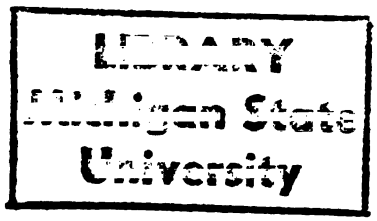

This is to certify that the

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Needs Assessment of Identified
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NEEDS ASSESSMENT OF IDENTIFIED STUDENT DRUG USERS IN A HIGH SCHOOL AND MIDDLE SCHOOL ENVIRONMENT

By

Robert J. Clark

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ABSTRACT

NEEDS ASSESSMENT OF IDENTIFIED STUDENT
DRUG USERS IN A HIGH SCHOOL AND
MIDDLE SCHOOL ENVIRONMENT

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The purposes of this study were to obtain social and psychological information from student drug users, and to obtain the students' opinions on the components implemented in various nation-wide drug programs. Data were collected from 34 Lansing, Michigan school age youths in grades 6-12. A variety of social, psychological, and attitudinal questions were presented in an interview format. Results indicated the following relationships: amount of drug use was negatively related to positive attitudes toward school rules and regulations, school administrators, school hall monitors, school sports teams, school clubs or organizations. The characteristics of drug programs rated most favorably by student drug users were: that the program should help student drug users stay out of drug trouble in school, that the drug counselor should have experience working with youths who use drugs, that the counselor should be able to answer drug usage questions, that any problem should be discussed (drug related or not), that movies and pictures about drugs and their effects should be shown.

To "K.K. La Dece"

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INTRODUCTION

Drug abuse is not a contemporary problem. Society has consistently been involved with mood and mind altering substances. Cohen (1967) notes that society has gone through cycles of intense periods of drug abuse. He stated that all classes of drugs have had their moments of popularity and decline. He made reference to the Bacchanalian orgies of Rome, the penny gin of the seventeenth century London, the widespread addiction that occurred during the opium wars, the extensive consumption of distilled spirits just following the Civil War, the drug cultures in Needle Park, New York and Haight-Ashbury in San Francisco where LSD, amphetamines, barbiturates and marijuana were popular. All of these periods in the past, along with many other events (Einstein, 1980), reflect milestones of social history which sometimes repeat themselves. Drug use in this manuscript refers to use of the following drugs: marijuana, cocaine, methaqualone, tranquilizers, barbiturates, PCP, LSD, inhalants, heroin, stimulants, alcohol, and tobacco.

Today's drug situation is in many ways a continuation of history. The use of drugs within religious ceremonies continues, Christian and Jewish rituals (for example) require alcohol consumption (wine drinking), and certain American Indian rituals call for mescaline (peyote) (Hess, 1980).

Recreational drug use is widespread today among youths as well as adults, and there seems to be a general perception

that this nonmedical or "social" drug use is more popular than in past years. Although an increase in nationwide drug use was found during the early to mid 1970's, (Abelson & Fishburne, 1976; Blackford, 1977), the years 1978 and 1979 marked a crest of a dramatic rise in marijuana use among American high school students (National Institute of Drug Abuse, 1981). Also it is important to note that between 1981 and 1982 nearly all classes of illicit drugs showed declines in current use (during the month preceding the interview) in a national survey report (National Institute on Drug Abuse, 1982). The study specifically found the greatest decline for marijuana, cocaine, stimulants, sedatives, tranquilizers, hallucinogens, and opiates other than heroin.

Since about 1970, police arrest records, hospital clinics, surveys, and the news media have all continued to show widespread drug use among the young. The increase of drug use in 1971 was so large that the President proclaimed drug abuse as one of America's most urgent problems (Althoff, 1971).

It was believed that drug use in the United States was rapidly increasing, not only among college students but also among adolescent youths and children.

According to the National Survey on drug abuse (1977) more than one-fourth (28.2 percent) of the youths aged 12 to 17 reported that they tried marijuana at least once and about one-sixth (16.1 percent) reported use of marijuana within a month of their survey response. These figures showed increases over the previous year in both prevalence (within a month of the interview) and current use of marijuana among

youth by 5.7 percent for prevalence and 3.7 percent for current use.

Another study that showed evidence of an increase in prevalence of use of psychotropic drugs was conducted by Abelson and Fishburne (1976). They conducted a nationwide study among youths and adults and found that only one-fifth of adults 26 years of age or older had reported ever using an illicit drug, but nearly one-third of youths aged 12 to 17, and over half the young adults aged 18 to 25 had reported illicit drug experience. These findings indicated that compared to earlier generations, increased proportions of individuals in the generation of the early to mid 1970's were becoming more involved with drug use.

Blackford (1977) conducted a study in San Mateo County, California. In this study it was found that nearly 23 percent of males in the 7th grade had used alcohol within the six months prior to their participation in the study, compared with only 11 percent who reported alcohol use in 1969. Blackford also found a 20 to 30 percent increase in recent (within the last six months of the study) use of alcohol among high school students between 1968 and 1977.

Abelson and Fishburne (1976) found that prevalent (within the last month) alcohol use in adolescents aged 12 to 17 increased between 1972 and 1975-1976. They also found the percentage of 14- and 15-year-olds who reported themselves as current users (within the last month) rising from 21 percent in 1972 to 31 percent in 1975-1976. Among students aged 16 to 17 an increase in current drinking was from 35 to 47 percent.

They also found that 23 percent reported themselves as current (within last month) cigarette smokers, and 50 percent of this group tried cigarettes at least once, while 41 percent of all adults 18 years of age or older claimed to smoke.

Johnston, Bachman, and O'Malley (1978) found similar results. They found that 29 percent of high school seniors reported themselves as daily smokers, with 19 percent smoking at least half a pack of cigarettes a day.

Cigarette smoking had reportedly increased among adolescent youths in the 1970's. Abelson and Fisburne (1976) found that 23 percent of youths reported they were smokers in 1976 while only 15 percent reported they were smokers in 1971.

