Household Survey on Drug Abuse.* Office of Applied Studies, NHSDA Series H-13, DHHS Publication No. (SMA) 01-3549. Rockville, MD, 2001.

Mosher, J.F., and Yanagisako, K.L. Public Health, not Social Warfare: A Public Health Approach to Illegal Drug Policy, *Journal of Public Health Policy*, 12(3):278-322, 1991.

Drugs Of Abuse

Drug	Major Effects	Symptoms of Overdose	Possible Effects of Withdrawal	Acute and Chronic Effects
Central Nervous System Depressants • Alcohol (beer, wine, liquor) • Barbiturates (Seconal [reds, red devils], Nembutal [yellows, yellow jackets], Tuinal [rainbows], Amytal [blues, blue heaven], Phenobarbital) • Nonbarbiturate sedative-hypnotics (Doriden [goofballs], Quaalude [ludes], Miltown, Equinil) • Benzodiazepines (Valium, Librium, Dalmane, Halcion, Xanax, Ativan) • Oxycontin • Over-the-counter medications (Nytol, Sominex)	• muscle relaxation • disinhibition • reduction in anxiety • impairment of judgment • impairment of motor coordination • decrease in reflexes • decrease in pulse rate • decrease in blood pressure • slurred speech • staggering • sleep • activate gastric juices	alcohol: • staggering • slurred speech • extreme disinhibition • blackouts • vomiting • possible coma and death Depressants have a synergistic, or potentiation, effect.	• anxiety • irritability • loss of appetite • tremors • insomnia • seizures • fever • rapid heartbeat • elevated blood pressure • hallucinations • death	alcohol: • memory loss • gastritis • esophagitis • ulcers • pancreatitis • cirrhosis of the liver • high blood pressure • weakened heart muscles • damage to fetus other depressants: • family, social, occupational, financial problems • accidents • violence

Drugs of Abuse (cont'd)

Drug	Major Effects	Symptoms of Overdose	Possible Effects of Withdrawal	Acute and Chronic Effects
Opioids • opium • codeine • morphine • heroin ("smack," "horse") • Vicodin • Dilaudid • Percodan • methadone • Darvon • Demerol • Talwin • LAAM	• suppression of pain • constipation • euphoria • sedation • constricted pupils	• slow breathing rate • decreased blood pressure • decreased pulse rate • decreased temperature • decreased reflexes • drowsiness • loss of consciousness • flushing and itching • abdominal pain • nausea • vomiting • death	• running eyes and nose • restlessness • goose bumps • sweating • muscle cramps or aching • nausea • vomiting • diarrhea • drug craving	• death from overdose from injecting opioids • criminal activity • prostitution • malnutrition

Drugs of Abuse (cont'd)

Drug	Major Effects	Symptoms of Overdose	Possible Effects of Withdrawal	Acute and Chronic Effects
Central Nervous System Stimulants • cocaine ("coke," "blow," "toot," "snow") • smokeable forms of cocaine ("crack," "rock," "base") • amphetamines (Benzedrine ["crosstops," "black beauties"], Methedrine ["crank," "meth," "crystal"], Dexedrine) • nonamphetamine stimulants (Ritalin, Cylert, Preludin) • caffeine (in coffees, teas, colas, chocolate, No Doz, Alert, Vivarin) • phenylpropanolamine (in Dexatrim) • nicotine (in tobacco)	• psychomotor stimulation • alertness • euphoria • elevation of mood • increase in heart rate • increase in blood pressure • suppression of appetite • death	• tremors • sweating and flushing • rapid heartbeat • anxiety • insomnia • paranoia • convulsions • heart attack • stroke	caffeine: • chronic headache • irritability • restlessness • anxiety • fatigue • lethargy cocaine and amphetamines: • intense drug craving • irritability • depression • anxiety • lethargy • suicidal ideation and attempts nicotine: • increased anger • hostility • aggression • loss of social cooperation	• heart attacks • strokes • seizures • respiratory depression • strokes • cardiovascular problems • depression • suicide • paranoid schizophrenia • perforation of the nasal septum • malnourishment

Drugs of Abuse (cont'd)

Drug	Major Effects	Symptoms of Overdose	Possible Effects of Withdrawal	Acute and Chronic Effects
Hallucinogen • LSD ("acid," "fry") • psilocybin ("magic mushrooms," "shrooms") • morning glory seeds ("heavenly blue") • mescaline ("mesc," "big chief," "peyote") • STP ("serenity," "tranquility," "peace") • MDMA ("ecstasy") • PCP ("angel dust," "hog") • Ketamine	• altered state of consciousness • increased suggestibility • delusions • depersonalization • dissociation • increase in pulse • increase in blood pressure	• acute intoxication and psychosis, including agitation, confusion, excitement, blank state, violent behavior • coma • analgesia • death "bad" trips of other hallucinogens: • paranoid ideation • depression • undesirable hallucinations • confusion	• drug craving	• flashbacks • increase in heart rate • increase in blood pressure • higher body temperature • dizziness • dilated pupils • sensory distortions • dreaminess • depersonalization • altered mood • impaired concentration • acute anxiety • paranoia • fear of loss of control • delusions

Drugs of Abuse (cont'd)

Drug	Major Effects	Symptoms of Overdose	Possible Effects of Withdrawal	Acute and Chronic Effects
Cannabinoids • marijuana ("grass," "pot," "weed," "joint," "reefer") • hashish • charas	• euphoria • enhancement of taste, touch, and smell • relaxation • increased appetite • altered time sense • impaired immediate recall • increase in pulse rate • increase in blood pressure • bloodshot eyes • dry mouth • impairment of motor skills • slowness of reaction time	• unusual to overdose	• irritability • restlessness • decreased appetite • insomnia • tremor • chills • increased body temperature	acute use: • impairment of ability to drive vehicles chronic use: • suppression of immune system • decrease of hormones
Inhalants and Volatile Hydrocarbons • aerosol sprays, gasoline, kerosene, chloroform, airplane glue, lacquer thinner, acetone, nail polish remover, model cement, lighter fluid, carbon tetrachloride, fluoride-based sprays, metallic paints, typewriter correction fluids • volatile nitrites (amyl nitrite ["poppers"], butyl, isobutyl ["locker room," "rush," "blot," "quick silver," "zoom"]) • nitrous oxide ("laughing gas")	• disinhibition • euphoria • dizziness • slurred speech • unsteady gait • drowsiness • constant involuntary movements of the eyes • giddiness • headaches	• hallucinations • muscle spasms • headaches • dizziness • loss of balance • irregular heartbeat • coma		• loss of consciousness • coma • death from lack of oxygen • brain damage • lung damage • kidney damage • liver damage

