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A DECADE WITH

PRIDE

National Parents' Resource Institute for Drug Education, Inc.

A DECADE WITH PRIDE

10th Annual Conference on Youth and Drugs

MARCH 19-21, 1987

International Days—March 16-18, 1987

Georgia World Congress Center • Atlanta

CONFERENCE REGISTRATION FORM

NAME _____ _____ _____
(LAST) (FIRST) (MID. INITIAL)

GROUP _____

SCHOOL/
COMPANY NAME _____

ADDRESS _____

CITY _____ STATE ____ ZIP _____

COUNTRY _____ HOME PHONE ____ _____

SOCIAL SECURITY NO. ___ __ ____ BUSINESS PHONE ____ _____

PLEASE CHECK ONE:

(A) ☐ Parent
(B) ☐ Youth
(C) ☐ Educator

Professional:
(D) ☐ Medical
(E) ☐ Military Representative
(F) ☐ Government
(G) ☐ Corporate

YOUTH CONFERENCE CERTIFICATION:

☐ Peer Teaching ☐ Leadership Effectiveness

RETURN THIS FORM WITH TOTAL AMOUNT DUE (U.S. FUNDS ONLY) TO:

PRIDE, INC.
100 Edgewood Avenue, Suite 1002
Atlanta, Georgia 30303
1-800-241-7946 404-658-2548

Check ONE	Fees Before Feb. 20	Fees After Feb. 20	
(P) ☐ Professional	$140.00	$165.00	$_____
(A) ☐ Adult/Educator	$ 95.00	$120.00	$_____
(Y) ☐ Youth	$ 25.00	$ 35.00	$_____

Tickets for food functions are not included in registration fees. Please order tickets below:

QUANTITY

(1) _____ Awards Banquet at $24.50 $_____
(2) _____ Celebration at $22.00 $_____
(3) _____ International Luncheon at $20.00 $_____

TOTAL AMOUNT DUE $_____

☐ Check for total amount is enclosed. (Make checks payable to PRIDE. All fees must be paid in U.S. funds)

☐ Charge to my ☐ VISA ☐ MasterCard

Card No. _____

Exp. Date _____

☐ Purchase order attached

CONFERENCE HIGHLIGHTS

Concurrent Sessions for Youth and Adults—Speakers, workshops, and panel discussions covering an enormous range of subjects. You'll find sessions to meet every need and satisfy every interest.

Adult Conference—Learn more about developing anti-drug abuse programs for young people. Improve your organizational skills. Hear the latest information on drugs. You'll want to attend every session!

Youth Conference—Meet other young people from throughout the nation and the world, and learn how they fight the drug problem back home. Enroll in Youth Certification Programs in *Peer Teaching* and *Leadership Effectiveness.* An experience you'll never forget! Youth Certification Program registration is limited.

Family Night Celebration—An informal evening of fun, food, fellowship and music for parents, youth and international participants. Let's celebrate!

Friday, March 20, 7:30 p.m. Blue Jeans.

Awards Banquet—A great evening! You'll help honor outstanding young people and adults for their efforts in combatting drug abuse. You'll hear from celebrities and enjoy top-notch entertainment.

Thursday, March 19, 7:30 p.m. Sunday dress.

International Luncheon—Close out the Conference by honoring the international participants. An outstanding leader in the field of drug abuse prevention will be the featured speaker.

Saturday, March 21, 1:00 p.m. As you are.

Youth Certification Program: The 1987 International Conference on Drugs will offer two certification programs in addition to general workshops as part of the Youth Conference. **Peer Teaching** covers basic drug abuse prevention, and communication skills. **Leadership Effectiveness** includes positive peer pressure, youth group organization, personal leadership and the creation of alternative activities. Indicate on your Registration Form if you want to complete one of these programs. Then plan to attend the required workshops and sessions during the Conference and a brief review on Friday afternoon, March 20. Upon completion of the program, you will receive a certificate; a letter of commendation to your school principal, student council and sponsor; and resource materials to help you put your new knowledge to work in your community.

Exhibits—View displays from leading educational, assistance, health and government organizations. A valuable opportunity to discover resources, support and information available to you.

AMONG THE SPEAKERS

Carlton E. Turner, Ph.D.—Deputy Assistant to the President of the U.S. for Drug Abuse Policy. Consultant to government agencies and private firms. Has headed cooperative programs on drug abuse with groups in 30 countries.

Marsha Manatt Schuchard, Ph.D.—A leading spokesman for the parent movement in the U.S. and abroad. Author of "Parents, Peers and Pot", a handbook for parents on the prevention of drug abuse among young people. Co-founder of PRIDE.

Donald Ian Macdonald, M.D.—Administrator for the Alcohol, Drug Abuse and Mental Health Administration (ADAMHA). Author of "Drugs, Drinking and Adolescents".

REGISTER EARLY

LIMITED TO 3,000!

PREREGISTRATION REQUIRED

REGISTER NOW!

GENERAL INFORMATION

Dates: Monday through Wednesday, March 16-18—International Days

Thursday through Saturday, March 19-21—International Conference on Drugs.

Location: Georgia World Congress Center, 285 International Boulevard, N.W., Atlanta, Georgia 30318

Hotel Reservations: Rooms have been reserved in hotels near the World Congress Center. Phone 1-800-282-0456 in Georgia and 1-800-631-3188 outside of Georgia.

Travel: Atlanta is one of the more accessible cities in the U.S. It is served by three interstate highways, trains, bus and the world's second busiest airport. DELTA AIR LINES is the official air carrier for the 1987 PRIDE Conference. Two discount plans are available: (1) Book reservation at the lowest applicable fare (30-, 21-, 14- or 3-day discount, remaining in Atlanta over Saturday night) and receive a further 5% discount. (2) If you are unable to qualify for a discounted fare less the additional 5%, you will be eligible for a 35% discount on Delta's regular coach fares. To make your reservation, phone Travelers Choice at 1-404-256-1818 and ask for Sara Eads or Mary Porter.

Youth and Adult Teams: PRIDE encourages young people to attend the Conference as a team with parents, teachers and organization representatives. Phone 1-800-241-7946 for more information and additional suggestions about teaming up for the Conference.

Fees: PRIDE keeps fees as low as possible so that as many interested young people and adults as possible can attend. The Awards Banquet, Family Night Celebration and International Luncheon help build enthusiasm, and they're fun! Tickets for these events are separate from your Registration Fee, so be sure to sign up for them on your Registration Form.

WHAT THEY'RE SAYING ABOUT PRIDE

"At the PRIDE Conference, I began to see the hope, the way we could save our children from drugs. I saw it in the faces of the mothers and fathers of PRIDE, and that visit genuinely marked a turning point for me"

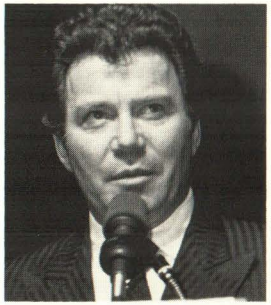
Nancy Reagan

"PRIDE stood up against drug abuse when too few others in the U.S. were paying attention. It continues today as a foremost leader in nationwide efforts to save our children and youth from damaging their lives by using dangerous drugs."

Donald Ian Macdonald, M.D.
Administrator, Alcohol, Drug Abuse
and Mental Health Administration

"I can't think of any organization or undertaking that means more than PRIDE to the future of our children and the welfare of our country. I am happy to join you in declaring that there is no such thing as responsible drug use among children."

William Shatner
PRIDE Spokesman
Star of "Star Trek"
"T. J. Hooker"



"I am well aware of the sterling work done over the years by [PRIDE] and of the commendable manner in which you share with others the lessons of your experience. At a time when drug abuse has in many countries attained almost epidemic proportions, the parents of our young people have a special burden to bear. In this regard, PRIDE and organizations like it provide parents with assistance, guidance and support which can only be termed invaluable.

Javiere Perez de Cuellar
The Secretary-General, United Nations

INTERNATIONAL CONFERENCE ON DRUGS

MARCH 19-21, 1987

International Days—March 16-18, 1987

Georgia World Congress Center, Atlanta

Co-sponsored by Georgia State University, the Benevolent and Protective Order of Elks, the National Institute on Drug Abuse and the United States Information Agency.

The PRIDE International Conference on Drugs, the world's largest youth and adult conference on drug abuse prevention, is celebrating its 10th Anniversary as a parent conference.

World leaders, celebrities and more than 100 speakers will join you in taking part in more than 50 sessions, panels, forums, a banquet and a celebration. U.S. First Lady Nancy Reagan and the First Ladies of nine countries were special guests at the 1986 Conference.

Make plans now to join the network of parents, young people and professionals who gather to review the latest research, share experiences, discuss new ideas and seek new resources.

The 1987 Conference promises to be the best ever—more facts, more ideas, more inspiration, more fun—as PRIDE begins its second decade of service to parents and young people worldwide.

Suite 1002, 100 Edgewood Avenue
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1987 INTERNATIONAL CONFERENCE ON DRUGS

"Teach Your Children Well"

A Parent's Guide to Drug Abuse Prevention

Dear Parent:

Drug experimentation and abuse have surged among America's youth. As parents, we often express concern over this "national" problem, but all too frequently, we feel insulated against the very real consequences it can have for our own families. Unfortunately, drug experimentation is a threat to everyone's children.

Parents can assume an active role in preventing drug experimentation in their own home by instituting an ongoing communication process with their children and by supervising their teenagers' social activities. This approach greatly reduces the serious risks involved in a "hands-off" approach.

Your Eckerd pharmacist sincerely hopes that you will find the information in this booklet helpful in your personal effort to teach your children well. We salute your concern and interest. Through individual efforts such as yours, America can begin to help its youth rid itself of the grave consequences of illegal drug use. At Eckerd, that's a very important goal because, to an Eckerd pharmacist, nothing is more important than your family's health.

Sincerely,

Bob Myers

Bob Myers
Vice President
Pharmacy Services

ECKERD®

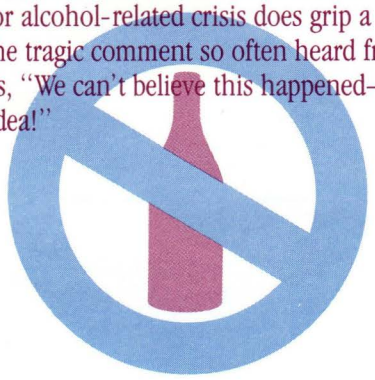
AMERICA'S FAMILY DRUG STORE

Drugs and alcohol are serious problems for young people. Recent surveys show that more than 60 percent of high school seniors have used illegal drugs and roughly one in 20 drinks on a daily basis.

Many parents feel powerless to fight the problem, overwhelmed by social forces beyond their control. What can one do when organized crime brings drugs into the country by the boatload, professional sports teams have to be screened for drug use, police can't keep 14-year-old marijuana peddlers off the school bus, and children listen more to their friends than to their parents?

In fact, parents can do a great deal. Surrendering to the feeling of helplessness is a big mistake. You may not be able to do much about international drug traffic, the problems of law enforcement, or the provocations of teenagers, but, as a parent, you do have power in your home, your family, your community, and your children's school. Your first duty is to learn about teenage drug and alcohol use, so that you can discuss the topic in terms children can relate to.

Your worst enemy is self-imposed insulation, the attitude that "drug abuse doesn't pose a real threat to my children—they've been brought up to know better." Unfortunately, drug and alcohol abuse are very real threats to *all* teenagers. Complacency allows such a problem to develop far beyond otherwise noticeable bounds before it is detected and confronted. Never assume you don't need to discuss drug and alcohol use with your children or that you shouldn't keep a mindful eye on their appearance, behavior, and friends. When a drug- or alcohol-related crisis does grip a family, the tragic comment so often heard from parents is, "We can't believe this happened—we had no idea!"



