From the early 1970s through the mid-1980s schools and communities were in chaos, attempting to respond to what was inaccurately perceived as a single drug epidemic. While there has been some improvement in delivering services, and state departments of education have developed guidelines which have helped school programs to function, problems still remain. It is becoming evident that just as there were several mini-epidemics simultaneously involving different populations and substances, stemming the tide of chemical use requires a range of services. These services must include prevention and treatment referral. Successful prevention efforts should include written policies and procedures; establishment of a philosophy based on empirical search; identification of problems and development of goals; and involvement of community and student groups. Research on drug abuse is available and needs to be used. (Research information on prevention programming by grade level is presented in a chart. The process of developing a comprehensive K-12 drug abuse prevention program of the Clifton Public Schools in Clifton, New Jersey is summarized and relevant documents are included.)
INTEGRATING PRIMARY PREVENTION INTO K-12 PROGRAMMING

Presented by:
J. Barry Mascari, NCC, CCMHC, CDC
Director of Counseling & Student Services
Clifton Public Schools
Clifton, New Jersey

At the American Association for Counseling & Development
national convention
Cincinnati, Ohio

March 17, 1990
Introduction & opening remarks: the Scope of the Problem

From the early 1970's through the mid-1980's schools and communities were in chaos, attempting to respond to what was inaccurately perceived as a single drug epidemic (Johnston & O'Malley, 1985-89). Most schools, with a few exceptions in some suburbs and large cities, offered limited services of a mental-health nature. The schools had "guidance" departments, special education services (psychologists, social workers) for classified students, but nothing resembling prevention programming. At best, schools provided crisis intervention but little understanding of ways to prevent "the drug problem". Few staff members saw drugs, or other issues considered parents' problem for that matter, as their responsibility or something they should be involved in.

Ironically, during this period of perceived epidemic, everyone was searching for the magic bullet, the one approach which would drive a stake into the heart of the drug problem and kill it. It was during this period that suicide increased, pregnancy became a teen problem, sexually transmitted diseases increased (coincidentally or correlationally), and SAT scores declined dramatically (DuPont, 1989). Schools were under siege, attempting to cope with drug impaired children who they could barely identify, while fending off criticism of their "poor work" at educating children as seen by declining test scores. Few people related these events in any way.

By the early 1980's schools were contracting services with outside agencies or bringing treatment professionals in to provide services, especially for drug problems. When it became clear that schools could not control outsiders very well they began hiring their own staff. Pressured by the community, parents and finally their own administration, programs were slapped into place so that communities could say "we have a
program, we are dealing with the drug problem". This hastily organized, poorly planned response created as many problems as solutions, including:
- non-theory based programs
- unclear goals & fuzzy outcomes
- add-on programs which were "fringe" and subject to cuts
- an invasion by outside experts
- poor service delivery to students
- confusion, splintering and dysfunction among staff (SACs vs. Counselors)
- chaos and conflict among professionals (turf & struggles over responsibility)
- lack of accountability
- little or no impact on the problem (drugs, sex, suicide, etc.)
- feelings of defeat, burnout, hopelessness
- a confused, distrusting public
(Mascari, 1989)

The Current "picture" in most schools
While there has been some improvement in delivering services, and state departments of education have developed guidelines which helped school programs function, problems still remain. School Counselors remain minimally trained in the drug and alcohol area and have shown little inclination to move en masse to upgrade skills in this area. New job titles such as "student assistance counselor" have sprung up in many states, creating more confusion and friction. The new positions are often tagged with the responsibility of solving the drug problem single handedly without much support from the rest of the staff.

Where prevention programs, or more likely intervention programs identifying late stage chemical dependency (usually high school level), have been put in place, they are often seen as aimed at drugs only if the teach of the "dangers". The lack of understanding about what the research identifies as precursors is evident. This is reflected by the fact that many programs are left on the preiphery of the school's total program. Accountability for these programs is often bounced among a variety of departments.

Some successful ventures are operating as evidenced by recent surveys indicating significant movement in drug use back to pre-1975 levels (Johnston & O'Malley, 1989). However, use of alcohol and cigarettes has remained constant and even increased, despite our best efforts (Class of 1989 survey). It is becoming clear that, just as there were several
mini-epidemics simultaneously involving different populations and substances, stemming the tide of student chemical use requires a range of services. These services must include prevention on the one end and treatment referral on the other. Unfortunately, most communities still remain focused on late stage chemical; they have no prevention programs or are unsure of early identification techniques.