Drugs of Abuse (cont'd)

Drug	Major Effects	Symptoms of Overdose	Possible Effects of Withdrawal	Acute and Chronic Effects
Anabolic Steroids • Depo-Testosterone • Durabolin • Danocrine • Halotestin • veterinary anabolic steroids (Finiject 30, Equipoise, Winstrol, Delatestryl, Testex, Maxibolan)	• increase of muscle strength • reduction of body mass • increased aggressiveness, competitiveness, and combativeness		• depression • fatigue • restlessness • insomnia • loss of appetite • decreased interest in sex	• increased risk of coronary artery disease • mood swings • periods of unreasonable and uncontrolled anger and violence males: • atrophy of testicles • impaired production of sperm • infertility • early baldness • acne • enlargement of breasts females: • increase in facial and body hair • lowered voice • irregularity or cessation of menses

Fisher & Harrison, 2000

Suggested Reading

Inaba, D. S., & Cohen, W. E. (2000). *Uppers, downers, all-arounders: Physical and mental effects of psychoactive drugs* (4th ed.). Ashland, OR: CNS Publications.

Setting Guidelines for Alcohol, Tobacco and Other Drug Use

WHAT'S A PERSON TO DO?

The decision whether or not to use alcohol or other drugs is an intensely personal one for which each person is accountable. However, people of all ages need to understand that the consequences of their personal decisions can have an important effect on others. We can make only two reasonable decisions regarding the use of alcohol, tobacco and other drugs:

1. Not to use them at all

2. To use them legally, safely and appropriately

It is important to note that people can experience a variety of problems that result from the inappropriate use of alcohol and other drugs, only one of which is dependency or addiction.

Alcohol is an example of a substance around which there is a great deal of confusion and few generally accepted guidelines for its use. We know that a significant number of people choose to abstain from any alcohol use. There are others who experience alcohol-related problems. Some are alcoholic; others occasionally misuse or abuse alcohol in risky and dangerous ways.

Yet, there is a large percentage of people that are neither abstainers nor problem/dependent drinkers. These people choose to use alcohol legally, occasionally, moderately and safely. By failing to affirm the safe, legal and appropriate use of alcoholic beverages, we have historically created two groups in our society—users and nonusers—and have driven a wedge between them.

One result of this wedge has been the labeling of individuals and their behavior. Nonusers have been referred to as "dry," "winners," "saints," "healthy" and "moral;" users as "wet," "sinners," "losers," "sick" or "immoral." These labels can sometimes be used to appropriately describe behavior associated with problematic or dependent use of alcohol or to describe some behavior associated with nonuse. These labels are *not helpful* in describing the behavior of the legal moderate, occasional and appropriate user. Their alcohol use behavior does not necessarily make them bad or immoral, and they certainly are not all sick or losers. The mere fact that non-users choose not to use alcohol does not necessarily make them saints, moral, healthy or winners. These labels serve as obstacles to open and helpful discussion about the appropriate use and nonuse of alcohol in our society. They interfere with developing clear guidelines for teaching appropriate behavior as well as providing an objective basis for intervening when someone's behavior is risky, unhealthy or inappropriate.

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What is needed is an approach that essentially removes the wedge between users and nonusers, regroups nonusers with moderate, appropriate, occasional users and identifies a clear set of guidelines to determine use that is risky, illegal, inappropriate, unhealthy and possibly dependent. People who follow these guidelines may choose to abstain from alcohol or choose to use it legally, occasionally, moderately and safely. All of these people are demonstrating healthy behavior regarding alcohol.

These guidelines presented on pages 1.43-1.47 can also serve as the basis for intervening with people who are using alcohol in a problematic, unhealthy, dangerous or dependent manner.

What can we say?
What parents and other significant adults say has a substantial effect on the choices young people make about the use and nonuse of alcohol and other drugs, as indicated earlier. One of the most significant influences on alcohol use decisions of young people is the degree to which they think their parents will be upset about their use (Search Institute, 1990). Those who feel their parents will be very upset are much more likely to abstain or use infrequently.

Yet it seems difficult for many parents to know what to say about the use and nonuse of alcohol when talking with their children. Even though over half the adults in this country drink alcoholic beverages, many of them don't know what to tell their children about alcohol and other drug use—even their own sons and daughters. Some fear that if they talk with them about alcohol it will somehow encourage them to drink. Other parents feel that if they drink alcohol it is impossible for them to ask their children to abstain. Even when their use of alcohol is within guidelines for safe, appropriate use, many parents simply do not know what to say, or fear they will do or say the wrong thing.

The result is that many parents simply say nothing or limit their comments to "Don't drink, it's against the law." By saying nothing, parents risk that their children will think that they approve of their drinking or that they don't care. We need to communicate our concern directly, clearly, and frequently from preschool through adulthood. Three messages should come through, loud and clear:

1. *Abstinence is a safe and acceptable lifelong decision that many young people are choosing.*

2. *We do not want you to use alcohol before you are legally allowed to do so, and we do not want you to use tobacco or illegal drugs at all.*

3. *Abstinence can be a lifelong decision. However, if you choose to use alcohol when you are an adult, we want you to know how to do so safely and appropriately.*

These three messages are clear, direct and can be communicated to our children simultaneously.