Age at First Use

The age group that tends to be affected most by initial drug use is unclear but most of the studies and literature addressing the issue, suggest that the adolescent years (early to late teens) tend to be the period where drug experimentation and use begins. Scott (1972) found that often drug use in girls started at ages 13 and 14. He continued stating that the age of puberty seems to trigger a rebellion against parents and school. Young people (ages 13-16) seem to also be the most desirable group to address when it comes to drug use. Hardy and Cull (1975) stated that young people bring forward the problems which are more subtle in adults. They further state that there are exceptions but, generally, young people tend to reveal the "real" problems behind their drug abuse more openly than adults. Therefore, Scott (1972) states that

junior high school (7th and 8th grade) is a critical time when preventive drug abuse measures should be implemented.

Current Drug Trends (Reported by Youth Age 12 to 17)

Drug trend information in this section was mainly noted from the results found in the National Institute on Drug Abuse National Survey (Main Findings) report of 1982.

Marijuana: It has been found (NIDA, 1982) that youths 12 to 17 who report having ever tried marijuana in a national survey was 27 percent. This represented the lowest use percentage rate since 1976 (22 percent). The percentage of youths who stated that they had used marijuana within one month of survey participation was 12 percent in 1982. This 12 percent represented the lowest monthly use rate since 1974. Yearly use rates among youths (age 12 to 17) in 1982 (21 percent) was the lowest since 1976 (19 percent).

Hallucinogens: When students aged 12 to 17 were asked, "How many occasions (if any) have you used psychedelics (LSD, mescaline, peyote, psilocybin, RCP, etc.), in the past year," a decrease in widespread use was shown. In 1979 evidence of use among students was 4.7 percent and in 1982 use among students was 3.6 percent (NIDA, 1982).

Cocaine: Cocaine prevalence (within one year of survey participation) among students age 12 to 17 remained fairly consistent. In 1979 cocaine use among this age group was 4.2 percent and in 1982 widespread prevalent use was 4.1 percent (NIDA, 1982).

Heroin: Use of this drug among youths age 12 to 17 has been less than .5 percent since 1972 with the exception of

1977 when widespread use for this age group was .6 percent (NIDA, 1982).

Stimulants: Use of these drugs among youths has increased between 1979 and 1982. In 1979 wide use of stimulants (within one year of survey participation) was 3 percent, but by 1982 use of stimulants was 6 percent among youths aged 12 to 17 (NIDA, 1982).

Sedatives: Use of these drugs has been shown (NIDA, 1982) to increase among youths. In 1979 the percentage of prevalent (within one year of survey) use of sedatives was 2 percent. But by 1982 popular nationwide use increased to 4 percent.

Tranquilizers: Use of these drugs among youths has also shown a slight increase (NIDA, 1982). In 1979 widespread use (use within one year of survey) among these drugs was 2.7 percent but in 1982 the percentage of widespread use was 3.3 percent.

Alcohol: The trend of prevalent (use within one year of survey) use of alchol has not been shown to be stable (NIDA, 1982). In 1977 prevalent use nationwide among youths was 47.5 percent, in 1979 use was 53.6 percent, and in 1982 it was back down to where it was in 1977 showing prevalent use at 47.3 percent.

Cigarettes: Prevalent (use within one year of the survey) use nationwide among youths in 1982 was 25 percent (NIDA, 1982). When youths (age 12 to 17) were asked if they had ever smoked in their life time, inconsistency seems to be the trend. In 1977, prevalent use nationally was 47.3 percent, in

1979 it was 54.1 percent and in 1982 prevalent use decreased to 49.5 percent.

Summary

Use of marijuana has been found to be concentrated in the teenage years (NIDA, 1982). Among youths who smoke marijuana, three percent first started using marijuana at 12 and 13 years of age, seven percent first used marijuana at ages 14 and 15, and eight percent first used marijuana at ages 16 and 17 (NIDA, 1982).

The age that seems to show the highest risk of first use of hallucinogens has been shown to be age 16 to 17 (NIDA, 1982).

It has also been found (NIDA, 19812) that four percent of all 16 to 17 year-old youths surveyed reported first using cocaine at the age of 16 or 17 (first use was within one year of survey participation).

For psychotherapeutic drugs (stimulants, sedatives, tranquilizers, and analgesics) used without a prescription by a doctor, first use age categories seemed about equal ranging from 12 to 13, 14 to 15, and 16 to 17 each obtaining two to three percent of first users (NIDA, 1982).

Drug Use Trends (Reported by High School Seniors)

Current studies suggest that anywhere between 20 and 40 percent of high school students use alcohol or drugs excessively (Singer & Tsralowitz, 1983).

The following information was obtained primarily from documents from the National Institute on Drug Abuse (National Trends, 1975-1984). Results were obtained from a large

representative national sample survey of high school seniors enrolled in public and private high schools across the United States from 1974 to 1984.

The latest National Institute on Drug Abuse (NIDA) report (1984) found that American young people are beginning to moderate their use of illicit drugs. Between 1981 and 1984 nearly all classes of illicit drugs showed declines in use.

Marijuana: This drug was shown to be the most widely used illicit drug nationally (NIDA, 1983) and has shown a consistent decline since 1979. While the proportion of high school seniors having ever tried the drug did not drop much (60% in 1979 vs. 59% in 1982) the 1982 use category (during the month preceding the survey) had dropped at a much higher rate (37% in 1979 to 29% in 1982). The survey also found that daily use or nearly daily use (defined as use on twenty or more occasions in the past thirty days of survey participation) showed a decrease. It was shown that between 1975 (when the study began) and 1978, daily marijuana use climbed steadily from 6% to 11% for all seniors participating in the survey. But in 1984 daily use is shown to be down to 5% (about one out of every 16 seniors). The survey also found that a possible contributing factor might be that 67% of peers in 1984 attributed great risk to regular marijuana use. This statistic had increased from 35% in 1978. It was also found that 80% of students in 1984 thought their friends would disapprove of regular marijuana use.

Cocaine: The annual prevalence (the proportion of respondents reporting any use in the year preceding the

survey) of cocaine was shown to more than double (5.6% in 1975 and 12.0% in 1979) between 1975 and 1979. Prevalent use was later shown to level off between 1979 and 1981 (12.0% in 1979 and 12.4% in 1981). In 1982-84 for the first time, prevalent use showed a decline from 12.4% in 1981 to 11.5% in 1982 (1984 showed 11.6%). It was also noted that Western and Northeastern regions of the United States showed over twice the prevalent use rate as those in the South and North Central regions in 1983, (Northeast 11%, Western 19%, North Central 2%, Southern 4%). This was shown to be one of the greatest regional differences for any drug used.