As prevention professionals, we have moved beyond the "jawboning" techniques of fighting drug abuse with empty, yet well meaning, slogans such as "just say no". We have begun to look at more effective programs which teach young people how to say no and how to "be smart, don't start". Unfortunately, these programs remain as other than part of the school's central core of services.

How to get started

It should also be clear by now that prevention is more cost effective, even though it is difficult to measure the impact of large scale efforts by local districts. But, judging by the slow integration of prevention programming into the comprehensive K-12 counseling and guidance programs, in most schools the lesson that prevention is where it's at has not been learned.

Planning prevention programs has become a science. These activities "should":
- be based on a thorough planning process that is empirically validated
- be comprehensive enough to reach their target audiences
- be both internally and externally consistent (in messages)
- include thorough training for those conducting them
- be community owned
- engage in continuous public evaluation

(Lewis, Dana & Blevins, 1988)

By now the lessons should be learned from our mistakes, if we understand that we have made them, but few realize what they are. The following is a sampling of some lessons which can help make our efforts more successful:

*people are not programs—programs need structure so that they can survive after charismatic figure leave and the denial of people in power positions: WRITE POLICY & PROCEDURES
*programs without philosophies wander (i.e. poor social skills lead to drug use): ESTABLISH A PHILOSOPHY BASED ON EMPIRICAL RESEARCH
*program design and implementation come only after homework:
IDENTIFY PROBLEMS & DEVELOP GOALS (use 5 year plans, be flexible & formally assess progress)
*isolation breeds failure: INVOLVE COMMUNITY & STUDENT GROUPS, SEEK INPUT (develop vehicles such as Advisory Committee, Interagency Council, etc.)
(Mascari, 1989)

The best way to begin building a comprehensive and effective school-based prevention program is to identify a model which can be used from start to finish. The model below is one developed by this presenter for Prevention Program Planning, adapted from the NIDA Prevention Planning materials:

```
Problem list compiled
Establish Goals
Write measurable objectives — Design programs
Set tasks, milestones & responsibilities
Design/Implement evaluation components (pre/post-tests, interviews, community advisory group: police information, drop-out numbers, etc.)
```

**The research is clear: Why don't we use it?**
The National Institutes of Drug Abuse and Alcoholism, along with the newly formed Office Of Substance Abuse Prevention (NIDA, NIAAA, OSAP) have spent billions of taxpayer dollars to fund projects and study outcome effectiveness. Some of these studies go back into the early 70's and appear to build on each other and validate major conclusions. The High School Senior and Household Surveys which address actual trends in "use" provide us with very rich information. So why aren't we using this information to a great extent in developing our programs?

While only speculation, it can be argued that in the age of over-information, we cannot read everything. In fact we seem to be so overwhelmed that if the information is not put in neat packages or scaled down to workable size. This paper will provide at least some of the essence of the literature however, it should not be considered a substitute.
for reading information which is free from the National Clearinghouse on Drug and Alcohol Information. In fact, OSAP monograph #1 (DuPont, 1989) is a sort of "Cliff's notes" of recent prevention research. Since we know that change and infusion of new ideas occurs slowly enough you are encouraged to bring this information back to share with your staff.

In an effort to make the essential research available to you, the following summaries are provided in "headline" format, with references where possible.

**Basic Research**

*use of "gateway drugs" greatly increases the likelihood that other substances will be tried. Alcohol is by far the most abused substance by youth; 38% drunk regularly, 5% drank daily. (Johnston, 1989)

*youth people using any drug before 21 years old (including tobacco & alcohol) are more likely to have problems with AOD later in life along with school failure and suicide attempts. (DuPont, 1984; Kandel, 1987; Kaplan, 1986; Hawkins, 1987; Kumpfer, 1987; Smith, 1980)

*90% of smokers began before age 21 (Surgeon General) and of the 12-17 year old smokers, 47% smoke marijuana as compared with 7% of non-tobacco using pot smokers. Pack-a-day smokers are 20 times more likely to be daily marijuana smokers than those never using cigarettes. (Johnston, 1985)

*Cigarette smoking begins in grade six (21%)

*When not drinking before 21, the decision to drink in later life is often made for moderate use or even abstinence. (Robins & Przybeck, 1985)

*Ninth grade is the critical year for alcohol initiation (20%), while 17% reported drunkeness before grade 9. (Johnston & O'Malley, 1975-89)