Preparing Children to Make Adult Choices

Getting a driver's license and obtaining the right to drink are often considered two of the major rites of passage from adolescence to adulthood. Each of these transition points is full of risks for young people. When thinking about preparing our children for adult choices about the use of alcohol, it is helpful to examine how our society prepares young people for each area.

First, driving education/preparation. Our society has established a sequence of events and set of guidelines for getting a driver's license. There is a minimum driving age in each state when a young person is legally able to drive. Classroom driver's education is offered by schools and private agencies to provide an understanding of laws and other information related to driving. Behind-the-wheel instruction is provided so that young people learn the skills necessary to drive. In addition, they are expected to practice driving with a licensed driver, often a parent, during a period of preparation. Then, before receiving a license, young people are required to take both written and skills tests. When written and skills tests are passed, the young person is given a license to drive and enters a world that has agreed on a set of guidelines for safe driving. Perhaps most importantly, those laws, training programs and procedures have received widespread acceptance and respect by adults and young people. In the interest of protecting the safety of individuals and the community, our society has agreed on this set of guidelines. There is even general agreement that when people break a traffic law they should suffer some consequence; a warning, a fine, or loss of driving privileges. Those charged with enforcing these laws attempt to do so consistently and parents rarely allow their unlicensed children to drive cars by themselves.

Typical Steps to a Driver's License

1. Min. driving age
2. Driver's education (classroom)
3. Driver's test (written)
4. Driver's education, behind the wheel
5. Drive with parent or other licensed driver
6. Driver's exam (behind the wheel)
7. LICENSE
8. Clear guidelines for safe driving

Second, drinking education/preparation. Unfortunately, these same conditions do not exist for young people as they confront decisions regarding the use and nonuse of alcohol. Our society has never agreed on a set of guidelines for the use of alcohol. Although our legislators have established a minimum legal drinking age, our inability to support and enforce these laws often defeats their purpose. Young people have no required course of instruction or testing prior to drinking, nor is there a mandatory time period during which they can watch appropriate drinking behavior. Continuing confusion about alcohol has made education programs difficult in many communities. Perhaps most importantly, we have not yet achieved broad scale community acceptance of a set of guidelines for safe and appropriate alcohol use or nonuse. The only prerequisite for a license to drink is one's age.

Typical Steps to a Drinking License

1. Minimum driving age
2. LICENSE
3. Unclear guidelines for low-risk drinking

We would never consider handing a young person car keys when he or she turns 16 without first providing training and guidelines for safe and appropriate use of a car. Just as importantly, we must not automatically open the doors of drinking establishments to our children of legal drinking age without first providing training and guidance. While the choice of abstinence should always be supported, we cannot wait until young people reach the age of 21 to discuss guidelines for the legal, safe, healthy and appropriate use and nonuse of alcohol with them.

A Timeline of Prevention

TIME	NATIONAL PERSPECTIVE	STRATEGY	ACTIVITIES
1950s	Drugs are a problem of the ghetto, used to escape pain and to avoid reality.	Scare tactics	Films and speakers
early 1960s	Drugs are used to escape pain and to avoid reality, but they're more than just a problem of the ghetto.	Scare tactics	Films and speakers
late 1960s	Drugs are used to intensify life, to have psychedelic experiences. Drug use is considered a national epidemic.	information	Films and speakers
early 1970s	A variety of drugs are used for a variety of reasons: to speed up experiences, to intensify experiences, to escape, to expand perceptions to relieve boredom, and to conform to peers.	Drug education	Curricula based on factual information
mid- to late 1970s	Users become more sophisticated and society develops an increasing tolerance of drug use.	Affective education and alternatives to drug use	Curricula based on communication, decision making, values clarification and self-esteem
late 1970s to early 1980s	Parents begin to form organizations that combat the incidence of drug abuse.	Affective education, alternatives to drug use and training	Blaming and cooperation

TIME	NATIONAL PERSPECTIVE	STRATEGY	ACTIVITIES
late 1980s to mid-1990s	Drug use is highly complex.	Partnerships	Research-based curricula, linkages and peer programs
mid-1990s to 2000	The gap between research and application is gradually being bridged.	Replication of research-based models and application of research-based approaches	Environmental approaches, comprehensive programs targeting many domains and strategies, evaluation of prevention programs, media campaigns and culturally sensitive programs

Benefits Of Nonuse For Adolescents

Parent: *Have a good time at the party tonight and remember I don't want you to do any drinking.*
Child: *Okay, but I don't see what the big deal is, you drink beer whenever you*

This dialogue is repeated in homes throughout the country every weekend night. We tell children not to drink alcohol or use other drugs and remind them that they are illegal. Often that's where the conversation ends and our children wonder if there are any real benefits from not using alcohol or other drugs.
Certainly we can tell our children about the risks of alcohol, tobacco and other drug use. We can give clear examples of how use is unhealthy, unnecessary and inappropriate, as well as illegal. However, what can we say about the benefits of nonuse that can help our children delay or avoid the use?

Here are a few suggestions:

1. **The risks of experiencing alcohol related problems are greatly reduced. The person who chooses not to drink, smoke or use other drugs will:**
   - not be troubled by legal problems from underage drinking or other drug use;
   - not become addicted;
   - reduce the risk of involvement in an alcohol, or other drug-related traffic crash;
   - reduce the risk of involvement in an alcohol, or other drug-related swimming or boating accident; and
   - reduce the risk of involvement in a violent act related to the use of alcohol or other drugs.

   Alcohol and other drug use is a major factor in all of these situations.

2. **Life skills can develop fully.**
   The adolescent who chooses to abstain from alcohol, tobacco or other drugs gives himself/herself the best opportunity to develop skills in:
   - stress management;
   - problem solving/decision making;
   - goal setting;
   - conflict resolution; and
   - effective communication.

   Alcohol, tobacco and other drug use can mask problems and interfere with the development of these important life skills.

3. Performance in many areas is best when free of the influence of alcohol, tobacco or other drugs.

When free of the influence of alcohol, tobacco and other drugs, young people can perform a variety of tasks with full judgment and physical skills, such as:

- academic performance;
- athletic performance;
- driving any kind of vehicle;
- using equipment and tools; and
- music or dramatic arts.