Methaqualone: These drugs showed an increase in popular use between 1979 and 1980 (5.9% in 1979, 7.2% in 1980) and leveled off in 1981 (7.6% in 1981). But in 1982-84 a decline in prevalent use was shown (6.8% in 1982, 5.4% in 1983, and 3.8% in 1984).

Tranquilizers: These drugs has shown a decline in popularity of use which started in 1977 and has continued up to the most recent NIDA report in 1985 (10.8% in 1977, 9.9% in 1978, 9.6% in 1979, 8.7% in 1980, 8.0% in 1981, 7.0% in 1982, 6.9% in 1983, and 6.1% in 1984).

Barbiturates: These drugs has also shown a steady decline in use as reported by high school seniors from 1975 to the most recent NIDA report in 1984. Annual prevalence, which in 1975 was 10.7% has decline annually (9.6% in 1976, 9.3% in 1977, 8.1% in 1978, 7.5% in 1979, 6.8% in 1980, 6.6% in 1981, 5.5% in 1982, 5.2% in 1983, and 4.9% in 1984).

PCP: This drug has shown large decreases since it was first included in the National Institute on Drug Abuse survey in 1979. Percent of prevalence (in last 12 months) for high school seniors showed 7.0% in 1979, 4.4% in 1980, 3.2% in 1981, 2.2% in 1982, 2.6% in 1983, and 2.3% in 1984.

LSD: This drug has remained fairly steady in prevalent use among high school seniors since an increase in 1978 (from 5.5% in 1977 to 6.3% in 1978) (6.6% in 1979, 6.5% in 1980, 6.5% in 1981, and 6.1% in 1982). However a decrease was found to be evident in 1983-84 (5.4% in 1983 and 4.7% in 1984).

Amyl and Butyl Nitrates (inhalants): Since these drugs have been included in the NIDA national survey in 1979 a drop has been noted in prevalent use between 1979 and 1983 from 6.5% in 1979 to 3.6% in 1983. However an increase to 4.0% in 1984 was found. (Previous under-reporting of these drugs was noted to possibly explain the upsurge in use of these types of drugs.)

Heroin: Prevalent use for this drug among high school seniors has remained the same since 1979 holding at .2% respectively. The use of opiates other than heroin has remained fairly constant since 1977 with a downward prevalent trend starting in 1981 and continuing in 1983 (6.4% in 1977, 6.0% in 1978, 6.2% in 1979, 6.3% in 1980, 5.9% in 1981, 5.3% in 1982 and 5.1% in 1983). A mild increase was noted in 1984 (5.2%).

Stimulants: These drugs was shown to be the second most widely used class of drugs used by responding high school seniors (NIDA, 1984). Prevalent use (use within 12 months of

survey participation) seemed somewhat even between 1975 and 1977 (16.2% in 1975, 15.8% in 1976, 16.3% in 1977). But starting in 1978 a steady increase in prevalent use was shown (18.3% in 1979, 20.8% in 1980, 26.0% in 1981) and seemed to level off in 1982 (26.0%), then decreased in 1983 (24.6%). These figures were stated as only estimates of amphetamine (prescription controlled substances) use but they do not necessarily control for nonprescription over-the-counter pharmaceuticals (diet pills, stay awake pills, and look alikes). These additional stimulants may have been included in the amphetamine use data.

Alcohol: The number of high school seniors who have reported ever trying alcohol has been shown to be somewhat stable since 1977 (92.5% in 1977, 93.1% in 1978, 93.0% in 1979, 93.2% in 1980, 92.6% in 1981, and 93% in 1982-1984) (NIDA, 1984). This shows that according to the latest NIDA national survey, 93 percent of all young people have tried alcohol by the end of their senior year of high school. Figures also show (NIDA, 1984) that 67 percent of high school seniors had used alcohol within one month of the survey. Daily drinking was shown to decrease from the highest percentage rate of 6.9 percent in 1979 to 5 percent in 1984. The rate of binge drinking (respondent stated that on at least one occasion they had five or more drinks in a row within two weeks of survey participation) seemed to be fairly stable since 1979 (41.2% in 1979, 41.2% in 1980, 41.4% in 1981, 40.5% in 1982 and 40.8% in 1983). However, in 1984 a reduction was found (39%) respectively.

Cigarette Smoking: The NIDA national survey (1984) found that between 1977 and 1981 there seemed to be a steady decline in daily use of cigarettes for high school students (28% in 1977, 27.5% in 1978, 25.4% in 1979, 21.3% in 1980, 20.3% in 1981). However a slight increase in daily use began to show in 1982 and 1983 (21.1% in 1982 and 21.2% in 1983) but went down in 1984 to 18.7%. When the survey asked students if they smoked every day, more females said they did than males since 1976. More recently (NIDA, 1982-83) more females than males said they smoked every day (females 23.2%, males 18.2% in 1982 and females 22.2%, males 19.2%). But when students were asked if they smoked a half-pack a day or more within thirty days of survey participation more females said they had in 1982 (females 14.7%, males 13.1%), but in 1983 the percentage of male or female students who smoke a half-pack or more a day seem about the same (females 13.6%, males 13.3%).

Summary

The most recent trend research (NIDA, 1985) seems to indicate reduced rates of drug use for all drugs except alcohol and cigarettes which seem to continue to fluctuate in popular use yearly. The late 1970's (1979) seemed to mark a level period for most drugs which continued to increase yearly. Between 1981-1984 decreases in widespread use was shown for most drugs except alcohol and cigarettes which indicated slight increases in widespread use by 1984.

Although drug use among high school students has shown a decrease in popular use, drugs continue to be used by high school students. It has been stated (NIDA, 1984) that about

62% of all high school students try an illicit drug before they finish high school. Also it has been shown (NIDA, 1984) that 40% of high school students have used an illicit drug other than marijuana.

One in every twenty high school seniors smoked marijuana on a daily basis. And 16% have smoked marijuana daily (for at least a month) in their lives (NIDA, 1984). Of the seniors which used marijuana daily at some time, 85% of them were found to have used it daily (at least one month) at some time in their lives by the end of the tenth grade (NIDA, 1983).