*there is a high correlation between drug use and both truancy and excessive absences of students. (Senior Survey, 1989)

*early school failure, poor performance are associated with later use of drugs or alcohol. (Holmberg, 1985; Jessor & Jessor, 1977)

*at-risk children are those with early school failure or aggressiveness. (Kelly, 1980)

*the more risk factors a student has, the greater the probability of future heavy use of AOD. (Bry, 1982 & 1988)
Program Effectiveness

- Knowledge only (information) programs are largely ineffective (Swisher, 1971; Faly & Sobet, 1983).
- Values clarification and affective education are not effective in preventing AOD use (Hawkins, 1985; Chaps, 1983).
- Problem solving, decision making, cognitive skills, as well as self-esteem/self-awareness activities and stress/anxiety coping, assertiveness, and interpersonal skill programs are effective (DeMarsh & Kumpfer, 1983 & 1988).
- Skill training for early aggressive youngsters works (Garrett, 1985; Sure & Spivak, 1989).
- Peer refusal skills are effective (Botvin & Willis, 1985).
- Family skills training and improved family communication has led to refusal of gateway drugs (DeMarsh & Kumpfer, 1983 & 1986).
- Multimodality programming aimed at different targets had measurable success (Edwards, US Dept. of Education Northeast Regional Center, 1989).
- Emphasis at changing behavior rather than attitudes showed success.
The research information synthesized into a visual developed by the author (Mascari, 1989) would look like this:

<table>
<thead>
<tr>
<th>Age/Grade level</th>
<th>Program/Skill</th>
<th>Research base</th>
</tr>
</thead>
<tbody>
<tr>
<td>age 5/grade K</td>
<td>-early identification</td>
<td>difficult behavior in early years correlates with heavy use of marijuana, alcohol, &amp; tobacco in later life.</td>
</tr>
<tr>
<td></td>
<td>-parenting intervention</td>
<td></td>
</tr>
<tr>
<td></td>
<td>-social/academic skills</td>
<td></td>
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<tr>
<td></td>
<td>-transition to school</td>
<td></td>
</tr>
<tr>
<td>K-1st grade</td>
<td>-understand's teacher expectations</td>
<td>Negative teacher-student interaction &quot;loops&quot; to poor self-image &amp; failure</td>
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<tr>
<td></td>
<td>-can employ skills with confidence</td>
<td></td>
</tr>
<tr>
<td>2nd-4th grades</td>
<td>-affective programs (skill)</td>
<td>Poor school performance leads to psychological casualties in early/later adolescence</td>
</tr>
<tr>
<td></td>
<td>-academic skill building</td>
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<tr>
<td></td>
<td>-correcting family dysfunction</td>
<td></td>
</tr>
<tr>
<td>5th-6th grades</td>
<td>-positive peer models</td>
<td>Decisions to smoke/drink made here. Action needed prior to use. &quot;Willing to try&quot; runs points ahead of actual later use.</td>
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<tr>
<td></td>
<td>-refusal skills</td>
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<td></td>
<td>-alternative programs</td>
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<td></td>
<td>-target smoking</td>
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<tr>
<td>7th grade</td>
<td>-resisting peer pressure</td>
<td>Decisions prior to use of drug critical here.</td>
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<tr>
<td></td>
<td>-psychosocial skills</td>
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<tr>
<td>8th-12th grades</td>
<td>-school-community teams using multi-modal programs*</td>
<td>Positive school climate leads to decrease in drugs, violence &amp; vandalism*</td>
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<tr>
<td></td>
<td>-firm messages which are enforced</td>
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<tr>
<td></td>
<td>-refusal skills and activities</td>
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<tr>
<td></td>
<td>based on alcohol in gr. 8 &amp; 9</td>
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<td></td>
<td>*from Edwards, Northeast Regional Center</td>
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</table>
A comprehensive model in process: Clifton Public Schools

Clifton Public Schools launched a campaign to develop a comprehensive K-12 program with the support of the Superintendent of Schools, Board of Education, and the community. The program's growth curve accelerated within the last three years however, the chronology below provides a sense of how long it really takes to bring a community into focus behind a prevention effort.