Alcohol, tobacco and other drug use can diminish motivation, impair judgment and reduce physical and intellectual performance in many areas.

4. Physical, emotional, social and spiritual development can occur normally and naturally.

The adolescent's goal of maturing toward independence, self-responsibility and a purposeful life is best achieved without the interference of alcohol, tobacco and other drug use.

Examples of benefits include:

- normal physiological and hormonal growth and development;
- normal moral, spiritual and emotional development;
- normal ability to solve typical problems and cope with normal stress; and
- normal ability to interact and get along with others.

Alcohol, tobacco and other drug use can disrupt normal development and actually interfere with maturation.

5. Relationships can develop honestly and be based on mutual interests.

Young people who meet and talk together when sober do not have to be concerned about the effect alcohol or other drugs might have on what they say or what is said to them.

- Morale on teams or groups can be improved.
- Sexual health problems such as unplanned pregnancy, sexually transmitted diseases, including AIDS, sexual assault and rape, will be reduced.
- People are less likely to say or do things to others they might later regret.
- Family standards or parent expectations will be satisfied.
- There is no need to lie to parents or be secretive.

Many relationships have been damaged by the excessive use of alcohol and other drugs.

The benefits to adolescents of not using alcohol, tobacco and other drugs are clear. While none of the suggested benefits alone is likely to persuade young people to delay a decision to use, together they can equip parents and other adults with talking points that go beyond the fact that smoking, drinking alcohol and using other drugs is illegal.

These benefits can be communicated to young people slowly, one at a time, by parents, teachers, prevention specialists, relatives, clergy, employers, coaches, advisors, activity directors and any other adult in the community.

Collectively, the same message by many messengers can be a powerful, positive influence on the choices young people make about alcohol and other drug use.

Suggested Guidelines

Choices about using or abstaining from alcohol, tobacco and other drugs based on a clear set of guidelines will enhance health and reduce the risk of experiencing the wide range of substance abuse problems that some people have experienced.

The following guidelines are suggested to help you think about the use and nonuse of alcohol, tobacco and other drugs.

1. **To use or not use alcohol is a personal choice.**
   Despite the perception that drinking is the norm, no one should feel pressured to drink or uneasy or embarrassed because of a personal choice to abstain. Most people will choose to use alcohol safely, moderately and appropriately. Others will simply have no desire to experience the effects of alcohol. Some people with a family history of chemical dependency or alcoholism may choose not to risk any use of alcohol. The bottom line is that no one should feel that he/she has to drink to be accepted.

2. **Alcohol use is not essential for enjoying social events.**
   The real value of parties and other social activities is being with friends and taking time out from the pressure of school and work. Drinking alcohol should not be seen as a necessary component for having fun and being with friends. If alcohol is used, it can be an enjoyable complement to other activities, not the only reason for socializing. Actually, focusing on alcohol use as the main reason for a party can result in intoxicated people who get sick, cannot carry on a conversation, and generally are not much fun to be with after a while.

3. **Illegal drug use has specific health, legal and ethical risks and should be avoided and discouraged.**
   Examples include:
   - Dosage is unpredictable
   - Purity is unpredictable
   - Criminal record

4. **Know when to abstain from alcohol and other dugs.**
   Examples include:
   - When recovering from chemical dependency
   - When the alcohol or other drug use is illegal
   - When pregnant or nursing
   - When operating equipment—motor vehicles, motorcycles, boats, tools, firearms, etc
   - When swimming, skiing, climbing, or doing other risky physical activities
   - When at work or studying
   - When performing in athletics or fine arts
   - When taking certain medications

Each of these situations presents specific risks and should be times when alcohol and other drug use is avoided.

5. **Drinking that leads to impairment or intoxication is unhealthy and risky.**
   Getting drunk is not a condition to be admired, laughed at, or taken lightly. Rude, destructive, or just plain foolish behavior triggered by alcohol use is socially unacceptable. It may also indicate an alcohol use problem. Drinking games and traditions often result in drunkenness and can present serious risks for those involved.

6. **Tobacco use has significant risks and should be avoided and discouraged.**
   The relationship between tobacco use and increased risk of heart disease and a variety of cancers and lung diseases has been clearly demonstrated. Current research efforts are further identifying the risks of secondhand smoke for nonsmokers. Tobacco is also considered a gateway drug for young people.

7. **Medications should only be used as prescribed or according to directions and never mixed with alcohol.**
   Drugs, both prescription and over-the-counter, should be used only when needed, and all labels and instructions should be read and followed carefully.

8. **Know personal limits of moderation.**
   It is essential that everyone who chooses to drink alcohol knows his/her personal limit of moderation. It is important that each person set a limit before having any alcohol, as judgment can be affected after even a small amount of alcohol intake. For example, the risk of being involved in an alcohol-related traffic crash increases significantly at alcohol concentration levels above .04.

In recent years, the alcohol industry has developed advertising with simple messages about moderation. “Know when to say when,” and “Think when you drink” are examples of slogans that seem to encourage moderation when consuming alcohol. However, neither of these messages offer specific guidelines about the frequency or quantity of alcohol use. Other organizations such as Enjoy Michigan Safety Coalition have developed campaigns that offer more specific advice about if, when, and how much alcohol fits the concept of moderation. The 0-1-3 campaign suggests specific times when alcohol should not be used, offers limits of how much alcohol to consume at any one time, and also suggests a maximum frequency of drinking. The federal government has published *Dietary Guidelines for Americans*, which recommends that if Americans choose to drink alcohol, they should do so in moderation. Moderation is defined as no more than one drink per day for women and no more than two drinks per day for men. Similar to guideline four on page 1.43, the U.S. Dietary Guidelines also suggest that some people should not drink at all.

For more information on the U.S. Dietary Guidelines see: *Dietary Guidelines for Americans*, 2000. 5th Edition. US Department of Agriculture.