OPEN COMMUNICATION WITH TEENS IS ESSENTIAL AND INVALUABLE

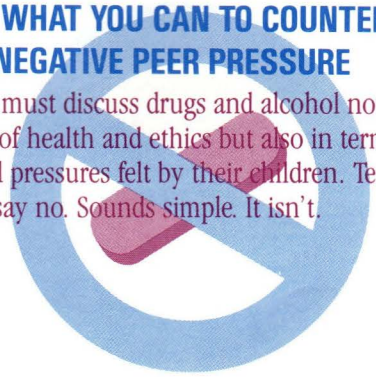
Talk to your children about drugs and alcohol. It is the most effective thing you can do to prevent alcohol and drug abuse in your home. It is never too early to start. Fully one-third of all young people who try drugs do so in their first year of junior high school, so talk to your children before they become teens. Anytime you bring up the subject, it is a signal to your children that you are willing to discuss the issue.

Many parents are afraid to discuss drug and alcohol use with their children, because they might appear mistrustful, foolish, overly preachy, or misinformed. They lack confidence in their own ability to express their concern or worry that such a talk might start an argument.

You do not have to become a world authority, but you do owe your children accurate, up-to-date facts on the health consequences of drug and alcohol use. Other resources include your family doctor or your children's health teacher. But giving them the facts about drugs and alcohol is only part of your duty. As parents, you are the moral benchmark by which your children measure their behavior. They might not agree with you on every specific, just as you didn't always agree with your parents. Nonetheless, it is parental guidance on life-style choices and decision-making skills, along with scientific evidence, on which your children will rely. It is vital that you be frank and specific about how you feel about the use of drugs and alcohol.

DO WHAT YOU CAN TO COUNTER NEGATIVE PEER PRESSURE

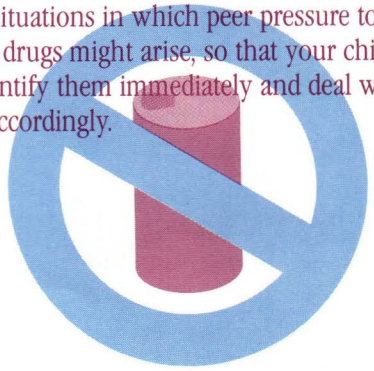
Parents must discuss drugs and alcohol not only in terms of health and ethics but also in terms of the social pressures felt by their children. Teach them to say no. Sounds simple. It isn't.



Many younger children have a mistaken impression of their potential future use of drugs. They think they would never use drugs unless some schoolyard bully or strangers forced them. Drugs are not forced on children in the physical sense, and it is not a stranger but a close friend or relative who will most likely first offer drugs or alcohol. The children who accept feel compelled to do so for some powerful reason. By adult standards it won't be a good reason, but it will be reason enough to overcome their fear, moral uncertainty, and better judgment. A girl may take drugs because a boy she likes takes them. A boy may drink because he thinks it will make him a man in the eyes of his friends. Teenagers drink or take drugs to be accepted by or to dominate their peer group. Some drink or take drugs for lack of anything more exciting to do; others do so to demonstrate their hostility toward their parents, school, and an unaccepting world.

Adults often underestimate just how forceful these pressures are. No matter how smart and knowledgeable young people are, they lack life experience. Without that accumulated judgment, each new social situation seems all-important and/or threatening.

When you talk to your kids about drugs and alcohol, create realistic hypothetical situations in which they might be offered drugs or alcohol. Give them the benefit of your experience, so that minor social situations do not become distorted and exaggerated to the point where your child feels he or she has to sacrifice his or her ethics and health to meet an abstract social pressure. Describe situations in which peer pressure to drink or take drugs might arise, so that your child can identify them immediately and deal with them accordingly.



GET TO KNOW THE PARENTS OF YOUR CHILDREN'S FRIENDS

Probably the oldest advice to parents is: "Know where your children are and who their friends are." With adolescents, it can be tough advice to follow. They'll tell you where they think they might be going, possibly who they will meet, and what they think they might do when they go there, if they get around to it. Keeping track of the exact whereabouts of teenagers can be nearly impossible.

One thing you can do is to encourage your children to make your home a meeting place. Sure, it'll get noisy at times, but if your children entertain friends at home, you'll have a natural situation in which to observe their behavior and attitudes in the presence of their friends, and vice versa.

Make a point of getting to know the parents of your children's best friends. Call them up. Ask about their rules, such as curfews, homework times, and places to go and not to go, and also tell them your rules. Feel free to call and make sure other parents are going to be home if your children say they are going there. Confer with other parents if you feel uneasy about some group activity the children have planned. In this way, you support other parents and they support you.

Parent networks of this sort have been markedly effective in reducing drug and alcohol abuse among adolescents in many communities. They provide young people with a sense of consistency and give parents peace of mind.

TRUST, LIMITS AND RESTRICTIONS MAKE A DIFFERENCE

Research suggests that a key part of substance abuse problems revolves around a misperception of trust on the part of children. Children who believe their parents are either undercontrolling or

overcontrolling are much worse drug risks than children who see the amount of control placed on them as appropriate. A careful distinction needs to be made. Your child's perception may be distorted, but whether or not the perception is accurate or distorted, if they believe it to be true, it will have the same effect on drug risk.

The critical concern here is to make sure you explain to your children why you are requiring them to make their own decisions, or, conversely, why you are not allowing them to make decisions.

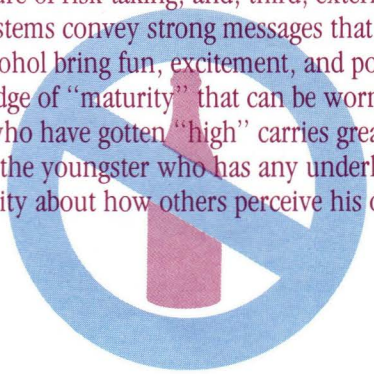
SCHOOLS CAN HELP

Make a point of meeting your children's teachers. Often they are the first to see a potential problem and can provide an objective viewpoint. However, teachers are unlikely to contact you unless the problem becomes severe or they know you are specifically interested in finding out such information immediately.

Schools are also a primary source of health, drug, and alcohol education. Through your participation in the PTA and personal contact with school authorities, you can ensure that your children receive the benefits of these programs.

ALCOHOL AND DRUGS: WHY THE ALLURE?

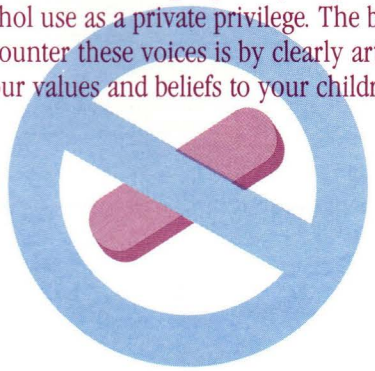
In addition to the perceived need to conform to the behavior of their peers, teenagers drink alcohol and take drugs for three other reasons: First, both alcohol and drugs are seen as being "for adults only," second, both provide the provocative allure of risk-taking, and, third, external advice systems convey strong messages that drugs and alcohol bring fun, excitement, and popularity. The badge of "maturity" that can be worn by teens who have gotten "high" carries great appeal to the youngster who has any underlying insecurity about how others perceive his or her progress toward adulthood. You must explain to your children that more constructive and convincing ways of demonstrating maturity exist, such as the ability to set long-term goals and keep to them and the ability to act independently and responsibly in the face of group pressure to do otherwise.



The second appeal holds the allure of risk-taking. Taking a chance appeals to a negative stimulation within us, whether it is drug abuse, gambling, speeding, or generally reckless behavior. Risk-takers usually weigh the certainty of a perceived short-term gain against a less certain but greater long-term punishment. People who take risks are generally impulsive and seek immediate gratification despite eventual negative consequences. You must help your children understand that delayed gratification without inherent risks is a more constructive form of behavior. If your child's behavior is dominated by impulsive acts and risk-taking, seek professional advice—either that available within your local school system or that of a private counselor.

The third enticement is as strong as it is pervasive. For more than two decades, the influence of our traditional education has been giving way to the new giants of education—an assortment of rock culture, television, movies, T-shirts, and bumper stickers, which present the illegal use of alcohol and drugs in a fun, exciting, and adventurous manner.

So, as our new education replaces the traditional, we find ourselves in quite a dilemma. Powerful voices and images portray illegal drug and alcohol use as a private privilege. The best way to counter these voices is by clearly articulating your values and beliefs to your children.



SIGNS AND SYMPTOMS OF EARLY DRUG USE

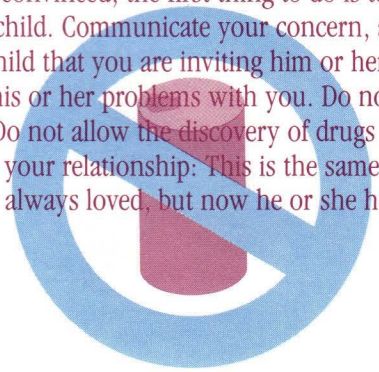
If you suspect your child is using drugs or alcohol, these are some of the warning signs:

- Changes in friends;
- Inexplicable mood swings, particularly when a child comes home after spending time with friends;
- Bloodshot eyes;
- An attitude of acceptance for other people's drug or alcohol use;
- Smell of alcohol on breath or smell of burnt rope (marijuana) on clothing;
- Withdrawal from family;
- Vague and secretive about friends and social activities;
- Unusual sleep patterns.

It is important to note that there are other causes for these symptoms and that they may not be symptoms of illicit drug use. You may have to trust your instincts when trying to determine if your child's actions are normal or chemically induced.

Watch for changes in your children. If these signs appear, be diagnostic. Sort through all the possibilities and then come to a reasonable risk assessment. If due cause exists, talk to the parents of your child's friends, the child's older brothers and sisters, and even the friends themselves. Don't feel guilty that you appear doubting or suspicious. Your actions, based on reasonable indications, show alertness and parental concern. No one feels guiltier than the parent who gets surprised after it's too late.

Once convinced, the first thing to do is to talk to the child. Communicate your concern, assure your child that you are inviting him or her to share his or her problems with you. Do not overreact. Do not allow the discovery of drugs to poison your relationship: This is the same child you've always loved, but now he or she has a problem. Assure the child of your love and concern, and at the same time set firm rules of no illegal drug use.



These rules should be clear and strict, yet practical and realistic. Place additional controls on the child's free time. Enlist the school's assistance in managing his or her time, if necessary.

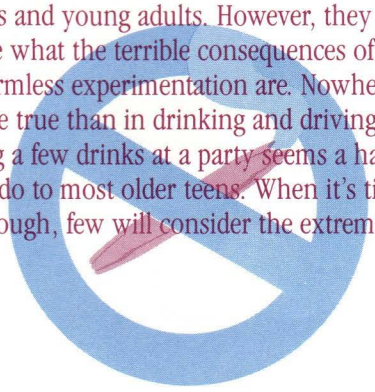
FORGET BLAME AND SHAME

An area that requires special consideration is other parents and children. Young people very rarely use drugs alone. If your son or daughter is experimenting, most likely his or her best friends are also experimenting.