About one in every twenty high school seniors have been found to drink alcohol daily (NIDA, 1984) and 39 percent were found to have had five or more drinks in a row at least once within two weeks of the survey (NIDA national survey 1984).

The survey (NIDA, 1984) also found that 29 percent of high school seniors had smoked cigarettes within one month of survey participation and 19 percent reported being daily users.

Recent trends clearly indicate that drug use among youth continues to exist at an alarming rate.

The widespread use of drugs has stimulated research that has investigated the effects and possible dangers of various drug use. The following section reviews some of the past research that studied the effects of certain drug use and possible dangers of such use.

Possible Dangers of Drug Use

The following is a brief description of some of the research findings describing the possible harm caused by

various drugs. It is not intended to be a complete overview of drug use research.

Marijuana: Biological and physiological studies involving THC (the active chemical in marijuana) and how this drug effects the lungs have been extensive. Some researchers have found (Taskin, Shapiro, & Frank, 1973; Vachon, Fitzgerald, Solliday, Gould, & Gaensler, 1973) that marijuana cigarette smoking dilated lung air passages and increased expiratory flow from lungs. Idem (1974) also found that lung air flow was increased in asthmatic subjects after smoking marijuana.

Controversy seems to exist concerning the physiological danger or benefits of the dilation effect that marijuana (THC) has on the respiratory system (Jones & Lovinger, 1985). Rosenkrantz and Fleischman (1979) found changes in the lungs of rats made to breathe marijuana smoke for extended periods of time. The study found that alveoli (air sacs) of the rats became inflamed, and became filled with cellular debris. The debris was found to have come from the deterioration of lung cells and from an accumulation of macrophales (cells that protect against foreign bodies or attack cellular debris) that had accumulated at an extensive rate. Roy, Magnan-Lapointe, Huy, and Boutet (1976) studied the effect of tobacco and marijuana smoke on dogs (Beagles). They found that the most serious result was the development of bronchiolitis which was found more in the marijuana smoking dogs.

Additional studies have shown that marijuana in some samples has been contaminated. Landrigan, Powell, James, and

Taylor (1983) found marijuana samples infected with salmonella muenchen. It was stated that those infected suffered from diarrhea, fever, and abdominal pain. Others have found that marijuana users also risk inhaling harmful fungi (Kagen, 1981), lethal herbicides (paraquat) (Landrigan et al., 1983), and other harmful bacteria (Vingerleider, Andrysiak, Tashkin, & Gail, 1982).

Male hormone damage has also been found with marijuana use. Kolodny, Lessin, Toro, Masters, and Cohen (1976) found that marijuana smoking decreased luteinizing hormone. But Coggins et al. (1976) found no support for the Kolodny et al. (1976) findings.

Female birth defects have been found in mice injected with marijuana (cannabis) resin (Persaud & Ellington, 1967). Rosenkrantz (1080) found that marijuana smoking caused a higher rate of "lost" (dead) fetuses. Grilly (1974) found that marijuana extract or synthetic THC given orally to chimpanzees had no apparent effect on sexual activity, reproduction, or offsprings. Smith, Smith, Besch, Smith, and Asch (1979) found evidence that THC in female monkeys appears to inhibit the pituitary gland from secreting sex hormones to the ovaries. They found that inhibited gland secretions can produce infertility in the female monkey that can last for several months (141 days). Smith, Almirez, Bergnber, and Asch (1983) studied the effect of discontinued use of THC on Rhesus monkeys. They found that it took an average of 116 days for regular menstruation to begin after which hormones and ovulation had returned to normal.

Marijuana has also been shown to affect the heart and increase blood pressure (Johnson & Domino, 1971). Renault, Schuster, Heinrich, and Freeman (1971) found that heart rate increased in individuals in proportion to the dose of marijuana taken. The study further showed that the most direct effect of marijuana smoking on heart rate is in the suppression of the normal sinus arrhythmia (the rhythm accelerating on inhalation and slowing on exhalation). Other researchers have found similar results (Beaconsfield, Ginsburg, & Rainsbury, 1972).

Many other studies have been done on marijuana (Jones & Lovinger, 1985; Nahas, Paton, & Idanpaan-Heikkila, 1976). There seems to exist many marijuana research contradictions and arguments over the generalizating of animal research findings pertaining to assumptions that humans may or may not respond to marijuana in ways similar to animals (Jones & Lovinger, 1985; Scarpitti & Datesman, 1980).

It has been stated that most researchers have concluded that consumption of marijuana is a potential health risk (Jones & Lovinger, 1985). But future research is needed to clarify quantity of risk, and under what conditions we could specifically expect the risk to occur (Scarpitti & Datesman, 1980).

Alcohol: Human studies on alcohol consumption have shown that alcohol damages the liver (Lieber, 1967; Lischner, Alexander, & Galambos, 1971; Galambos, 1972).

Although it has been stated (Edwards & Grant, 1976) that most alcoholics have damaged (fatty) liver cells when liver

biopsies were conducted, it has been found (Leevy, 1968) that up to one-third of alcoholics may have no apparent abnormality.

Chronic brain damage has been associated with alcoholism (Parsons & Lieber, 1982). Parsons (1977) estimated that about 10 percent of alcoholics who have sought treatment qualify as having chronic brain syndrome. Postmortem studies (Ron, 1977; Wilkinson & Carlen, 1981) have found that atrophy (loss of brain cells) is one of the major consequences of alcoholism. Beck, Dustman, Blusewicz, Schenkenberg, and Canon (1978) found that premature aging may also occur in alcoholics.

Cognitive deficits have been found in alcoholics (Jenkins & Parsons, 1980; Parker & Nobel, 1980). Wernicke-Korsakoff Syndrome has also been found to occur in chronic alcoholics (Butters, 1982). The main symptoms of the Wernicke stage have been stated (Victor, Adams, & Collins, 1971) to include a global confusional state, Nystagmus, Ataxia, and Polyneuropathy (loss of pain sensation, weakness, etc.) of legs and arms. The person is also disoriented as to time and place, unable to recognize familiar people, apathy, inattentive, and unable to maintain a coherent conversation (Butters, 1982; Victor, Adams, & Collins, 1971; Seltzer & Benson, 1974).