(1983) Student survey of alcohol/drug use administered
       Consulting agency conducts community forums, staff training, and establishes TIDE (Teachers Interested in Drug Education) team
       Community committee formed

(1984) Board of Education Drug Committee formed
       CASA-Clifton Against Substance Abuse Founded

(1985) Substance Abuse Counselor position established
       On-site drug testing begun
       Additional inservice training held

(1987) Special Assistant to the Superintendent for Student Assistance Programs hired reporting to the Supt.
       High School Student Assistance Program reorganized and expanded
       High School nominated for Recognition Award
       In-district CORE Team training held for middle & high schools
       Chemical Health Curriculum project started (integrating activities into all subject areas)
       Interagency Council founded

(1988) Residential Training with Northeast Regional Center for Drug Free Schools and Communities and subsequent "superteam" projects (critical mass increased to 65)
       Social Problem Solving program established grade 1
       Assessment of all counseling services and presentation of Long Range Plan for student services
       Local Advisory Committee on Substance Abuse formed
(1989) Department formed as umbrella for general education support services and prevention programs (Counseling & Student Services)
School Resource Committees established in all buildings
Quest Skills for Adolescence added to middle school curriculum
Student Assistance Counselors added to middle school Counseling & Guidance program
Survey conducted by the Northeast Regional Center

(1990) Assessment of current program priorities and funding needs for 1990-91
CASA established as municipal alliance (funding program) by City and State program
High School Nominated for Drug Free Schools Recognition Award (results pending)
District Nominated for US Dept. of Education Recognition as a "comprehensive program" by the Northeast Regional Center (results pending)

[see the appended chart of complete programs K-12]

While the Clifton program is far from perfect and clearly has a great deal more to implement, the efforts toward innoculating and minimizing risk for AOD problems must be recognized. Not only do the students have a better chance of avoiding mental health problems but also have a better chance in the academic world, not to mention life. The Clifton program ties together drug and alcohol prevention and solid education as partners rather than co-existants. The program recognizes the research which says that the emotional/social problems experienced by young people cannot be separated or isolated from learning, but rather we must address the total child. The district has moved from the days of add-ons to program integration, with drug and alcohol prevention on the surface being barely discernable from what one would consider a basic school program. It is this approach which sets Clifton apart from many other communities.

Appended handouts:

Clifton Schools K-12 program chart
School Resource Committee Brochure
Dept. of Counseling & Student Services brochure

9
# SUPPORT SERVICES PLAN - K-12

### CLIFTON PUBLIC SCHOOLS

<table>
<thead>
<tr>
<th>Type of Activity</th>
<th>K</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
<th>11</th>
<th>12</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Primary Prevention</strong> (in-class programs)</td>
<td>C.A.P.</td>
<td>Social Problem Solving program</td>
<td>Lion's Quest S.F.A.</td>
<td>Career Development activities Student Assistance &quot;outreach&quot;</td>
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<tr>
<td>(co-curricular)</td>
<td>Chemical Health Education Curriculum (scope &amp; sequence integrated by subject areas- required)</td>
<td>T.I.D.E. Team activities (Teachers Interested in Drug Education - building &quot;leaders&quot; assigned)</td>
<td>Mentoring programs</td>
<td>Peer Counseling program</td>
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<td></td>
<td>&quot;Superteams&quot; program - continuation of the Northeast Regional Center's Training project</td>
<td>Family Communication Project (evening pregnancy prevention program)</td>
<td>Career Guidance Counseling &amp; Guidance activities (personal, career, vocational)</td>
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<td></td>
<td>Fairfield-Formica Parenting Workshop</td>
<td>Athletics Helping Athletes Programs (including steroid testing)</td>
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<td><strong>Secondary Prevention</strong></td>
<td>Counseling groups for identified &quot;high risk&quot; students - Student Assistance Counselors</td>
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<td></td>
<td>Teacher-led &quot;self-help groups (Alanon, AA/NA, ACOA, etc.)</td>
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<tr>
<td><strong>Early Intervention</strong></td>
<td>Educational Support Council/Student Assistance Programs (counseling, consultation, referral)</td>
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<tr>
<td><strong>Pre-referral Intervention</strong></td>
<td>Truancy Identification and Intervention (including Domicile Investigation staff)</td>
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<tr>
<td><strong>Child Study Team referral and evaluation</strong></td>
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</tbody>
</table>

### 1989-90 Staffing:

<table>
<thead>
<tr>
<th>SC-</th>
<th>1 Psychologist</th>
</tr>
</thead>
<tbody>
<tr>
<td>2 LDTCs</td>
<td></td>
</tr>
<tr>
<td>1 LDTC (3 days)</td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Student Assistance Program-</th>
<th>3 Counselors (HS)</th>
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<tbody>
<tr>
<td>2 Counselors (MS)</td>
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<table>
<thead>
<tr>
<th>School Counselors-</th>
<th>11 Counselors (HS)</th>
</tr>
</thead>
<tbody>
<tr>
<td>4 Counselors (MS)</td>
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</table>
THE SCHOOL RESOURCE COMMITTEE & THE PRE-REFERRAL INTERVENTION PROCESS