The discovery of drug abuse always places severe strain on the family. The parents may be consumed with anger, guilt, and fear. You have to overcome these feelings, fight the urge to assign blame. What counts is getting the family working together. This can be accomplished through judicious discipline of the misbehavior, and a reaffirmation of the family's respect for one another. If it seems helpful, a family counselor can be located through the local school system, municipal or county government, and volunteer and religious organizations. You should make sure that the counselor is well-informed about adolescent alcohol and drug use.

DRINKING AND DRIVING: THE UNFORGIVING EXPERIMENT

The serious dangers of alcoholism and drug addiction are generally accepted facts by most teenagers and young adults. However, they fail to realize what the terrible consequences of seemingly harmless experimentation are. Nowhere is this more true than in drinking and driving. Downing a few drinks at a party seems a harmless thing to do to most older teens. When it's time to leave, though, few will consider the extreme



danger of getting behind the wheel of a car while intoxicated. Emphasize to your children the notion that it is dangerous to drink and drive. The facts are plain and compelling: More teenagers are killed by alcohol-related car accidents than by anything else. Age limits for drinking in most states make teenage drinking illegal. Most states enforce very stringent penalties against drunk driving—another reality to consider.

You can provide real help to your children by offering to drop them off and pick them up when they go to parties. Let them know that no hour is too late and no location is too far that you aren't more than willing to provide a ride home if they or their friends aren't in a condition to drive. If you do get such a call, don't lecture or argue with them or their friends. A reasoned yet serious discussion about it the next day alone with your child will have a much more beneficial effect.

ONGOING USE

Many young people do not progress beyond early experimentation with drugs and chiefly abuse marijuana and alcohol. But for a disturbing number, the perceived rewards of drugs outweigh the disruption of family life, parental and societal disapproval, and physical and mental danger. If substance abuse becomes an ongoing thing, the abuser becomes sophisticated about the effects of drugs. Such individuals may continue to experiment, but the choice of drugs becomes more selective and the amount and incidence of use increases. Social relationships are still important in the pattern of abuse, but they increasingly revolve around buying and using drugs.

Secondary physical effects of drugs also start to play a role in the pattern of abuse. Two important effects are tolerance and rebound.

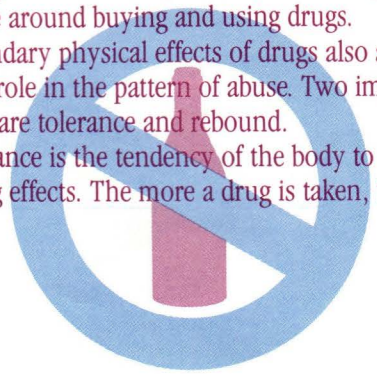
Tolerance is the tendency of the body to adapt to drug effects. The more a drug is taken, the more the body adapts. The result is that ever-increasing doses of the drug are required to achieve the same effect.

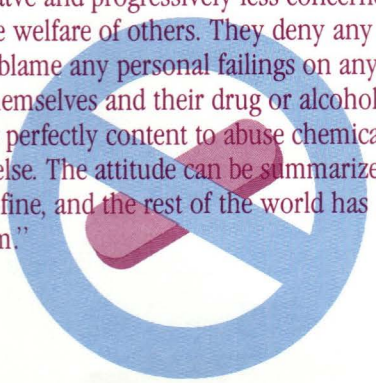
Rebound is the body's reaction to the effects drugs have on the central nervous system. For example, when you drink coffee at breakfast, the caffeine stimulates the nervous system. By mid-morning, the effect will have worn off, but instead of feeling normal, you feel tired and sluggish. Your body has swung to depression as an equal and opposite reaction to the caffeine's effects. More powerful drugs have stronger rebounds. Cocaine, a powerful stimulant, has a particularly unpleasant rebound effect. To escape this effect, the drug user takes more drugs. This initiates a cycle in which the drugs are used not only to get high but also as a medication against their unpleasant side effects.

SIGNS AND SYMPTOMS OF ONGOING USE

- Consistent drop in general performance in school, on the job, and in standards of grooming;
- Drugs and drug paraphernalia (rolling papers, "coke spoons," pipes) found repeatedly;
- Number of friends decreases;
- Less and less time spent at home.

In this phase, drug users are in the midst of a recognizable disease. They become less and less able to take care of themselves but compensate by becoming better and better at getting others to take care of them. They become increasingly manipulatve and progressively less concerned about the welfare of others. They deny any problem and blame any personal failings on anything except themselves and their drug or alcohol use. They are perfectly content to abuse chemicals and do little else. The attitude can be summarized as: "I'm fine, and the rest of the world has a problem."





At this stage, the family must consider professional assistance. The substance abuser will initially refuse treatment and must be cajoled or forced. Often they seek assistance only because it is easier than, for example, being deprived privileges or getting thrown out of the house. Many families also find it helpful to join self-help groups, where they can meet others with similar problems. Al-Anon and Families Anonymous are two well-established national networks.

Do nothing that assists the person's substance abuse. This runs counter to most parents' instinct. Most parents tend to provide support and wait the person out, but drug and alcohol abusers will not improve under those circumstances. Do not give them money. Restrict or supervise all free time. Do not provide transportation unless it is to such specific destinations as school, work, or the counselor's office.

(National Parents' Resource Institute for Drug Education, Inc.)

PRIDE is a resource information, conference and training organization, located at and working in cooperation with Georgia State University. Operating on a non-profit basis, it serves parents and other adults and young people concerned about adolescent drug abuse. For more information on drug abuse prevention and a complete list of materials available, write or call PRIDE:

Robert W. Woodruff Building
Volunteer Service Center, Suite 1002, 100 Edgewood Avenue
Atlanta, Georgia 30303

(404) 658-2548 National Toll Free: 800/241-7946

HOW CAN I TELL IF MY CHILD IS USING DRUGS?

One of the questions asked increasingly by parents is: "How can I tell if my child is using drugs?" This is a most difficult question when signs and symptoms associated with behavior are used as a basis for (knowing) suspicion. It is difficult to separate the typical adolescent behavior from the drug-induced behavior; but the parent should consider the following behavior suspect:

1. **Does the child seem to be changing . . .**
   Is the child becoming more: irritable, less affectionate, secretive, unpredictable, hostile, depressed, uncooperative, apathetic, withdrawn, sullen, easily provoked, oversensitive?
2. **Is the child becoming less responsible?**
   Is the child: not doing chores, late coming home, tardy at school, forgetful of family occasions (birthdays, etc.), not cutting grass, allowing room to be untidy, not completing homework?
3. **Is the child changing friends, dress code or interests?**
   Has the child: a new group of friends, the language of new friends, hair styles like new friends, switched clothes styles, become reluctant to talk about new friends, become very interested in rock music and concerts, become less interested in school, sports and academic hobbies, refused to talk about parents of new friends, started insisting on more privacy, demanded permission to stay out later than usual?
4. **Is the child more difficult to communicate with?**
   Does the child: refuse to talk about details of friendship group activities, refuse to discuss "drug issues," become defensive when negative effects of drug use are discussed, strongly defend occasional use or experimental use of drugs by peers, insist that adults hassel their children, begin to defend "rights" of youth, prefer to talk about bad habits of adults?
5. **Is the child beginning to show physical and/or mental deterioration?**
   Does the child show: disordered thinking or ideas and thought patterns that seem out-of-order, heightened sensitivity to touch, smell and taste, increased appetite from marijuana smoking (known as the "munchies"), loss of ability to blush, decreased ability in rapid thought processes, amotivational syndrome, weight loss?

Behavioral changes as discussed in 1 through 5 may occur over a period of a few months, the summer, or over a year or more. These behavioral patterns should be monitored closely by the parent. More blatant behavior will begin if the child can manipulate his way through the aforementioned examples and more obvious drug use behavior will begin to occur.

6. **Is the child's behavior becoming more intolerable to parent?**
   Does the child: demand his right to drink alcohol, refuse to spend additional time on studies even though grades are down, insist that teachers are unfair, become extremely irritable, refuse to do chores, use bad language, come home late with alcohol on breath, claim people are telling lies on him, claim never to have smoked pot, not want to eat with or spend time with family, act very secretive on telephone?

After behavioral clues to drug use, there usually comes the tell-tale physical evidence which is difficult to deny. The child will usually lie or give half-truths to parents when caught.

7. **Is the child becoming careless in his drug use?**
   Does the child: forget to replace the liquor stolen from parents' cabinet, put the bottle between mattresses, leave the "roach" in flower pot, in bathroom or car ashtray, forget who vomited in family car, insist that marijuana found in car or room belongs to someone else?
8. **Is the child becoming drug dependent?**
   Does the child: take money from his parents, brothers or sisters, steal objects from home that are easily converted to cash, lie chronically, drop out of school?
   Is the child: caught shoplifting, charged with burglary, charged with prostitution, arrested for drug use or delinquent act?
   Does the child attempt suicide? —*Thomas J. Gleaton, Ed.D.*

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COCAINE—

THE WHITE LINE ON THE HIGHWAY TO ADDICTION

published by
PRIDE
National Parents' Resource Institute for
Drug Education, Inc.
100 Edgewood Avenue
Suite 1216
Atlanta, Georgia 30303
(800) 241-7946

Printing made possible by a grant from
The Reader's Digest Association, Inc.

COCAINE—THE WHITE LINE ON THE HIGHWAY TO ADDICTION

A Predictable Epidemic: The casual attitudes about illegal marijuana use in the 1970s were extended to cocaine use in the 1980s. The teen-agers who had "partied with pot" moved into the adult working world and soon added cocaine to their "recreational" drug use. The same "experts" who tried to convince Americans that marijuana was harmless now described cocaine as a "soft" drug that should be used "responsibly" by progressive and sophisticated young adults. The commercialized drug culture marketed jewelry, paraphernalia, T-shirts, comic books and records that made "snorting" seem fun, while respectable newsmagazines, television shows and movies portrayed cocaine as the "champagne of

drugs." It should come as no surprise that cocaine use tripled between 1979 and 1985, or that 5000 new teen-agers and adults try cocaine each day in the United States.

Not the First Epidemic: The 1980s epidemic was pre-figured in the 1880s, when cocaine was promoted and marketed as a wonder drug in wines, toothpaste, soft drinks, medications for headaches and piles, and "cures" for alcoholism and morphinism. Though the chewing of coca leaves in ancient Indian cultures had a 5000 year history, not until the isolation of pure cocaine by a German chemist in 1859 was the stronger drug available for use. "Experts" like Sigmund Freud, the Surgeon General, Queen Victoria and the Pope all praised cocaine's beneficial and benign powers. However, within a few years of increasingly widespread use, the addictive and destructive nature of the drug became evident. Cocaine was banned in this country by the Pure Food and Drug Laws in 1905, when it was also removed from Coca-Cola. The first cocaine epidemic was over.

In 1961, the *United Nations Single Convention on Narcotic Drugs* reaffirmed the treaty-bound commitment of 115 nations to prohibit the use, sale, or production of cocaine except for legitimate medical purposes (as a local anesthetic in some forms of eye, nose and throat surgery). With little demand for the drug, pilot projects in coca-crop eradication began to make headway in South America.

Why a Second Time Around? During the past 15 years, the willingness of millions of Americans to casually break the drug laws and to carelessly alter their minds with chemicals created a growing consumer market. This was rapidly exploited by criminals who view each "social" drug user as a potential addict who will pay thousands, even millions, of dollars to suppliers. Once an individual breaks the marijuana law—the first step into the drug culture—the next illegal step is easy. Moreover, the marijuana-altered mind and emotions often require more potent chemicals to counteract lethargy and to achieve euphoria. With the media inaccurately reporting that cocaine is not addictive, many materialistic and self indulgent status seekers welcomed a new drug that would give them happiness, energy and, significantly, keep them thin. The only thing new about America's second cocaine epidemic is the rapidity of spread to "partiers" of all ages and the massive increase in supplies through the powerful criminal syndicates in South America.