Alcohol related traffic accidents have been reported. Douglass (1982) stated that between 45 and 60 percent of all fatal traffic accidents with a young driver are alcohol related. It has also been stated that no other cause of death is as predictably associated with youth traffic accidents as

beverage alcohol and a young drivers ability to control an automobile (Comptroller General of the United States, 1979).

It has been found (Lacey, Stewart, & Council, 1979) that young drivers are more likely to have more traffic accidents than older drivers with and without alcohol involvement, because of lack of driving experience. Preusser, Oates, and Orban (1975) controlled for driving experience and found that young people between the age of 16 and 24 that drank alcohol were still more likely to be in a traffic accident than older drivers. Waller (1972) has indicated that teenagers were more likely than older drivers to have caused an automobile accident while having lower blood alcohol concentrations than adults.

Risk of alcohol use during pregnancy has been studied. The Fetal Alcohol Syndrome (FAS) has been stated (Landsman-Dwyer, 1982) to be a pattern of abnormal physical and mental development detected with increasing frequency among infants born to chronically alcoholic women. Sokol, Miller, and Reed (1980) found that maternal use of alcohol is related to decreased growth of infants. This was reflected in birth weight, length, and head circumference in the infant. Harlap, Shiono, and Ramcharan (1979) found that spontaneous abortions increased significantly with increases in the amount of alcohol consumed by women while pregnant.

There seem to be no studies that dispute that alcohol crosses the placental barrier, enters the fetal circulatory system almost instanteously (Landesman-Dwyer, 1982) and can

depress central nervous system functioning in the fetus and newborn (Lewis & Boylan, 1979).

Cocaine: Waldorf, Murphy, Reinarman, and Joyce (1977) stated that cocaine taken daily can produce lack of appetite, lack of sleep, difficulty in concentration, and psychological dependence. It has also been stated (Grinspoon & Bakalar, 1979) that cocaine does not produce physical dependence to the extent that heroin or alcohol does, but in some cases mild withdrawal symptoms of anxiety and depression occur. Also perceptual disturbances and paranoid thinking have been found to occur (Wesson & Smith, 1977; Siegel, 1977).

A runny nose or clogged nose has been found (Grinspoon & Bakalar, 1979) to be common among cocaine users who snort the drug. They also report that perforation of the nasal septum occur, but these cases were rarely found.

Resnick and Schuyten-Resnick (1976) compared intranasal (snorting) cocaine use with intravenous use. They found that intravenous use had notably greater effects than when the same dose was used intravenously.

Fischman et al. (1976) studied the cardiovascular and subjective effects of intravenous cocaine injections. Cocaine, dextroamphetamine (speed) and placebos were administered in a double-blind experiment. They found that the stimulant effect of cocaine is similar to the stimulant effect of speed.

In an animal study where unlimited access to intravenous cocaine was provided, animals have been found to kill themselves by voluntary injections. Johanson, Balister, and

Bonese (1976) found that monkeys that were given the opportunity to inject themselves intravenously 23 hours a day developed hyperactivity, tactile hallucinations, ataxia, weight loss, tremors, and convulsions as they continued to inject themselves with the drug. The monkeys died within five days. Johanson et al. (1976) also found that methamphetamine and dextroamphetamine (two types of speed) also had similar effects.

Many studies have been done concerning the psychological and physiological effects of cocaine (Byck & Van Dyke, 1977). Further review of many animal studies involving the effects of cocaine are available (Woods, 1977).

Stimulants: It has been stated (Kalant, 1973) that amphetamine effects include an increase in blood pressure, pupillary dilation, relaxation of smooth muscle of the gastrointestinal tract, bronchioles (wall of the bronchial tube), urinary bladder, and secretion of sparse, thick saliva. Kalant also stated that the most consistent central nervous system effect is the production of a state of arousal or wakefulness.

It has also been noted (Cassel, 1971; Kalant, 1973) that another effect on the central nervous system is the inhibition of appetite.

Studies have shown toxic effects concerning amphetamine use. Rumbaugh (1977) found that amphetamine intoxication may effect small blood vessels. Seiden et al. (1977) found that amphetamine use in animals showed a permanent depletion (70% of dopamine in the caudate (tail).

Martin and Ellingwood (1973) found that methamphetamines injected into rats induced taste aversion to saccharin solution (saccharin was used to motivate rats to perform tasks). Stimulants have also been shown (Fishman et al., 1976) to have similar effects as cocaine in many studies (Grinspoon & Bakalar, 1979).

Further elaboration of stimulants use are available (Ellingwood, 1979; Beschner & Friedman, 1979).

Inhalants: Benzene has been found to cause impairment to bone marrow, liver, heart, and kidney (Cohen, 1979).

Reports to the toxic physiological effects of toluene have been found. Cohen (1979) stated that gastrointestinal reactions to toluene include nausea, epigastric discomfort, anorexia, jaundice, and hepatomegaly apparently from a fatty liver. Also neurological effects of toluene have been found (Kelly, 1975; Grabski, 1961) to cause tremors, nystagmus, and cerebellar ataxia.

Gasoline exposure has been stated (Cohen, 1979) not to be severe. But high levels of gasoline exposure may cause some toxicity. Gasoline additives, tetraethyl lead, benzene, and other substances seem to be the cause of health problems (Cohen, 1979).

The presence of lead, has been shown (Durden & Chipman, 1967) to lead to plumbism (lead poisoning). Plumbism has been shown (Law & Nelson, 1968) to lead to encephalopathy (inflammation of the brain).

Other studies have shown that inhalants can contribute to brain damage (Wyse, 1973; Knox & Nelson, 1966). Further review of inhalant use literature can be found (Cassel, 1971).

Barbiturates: In acute barbiturate intoxication, depression of the central nervous system has been observed from mild depression to profound coma (Locket & Angus, 1952).

The problem of tolerance and variation in response to sedatives have been studied. Richards and Taylor (1956) found that the response to barbiturates in experimental animals could differ as much as 50 percent. They also showed that individual animals demonstrated different effects with the same dose of drugs given on different occasions.

Other studies have shown (Gruber & Keyser, 1946) that tolerance can develop to barbiturates. Further review of barbiturate use can be found (Matther, 1971; Beschner & Friedman, 1979).