CLIFTON PUBLIC SCHOOLS
Clifton, New Jersey
PROCEDURES FOR THE
SCHOOL RESOURCE
COMMITTEE MEETINGS

Purpose
The School Resource Committee develops and monitors early and pre-referral intervention strategies for students experiencing academic or behavioral difficulties. The SRC also provides identification and intervention with students who are disruptive, disaffected, and potential dropouts. Referrals may come from staff, students, parents and/or guardians. The SRC considers pre-referral strategies, including chemical dependency assessments and crisis intervention with suicidal students, prior to any request for Child Study Team evaluation.

Organization
The School Resource Committee should meet at least once a month, more often as needed, to consider pre-referral intervention strategies for general education students experiencing academic or behavioral problems.

The SRC is chaired by the building principal or his/her designee. This designee is preferably, but not necessarily, a member of the building's administration.

The SRC should include the following members:

-the Educational Support or Student Assistance Counselors serving the building.
-the affected students' school Counselor
-a representative of the building administration.
-a school nurse, as needed.
-at least two teachers, who may vary depending on the nature of the problem and the students affected.
-a representative of the Child Study Team.
Operational Details

The SRC should have the following procedures to insure a smooth operation in which all members are well informed:

- Ample notice of impending meetings or changes to members
- Sign-in for all members present at the SRC
- List topics or students to be discussed
- Maintain notes on action or recommendations made regarding individual students
- Keep parents/guardians informed about intervention plans for their children
- Insure that any conferences with parents and support staff, as well as other actions, be reviewed with the principal as soon as possible
- Decisions of the SRC are based on the voting of the members present with all members having equal weight
- In cases where parents/guardians, and/or students are present, the SRC will discuss any action or decision behind closed doors

Resolving disputes among SRC members

Decisions of the SRC should be made by group consensus, taking into account the best interests of the student. Members of the Committee who disagree with the majority and wish to appeal the decision must do so in writing to the SRC chair and copy to the Director of Counseling & Student Services. The following process will be used:

1. the Director will meet with the SRC and attempt to reach group consensus. If the group remains deadlocked, a request by the Director for an appeal to the Assistant Superintendent will be made.
2. the Assistant Superintendent will hear the SRC appeal and if resolution cannot be achieved at this level, a further appeal to the Superintendent will be made.
Referral to the Child Study Team for an Evaluation

When the SRC agrees that intervention strategies in general education have been exhausted and that additional information about the student’s educational needs would be helpful, a referral to the Child Study Team can be made. The following steps are used in making a referral:

1. When the SRC determines that a referral to the Child Study Team is planned, a member shall consult with the Director of Counseling & Student Services prior to obtaining a parent signature.

2. The Director shall review the Summary of Pre-Referral Interventions form and will either sign the designated space in agreement, or return the request with additional considerations before getting parent permission to obtain an evaluation.

   In instances where a case for bypassing the pre-referral stage can be made, the Director shall review documentation to insure documentary compliance. While any staff member may make a referral, they are encouraged to use the SRC and consider the age/grade of the child, impact of his/her behavior on others, and benefits of interventions in general education.

Disputes arising from request without pre-referral will be appealed to the Associate Assistant Superintendent for Special Education. The next appeal level shall be the Assistant Superintendent.

Obtaining parental/guardian permission is the responsibility of the building principal; however, any member of the SRC having a working relationship with the parent/guardian may obtain the signature. This should be decided at the SRC meeting.

3. When a request is approved, the following documents shall be returned to the Director of Counseling & Student Services for referral to the Child Study Team:
   a) Child Study Team Referral "Cover sheet"
   b) Parent/guardian permission form
   c) Summary of Pre-referral Interventions form
4. The Department of Counseling & Student Services shall keep a log indicating:
   a) dates reviewed by the Director
   b) date of parent signature
   c) date delivered by the Director, or designee
to the Department of Special Education.
At this point Pre-Referral Intervention strategies shall cease.