What Is Cocaine? Cocaine is an alkaloid extracted from the leaf of the coca bush, which is cultivated at high altitudes in Peru, Bolivia and now in an increasing number of mountainous countries. The chemical is a powerful stimulant to the central nervous system, with mind-altering and energy-producing qualities similar to those of amphetamines. In ancient Inca civilizations, the leaves were used by priests to induce trances and elicit prophecies, but popular use was forbidden. Later, the leaves were chewed by peasant laborers working at high altitudes to mask oxygen deficiencies, raise body tempera-

tures, and anesthetize the pain of hunger and fatigue. The Spanish conquerors encouraged its use because it made possible excruciating slave-labor by Indians whose life-span averaged 30 years. Coca leaves contain only a minute amount of the drug, but the extraction and purification of cocaine produces a new and immensely more powerful substance.

What Do Users Like About Cocaine? When cocaine is processed into a white powder ("snow"), it can be absorbed into the bloodstream by the mucous membranes of the nose, mouth, rectum or vagina. Sniffing, or snorting, it through the nose is the most popular method, for the drug moves rapidly to the brain. There it changes brain chemistry and produces a surge of energy, pleasure and sense of confidence that lasts about 20 minutes. For some, the first experiments are unimpressive or not worth the risks, and their usage stops or is repeated infrequently. For others, the first cocaine experiences are intense and unforgettable; they move from casual experimentation to deliberate drug-seeking. Some then use the drug purposefully to help them through situations—to gain social confidence, to initiate sex, to overcome job fatigue, to numb athletic pain, to reduce appetite. Within a few months or years, many will move into compulsive use, where the craving for the drug dominates their lives. The limited availability and high cost of cocaine (about $60,000 a kilo or $20 a snort in 1982) have been the main restricting force on consumption. With rapidly increasing supplies and decreasing prices ($30,000 a kilo in 1983) many casual or "trendy" users are moving into compulsive use.

Why Is Cocaine So Dangerous? Like other powerful stimulants, cocaine acts directly on the limbic system or "old brain," where the chemical centers for instinctive pleasure are located. In evolution, the stimulation of these pleasure centers is tied to the survival mechanisms of hunger, thirst, sex, and the fight-flight instinct. When cocaine artificially triggers these centers, a detour or short circuit of the brain's biological purpose is achieved. Intense euphoria, arousal, alertness and energy are achieved that serve no natural purpose for the health, safety or welfare of the species. With repeated artificial stimulation, the "deceived" brain transforms cocaine into the force and compulsion of an instinctive, biological drive. Experimental animals will press mechanical bars thousands of times to receive an injection of cocaine; they will choose painful electric shocks to increase their dose of cocaine; they will choose cocaine over food, water and sex. With cocaine increasingly available, millions of Americans are "bar-pressing" their way to addiction and possible death. More than any other drug, cocaine can turn *Homo sapiens* into *Homo slave-iens.*

Seeking Higher Highs, Finding Lower Lows: In the early seventies, the small supply and low purity of cocaine available in the United States led many experts and intra-nasal users to believe it was not addictive. As supplies and potency increased, more "snorters" became compulsive users. After the 20-minute "high", the

drug withdraws rapidly from the brain, making the user feel depressed, irritable and fatigued. This "coke crash" reinforces the brain's craving for a repeated dose to alleviate the distressing withdrawal symptoms. By 1980, many "snorters" were smoking the fumes of specially prepared and burned cocaine base (called "free-basing"), to speed up and intensify the drug's impact on the pleasure centers. Others inject cocaine as their dependency increases. In South America, the smoking of coca paste on marijuana or tobacco cigarettes (called basuco) delivers a powerful dose to the brain. Withdrawal effects thus become increasingly intolerable. Alcohol, heroin, barbiturates and tranquilizers are used to alleviate the "wired-out" sensation of cocaine abuse. The chemically disturbed brain produces increasing paranoia, hallucinations, insomnia, aggression and suicidal depression. If enough cocaine is available, these addicts will smoke or inject every 20 minutes around the clock.

For Many, a Highway to Death: Because of its powerful stimulation of the central nervous system, even one "snort" of cocaine can be deadly to susceptible people. Though still rare, "snorting" has killed people through cardiac arrest, irregular heart rhythms, suppression of the respiratory system, or epileptic-type convulsions. More common health problems from nasal use are sinusitis, damage to vocal cords, ulceration of nasal membranes, dental infection, malnutrition and vitamin deficiencies. With larger doses, via free-basing, basuco, and injection, the risks of death grow, as well as lung damage, hepatitis, and AIDS (from infected needles). Violence, suicide and reckless driving also kill many coke abusers.

High Stakes for North and South America: The fashionable, sophisticated American demand for cocaine has spawned an expanding criminal network of suppliers. In South America, powerful syndicates have taken over large land areas to increase coca growing, to build new processing labs, and to develop transportation fleets for exporting drugs. During their exploration of the Amazon waterways, the famed Cousteau family found that cocaine traffickers are exploiting the peasantry, destroying food crops, polluting the rivers, and corrupting police and government officials. As more South American youngsters become users, the jungles are being populated with emaciated, dying addicts who look like concentration-camp inmates. Armed terrorists boast that they are using drug warfare to destroy the United States and its allies in South America. The honest government leaders and decent people of the drug-producing countries fear that they will lose the battle unless the U.S. demand for drugs decreases dramatically—and soon.

What Can You Do to Help? The drug criminals thrive on the ignorance, apathy and irresponsibility of ordinary citizens. But the situation is not yet hopeless. PRIDE invites you to join the national citizens' movement for drug-free youth. **YOU CAN MAKE A DIFFERENCE.** Here's how:

1) Educate yourself and your family about the health hazards of drugs.

2) Prevent the illegal use by youngsters of the Gateway Drugs—alcohol, tobacco and marijuana.

3) Work for better drug education in the schools, work place, churches and civic associations.

4) Rebuild understanding and respect for the laws concerning alcohol, marijuana, cocaine and other drugs.

5) Recognize the responsibility of the illegal consumer as well as the illegal supplier for the drug epidemic.

6) Support crop-eradication and law-enforcement efforts at home and abroad.

7) Write letters to, telephone and visit personally those members of the publishing, merchandising, and media world who glamorize, trivialize or subsidize the drug culture.

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PRIDE believes that when millions of American citizens speak out and work for drug-free youth, the COCAINE CONNECTION that threatens the future of North and South America will finally be broken.

MARIJUANA—
THE GATEWAY DRUG

published by
PRIDE
National Parents' Resource Institute for
Drug Education, Inc.
100 Edgewood Avenue
Suite 1216
Atlanta, Georgia 30303
(800) 241-7946

Printing made possible by a grant from
The Reader's Digest Association, Inc.

MARIJUANA—THE GATEWAY DRUG

A CHALLENGE TO ALL AMERICANS:

The United States entered the 1980s with the most extensive drug epidemic among its young people of any country in history. However, increased citizen education and activism is beginning to reverse the escalating trend. PRIDE invites you to educate yourself about drugs and to share our commitment to raising a new generation of drug-free young Americans. Let's leave the 1980s with the destructive drug culture behind us.

THE DRUG EPIDEMIC:

The United States does not have a long tradition of drug abuse; thus, it was caught off-guard by the surge in marijuana use during the last two decades. In the late 1950s fewer than one percent of American teen-agers had ever tried marijuana or any other illegal drug. In 1980, over 60 percent had experimented with drugs. This 6000 percent increase was unprecedented in world history.

Initially, marijuana use was confined to subcultural groups of young adults who were protesting perceived injustices in mainstream

society. Gradually, in the face of ignorance about the health effects of marijuana and controversies about law enforcement, usage expanded to mainstream America.

The average age of initial use dropped from 19 to 12. By 1980, pot-smoking had become a "normalized" rite of passage into teen-age social life. "Partying" meant "getting high" and over 40 percent of teens became "social" or regular users. Ten percent of high-school seniors were stoned every day. Among high-school dropouts, truants and uncooperative students, daily use was estimated at 25 to 50 percent. These young drug users carried their habits into the work force and the military, causing a decline in economic productivity and a threat to national security.

THE INFORMATION GAP:

Marijuana and hashish had been consumed for hundreds of years in some societies (Egypt, Turkey, India, parts of Africa), but its use was generally confined to lower-class, adult males. America experienced the first democratic, egalitarian drug epidemic, which included the highly educated and skilled-labor classes—as well as children, adolescents, females, and fetuses. Scientific research on the drug's effects on these new and vulnerable groups lagged behind the realities of widespread usage. The 1950s' myth of "reefer madness" was replaced by the 1970s' myth of "harmless marijuana"—the "soft drug," the "mellow herb."

THE DRUG CULTURE:

The information gap was filled by the commercialized drug culture, which advertised and marketed the "joy of getting high" as an attractive, amusing consumer product. Drug-related comic books, slick magazines, toys, board games, T-shirts, and candy-flavored rolling papers made pot-smoking seem like "fun and games." Popular music, movies and T.V. shows portrayed marijuana use as socially acceptable and inevitable. By the 1980s, the economic profits from the marijuana trade were just under those of EXXON and General Motors.

THE PARENTS' COUNTER-MOVEMENT:

Despite the widespread myth of marijuana's harmlessness and the multibillion-dollar drug culture, increasing numbers of American parents recognized the drug's harmful effects on their children. Joining together in parent groups, community task forces and civic associations, they collected the latest scientific research findings to educate themselves and their children. Concerned parents and citizens are implementing stronger guidelines in the home, school and community to prevent and intervene in illegal drug use. And they are making a difference.

In the past four years, the escalating trends have begun to reverse. Among high-school seniors, casual experimentation is still shockingly high (57 percent), but social usage has dropped to 27 percent and daily use to 5.5 percent. However, the problem has intensified among dropouts and disadvantaged groups, and is severely aggravated by the increased availability of cocaine.

Committed volunteers are showing that the drug problem can be significantly reduced. But America still has a long way to go to reclaim the drug-free lifestyle as the norm for a healthy and productive society.

EDUCATION—THE KEY TO PREVENTION:

The most effective deterrent to marijuana use is accurate, relevant and up-to-date information on its biological effects. If youngsters say NO to marijuana, they say NO to the whole drug culture. It is quite rare for a non-marijuana user to try any other illegal drug.

The most effective deterrent to marijuana

dealing is tough and consistent law enforcement. Greater public awareness of the health hazards of the drug will rebuild respect for the drug laws and will strengthen community support for local and federal law enforcement.

WHAT YOU NEED TO KNOW ABOUT MARIJUANA:

1. **NOT A SIMPLE HERB:** Despite the 1970s' image of marijuana as a "natural, organic product," the *cannabis sativa* plant is a complex chemical factory. The crude drug *marijuana*, which is made from its dried leaves and flowering tops, contains 426 known chemicals which are transformed into 2000 chemicals when smoked. The 70 *cannabinoids*, which are found nowhere else in nature, are fat-soluble and retained in fatty membranes for weeks. (Alcohol, which is also a drug, is water-soluble and metabolizes rapidly out of the body). Repeated use of marijuana leads to accumulation of chemicals in the body and to gradual deterioration. *Delta-9-tetrahydrocannabinol* (THC) is the most potent psychoactive or mind-altering chemical, but other cannabinoids (about which little is known) also affect the mind. The chemical half-life of THC is 3 to 7 days, and it can be traced in urine 7 to 10 days after smoking a single "joint."