LSD: The following has been stated (Cassel, 1971) as representing some of the typical physical effects of LSD: increased activity of the central nervous system (has a stimulant effect on behavior), numbness of hands and feet, increased ability to hear and feel, the brain's selective mechanism becomes blocked causing the brain to become flooded with unselected sights and sounds. Pulse and heart rate also increases, this causes a rise in blood pressure and temperature. The following effects have also been reported: dilated pupils, shaking of hands and feet, cold sweaty palms, a flushed face or paleness, shivering, chills with goose

pimples, irregular breathing, nausea, loss of appetite, and increased blood sugar levels (Cassel, 1971).

Many animal studies have been conducted. Evarts (1956) found that an intravenous injection of 1mg/kg of LSD in monkeys caused visual disturbances, blindness and ataxia.

Buscaino and Fronglia (1953) found that LSD caused psychomotor excitement (increased activity) followed by slowed motor activity in dogs.

Berenstein and Otero (1958) found that LSD caused ataxia, lack of reaction to pain and increased reaction to sound in dogs.

Cook and Weidley (1957) found that high doses of LSD blocked conditioned avoidance and escape responses in rats.

Blough (1957) found that LSD increases the visual threshold in pigeons, and improves visual discrimination performance although the rate of response is decreased.

Further information on LSD is available (Sankar, 1975; DeBold & Leaf, 1967; Hofmann, 1983).

PCP: Some studies have shown (Domino, 1964; Luby, Cohen, Rosenbaum, Gottlieb, & Kelly, 1959) that doses of phencyclidine (PCP) given to normal subjects intravenously or administered orally consistently produced decreased reaction to touch, pain, special orientation associated with nystagmus, ataxia, and hyperflexia. In another study (Davies, 1961) patients were given phencycliding orally 30 to 60 minutes later subjects reported changes in their physical and/or mental state.

Lerner and Burns (1979) stated that phencyclidine produces profound alterations of thought, perception and disposition at doses less than the amount that produces an anesthetic effect.

Davies and Beech (1960) studied the mental effects of PCP in normal volunteers. They stated that effects from volunteers included changes in body image, depersonalization associated with feelings of estrangement, isolation and dependency.

More extensive elaboration of the effects of phencyclidine can be found (Lerner & Burns, 1979; Pittel & Oppedahl, 1979).

Heroin: It has been stated (Janssen, 1969) that the most potent analgesics (pain-killers) known are pharmacologically and chemically related to morphine (morphine is the major alkaloid of opium). Heroin like all the other opiates, is a central nervous system depressant. Heroin has been reported (Martin, 1968) to produce euphoria, respiratory depression, and constipation.

Platt and Labate (1976) stated that the main actions of heroin are a result of a transformation by hydrolysis to 6-mono-acetylmorphine (MAM) after this transformation it later becomes morphine. It has been shown (Way, 1868) that because heroin and MAM develops into a more soluble fluid, the two chemicals are better able to penetrate the brain where rapid deacetylation of these compounds to morphine occurs. Platt and Labate (1976) stated that after heroin and MAM reach the brain it later is absorbed and concentrates in the internal

organs such as the lungs, kidneys, liver, spleen, endrocine glands and, to a lesser extent, in skeletal muscle.

Platt and Labate (1976) have stated that the presence of physical dependence is clear from the appearance the abstinence syndrome (withdrawal), which is characterized by anxiety, restlessness, irritability, lacrimation, general body aches, insomnia, perspiration, dilated pupils, "goose flesh" hot flashes, nausea, vomiting, diarrhea, fever, increased heart rate, increased blood pressure, abdominal and other muscle cramps, with dehydration and loss of weight. Studies have found that symptoms during withdrawal may include nervousness, hyperactivity, leg cramps, generalized muscle twitches, and alternating profuse sweating and chills (Eiseman, Lam, & Rush, 1964).

Seevers and Deneau (1963) found that in long acting compounds like morphine withdrawal, symptoms will maximize within 24 to 48 hours and will take 7 to 10 days to subside. Others have found that withdrawal last longer. Himmelsbach (1942) found that physical signs of morphine withdrawal lasted for up to 6 months. Wikler et al. (1953) found similar results that support this. They noted that rats showed signs of withdrawal for as long as 6 months also.

Lewis et al. (1970) found that withdrawal from heroin produced abnormalities in REM sleep that continued for about 5 weeks. They further stated that after one week of withdrawal REM sleep increased. Increases in REM sleep was found to continue to rise each day for approximately 5 days.

Madinaveitia (1969) stated that any opiate can be substituted for another to postpone withdrawal symptoms.

Further information can be found that entail the study of heroin use (Hofman, 1983).

Cigarette Smoking: It has been stated (Mitchell, 1962) that when cigarette smoke is inhaled, the amount of particles in the mouth, respiratory tract, and pulmonary parenchyma is about 80-90 percent. This was found to be true even when the smoke is held in the lung for a relatively short period (two-to-five seconds). Mitchell (1962) also stated that when cigarette smoke is deliberately held in the lungs for periods as long as 30 seconds, retention of particles is almost complete.

Radioactive tracers in smoke have been used to study site deposition in animals (U.S. Department of Health, Education and Welfare, 1964).

Holland (1958) found that cigarette inhalation in rabbits produced deposition of particles (a heterogeneous mixture of a large number of compounds with gaseous and particulate phases) on the larynx, carina, and major bronchi. But it was further stated that a deposit of particles was also retained by the smaller bronchi, bronchioles, and pulmonary tissue.

It has been concluded that it is likely that most cigarette smoke particles penetrated into the respiratory tract and are depositied on the surface of the terminal bronchioles, respiratory bronchioles, and pulmonary parenchyma (U.S. Department of Health, Education, and Welfare (1964).

Balchum et al. (1962) randomly sampled 1,456 mill workers who volunteered for chest X-rays and pulmonary function tests. It was found that of the 1,198 who reported that they smoked cigarettes, 23.3 percent reported that they cough frequently. Of the 253 nonsmokers, 10.2 percent reported frequent cough.

Bower (1961) studied 172 men and women employed in a bank. It was found that 18 percent of 95 men and 17 percent of 77 women admitted to cough almost every day. Of the smokers, 27.6 percent admitted to daily cough (12 of 42 men, and 9 of 34 women), while 4.1 percent of nonsmokers admitted to daily cough (0 of 13 men, and 2 of 36 women).