**Parent/guardian refusal to give permission for a referral**

When the SRC agrees that a referral to the Child Study Team is in the best interests of the child and the parent/guardian has refused to sign the Permission form, the Associate Assistant Superintendent for Special Education and the Director of Counseling & Student Services shall consult to determine whether Due Process is to be considered.
Table 5. Summary of study findings on effectiveness of prevention programs

<table>
<thead>
<tr>
<th>PROGRAM TYPE</th>
<th>INVESTIGATORS</th>
<th>FINDINGS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Targeted</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Primary prevention</td>
<td>McAlister et al. 1980.</td>
<td>Peer-resistance training found to prevent initiation of tobacco, alcohol, and marijuana use by junior high school students.</td>
</tr>
<tr>
<td></td>
<td>Evans et al. 1981.</td>
<td>Peer-resistance training found to prevent initiation of tobacco use by adolescents.</td>
</tr>
<tr>
<td></td>
<td>Botvin et al. 1983, 1984.</td>
<td>Life-skills training, involving training in personal and interpersonal skills as well as peer resistance, reduced use of tobacco and marijuana up to 1 year after training for fourth to eighth grades.</td>
</tr>
<tr>
<td></td>
<td>Perry et al. 1983.</td>
<td>Use of both teachers and peers employing peer-resistance, health education, and social skills training led to reduction in smoking with high school students.</td>
</tr>
<tr>
<td>Early intervention</td>
<td>Kumpfer and DeMarsh 1983; DeMarsh and Kumpfer 1986.</td>
<td>Skills training program for children of drug abuse clients and their parents led to improved family communication, diminished problems in children, and reduced intention to use alcohol or tobacco.</td>
</tr>
</tbody>
</table>

Large-scale

<table>
<thead>
<tr>
<th>MEDIA</th>
<th>Hanneman et al. 1977, 1978.</th>
<th>Media campaign plus community mobilization led to greatest behavioral change when target was prescription drug use by women.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Classroom manage-</td>
<td>Flay and Sobel 1985.</td>
<td>Classroom management program using teachers to teach skills in interpersonal behavior and self-control in the classroom setting to low achievers led to improved school-related behaviors, attitudes.</td>
</tr>
<tr>
<td>Skills training</td>
<td>Berrueta-Clement et al. 1983, 1984.</td>
<td>Skills-training program for preschool youth and parents led to lower rates of antisocial behavior and greater academic success than was shown by a control group in late adolescence.</td>
</tr>
</tbody>
</table>
Table 6. Summary of study findings on risk factors and correlates to alcohol and other drug use

<table>
<thead>
<tr>
<th>FACTORS</th>
<th>INVESTIGATORS</th>
<th>FINDINGS</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>Wolin et al. 1979, 1980; Bennett and Wolin 1985</td>
<td>Family rituals more largely absent in homes of AOD abusers.</td>
</tr>
<tr>
<td>Parental supervision</td>
<td>Kumpfer and DeMarsh 1986; Kumpfer 1987.</td>
<td>Disorganization, home/family management skills less evident in homes of AOD abusers, less time with children, less evidence of support.</td>
</tr>
<tr>
<td></td>
<td>Bachman et al. 1981.</td>
<td>AOD use strongly correlated with number of evenings per week outside the home.</td>
</tr>
<tr>
<td></td>
<td>Schuckit et al. 1972.</td>
<td>Half-siblings of alcoholic parent or parents disproportionately alcoholic.</td>
</tr>
<tr>
<td></td>
<td>Kaij 1960.</td>
<td>Rates of alcoholism higher in monozygotic twins (71.4 percent) than in dizygotic (32.3 percent).</td>
</tr>
<tr>
<td></td>
<td>Gurling et al. 1981.</td>
<td>Alcoholism concordance rates higher in male twins (33 percent monozygotic, 30 percent dizygotic) than in female twins (8 percent monozygotic, 13 percent dizygotic).</td>
</tr>
</tbody>
</table>
Drug use and delinquent behavior

Partanen et al. 1966.

No differences in alcoholism concordance rates between monozygotic and dizygotic twins for uncontrolled drinking; differences for quantity consumed.

Cadoret and Grath 1978; Cadoret et al. 1980.

Adoptees with alcoholic biological parents have greater tendency to alcohol abuse.


Children without alcoholic biological parents raised in alcoholic adoptive families showed no tendency to alcohol abuse.


Adopted sons and daughters with biological parents who were alcoholics were more likely to become alcoholic than adoptees without family histories of alcoholism.


Peers' attitudes toward drug use and use of drugs related to adolescents' own use.