Standard Drink

All these drinks contain the same amount of alcohol.

One 5 oz.glass of wine

One 1.5 oz. shot of liquor

One 9 oz. wine cooler

One 12 oz. beer

Concise guidelines such as these offer clear guidance for the general public that, if followed, will reduce the risks of alcohol-related problems. Because these guidelines do not reflect individual differences in weight, age, time spent drinking, and other factors, they are often not completely accepted or followed. Despite criticism from some prevention specialists, alcohol concentration charts can provide guidance about moderation for some people. Alcohol concentration, or AC level, is the amount of alcohol in the blood in relation to other fluids in the body. The more alcohol in your blood, the greater the degree of impairment.

Generally, alcohol is eliminated from the body at the rate of just less than one standard drink per hour, or .015 AC level. However, a variety of other factors may also influence the level of alcohol retained:

Gender. Because of differences in body composition and chemistry, males and females are affected differently by alcohol. Men generally have more muscle and women more fatty tissue per pound. Fatty tissue has a smaller blood supply than muscle tissue, so more of the alcohol goes into the bloodstream. The result is that when a man and woman of equal weight drink equal amounts of alcohol, the AC level will be higher in the woman than in the man.

Body weight. Total body weight and the ratio of body fat to muscle affect the AC level. Lower weight and/or a higher ratio of fat to muscle result in a higher AC level.

Time. The number of hours you have been drinking affects your AC level. Unless you drink less than one standard drink per hour, your AC level will continue to increase over time. The body slowly eliminates the alcohol as follows: oxidation by the liver (95%), breath (2%), urine (2%), and perspiration (1%). The liver's rate of oxidation is constant and cannot be increased by drinking coffee, physical activity, or cold showers.

Strength and quantity of drinks. It does not matter what kind of alcohol you drink—what counts is how much. The table to the left highlights the fact that a 5 oz. glass of wine, a mixed drink with 1.5 oz. of rum, whiskey, gin, vodka, etc., a 9 oz. wine cooler, and a 12 oz. beer all contain the same amount of alcohol. It is very important to be aware that mixed drinks often contain more than 1-1/2 oz.

Food intake. Drinking on an empty stomach can have a greater effect on judgement and behavior than expected. At the same time, although a full stomach will slow down the absorption of alcohol, it is much less important than most people believe.

Age. Age is rarely considered in a discussion of AC levels, yet it is very important since the human body becomes less tolerant with aging. This is due to a gradual change or slowing down of the metabolic rate. The ratio of body fat to muscle also increases with age. The effect of these factors is that the same amount of alcohol intake per body weight consumed by older people can result in higher AC levels, and the effects may last longer.

Age is also a factor for young people. Research shows that adolescents are involved in fatal crashes at significantly lower AC levels than those found in adults. Young people are just developing many adult skills, including driving, and these skills can be negatively affected at lower AC levels than in adults.

Mood. Although one's mood does not directly affect the AC level, the effects of alcohol can be greater than expected when a person is tired, stressed out, angry, lonely or dealing with any other strong emotion.

For those who choose to use alcohol, the Alcohol Concentration Work Sheet on page 1.48-1.49 can help establish limits of safe, moderate and appropriate amounts of alcohol to drink. It is important to remember that, even at very low AC levels, some people will show evidence of decreased performance. There is ample evidence that many persons show impaired judgment at AC levels at or below .04. There is strong evidence that all persons show impaired behavior, including driving performance, at AC levels between .04 and .10.

9. There are ways to minimize health and safety risks when serving alcohol.

Examples include:

- Emphasize friendship, conversation and other activities rather than drinking alcohol.
- Offer a variety of attractive nonalcoholic drinks that are readily available.
- Provide a variety of foods.
- Serve all drinks to guests rather than having an open bar.
- Inform guests whether or not beverages such as punch contain alcohol.
- Stay alert and assume responsibility to help a guest who may have had too much to drink.
- Create an environment that allows guests to feel comfortable making a personal choice about alcohol use or nonuse.

10. Avoid situations where someone else's alcohol, tobacco or other drug use may put you at risk.

Examples include:

- Not riding with an impaired or intoxicated driver.
- Using seat belts at all times to protect both drinkers and nondrinkers against being injured or killed in an alcohol-related crash.
- Exercising caution in unfamiliar environments.
- Recognizing and avoiding high-risk sexual situations.

Summary

Preventing alcohol, tobacco and other drug use problems can begin in very small ways by first examining our own attitudes and guidelines about use and nonuse. The guidelines suggested here can provide a framework within which to examine the use of alcohol, tobacco and other drugs and the use of alcohol as part of family and social events. The need for guidelines about alcohol, tobacco and other drug use is clear and the responsibility for establishing and following them is shared by all of us. We can affirm the right of adults to drink alcohol safely and wisely. We can share our concerns with those who drink, smoke or use other drugs illegally or inappropriately. We can support those who choose not to drink. We can be compassionate to those whose lives have been affected by alcoholism and other drug-related problems. Lastly, we can encourage discussions about alcohol use and be role models for healthy and appropriate choices about whether, when and how much to drink.

Alcohol Concentration Worksheet

To estimate your own personal limit to avoid future problems related to a drinking and driving violation, you can use the following steps to calculate the maximum number of drinks you can have at any time. Remember, in order for this limit to be helpful, you must decide what is low risk drinking before you begin drinking. Research has shown clearly that a person who has started to drink will underestimate his/her alcohol concentration (AC) level.

Step 1: Determine your weight_____.

Step 2: Using the appropriate AC Chart on page 1.49, find the column that is closest to your weight. If your weight is between two columns, use the lower weight column to insure that your calculations will be within limits that are legal and low risk.

Step 3: Read down the column you located in Step 2 that is closest to your weight until you find an AC level of .04. This is the highest AC level you can reach without showing significant impairment of body functions and skills that affect your driving and other behavior.