2. **UNPREDICTABLE POTENCY:** In the 1960s most American marijuana contained one-half to one percent THC and gained a popular reputation as a "harmless weed." Improved plant genetics and cultivation techniques led to increasing potency. In the 1980s, imported marijuana averages 3 to 5 percent THC, and California-developed *sinsemilla* rises to 14 percent THC. High potency marijuana can cause serious psychiatric and physical problems—it is not a "soft" drug. Young experimenters are rarely aware of the potency or adulterants in the "pot" they play around with.

3. **CAN BE ADDICTIVE:** Despite some doubt in the 1970s, most researchers now agree that marijuana can be addictive. Heavy users develop tolerance to the drug (need increasing doses to get "high"), experience withdrawal symptoms (irritability, restlessness, sweating, decreased appetite), and have difficulty stopping use. Because of the drug's slow elimination from the body, withdrawal is not abrupt or dramatic as with alcohol and opiates (which are rapidly metabolized out of the body). However, habituation to the marijuana "high" and post-"high" depression are factors in the addiction process, which involves approximately 20 to 50 percent of users.

4. **LEADS TO "HARDER" DRUGS:** Ten years of national surveys now reinforce the public's perception that marijuana is the gateway into further illegal-drug usage. Certainly many casual experimenters do *not* try other drugs, but among pot-smokers, a shocking 60 percent do progress to "harder" drugs. Conversely, if young people do *not* smoke pot, the odds are 98 to 1 that they will *never* try any other illicit drug. Among high-school seniors, some 27 percent try stimulants, 16 percent sedatives, 16 percent cocaine, 9 percent LSD, and 6 percent PCP. Nearly all of them started with marijuana.

5. **CHANGES BRAIN FUNCTION:** Marijuana changes brain chemistry to produce a "high"—euphoria, hilarity, relaxation, free associational thinking, forgetfulness. It can also produce panic, anxiety, hallucinations, flashbacks and toxic psychoses—depending on the potency of the drug and the susceptibility of the user. Heavy and/or long-term usage lead to impaired memory, sometimes equivalent to pre-senile dementia. Recent biopsies of drug-exposed monkey brains reveal widened synaptic gaps and tissue atrophy, similar to earlier clinical reports on humans. Chemical overstimulation of brain

pleasure centers and cumulative sedation of the central nervous system may contribute to the emotional flatness and "spacey" gaps in thinking reported by heavy users. Unfortunately, teen-agers' slang descriptions of abusers as "burn-outs", "air-heads" and "space-cadets" seem to accurately portray these brain changes.

6. HARD ON HORMONES: Many chemicals in marijuana effect hormonal function, some through changes in brain signals and others through absorption into reproductive organs. The unborn baby and the adolescent are most vulnerable to these complex and unpredictable effects because they are undergoing rapid cellular changes.

MALES: Smoking even one marijuana cigarette can cause a temporary drop in testosterone production (the major male hormone). Heavy and prolonged use can alter male hormones enough to cause deficient pubertal development in teen-age boys. Alcohol plus marijuana increases the risk of uneven or abnormal sexual development in boys. A stereotypical "wasted" physique is observed in some teen-agers who are heavy users: narrow shoulders, lack of muscle development in arms, chest and buttocks; heavy-lidded, reddened eyes; facial pallor; some feminization of voice, facial or genital development. Heavy use can lead to lowered sperm count and motility and to increased abnormalities in sperm. The "amotivational syndrome" (characterized by apathy, lethargy and goallessness) is probably caused by deficiencies of sex and energy hormones as well as sedation of the central nervous system.

FEMALES: Marijuana chemicals are absorbed into the female reproductive organs, where they may cause some atrophy of tissues and interference with regular menstrual cycles. Changes in brain signals may lead to impaired ovulation and decreased fertility. In some users, menstrual periods do not recur until several months of abstinence from the drug. The chemicals can be toxic to the developing fetus, causing increases in miscarriages, stillbirths, and early post-natal deaths. A "fetal marijuana syndrome," characterized by lower birth weights and developmental abnormalities, is reported to occur five times more often than the "fetal alcohol syndrome." Unfortunately, much casual marijuana use takes place in the early weeks of pregnancy, when the woman is unaware that she is pregnant. Marijuana chemicals are transferred through the mother's milk to the nursing infant.

7. GENETIC ROULETTE: Researchers are concerned that the chemical price for "partying with pot" may be paid by the next generations of children. Human and animal studies show changes in the sperm's transmission of the genetic code. Male animals exposed to marijuana pass on increased risks for hormonal deficiencies, sexual abnormalities and birth defects in their sons and grandsons. No studies have yet been done on second- and third-generation humans. Still unresearched is the possibility of genetic changes in the female's ova (eggs) through pre-pregnancy marijuana use. Every female is born with a lifetime supply of immature ova, and exposure to toxic substances at any time may cause future fetal problems.

8. LETHAL IN LUNGS: Though nicotine's high addiction factor causes tobacco smokers to consume more cigarettes than marijuana smokers "joints," the higher level of cancer-causing chemicals and methods of deep inhalation in marijuana are raising grave concerns about new outbreaks of lung cancer by the late 1980s. Moreover, most pot-smokers also smoke tobacco. The use of special pipes, "bongs," and "powerhitters," all designed to maximize lung exposure to marijuana smoke, increase the cancer and emphysema risk.

Marijuana also immobilizes the alveolar macrophages, cells in the lung which defend against bacteria, viruses and pollutants.

9. DEPRESSES IMMUNE SYSTEM: The body defends itself against disease and pollution by mobilizing its immune system. The rapidity and persistence of this response is the key to successfully fighting cancer, viral infections and sexually transmitted diseases. Marijuana depresses cell-mediated immunity, which leads to increased susceptibility to bacterial and viral infections, including venereal diseases such as *herpes simplex*. Marijuana smoking may also trigger recurrent outbreaks of latent herpes infections. The many contaminants in the dried plant material, such as aspergillus fungus and salmonella bacteria, may lead to complications of colds, pneumonias and mononucleosis, as well as respiratory and intestinal disorders.

MARIJUANA IS ILLEGAL—BY LOCAL, FEDERAL, AND INTERNATIONAL LAW:

Despite misleading statements in the media, marijuana remains an illegal drug in the United States. In fact, the possession, cultivation and trafficking in *cannabis sativa* are specifically forbidden by international drug laws. The United States and 115 other nations are signatories to the *United Nations Single Convention on Narcotic Drugs*, which prohibits all nonmedical consumption of marijuana, cocaine, heroin and other drugs of abuse. An international treaty is the highest law of the land, and local and state governments cannot independently choose to disregard it, despite local political concerns. Local and national governments can vary the severity of penalties for drug possession, as has happened in some areas with decriminalization (substituting fines for incarceration). However, public sentiment increasingly demands tougher drug laws and stricter enforcement.

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Drug Scene Update

PRIDE: DRUG SCENE UPDATE

OVERVIEW: After ten years of steadily increasing drug use among teenagers, a counter-trend began in 1980, as more young people turned away from drugs and sought a healthier lifestyle. The major factor in this encouraging trend was growing public awareness of the health hazards of marijuana and its role as the gateway into illegal drug use. In 1985, however, the decline in marijuana use stalled, as media coverage of the drug's negative effects faded. Public attention became focused on the dramatic emergence of smoked cocaine, or "crack." PRIDE believes that the most effective deterrant to "crack" use is sound and consistent *primary prevention of "gateway" drug use.* Youngsters who avoid the illegal use of alcohol, tobacco, and marijuana—the entry drugs—do not progress to cocaine, heroin, or any other drug use. For the sake of our children's health and safety, "LET'S SHUT THE GATE ON GATEWAY DRUGS!"

EPIDEMIC SPREAD: In 1960, less than 1% of American teenagers had ever tried marijuana or any other illicit drug. By 1980, over 60% had experimented with drugs. This 6,000% increase within 20 years was unprecedented in world history. Initially, marijuana use was confined to sub-cultural groups of young adults who were protesting perceived injustices in mainstream society. Gradually, in the face of ignorance about the health effects of marijuana and controversies about law enforcement, usage expanded to mainstream America. The average age of first use dropped from 19 to 12. By 1980, pot-smoking had become a "normalized" rite of passage into teenage social life. "Partying" meant getting high on drugs *and* alcohol, and over 40% of teens became "social" or regular users. Ten percent of high school seniors were stoned every day. Among high school dropouts, truants, and uncooperative students, daily use was estimated at 25 to 50%. These young drug users carried their habits into the work force and the military, causing a decline in economic productivity and national security.

The commercialized drug culture depends upon an expanding economic market of young consumers. Thus, it broadcasts a "drugs are fun" message in youth-oriented movies, music, TV programs, magazines, and T-shirts. The most effective counter-message to the illegal drug merchandisers is sound health information. INFORMED parents and citizens can reverse the drug epidemic.

CURRENT USAGE: In 1985, some 61% of high school seniors admitted trying an illicit drug. Fifty-four percent used marijuana (down from 60% in 1979), and 40% used other drugs (vs. 37% in 1979). Current marijuana use declined from 37% to 26%, while daily use dropped from 11% to 5%. Despite the significant 7-year decline, the U.S. figures are still the highest in the developed world. More

development. Heavy use may lead to lowered sperm count and motility, to increased abnormalities of sperm, and to impotence. The "amotivational syndrome" (characterized by lethargy, apathy, and goal-lessness) may be caused by depression of the central nervous system and deficiencies of sex and energy hormones.

FEMALES: Regular use affects the menstrual cycle, sometimes leading to lack of ovulation and decreased fertility (Smith, 1983). In adolescent girls, chronic exposure may delay onset of menstruation and vaginal cornification (Field, 1985). Atrophy of tissue in the ovaries and uterus and vaginal dryness have been reported in some users. Hormonal and menstrual disruptions may linger for some months after cessation of usage. Young girls are particularly vulnerable to these reproductive effects, for the complex process of sexual maturation takes several years for completion. Marijuana in combination with tobacco smoking and/or birth control pills may complicate the hormonal abnormalities.

FETUS: Marijuana chemicals can be toxic to the developing fetus, causing increases in miscarriages, stillbirths, and early postnatal deaths. A "fetal marijuana syndrome," characterized by lower birthweight and developmental anomalies, occurs 5 times more frequently than the "fetal alcohol syndrome" (Hingson, 1982). Exposed babies show problems in eye development and focusing that last for several years (Fried, 1986). Human and animal studies show changes in the sperm's transmmission of the genetic code (Issidorides, 1979; Dalterio, 1986). In animals, birth defects occur in succeeding generations. There is growing concern that marijuana use may effect the genetic health of future human generations.

IMMUNE SYSTEM: Marijuana's depressant effect on cell-mediated immunity can lead to increased susceptibility to bacterial and viral infections, including sexually transmitted diseases such as *Herpes simplex* and *AIDS* (Juel-Jensen, 1972; Morahan, 1979; Cabral, 1985; Lopez-Cepero, 1986). The many contaminants in the dried plant material, such as aspergillus fungus and salmonella bacteria, may lead to complications of colds, pneumonias, and mononucleosis, as well as respiratory and intestinal disorders.

LUNGS: The high level of carcinogens in marijuana smoke and the method of deep inhalation cause researchers to predict an outbreak of respiratory cancers by the late 1980's. Combined smoking of tobacco and marijuana and use of bongs and powerhitters increase the respiratory dangers.