Robins and Ratcliff 1979; Jessor and Jessor 1978.

Beliefs about drug use by peers and orientation to peers associated with own use.


Associations with drug-using peers associated with own use.

Psychological

Temperament

Zuckerman 1979; Penning and Barnes 1982; Spotts and Shontz 1984.


Sensation-seeking related to marijuana use and to number of drugs used in adolescence.

Risk taking by child associated with expectations to use and later use of tobacco and alcohol.


Decreased attention span associated with alcoholism.

Rosenberg 1969.

Decreased ability to return to emotional homeostasis in alcoholic.

Cantwell 1972; Morrison and Stewart 1973.

Hyperactivity in children with alcoholic parent(s).

Goodwin et al. 1975.

Emotional lability and hypersensitivity associated with alcoholism.

Aronson and Gilbert 1963.

Depression, low frustration tolerance and emotional immaturity in sons of alcoholic fathers.


Early antisocial behavior associated with later adolescent drug use.


Rebelliousness associated with later drug use.

Kellam and Brown 1982.

Early (first-grade) aggressiveness in males, particularly in combination with shyness, associated with adolescent drug use.


Early use of drugs associated with later regular use.
### School behaviors

<table>
<thead>
<tr>
<th>Author(s)</th>
<th>Table Entry</th>
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<tbody>
<tr>
<td>Kumpfer and DeMarsh 1986.</td>
<td>Alienation from school, school peers, and decreased attendance associated with later AOD abuse.</td>
</tr>
<tr>
<td>Holmberg 1985.</td>
<td>Tardiness and truancy associated with later drug use.</td>
</tr>
<tr>
<td>Johnston et al. 1985.</td>
<td>Plans to attend college associated with lower levels of drug use.</td>
</tr>
<tr>
<td>Friedman 1983; Johnston and Bachman 1980.</td>
<td>Attitude toward school and time spent on homework associated with drug use.</td>
</tr>
</tbody>
</table>

### Biological

<table>
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<tr>
<td>Schuckit and Bernstein 1981.</td>
<td>Less time sleeping by children of alcoholics.</td>
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<tr>
<td>Begleiter et al. 1984; Porjesz and Begleiter 1985.</td>
<td>Differences between sons of alcoholic fathers and matched ones in evoked potentials findings.</td>
</tr>
<tr>
<td>Bloom et al. 1982; O'Connor and Hesselbrock 1985.</td>
<td>Differences in evoked potentials in sons of alcoholic fathers after administration of alcohol.</td>
</tr>
<tr>
<td>Gabrielli and Mednick 1983.</td>
<td>Lower verbal ability and IQ associated with family history of alcoholism.</td>
</tr>
<tr>
<td>Goodwin 1985; Kent et al. in press.</td>
<td>Differences in serotonin levels in children of alcoholics compared to others.</td>
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</tbody>
</table>
Metabolism of AODs

<table>
<thead>
<tr>
<th>Reference</th>
<th>Findings</th>
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<tr>
<td>Schuckit 1983</td>
<td>Lower levels of dopamine associated with family history of alcoholism.</td>
</tr>
<tr>
<td>Schuckit et al. 1983</td>
<td>Higher levels of prolactin after alcohol consumption in sons of alcoholics than in sons of nonalcoholics.</td>
</tr>
<tr>
<td>Schuckit et al. 1981</td>
<td>Decreased muscle tension consequent to alcohol consumption for males with family histories of alcoholism.</td>
</tr>
<tr>
<td>Schuckit 1980</td>
<td>Lower report of intoxication by sons with family histories of alcoholism than other males at same alcohol blood levels.</td>
</tr>
<tr>
<td>Schuckit 1985</td>
<td>Decreased static ataxia in males with family histories of alcoholism.</td>
</tr>
<tr>
<td>Wilson 1982</td>
<td>Differences in psychomotor functioning after alcohol ingestion between sons of alcoholics and males without family histories of alcoholism.</td>
</tr>
</tbody>
</table>

Community privation


Community disorganization related to higher levels of delinquency.

Poverty, inadequate housing, and living conditions associated with delinquency and drug use.

Residential stability associated with lower rates of initiating drugs and lower frequency of drug use.

Neighborhood involvement


THE FUTURE OF PREVENTION


More mobile adolescents felt more alienated from family and school and were more likely to have friends using drugs.


Delinquency and crime associated with low stability of neighborhood population.

Religious commitment


Adolescents attending religious services more frequently and rating religion important in their lives less likely to use any substance.