Step 4: To calculate your AC level subtract the time factor from the figure on the chart to obtain the approximate AC. For example, for a 160 lb. man who has had 4 drinks in two hours, take the figure .09 (from the chart for males) and subtract .03 (from the Time Factor Table) to obtain an AC of .06%

Body Weight: Calculations are for people with a normal body weight for their height, free of drugs or other affecting medication and neither unusually thin nor obese.

Driving: There are two ways to ensure that your AC level does not impair your ability to drive: (1) pace your drinks at a rate that never results in a cumulative AC level of greater than .04 or (2) allow enough time after drinking for the body to eliminate enough alcohol so that the AC level remaining is not greater than .04 before you drive.

The only low risk method is to pace your drinks so you never reach an AC level which will impair your driving. As stated earlier, judgment is one of the first areas impaired by alcohol and once you have exceeded a .04 AC level it becomes increasingly difficult to accurately assess your level of impairment.

If you drink enough alcohol to go beyond an AC level of .04 or higher, the best thing to do is not to drive and find another person to drive you or call a cab. If neither of those options is available, the following Time Factor Table will help you determine when enough alcohol will have been eliminated from your body to reduce your AC level to below .04.

This is extremely important because it is possible for a person who has consumed a large amount of alcohol to stop drinking late at night, sleep for several hours and still have an AC level high enough to significantly impair their driving the next morning.

Step 5: Now calculate the maximum number of drinks you can have without reaching an AC level of .04 in:

1 Hour _____
2 Hours _____
3 Hours _____
4 Hours _____
5 Hours _____

NOTE: Be sure to subtract .015 for each hour after drinking including the first.

TIME FACTOR TABLE

Hours since first drink	1	2	3	4	5	6	7	8
Subtract from AC level	.015	.030	.045	.060	.075	.090	.105	.120

ESTIMATING TABLE FOR WOMEN

	body weight pounds							
Drinks	100	120	140	160	180	200	220	240
0	0	0	0	0	0	0	0	0
1	.05	.04	.03	.03	.03	.02	.02	.02
2	.09	.08	.06	.06	.05	.05	.04	.04
3	.14	.11	.10	.09	.08	.07	.06	.06
4	.18	.15	.13	.11	.10	.09	.08	.08
5	.23	.19	.16	.14	.13	.11	.10	.09
6	.27	.23	.19	.17	.15	.14	.12	.11
7	.32	.27	.23	.20	.18	.16	.14	.13
8	.36	.30	.26	.23	.20	.18	.17	.15

ESTIMATING TABLE FOR MEN

	body weight pounds								
Drinks	100	120	140	160	180	200	220	240	260
0	0	0	0	0	0	0	0	0	0
1	.04	.03	.03	.02	.02	.02	.02	.02	.01
2	.07	.06	.05	.05	.04	.04	.03	.03	.03
3	.11	.09	.08	.07	.06	.06	.05	.05	.04
4	.15	.12	.11	.09	.08	.07	.07	.06	.06
5	.19	.16	.13	.12	.10	.09	.08	.08	.07
6	.22	.19	.16	.14	.12	.11	.10	.09	.09
7	.26	.22	.19	.16	.15	.13	.12	.11	.10
8	.30	.25	.21	.19	.17	.15	.14	.12	.11

How To Have Fun Without Alcohol

America is drinking less and enjoying itself more. We are all looking for ways to be responsible hosts. The Minnesota Prevention Resource Center has published *Non-Alcoholic Party Drinks*, a 35-page recipe book, including hosting tips, from which much of this information sheet was taken. New drinking habits make good sense. Everyone feels, looks, and acts better. Our highways are safer, corporate behavior becomes more professional, and the "morning after" becomes a time to do, not to doze.

The following suggestions, easy to follow at work or at home, lead to healthy, good times with no worries.

1. Focus your event on something fun and creative other than drinking, such as dancing, games or good conversation.

2. Have lots of nonalcoholic drinks (or mixers) available. And don't bury them in the back of the refrigerator.

3. Prepare some snazzy snacks to go with the beverages. Go easy on the salty, thirst-provoking appetizers.

4. Make sure everyone knows that nonalcoholic drinks are available. If it's a big event, place posters and banners around the room announcing the nonalcoholic beverages.

5. Toss together nonalcoholic drinks with as much flair as you would alcoholic beverages.

6. Tend bar yourself or have someone mix the drinks who's humorous yet responsible.

7. Permit each person to comfortably say "no" to an alcoholic drink. Even during a meal, don't assume everyone wants a glass of wine or other alcoholic beverage.

8. When serving alcohol at a company function or private dinner party, limit your cocktail time to under an hour.

9. Find someone to drive an intoxicated guest home, or call a taxi. Offer overnight stays if necessary. Stay alert yourself so you can be a good judge of your guests' condition. They're your responsibility.

10. Show concern, not amusement, for guests who've "had too much." This conveys that you are a responsible host and encourages others to know their limits.

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Evolution and Training of the Prevention Discipline

Hundreds of years ago, barbers who used techniques like “blood letting” practiced medicine. Fifty years ago, school counseling was conducted by teachers or athletic coaches who had no formal training in counseling or human behavior. In the alcohol and other drug field, twenty years ago nearly all treatment providers were alcoholics and addicts in recovery who used only their own recovery experience to help others. As we know, physicians now undergo years of academic training and extensive internships. Nearly all school counselors complete graduate-training programs specifically designed for this field. Finally, more and more universities have undergraduate and graduate courses of study in addiction counseling.

Professions often evolve in this manner. As the public comes to understand the value or need for a discipline, there is often an effort to develop standards for training and practice of the profession. Frequently, states develop certification and/or licensure requirements and universities develop programs to train people to work in the profession. There is logic behind this sequence. In medicine, barbers weren’t very effective in curing illnesses and diseases. Teachers and coaches were ill-equipped to deal with the complex problems of youth in the 1960s. Recovering individuals did not know how to treat poly-drug abusers, culturally and ethnically diverse clients, women and their children, addicts involved with the criminal justice system, clients with co-occurring disorders and so on. Therefore, the stimulus to develop standards of training and practice for a profession is often the lack of expertise of practitioners to handle the complexity of the discipline.