BEYOND THE GATEWAY DRUGS: COCAINE

Cocaine is rarely the first drug used; rather, it is added to a drug use pattern of marijuana smoking and

youngsters are indeed saying NO to drugs, but those who say YES to experimentation are increasingly at risk, because of increased supplies of high-potency marijuana, cocaine, and "designer" drugs. Stimulant use remains high (30%), a trend associated with increased advertising and availability of diet pills, study aids, and "look-alike" drugs. Media glamorization contributed to the doubling of cocaine use (to 17%), a figure that will increase as supplies grow and prices drop.

STEPPING STONES OF ABUSE: Tobacco smoking is a major pre-disposer to marijuana smoking. Eighty-one percent of teenage smokers also try marijuana, versus only 21% of non-smokers. After underage consumption of beer and wine, the movement to hard liquor is associated with marijuana use. Marijuana continues to be the gateway to illicit drug use. Sixty-seven percent of marijuana users progress to other drugs, while youngsters who do not smoke pot rarely try other drugs (98% abstention rate). Stimulants, especially in the form of diet pills, are beginning to play a gateway role among young girls.

HEALTH EFFECT OF GATEWAY DRUGS

TOBACCO: Cigarette smoking is the largest preventable cause of death in the U.S. It is linked with cancers of the lungs, throat, and bladders, and with emphysema, bronchitis, and heart disease. The younger the age of initiation to smoking, the greater the chances of serious health impairment. Nicotine is one of the most addictive chemicals known, and cigarette dependency one of the most difficult drug habits to break. Of youngsters who experiment with only 5 to 10 cigarettes, nearly 85% will become habituated smokers.

ALCOHOL: Of adults who drink, some 7 to 10% will become chornic alcoholics, generally within 15 to 20 years. Adult alcoholism is increasingly recognized as an inherited or metablic disease, rather than a character disorder. Of juveniles who drink, the odds for alcoholism are 2 or 3 times as high. The increased vulnerability is caused by metabolic and neurological immaturity. Until full physical maturity is reached, usually between 19 and 23 for girls and boys respectively, the young body does not metabolize alcohol effectively. Lack of completely organized brain systems and fully developed body mass make the still-growing adolescent more vulnerable to alcohol toxicity and dependence. Imbalances in hormonal and hypothalmic function—which are associated with typical adolescent traits of impulsivity, volatile mood swings, and risk-taking—are exaggerated by alcohol.

Alcohol abuse by inexperienced teenage drivers is the number one cause of death. Sexual problems of premature and unprotected intercourse, as well as venereal disease, are associated with teenage intoxication. Regular drinking contributes to the developmental disruption called "chemical immaturity," in which chronological adults remain emotional adolescents.

MARIJUANA: The increasing potency in commercially cultivated marijuana is associated with more rapid and serious deterioration of mental and physical health. Delta-9-THC content has risen from an average 1% to 4%, with California-style *sinsemilla* escalating to 14%. Marijuana intoxication has lingering effects on psychomotor function, long after the "high" has worn off. The complex actions of the 421 known chemicals in the plant and the long-lasting effects of the 70 lipid-soluble *cannabinoids* are responsible for the system-wide biological impairment observed in marijuana abusers. Periodic release by cell membranes and recirculation of cannabinoids contribute to the cumulative effects and delayed toxicity of longterm usage. Urine testing reveals cannabinoids still present after six weeks of abstinence by heavy users.

BRAIN: High potency marijuana is linked with increasing incidents and panic reactions, paranoia, flashbacks, and toxic psychoses. Clinicians in several countries report significant increases in marijuana-related mental illness (Rydberg, 1986). Heavy use can reduce blood flow in the brain and cause severe memory impairment, in some cases equivalent to senile dementia (Tunvig, 1986; Stuart, 1981). Biopsies of drug-exposed monkey brains reveal enlarged ventricles and tissue atrophy, similar to the widened synapses and chemical clumping reported earlier in humans and monkeys (Sassenrath, 1983; Heath, 1980; Campbell, 1971). The first autopsy studies of human brains from longterm users reveal micro-lesions and depleted proteins in neurons, which are strikingly similar to those in clinically depressed suicide victims (Issidorides, 1986). Chemical over-stimulation of brain pleasure centers and cumulative sedation of the central nervous system may explain the emotional flatness (anhedonism) observed in heavy users. Teenage slang descriptions of abusers as "burnouts" and "air heads" are unfortunately accurate.

ENDOCRINE FUNCTION: Many chemicals in marijuana effect hormonal function, some through action on the hypothalamus and pituitary and others through absorption into reproductive tissues. the fetus and adolescent are most vulnerable to these complex and unpredictable effects because of the rapid cellular changes they are undergoing.

MALES: Heavy marijuana use decreases testosterone production, sometimes leading to deficient pubertal development (Copeland, 1980; Diamond, 1986). A stereotypical "wasted" physique is observed in some teenagers who are heavy users: narrow shoulders; lack of muscle development in arms, chest, and buttocks; reddened, heavy-lidded eyes; facial pallor; some feminization of facial or genital development. The estrogenic action of *cannabis pirans,* chemicals found in much Colombian marijuana, may aggravate problems of sexual

development. Heavy use may lead to lowered sperm count and motility, to increased abnormalities of sperm, and to impotence. The "amotivational syndrome" (characterized by lethargy, apathy, and goal-lessness) may be caused by depression of the central nervous system and deficiencies of sex and energy hormones.

FEMALES: Regular use affects the menstrual cycle, sometimes leading to lack of ovulation and decreased fertility (Smith, 1983). In adolescent girls, chronic exposure may delay onset of menstruation and vaginal cornification (Field, 1985). Atrophy of tissue in the ovaries and uterus and vaginal dryness have been reported in some users. Hormonal and menstrual disruptions may linger for some months after cessation of usage. Young girls are particularly vulnerable to these reproductive effects, for the complex process of sexual maturation takes several years for completion. Marijuana in combination with tobacco smoking and/or birth control pills may complicate the hormonal abnormalities.

FETUS: Marijuana chemicals can be toxic to the developing fetus, causing increases in miscarriages, stillbirths, and early postnatal deaths. A "fetal marijuana syndrome," characterized by lower birthweight and developmental anomalies, occurs 5 times more frequently than the "fetal alcohol syndrome" (Hingson, 1982). Exposed babies show problems in eye development and focusing that last for several years (Fried, 1986). Human and animal studies show changes in the sperm's transmmission of the genetic code (Issidorides, 1979; Dalterio, 1986). In animals, birth defects occur in succeeding generations. There is growing concern that marijuana use may effect the genetic health of future human generations.

IMMUNE SYSTEM: Marijuana's depressant effect on cell-mediated immunity can lead to increased susceptibility to bacterial and viral infections, including sexually transmitted diseases such as *Herpes simplex* and *AIDS* (Juel-Jensen, 1972; Morahan, 1979; Cabral, 1985; Lopez-Cepero, 1986). The many contaminants in the dried plant material, such as aspergillus fungus and salmonella bacteria, may lead to complications of colds, pneumonias, and mononucleosis, as well as respiratory and intestinal disorders.

LUNGS: The high level of carcinogens in marijuana smoke and the method of deep inhalation cause researchers to predict an outbreak of respiratory cancers by the late 1980's. Combined smoking of tobacco and marijuana and use of bongs and powerhitters increase the respiratory dangers.

BEYOND THE GATEWAY DRUGS: COCAINE

Cocaine is rarely the first drug used; rather, it is added to a drug use pattern of marijuana smoking and excessive drinking (Gold, 1986; Adams, 1986). The high cost and low potency of cocaine kept usage low and damage rare in the Seventies. Faced with a declining drug consumer market in the Eighties, the drug cartels developed a highly addictive, inexpensive form of cocaine, targeted at the smoking market.

Cocaine is an alkaloid extracted from the leaf of the coca bush. A powerful stimulant to the central nervous system, cocaine has mind-altering and energy-producing qualities similar to amphetamines. When snorted in powder form, cocaine changes brain chemistry and produces a surge of energy, euphoria, and alertness that lasts about 20 minutes. The drug then withdraws rapidly from the brain, making the user feel depressed, irritable, and fatigued. Though still infrequent, snorting cocaine can be deadly to susceptible people (through cardiac arrest, irregular heart rhythms, respiratory suppression, or seizures).

The coke "crash" reinforces the brain's craving for a repeated dose, to alleviate the distressing withdrawal symptoms. Higher potency and more frequent use change the mechanisms of biological drives in the brain. Cocaine use becomes a more powerful drive than the survival instincts of hunger, thirst, sex, and fight-flight. Hoping to produce a growing addict market, the drug cartels are flooding the U.S. with cheaper cocaine in smokeable forms (free-base, *basuco*, and "crack"). The "new" cocaine is tailor-made for marijuana smokers who move easily into a more powerful drug that fits into familiar social patterns and paraphernalia ("socially acceptable" pipes and cigarettes versus injection needles). Many cocaine smokers then progress to heroin smoking ("chasing the dragon"), in order to medicate their "wired-out" central nervous system.

CONCLUSION: Ninety-eight percent of cocaine and heroin users started with marijuana.

BY SHUTTING THE GATE ON GATEWAY DRUGS, THE U.S. WILL BLOCK THE ROAD TO COCAINE AND HEROIN ADDICTION.

DOCUMENTATION: Nahas and Patton, *Marijuana: Biological Effects* (1979); *Marijuana and Health:* National Academy of Sciences (1982); Report of Addiction Research Foundation and World Health Organization on . . . Cannabis Use (1981), plus special articles by named researchers which can be ordered by PRIDE.

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National Parents' Resource Institute for Drug Education, Inc.

If you're concerned . . . become informed.

PRIDE, the National Parents' Resource Institute for Drug Education, Inc., is a private, non-profit organization headquartered in Atlanta, Georgia. Pride's goal is to stem the epidemic of drug use, especially among adolescents and young adults. To accomplish this goal, PRIDE has developed a program which includes the dissemination of accurate health information, as well as the formation of parent and youth networks.

PRIDE believes that the best way to solve a drug problem is to prevent it from ever beginning through a scientifically sound program tailored to specific audiences. Both younger children in elementary school and older boys and girls who are likely to be faced with temptation are included in PRIDE's audience. PRIDE assists parents in forming parent networks to make peer pressure a positive force for freedom from drug dependence rather than a negative force. One of the many examples of the success PRIDE has enjoyed is Atlanta's Northside High School, now a model for the nation. A group of parents from Northside took the ideas gained at a PRIDE conference and implemented a program to make the school drug-free.

PRIDE has grown rapidly in its first years of existence. Its unique approach has received numerous votes of confidence from the public, from health professionals, from government officials and from the parents and young people PRIDE serves.

Concerned about drug abuse by youth as long ago as 1970, Dr. Thomas Gleaton began teaching a course on drugs and youth at Georgia State University. To address the pressing need for information transmittal, he and a group of colleagues initiated the Southeast Drug Conference in 1975 to assist educators and counselors in

working with drug problems among their students. This successful conference became an annual event, with participation increasing with each succeeding year. In 1977, the conference featured Dr. Norman Doorenbos, research chemist and director of the National Marijuana Research Project. Dr. Doorenbos updated the conference participants on the complex biochemical effects of marijuana, information not generally available at the time. This new information caused those who had previously dismissed marijuana as a relatively harmless substance to have serious second thoughts.