Flick and Paton (1959) studied patients excluding those with cardiac and respiratory disorders. They found that 55 percent of 157 smokers admitted to habitual cough while 10 percent of 51 nonsmokers admitted to a habitual cough.

It has been stated (U.S. Department of Health, Education, and Welfare, 1964) that chronic bronchitis and emphysema represent disorders of multiple causality. But it was noted that cigarette smoking is the most important cause of chronic bronchitis in the United States, and increases the risk of dying from chronic bronchitis and emphysema.

Lung cancer. Cigarette smoking has also been stated (U.S. Department of Health, Education and Welfare, 1964) that the risk of developing cancer of the lung increases with duration of smoking and the number of cigarettes smoked per day, and the risk seems to diminish when cigarette smoking is discontinued. It was further stated that cigarette smoking is a contributing factor in the causation of cancer of the larynx.

Further information on smoking can be found in the literature (U.S. Department of Health, Education and Welfare).

Youth Perceived Harmfulness of Drugs

It has been found (National Institute on Drug Abuse, 1984) in a National Survey, that a substantial majority of high school seniors perceived regular use of certain drugs as involving "great risk" (harm for the user).

The National Survey (NIDA, 1984) found that 87 percent of high school students reported that heroin use involves great risk (harm) for those who use it regularly (a definition for regular use was not specified).

The percent of students reporting great risk for regular LSD use was 84 percent.

Students reporting great risk for regular use of Cocaine was 79 percent.

Students reporting great risk for regular use of Barbiturates was 69 percent.

Students reporting great risk for regular use of Amphetamines was 67 percent.

Students reporting great risk in smoking one or more packs of Cigarettes per day was 64 percent.

Students reporting great risk in drinking five or more Alcoholic Beverages once or twice each weekend was 42 percent.

The following shows the amount of increase among students who perceive great risk involved with regular drug use between 1983 and 1984: Heroin - 1 percent increase, LSD - .06 percent increase, cocaine - 6 percent increase, barbiturates - .8 percent increase, amphetamines - 2.3 percent increase,

cigarettes - 2.6 percent increase, and alcohol showed a 3.1 percent increase.

School Drug Problems

As greater awareness of youthful drug involvement developed, the United States government began to encourage the development and implementation of a variety of programs aimed at preventing people from using prohibited substances (Goldberg & Meyers, 1980). Confusion exists about what constitutes an effective school drug program aimed at youth. It seems that one of the major causes for this confusion has been the lack of interest in pursuing feedback from the student drug users' viewpoint concerning how any particular drug program has affected his/her drug use. School drug programs that have involved the student drug user's opinions and/or ideas on the development of a school drug program seem to be nonexistent.

It seems that one of the most practical ways of making contact with young adolescents is through the school system. The personal problems and concerns of student drug users in a school setting are largely ignored or overlooked in terms of present approaches to drug programs in schools and toward students.

Presently in schools located in the United States there seems to be basically only two ways in which the schools address drugs and drug use among students: 1) if a school does have a drug abuse program it almost always will take the form of drug education or prevention aimed at the general student population; 2) since there are no developed drug

programs in schools for students caught using or in possession of drugs, administrators have no available option but to temporarily or permanently suspend these students, with very few further attempts to address the students' drug use.

Three questions seem apparent from this information: 1) what type of programs exist?, 2) are present drug programs effective?, and 3) what can be done to develop an effective school drug program for student drug users?

Because drug education programs seem to be the most widely used form of drug prevention in schools today, these programs will be briefly discussed by reviewing a sample of some of the major drug education programs and by examining the neglect of these programs in evaluating effects on actual drug use among students.

As recognition of drug abuse as a nationwide problem began to emerge in the late sixties, the educational establishment began to perceive a need to address the problem. A combination of community pressure from concerned parents who demanded that the schools take a preventive action against drug abuse along with constant mass-media attention to the drug problem produced an enormous need for the development of effective drug prevention programs throughout the country aimed at school aged youth (Wepner, 1979).

Initially schools responded with an abundance of bulletins, pamphlets, and teacher guides. Often nothing more than restatements of earlier curricula, some did incorporate the concept needed sensitivity to the problem on the part of the school administration and teachers (Wepner, 1979). The

pamphlets did promote teacher knowledge of drugs and pedagogical techniques useful in discouraging drug abuse.

By the end of the 1960's through the 70's many drug education programs were started, but it seems that the concerns and problems of the drug users were not sought by program developers.

One of the first techniques started in a Baltimore public school (Drug Abuse Education, 1969). In the program, unit plans were developed for grades five, seven, and nine which outline curricular content and learning activities. The objectives for grades five were to acquaint the student with harmful and beneficial drugs. Grade seven dealt with the sociopsychological problems of drug use as well and stressed interpersonal relationships in preventing drug abuse. By grade nine the students studied the use and abuse of stimulants, depressants, narcotics, and hallucinogens; drug dependence; drug laws; rehabilitation and decision-making. Throughout the program the students were active participants and the stress was on sharing ideas, thinking logically, and arriving at valid decisions. Although it has been shown (Goodstadt, 1980) that some drug education studies render negative effects, and also could increase drug use, there was no attempt to evaluate the participants' subsequent drug use.

Freedman, Stolow, and Lewis (1969) described a program utilizing drug experienced youths which was begun in the Silver Lake Regional High School of South Boston. The program employed ex-addicts and began with the help of the local Junior Chamber of Commerce. A former addict would speak to

groups of fifteen students for 45 minutes with a teacher present. A central information and service center was set up for private counseling. Self-report questionnaires issued to the students were the only data collected. The program's success was measured by the interest and support given to the program. Nothing was mentioned about the effect of the program on students' personal drug use. Also no pre or post-test on student drug use was ever administered concerning program effectiveness.

A Nation's School article described drug education programs in various states (Drugs and the Educational Antidote, 1970). One of the earliest drug education programs was started in Montgomery County, Maryland in 1963. A six week course was given as part of the Health Education curriculum to provide drug information to ninth grade students. Again, no evaluation was made on how the increased drug information was used by the students.

The Ann Arbor, Michigan School District has conducted a structured drug program since 1966. Units on drug abuse were included in Science, Social Studies, and Physical Education. In the elementary school, warnings were given against household drugs. In the junior high school, the effects of stimulants, depressants, and hallucinogens were discussed. In the high schools, drug abuse and social problems were explored. The entire program also involved an inservice course for teachers. There was no mention of any outcome evaluation in this program.