The ATOD prevention field is currently in the beginning stages of this evolution. Society’s need to impact the ATOD problems of this country combined with a growing body of knowledge of “what works” is stimulating an effort to increase the professionalism of prevention providers. In addition, the prevention field has had the burden of explaining why some highly publicized, widespread prevention programs have failed to demonstrate an impact on the ATOD use patterns of youth. Consequently, there are state and national efforts to develop certification standards for prevention providers. Universities are developing courses and internships in prevention. In addition, government entities that distribute prevention dollars are beginning to insist that prevention programs use “scientifically-defensible” prevention strategies and programs and use established practices to evaluate the outcomes of funded programs. A well-trained staff is necessary to meet these requirements.

This curriculum is designed to be part of the effort to professionalize the prevention field. We know that there are numerous individuals working in prevention programs in this country who want to increase their effectiveness and are eager to find out “what works.” There are many college students who are interested in working in prevention and need

training and experience to develop entry-level competence. We designed this curriculum as a general overview of the prevention field and as a stimulus for further learning.

Attitudes About ATOD

Close your eyes and visualize an alcoholic. Now visualize a crack addict. What were your visualizations like? What was the ethnic background of your alcoholic? What sex was your crack addict? Did you see a seedy, down-and-out person going through garbage cans? Did you visualize a well-known comedian or a professional athlete? If a 15-year-old is caught with a marijuana joint, does that person have a problem? What about the same kid with a bottle of beer?

It's essential for professionals who work in the ATOD prevention field to examine their attitudes about ATOD. Obviously, knowledge is important and can affect some attitudes. However, sometimes we're not even aware of how firmly attitudes are entrenched. For example, most of you know that addiction to alcohol and other drugs is not a function of sex, ethnicity or socioeconomic class. However, when you visualized an alcoholic and a crack addict, there was probably some stereotype you held that came out in your visualization. That's normal and isn't harmful as long as you understand that your stereotype does not reflect reality. For example, if you work in a prevention program that has a largely white clientele, it would be erroneous to assume that crack is not used in the community. A 15-year-old with a joint or a beer may or may not have a problem. Only an assessment can determine this. However, in this case, the drug of choice is not related to a conclusion as to whether a problem exists or not.

Prevention providers are encouraged to examine their attitudes about ATOD and to learn as much about substances as possible. The information in this module on **Drugs of Abuse** is only a start. While you certainly don't need to be an expert on pharmacology, you do need to understand basic information about the categories of drugs and their effects. This information should be based on science and not on scare tactics.

Definitions of Use, Misuse, Abuse and Dependence/ Addiction

For most helping professionals who don't have extensive training in the alcohol and other drug field, it is somewhat difficult to determine if a client's substance use is or is not problematic. They may rely on personal experience and information (or misinformation) they pick up. For example, a high school counselor gets a call from a parent of one of the students. The young man is 17 years old, came home from a party on Saturday night smelling of alcohol, and admitted to drinking at the party. His parents belong to a religious group, which prohibits the use of alcohol, so neither has any experience with alcohol or other drug use. They want to know if their son has a problem. The high school

Definitions of Use, Misuse, Abuse and Dependence/ Addiction – continued

counselor did her share of experimentation in adolescence but is a moderate user as an adult. She assures the parents that nearly all adolescents experiment and they have nothing to worry about. Is she right?

A simple conceptualization of the distinction between different levels of use can be helpful to the mental health professional in determining the type of intervention that's appropriate for a client. Yet, these definitions aren't appropriate for diagnosis. They simply are a guide for the mental health professional in recommending the course of action for a client. The following definitions are offered to frame the discussion of alcohol and drug abuse progression. It should be understood that multiple definitions of use, abuse and misuse exist. However, for purposes of this discussion, these definitions are offered for consideration.

Nearly everyone uses alcohol or other drugs (including caffeine and tobacco) at some point in their life. We define "use" as the ingestion of alcohol or other drugs without the experience of any negative consequences. If our high school student had drunk a beer at the party and his parents hadn't found out, we could say that he'd used alcohol. Any drug can be "used," according to this definition. However, the type of drug taken and the characteristics of the individual contribute to the probability of experiencing negative consequences. For example, it's illegal for minors to drink alcohol. Therefore, the probability that our high school student will experience negative consequences from drinking alcohol may be far greater than the probability is for an adult. The chances that an adult will experience negative consequences from shooting heroin are greater than negative consequences from drinking alcohol.

When a person experiences negative consequences from the use of alcohol or other drugs, it is defined as "misuse." Again, a large percentage of the population misuses alcohol or other drugs at some point. Our high school student misused alcohol because his parents found out he'd been drinking at a party and because it's illegal for him to drink. Many people overuse alcohol at some point, become ill and experience the symptoms of a hangover. This is misuse. However, misuse doesn't imply that the negative consequences are minor. Let's say that an adult uses alcohol on an infrequent basis. It's her 30th birthday, and her friends throw a surprise party. She drinks more than usual and, on the way home, is arrested for a DUI. She really doesn't have any problems with alcohol, but, in this instance, the consequence isn't minor.

Definitions of Use, Misuse, Abuse and Dependence/ Addiction – continued

You may be wondering about the heavy user of alcohol or other drugs who doesn't **appear** to experience negative consequences. First of all, remember that these definitions are meant to provide the helping professional with a simple conceptualization as a guide. Second, the probability of experiencing negative consequences is directly related to the frequency and level of use. If a person uses alcohol or other drugs on an occasional basis, the probability of negative consequences is far less than if one uses on a daily basis. However, since we are talking about probability, it's possible that a person could be a daily, heavy user and not experience negative consequences that are obvious to others. We say "obvious" because people may be damaging their health without anyone being aware of this for a long period of time.