At the urging of Dr. Marsha Manatt Schuchard, who had formed the first parent network in Atlanta, Dr. Gleaton targeted the 1978 conference toward ordinary parents. With sound scientific data, reasoned Dr. Gleaton, parents could articulate a credible pro-health, anti-drug message to their children.

The 1978 conference led to the opening of the PRIDE center at Georgia State University. The PRIDE philosophy of accurate health information and a parent network based on the child's friendship circle was defined by Dr. Schuchard in her book *Parents, Peers and Pot,* published by the National Institute on Drug Abuse in 1979. This handbook for parents, explaining how to form a parent network and providing the parents with current information on marijuana, has become a government "best seller."

PRIDE has also supplied information to *Reader's Digest, Ladies' Home Journal, McCall's, Family Circle, Good Housekeeping,* the *Washington Post,* the *New York Times,* the *Christian Science Monitor,* and major TV networks reaching millions of parents and young people.

PRIDE continues to sponsor annual conferences. In 1982, attendance totaled 1,000 people representing 40 states and four foreign countries. By 1986, the conference attained an international reputation as more than 5,000 participants representing 70 nations joined U.S. participants from 44 states. Many are young people, who come from throughout the nation and other parts of the world to attend the concurrent youth conference which the adult conference has spawned.

The PRIDE organization also sponsors one-day seminars for parent-school-community teams which have served 700 schools and civic organizations. PRIDE consultants have visited 36 states to help organize parent groups, local conferences and

workshops. They have testified at congressional hearings and presented programs at medical schools, military bases, the White House and international conventions. PRIDE recently opened its first international office in Belize, Central America.

PRIDE does not compete with any drug treatment facility or program. It functions as a clearinghouse and reference source to direct parents and children to the nearest appropriate facility in their area. PRIDE groups have organized to combat drug use by youth in many communities across the nation. The practical steps which parents and communities can take to help their children resist the use of drugs are available from PRIDE.

PRIDE has enjoyed remarkable success. The annual conference it instituted in 1978 with 175 participants has mushroomed into the PRIDE International Conference which in 1986 had more than 5,000 youth and adult participants from the 44 states and 70 foreign countries. Mrs. Nancy Reagan and the First Ladies of nine countries were guests of honor. *Parents, Peers and Pot* has passed the million copy mark. The PRIDE newsletter has grown from a Georgia quarterly to an information source for an international audience.

There are more than 7,000 organized parent groups for drug-free youth in the United States. Most turn to PRIDE for organizational advice. To respond to this need, PRIDE has identified contact persons in every state to refer callers to resources, including treatment facilities, workshops, parent group activities and individuals who are willing to share their experience and information.

PRIDE began presenting programs in greater Atlanta, but the effect has reached far beyond this area. H. Ross Perot, Board Chairman of Electronic Data Systems, Inc., in Dallas, credits PRIDE for its crucial assistance to him as the Governor's Chair of the Texans' War on Drugs Committee. "The advice and expertise of PRIDE," he stated at the 1981 PRIDE conference, "has been the single most important resource available to us in our war against drugs in Texas."

For more information, call or write:

PRIDE
100 Edgewood Avenue, Suite 1002
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"Three years ago I attended my first PRIDE Conference. It was during that trip that my thinking on drug abuse began to crystalize. I had already seen the pain our children were suffering, but I had not seen the answer. At the PRIDE Conference, I began to see the hope, the way we could save our children from drugs. I saw it in the faces of the mothers and the fathers of PRIDE, and that visit genuinely marked a turning point for me."

—Nancy Reagan

"I can't think of any organization or undertaking that means more than PRIDE to the future of our children and the welfare of our country. I am happy to join you in declaring that there is no such thing as responsible drug use among children."

—William Shatner, PRIDE Spokesman
Star of "Star Trek"

"PRIDE is a great program, because it realistically involves parents, students, school staffs and other concerned groups. The concept used by PRIDE of building a network for students strengthens families and brings about a renewal of a sense of community."

—Alonzo Crim
Superintendent of Schools
City of Atlanta Public Schools

"Since I started writing on the subject of marijuana in July of 1978, PRIDE has been the single most important source for information. PRIDE's contribution to the American people is inestimable and may one day be regarded as historic."

—Peggy Mann
Author and Journalist

"PRIDE stood up against drug abuse when too few others in the U.S. were paying attention. It continues today as a foremost leader in nationwide efforts to save our children and youth from damaging their lives by using dangerous drugs."

—Donald Ian Macdonald, M.D.
Administrator, Alcohol, Drug Abuse
and Mental Health Administration

"The advice and expertise of PRIDE has been the single most important resource available to us in our war against drugs in Texas.

— H. Ross Perot, Chairman
Electronic Data Systems
Chairman, Texas Governor's War on Drugs

"I am well aware of the sterling work done over the years by PRIDE and of the commendable manner in which you share with others the lessons of your experience. At a time when drug abuse has in many countries attained almost epidemic proportions, the parents of our young people have a special burden to bear. In this regard, PRIDE and organizations like it provide parents with assistance, guidance and support which can only be termed invaluable.

—Javiere Perez de Cuellar
The Secretary-General, United Nations

PRIDE

COMMUNITY PLAN; DRUG ABUSE PREVENTION

by Thomas J. Gleaton, Ed.D.

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PRIDE'S COMMUNITY PLAN
for Drug Abuse Prevention

Introduction

The United States entered the 1980s with an historically unprecedented epidemic of drug use among its young people. Twenty years ago, less than 2% of American teenagers had ever tried any illegal drug; today, nearly 70% have used marijuana with an estimated 10% to 20% using it daily. At the same time, youngsters are drinking heavily and mixing drugs in ways that are increasingly hazardous to their health and safety.

The commercialized drug culture utilizes sophisticated advertising and entertainment techniques to send a steady stream of messages to children that "drugs are fun." Thus, a majority of adolescents now associate "partying" (that is, having a normal social life of friends and fun) with intoxication by drugs and alcohol.

The disruption of psychological maturation and deficiency of intellectual and physical development that occurs in adolescent drug abusers is already producing a growing percentage of young adults who are immature, unmotivated, inefficient and unproductive. They are increasingly dependent on overburdened families, employers, courts and social services. The resultant drain on the economy, schools and industry is exacting a high price from America.

Preventing Drug Abuse

To prevent drug abuse by youth in a highly mobile, consumeristic and hedonistic society demands a dedicated community effort from parents, schools, volunteer agencies, business, law enforcement and judicial systems. It is our belief at PRIDE that the effort must be guided by dedicated parents and that their role is the most vital element in the total process. Parents have the most to lose — their children — and the most to gain — healthy, productive and mature young adults. If drug abuse is not prevented, the local community and the larger society stand to lose much of the production potential of the individual and may end up with an individual who is a liability rather than an asset.

The PRIDE plan consists of three action levels:

I. COMMUNITY ALERT
II. SCHOOL COOPERATION
III. PARENT EDUCATION

The action levels may happen independently of each other. But an overall plan of action which allows the community to work together in a non-blaming manner will add much to the probability of success. The following plan of action should be refined, revised, improved, and most of all, utilized in a way that best fits the particular needs of the community and the individual personalities who attempt to implement a drug abuse prevention plan.

I. COMMUNITY ALERT

Drug use by the youth of this nation must be viewed from a broad perspective. There are many factors causing drug use and they will be discussed later in PRIDE's list of recommended resources for understanding why youth use drugs. Paramount in the community alert is a group of parents willing to commit themselves to a belief in self-help, non-blaming "we can make a difference" philosophy. The parent group or groups are the key ingredient to a successful community alert program. They must first begin to educate themselves and there are sufficient resources available for parents to complete this first step within a few weeks. This does not mean that parents have to become drug abuse experts, but they do need a sufficient amount of information to feel comfortable with their knowledge and be ready to share their insights with friends, neighbors and the larger community.

A plan for "drug abuse awareness week" for the community should include informing and soliciting help from the news media, school system, PTA, law enforcement, judicial system, churches, mayor, elected officials, medical association, business leaders (Chamber of Commerce) and any other facet of your community that may be of assistance in this effort. Solicit their perceptions of the problem, assist in defining roles and responsibilities and share practical ideas on how they can help. The following listings are just some of the ideas of roles and responsibilities of various facets of community life. These are NOT all-inclusive, but might be applicable to your community.

A. Parents

Parents are the first line of defense against drug use by children and youth. Parents should become informed about the impact which drug use may have on the mental, physical and social health of young people.

Practical "action ideas" for parents may include:

1. Gathering information about the effect of drug and alcohol use on children and youth. Find out as much as possible what the local drug scene is like in your neighborhood and community.
2. At home, talk to your child about what you are learning and commit yourselves to a **mutual** drug and alcohol education.
3. Make a clear and firm stand against **any** illegal drug usage by your child.
4. Contact the parents of your child's friendship group and ask that they meet to share the information which you are gathering.
5. Get the parents together and commit to a mutual learning process.
6. In your parent group, work out a common code of basic behavior rules — on drugs and drinking, car-dating, curfews, chaperoning, etc.
7. Maintain a communication network among families so that you can keep up with changing trends and social situations.
8. Work hard at developing fun, meaningful and constructive alternatives to drug and alcohol use for the youth in your community.

9. Recognize that it will not be all sweetness and light. Kids who are cocooned into a drug-using peer-group will fight to maintain that secure circle of friends.
10. After educating yourself, your child, and forming a parent group based on your child's friendship circle, you may want to become involved in other aspects of the community prevention efforts.

B. Youth

While the parents are the first line of defense against drug abuse by their children, the students themselves must become a part of the effort. Positive peer pressure provides the security and support needed to remain drug-free.

Practical "action ideas" for youth may include:

1. Gather information about the physiological effects of the popular drugs today, as well as any special problems caused by their use during adolescent development (physical and social).
2. Explore the social pressures in your area that influence or encourage the use of drugs and ignore the health effects.
3. Share information on the impact of social pressure to participate in drug use with others in your school, community, clubs, teams, etc.
4. Encourage others to become involved, not because those who use drugs are "bad" or "dumb," but because they deserve to know about the real effects of drug use while they still have the choice to stop or never start.
5. Develop ways to show others how to have fun without being intoxicated while at the same time showing them that others will accept and like them while they are sober.
6. Work with all sectors of the community to help younger students remain drug-free.
7. Investigate the social scene in your community. Be on the lookout for ways that you and your friends can help remove the pressures to use drugs.
8. Keep spreading the word. There are many students out there who would like to stay free from drugs, but can't do it alone. Show them how easy it is to say "no" together!

C. News Media

Your grass root parent effort is "newsworthy" and time spent on meetings with the representatives of the different news media will be time well spent.

Practical "action ideas" for media may include:

1. Form a citizens advisory committee to work with media on developing a community awareness of youthful drug and alcohol abuse. (Utilize existing service organizations and clubs to form the citizens advisory committee).
2. Ask movie and T.V. programmers to alert their audience if drug use is a part of the film content. (The Movie Rating Board of the Motion Picture Association of America could include drug usage as a negative consideration in their ratings).
3. Solicit celebrities and sports figures to volunteer public service announcements (PSAs) to alert the public to the dangers of alcohol and drugs.

4. Ask media for special reports on events which promote drug use (rock concerts, marijuana smoke-ins, Hash Bashes, etc.).
5. Develop a media-watch by citizens and ask that concerns be reported by an ombudsmen who is acceptable to both media representatives and citizens.

D. Law Enforcement

If a child becomes involved with drugs, there is a good chance that he or she will confront the law enforcement system. In a community project, it is very important to solicit the support of law enforcement officials.