Religious commitment
BIBLIOGRAPHY


Domicile/Attendance Investigations

...provides investigation & home visits for verification of absences, truancy and residency questions.

Investigators:
Judith Hoff
Diane Messina
Messages may be left at 470-5697

Additional Departmental Activities

* implementing & expanding the Elementary grades' Social Problem Solving Program (TRACS-teaching responsibility & critical thinking skills)
* developing & implementing the Chemical Health Education Curriculum & prevention programs (K-12)
* implementing the Quest Skills for Adolescents program
* conducting the Parent Workshop (K-8)
* hosting the Interagency Council
* meeting with the Local Advisory Committee
* conducting on-going planning and implementation of programs for students who are disruptive, disaffected, or in danger of dropping out
* liaison activities with DYFS, Family Court, municipal police, & community agencies.
* organizing the suicide & community Crisis Response Team
* providing counseling for students identified as Gifted & Talented

Mr. William C. Liess,
Superintendent of Schools

Dr. Osborne Abbey,
Assistant Superintendent of Schools

Mr. J. Barry Mascari,
Director of Counseling & Student Services
About the Department of Counseling & Student Services

The Department offers a variety of services for maximizing student potential in general education through prevention and early intervention programs. The Department is also responsible for long range planning of services and liaison efforts with community agencies.

Director:

J. Barry Mascarl, MS, CCMHC, CDC

Secretary:

Gloria LaBruzza

470-5697

Department Goals

To assist students in:
- developing effective decision making skills
- achieving their maximum potential
- maintaining an alcohol & drug free lifestyle
- developing skills necessary for success in today's world
- having a caring school environment
- minimizing the impact of personal and/or learning problems through early intervention

...or being there for a student, family member, or staff in time of need.

About the School Resource Committees

The Educational Support & Student Assistance Teams, as part of the School Resource Committees, develop and monitor early intervention strategies for students experiencing academic or behavioral difficulties. Strategies for students who are disruptive, disaffected, or "at risk" are also developed. Referrals may come from staff, students, or parents/guardians. Pre-Referral intervention strategies are considered prior to any request for Child Study Team Evaluation. As always, staff, parents and/or guardians have the right to appeal decisions of the SRC.

AVAILABLE PROGRAMS...

The Educational Support Team (Grades K-8)

...provides services to prevent an academic or behavioral condition from becoming a handicap needing special education by providing staff, students, and families with consultation, planning, intervention, and follow-up.

Educational Support Counselors:

Bernadette De Simone, MA-LDTC
Marlene Krole, MA-LDTC
Sharyn Paciernack, M.Ed.-LDTC
Joanne Shapiro, MA, NCSP
470-2291

The Student Assistance Program (Grades 6-12)

...provides short term counseling, consultation, and referral for students experiencing difficulty at school due to:
- their use of alcohol or other drugs
- family members' use of alcohol, other drugs, or marital problems
- other personal, school, or behavioral problems

Student Assistance Counselors:

Christopher Columbus Middle School-

Linda Lis, MS 470-2364

Woodrow Wilson Middle School-

Jan Stauber, MS, CAC 470-2347

Clifton High School-

Florence Calise, MA 470-2318
Anne Friedland, MA, NCSP 470-2453
Peter Lorraine, Ed. 470-2424

The Counseling & Guidance Program (Grades K-12)

...provides assistance for students in making successful adjustment to every phase of development. Programs in the elementary schools are conducted by classroom teachers, and in the middle and high schools by counselors who assist students with:
- career & vocational decision making
- course selection & scheduling
- adjustment to personal & academic difficulties
- advocacy in school related issues
- college, financial aid, & scholarship applications
- effective decision making

Supervisor (Grades 6-12):

Christine Bell, MA 470-2324

Counselors

Christopher Columbus Middle School-

Janet De Benedetti, MA 470-2366
Dennis Zahorian, MA 470-2363

Woodrow Wilson Middle School-

Elizabeth Maguire, MA 470-2347
Richard Prunk, MA 470-2346

Clifton High School-

Joyce Arlock, MS 470-2321
Jean Bernstein, MA 470-2308
Diane Casey, MA 470-2341
Louis Fraulo, MA 470-2340
Caroline Garcia, MA 470-2323
Frank Mogavero, MA 470-2339
Connie Molesphini, MA 470-2306
Richard Rotella, MA 470-2307
Wallace Sokolewicz, MA 470-2322