We define "abuse" as the continued use of alcohol or other drugs in spite of negative consequences. Our high school student is grounded for two weeks by his parents. Right after his grounding is completed, he goes to a party and drinks again. He continues to drink in spite of the consequences he experienced. Now, he might become sneakier and escape detection. However, as we discussed previously, the probability of detection increases the more he uses and, if he does have a problem with alcohol, it's likely that his use will be discovered. As another example, let's go back to the DUI the woman got after her birthday party. For people who don't have an alcohol or other drug problem, getting a DUI would be so disturbing that they would avoid alcohol altogether or only use at home. If, a month after the DUI, the woman was at another party or a bar drinking when she would be driving, this would be considered abuse.

Addiction/dependence is the "compulsive" use of alcohol or other drugs regardless of the consequences. We worked with a man who had received three DUIs in one year. He was on probation and would be sentenced to one year in prison if he were caught using alcohol. Yet, he continued to drink. The man was clearly addicted to alcohol, as the negative consequences did not affect his use.

Justification for Theory

As disciplines develop, one of the core commonalties they achieve is a body of theories, which drive both research and application. A theory is a "formulation of apparent relationships or underlying principles of certain observed phenomena which has been verified to some degree" (Guralnik, 1984: 1475). This curriculum advances the current theories used in substance abuse prevention, which include the perspectives of risk and protection factors, resiliency and the assets model. Some theories and related research have reached high levels of scientific rigor, which means that they've been tested and have shown some consistent correlations or outcomes. All disciplines support certain theories that attempt to explain why a certain condition exists. In

Justification for Theory – continued

substance abuse prevention, for example, the theory of risk and protection predicts that the greater the number of risk factors, the greater the likelihood that youth will abuse substances at some point in their development. The ultimate goal of this curriculum is to move the field of substance abuse prevention to "praxis." Praxis means the combination of both theory and practice. The practice of substance abuse prevention should be enlightened and informed by theory. One of the challenges we face in prevention is understanding theory and the findings from research to the degree that we can apply them to our substance abuse prevention programs. When we achieve this goal, we have engaged in "prevention praxis." If our field didn't have a theoretical base, we'd simply run prevention programs with what we thought or felt were the right ideas. We'd try and glean progress from only our own observations and wouldn't consider what had been tried, tested, changed and tested again. Theory really helps us understand how to prevent substance abuse and answers questions about why some youth use substances and others don't.

The Substance Abuse Prevention Specialist Training curriculum presents, in depth, the three most dominant theoretical perspectives today. This doesn't mean that other theories don't exist or that these are the three best theories available. You see theories change and go through a dynamic process like most things do in life. Thomas Kuhn (1970) identified four steps or changes that theories cycle through and include normal science, anomalies, crisis and revolution. Normal science, the first step, is when theory is accepted as the dominant view in the field. Researchers experiment with new applications of the established theory, extend and refine it and accumulate knowledge. The second step is the anomalies stage. During this stage, people question why the theory doesn't fit the social problem they're trying to solve. Things happen in the social world and the theory can't explain why this is occurring. The third stage is crisis. During this step questions abound and people severely critique the theory, the field shifts their interests and new theories emerge that propose alternative ways of looking at the social problem. Anomalies to the original theory mount and accumulate as people begin formally attacking the perspective. The fourth state is called revolution. During revolution a new theory establishes itself as the reigning paradigm. The old theory is overthrown and the new theory establishes itself as the dominant perspective.

The point in explaining this sophisticated process is that the theories of today may not be the theories of tomorrow. So, you may be thinking, why even consider any theory at all if they'll go through this process eventually? The answer is that all theories help us understand the larger social context of substance abuse prevention. Without theories to guide

us, we simply employ old techniques that may "feel" like they work, but in fact may be harmful. Theories, like research knowledge, change over time. This is normal, expected and a valid part of a developing discipline.

Building Blocks for the Prevention Profession

The Substance Abuse Prevention Specialist Training curriculum is designed to provide some crucial building blocks of knowledge for the prevention professional. This curriculum isn't designed to answer every question a professional has about prevention nor is it equipped to be the only learning tool about the field. Instead, this curriculum is designed to "jump start" the learning process for new professionals in the field. It contains science-based information, orients the professional to current issues in prevention and provides a few of the many essential building blocks one needs to know when working in prevention programs or coalitions.

As with any developing profession, key building blocks or essential facts need to be presented and explored to train new members in the field. This curriculum has many core modules that are important to understand before implementing prevention programming. Just as the discipline of medicine began by advancing fundamental courses needed for all future doctors, this curriculum contains fundamental information for all preventionists. This curriculum, as mentioned earlier, is to be viewed as the "first step" to gaining knowledge about the field of substance abuse prevention. Like any discipline, as this body of knowledge grows and expands, the professional must grow and expand to properly apply the principles identified by science. We may find that strategies we employ in our prevention programs are no longer working or have been shown to need more rigorous evaluation to determine the degree to which they are or are not working.

We are at an exciting time in the evolution of prevention. We know more about what works in substance abuse prevention programming than we've known in the past. At the same time, new cohorts of substance abuse prevention specialists and coordinators are demonstrating interest in the field. College campuses are offering courses in substance abuse prevention and students can earn degrees in this field. This curriculum captures some of the fundamental building blocks that all students and prevention professionals need to incorporate into their practice to help advance effective and efficient substance abuse prevention programming at the national, state, county and community levels.

References used in this section:
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Building Blocks for Successful Prevention Programs

- **The program is facilitated by knowledgeable and competent staff.**
  Purpose of the Substance Abuse Prevention Specialist Curriculum
- **The program is based on sound theory and uses practices grounded in research.**
  Module 2 – "Prevention Research"
- **The program is systematically planned and assessed.**
  Module 3 – "Prevention Program Planning"
- **The program is evaluated.**
  Module 4 – "Evaluation"
- **The program is developmentally appropriate.**
  Module 5 – "Using Human Development in Prevention"
- The program addresses participants from a variety of backgrounds and **cultures, and it uses a code of ethics.**
  Module 6 – "The Cultural Context and Ethics of Prevention"
- **The program incorporates the media.**
  Module 7 – "Prevention and the Media"