Practical "action ideas" for law enforcement officials may include:

1. Identify areas where drugs are being used (the strip, concerts, parks, etc.).
2. Help identify ways to decrease drug use.
3. Familiarize parents with the sequence of events following arrest and discuss how these events may be improved or changed.
6. Notify businesses selling or serving liquor that a special effort will be made to monitor alcohol sales to minors.
5. Provide speakers to parent groups.
6. Develop a drug case reporting system that can be published in local paper or newsletter to parents.

Judicial System

The judicial system makes vital decisions about the lives of children involved with drug use. The judicial actions should be defined and publicized to children and parents before trouble occurs.

Practical "action ideas" for officials in the judicial system may include:

1. Develop a brief pamphlet on the judicial process, making sure it is clear, obvious and consistent.
2. Make sure judicial action is always dependent on the incident, not on the individual's economic position or influence in the community.
3. Develop alternative consequences to imprisonment that are punitive, imaginative and memorable (e.g., drug school similar to driving school where child and parents are compelled to attend).

F. Health Professions

The health professional can give credible expertise on biological effects of adolescent drug and alcohol use. The message about the harmful effect of psychoactive drugs on youth should be consistent and emphasize the gateway drugs — tobacco, alcohol, marijuana, etc.

Practical "action ideas" for health professionals may include:

1. Develop a tutorial program designed to train students to educate and influence their peers in a positive way.
2. Identify the most popular drugs being used and the effects of the drugs that are most available in the community.
3. Develop continuing programs for health professionals on all aspects of drug abuse, e.g., prevention, diagnosis, effects, treatment.

4. Develop a Health Professional's Regional Resource Team to meet with conferences, workshops and concerned groups regarding drug abuse.
5. Establish a "Health Professions Clearing house" **to provide drug education materials** and **support services** to families and interacting agencies.

G. Churches and Synagogues

Churches and synagogues are vital components of all communities and many times are overlooked as resources. They can provide counseling and education programs for families. More than any other institutions they can define a counter system of values to the self-indulgence and hedonism of the drug culture.

Practical "action ideas" for churches and synagogues may include:

1. Provide drug information workshops for clergy and staff. Speakers with expertise on health, education or parenting could be utilized.
2. Inform congregations of the scope of the drug problem through newsletters, Sunday bulletins, etc., and include a list of community resources, such as counselors, educational materials, speakers and treatment facilities.
3. Develop a curriculum for church youth which would include drug education and peer counseling.
4. Provide speakers for parent groups within the congregation. Speakers should be able to provide groups with factual information regarding drug use and stimulate members to form additional groups.
5. Contact all ministerial alliances within the area and encourage placement of "drug use" on the agenda of their next meeting.

H. Business and Industry

You need to educate this facet of the community because today's youth are tomorrow's work force and community leaders. There is a growing concern over drug use at all levels of our work force. Drug use spans blue collar and highest levels of management.

Practical "action ideas" for business may include:

1. Provide money, phones, office equipment, printing and advertising for drug abuse prevention efforts.
2. Provide employees with information pertinent to their own families' health and role in community.
3. Develop an employee assistance program (EAP) to serve their own employees.
4. Develop a clear and consistent company policy on drug use by employees.

I. Schools

The primary role and responsibility of educators is EDUCATION. They are not police officers, judges, social workers, etc. They do need information about the signs and symptoms of drug abuse. Even though drug abuse should not be viewed as the school's "problem," schools, PTAs, booster clubs, etc. should be a focal point for your community thrust.

Practical "action ideas" for schools may include:

1. Review curriculum to make sure the most up-to-date information is available to students and staff.
2. Review library material on drugs and drug abuse.
3. Survey students to determine levels of drug and alcohol use in the school community.
4. Assist the community by making facilities, audio visual equipment, etc., available for educating parents whose children make up the school population.
5. Educate parents through a school-parent team project, Parent Teacher Association committee, or other service organization.

Once the various community segments are contacted and are aware of the problem of drug use by youth, you might want to set up a community steering committee. Recruit representatives from each segment — e.g., chief of police, newspaper editor, juvenile court judge, minister, Chamber of Commerce president, school superintendent, etc., and meet periodically to discuss, enlighten and map out community strategies.

II. SCHOOL COOPERATION

School-Community-Team — after your community has been alerted to your concerns and understands that the first goal is to educate all the parents in your community about drugs and alcohol effects on youth, you now seek the help of your school system. School personnel and can assist you in identifying parents who would make good team members, can provide the number of classrooms in each school, and advise parents about school policy. The number of parents on a team will depend on the number of classrooms in the school. It is suggested that there be a parent trainer on the team for each four classrooms in the school.

Select a school/community team from each school in your county, city, parish, etc. The team will consist of enough parents so that no parent will be responsible for more than four classrooms. In the case of large high schools, each grade level may have a team.

Example: A school/community team from a school with 20 classrooms should consist of: 5 parents (20 divided by 4 ‡ 5) plus a team captain. The team should invite an administrator and a teacher to attend training and planning sessions. The school representatives usually become very good advocates in the school for your efforts.

It is highly recommended that a survey of drug use prevalence be administered in grades 6-12. Many schools have given the PRIDE Survey to determine the amount and kinds of drug use by youth in the community. The survey can be very helpful in alerting the community and monitoring drug use trends. A sample of the survey can be obtained from the PRIDE office.

III. PARENT EDUCATION

After alerting the community, obtaining the cooperation of the school system, surveying drug use by youth, and selecting your School/Community Team, you are now ready to begin training workshops. The workshop, training session, and report meetings are crucial and PRIDE suggests the following format:

The first training workshop for the school/community team should be conducted at a site in the community which is familiar and non-threatening: such as, a local school or community center. A notice of the time, place, date and workshop agenda should be sent to team members. The following outline for training a parent/school team may be divided into more than one session. Content of the workshops may change as new medical research becomes available, and the social scene changes.

SUGGESTED TRAINING AGENDA

9:00- 9:15	Welcome (Parent group leader, school superintendent, etc.).
9:15- 9:30	Overview of Action Plan (Explain plan, discuss times, dates and expectations of team members).
9:30-10:15	Favorite drugs of youth — Alcohol, tobacco and marijuana (Emphasize pharmacology).
10:15-10:30	Break
10:30-11:00	The "Do-Drug Messages" to children (music, paraphernalia, movies, T.V. news sources, clothing industry, etc.).
11:00-12:00	Review of films available
12:00- 1:00	Lunch
1:00- 1:30	PRIDE slide presentation ("Marijuana and Youth") and discussion.
1:30- 2:00	Discussion of PRIDE (How to utilize the institute).
2:00- 2:30	Teams meet and select captains.
2:30- 2:50	Teams report back to workshop leader with team captains, team member's addresses and telephone numbers completed. (Form 1). Team members should sign the community Drug Abuse Prevention Pledge. The pledge will be helpful in clarifying the team objective.
2:50-3:00	Captains to set dates and agenda for Reporting/Training Sessions at their school.

The team captains should plan at least two report and training sessions for their team. The team members should have name, telephone numbers and addresses of classroom parent leader and teacher (Form II).

SUGGESTED AGENDA for First Reporting/Training Session for Team Captains:

5:50- 6:00	Introduction and Discussion of Materials.
6:00- 6:45	Video Tape or film.
6:45- 7:00	Break.
7:00- 8:00	Film.
8:00- 8:30	Discussion and Reports
8:30- 9:00	Summary

SUGGESTED AGENDA for Second Reporting/Training Session for Team Captains:

5:30- 6:00	Recap and Discussion
6:00- 7:00	Video Tape
7:00- 7:15	Break
7:15- 8:00	Formulate Plan for completing Team Work/Activities
8:00- 8:30	Plans for year and report meeting
8:30- 9:00	Summary

NOTE: Also, team captains agree to be present for two report sessions during the school year and to be responsible for assisting team members, completing progress reports and seeing that the team is in place for next year's effort.

The parent team members should work with the teachers of their assigned classroom in identifying parents who will take a leadership role in this program. It is very important that a parent from the classroom be selected who will commit to educating all parents of the classroom

SUGGESTED PROGRAM for Parent Team Trainer's Meeting with Classroom Parents:

1. Twenty minute slide presentations (PRIDE) or overview by team member.
2. Materials: As chosen by team for distributing to parents.
3. Reporting Forms.
4. Plans for how progress reports will be collected.
5. Discussion.

The Classroom Parent leader may chose to recruit four or five sets of parents from their child's classroom and ask that they assist in educating other parents from the classroom. They form the small group of 8 to 10 parents that will meet together at least 2 times during the year to share information and have open discussion on youth and drug issues. A list of parents with address, telephone and child's name should be obtained.

PRIDE recommends an end of the year report meeting where team members and classroom parent leaders are recognized for their efforts. This meeting could also serve to initiate next year's program by announcing new team members and discussing next year's plan of action.

COMMUNITY DRUG ABUSE PREVENTION PLEDGE

WHEREAS, we believe that a child's parents are his or her best bulwark against drug involvement, and

WHEREAS, we believe that the universal instinct of parents to protect their young is society's best bulwark against the expansion of the commercialized drug culture, and

WHEREAS, we believe that the most innovative and effective drug use prevention effort is that of concerned parents helping other parents become informed about adolescent drug and drinking problems,

WE DO HEREBY PLEDGE
TO EDUCATE PARENTS TO THE BEST OF OUR ABILITY,

ABOUT the current trends in drug and drinking behavior among children and adolescents;

ABOUT the health effects of legal and illegal drugs on particular stages of adolescent development, and

ABOUT the forces in the local community and in the larger society which encourage youngsters to use intoxicants for fun and escape.

TEAM MEMBERS

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

(School) (Date)

_____ _____

REPORT FORM I

PRIDE
School/Community Team Information

SCHOOL: Name _____ Phone # _____

Address _____

City _____ State _____ Zip _____

Captain: Name _____ Phone # _____

Address _____

City _____ State _____ Zip _____

Co-Captain: Name _____ Phone # _____

Address _____

City _____ State _____ Zip _____

Team Members (Name, Address and Telephone Number):

1. Name _____ Phone # _____
   Address _____
   City _____ State _____ Zip _____
2. Name _____ Phone # _____
   Address _____
   City _____ State _____ Zip _____
3. Name _____ Phone # _____
   Address _____
   City _____ State _____ Zip _____
4. Name _____ Phone # _____
   Address _____
   City _____ State _____ Zip _____
5. Name _____ Phone # _____
   Address _____
   City _____ State _____ Zip _____

6. Name _____ Phone # _____

Address _____

City _____ State _____ Zip _____

7. Name _____ Phone # _____

Address _____

City _____ State _____ Zip _____

8. Name _____ Phone # _____

Address _____

City _____ State _____ Zip _____

9. Name _____ Phone # _____

Address _____

City _____ State _____ Zip _____

10. Name _____ Phone # _____

Address _____

City _____ State _____ Zip _____

Notes: _____

REPORT FORM II
Classroom Leaders

School _____ Phone # _____

Principal _____

1. Classroom Parent Leader _____

Address _____ Phone # _____

2. Classroom Parent Leader _____

Address _____ Phone # _____

3. Classroom Parent Leader _____

Address _____ Phone # _____

4. Classroom Parent Leader _____

Address _____ Phone # _____

5. Classroom Parent Leader _____

Address _____ Phone # _____

6. 7. Classroom Parent Leader _____

Address _____ Phone # _____

8 Classroom Parent Leader _____

Address _____ Phone # _____

9 Classroom Parent Leader _____

Address _____ Phone # _____

10 Classroom Parent Leader _____

Address _____ Phone # _____