The Los Angeles school system has a program completely run

by former addicts and did not require the presence of school personnel. They presented differing viewpoints which allowed students to weight alternatives. During 1969, the program reached 150,000 students in Los Angeles and 360,000 throughout Southern California (Wepner, 1979). No evaluative information or follow-up data concerning how the program effected students drug use was mentioned.

Zoller and Weiss (1981) developed an interdisciplinary, chemically-oriented curricular unit called "Hashish and Marijuana." This program was an attempt to cope effectively with the drug abuse program among young people by means of a "drug education" model to be implemented within the realm of natural sciences-social sciences that interface at high schools. The preventive program in drug education which equally emphasizes the cognitive and affective domains was developed at Haifa University in Israel. The evaluation seemed to be based on how significantly the new program was favorably accepted by both students and teachers. The evaluation showed a significant change in the cognitive levels of knowledge about the "drug issue," and positive levels of knowledge about the "drug issue." This type of evaluation description seems very vague and nonspecific.

Winston (1969) described a unique program in the South San Francisco Unified School District. The program was created to deal with students who had violated narcotics laws. These secondary school students were not considered hard-core users or sellers. Drug counseling workshops using a number of techniques (not described) were provided two hours per week

for four weeks. The sessions involved the students and their parents. If either student or parent refused to attend, the student was expelled from school. Although in this program the session leader was a psychologist or "qualified staff member," there was no mention of the student violator's ideas or concerns being part of the program development process.

Effects of Drug Education

Formal research on this topic is sparse involving pre-post evaluation but there is evidence that shows that some drug education programs have been counterproductive. Goodstadt (1980) reviewed...studies reporting "negative" effects of drug education programs, and found the following: 1) studies sometimes asked respondents about the effectiveness of drug education programs. These studies have shown that drug education has had little effect on "stopping use of drugs" or in "effecting use" and also have shown mixed effects; 2) little data exist from survey studies to show that drug education has increased use; more commonly it has been found that exposure to drug education does not decrease drug use; and 3) few studies in the area have been free from experimental design problems.

Sawyer (1978) also discussed the fact that numerous drug education programs produce little or no apparent change in students' attitudes toward drugs.

Many drug education programs exist but in most cases it is unknown what effect the programs have made on students, because of lack of relevant outcome information. Research

dealing specifically with the effectiveness of drug education programs on student drug use is virtually nonexistent.

Past Evaluative Concepts and Problems

The following examples show some evaluations of outcomes resulting from some drug education programs.

Sehwan (1981) designed a study to measure the outcome of a drug program. The drug program was at the time of evaluation, being disseminated nationwide since its approval as a national model by the Department of Education. The evaluation found the following: 1) at the conclusion of the program a significantly larger proportion of students in the treatment group has favorable attitudes toward their regular school teachers than those in the control group; 2) a significantly larger proportion of students in the treatment group reported more favorable attitudes toward the program instructors than did either the treatment or control groups with regard to their own classroom teachers; 3) the program was more comprehensive among students whose regular classroom teachers have had program training than those whose teachers did not have such training; and 4) the program was more comprehensive among elementary than junior high school students.

In this evaluation it can clearly be seen that knowledge of the programs impact on student actual drug use behavior is not mentioned.

Drug programs that try to evaluate program outcomes have found problems in instrument selection, logistical constraints, and data analysis.

Chng (1981) stated that drug education in the schools today has "failed." He continued by stating that after more than a decade of intensive efforts, these programs have made no significant impact on the "drug problem."

Monismith et al. (1981) examined the opinion of 3,100 seventh- to twelfth-grade students regarding the perceived effectiveness of various components of both prosmoking and antismoking messages. They found that nonsmokers found antismoking messages to be interesting and they wanted to know more about smoking, while smokers often found antismoking messages to be boring and useless.

Schaps et al. (1982) evaluated a drug education program taught to seventh and eighth graders. The evaluation involved random assignment from nine matched pairs of social studies classes to experimental and control conditions. Pre and posttest covered 1) drug knowledge, 2) general attitudes toward drugs, 3) perceived benefits and cost of substance use, 4) perceived peer attitudes toward, and use of various substances, and 5) intentions to use current drug use and lifetime drug use of various substances. They found that for seventh grade females, the course increased drug knowledge, decreased perceptions of favorable attitudes towards peer drug use, and decreased personal involvement (self-reported) in alcohol and marijuana use. They found very few significant effects for 7th-grade males, 8th-grade males and females and control.

William et al. (1985) found that evaluations of alcohol education programs employing social psychological principles

in an attempt to persuade subjects to adopt a favorable attitude toward "responsible" alcohol use have been mixed. They found some programs show attitude change while others find no significant impact.

Sehwan (1982) suggested a systematic approach toward a remedy of current stagnation in program monitoring and program evaluation, with emphasis in the field of drug abuse prevention and intervention. A Uniform Progress and Evaluation Reporting System (UPERS) was introduced which would render comparative judgment across various agency performances. Some of the comparative inquiries made through the UPERS were: 1) the degree to which theoretical involvement justified one's program; 2) the degree to which the program is fully developed to accommodate consistent replications of the program; and 3) the degree to which evaluation is implemented by the program agency toward an enhancement of one's existing program or toward a development of valid and more useful program in the future. This system seems to suggest a more positive and productive evaluation system that may lead to more meaningful and useful program results.

Disagreement Concerning School Drug Programs

It is unclear what should be done to have an effective school prevention program. A brief summary of some of the various points of view will be discussed here.

Ahlgren et al. (1982) assessed 600 fifth- and sixth-grade students regarding previous and current smoking activity, parents' smoking, four dimensions of self-esteem, and variety

of attitudes toward school. Results showed that students were more likely to begin smoking if they had parents providing a smoking model, had low self-esteem (particularly with respect to family and school contexts), and disliked school and feared failure.

Bedworth (1972) stressed that the goal of drug education should not be to eliminate use but to provide individuals with the ability to make a choice regarding such use. It seems that young people draw their own conclusions, to a considerable extent, from the information provided by friends and their own personal experience (Smart, 1971; Kohn 1974).

Olsen and Baffi (1982) stated that it is important for educators to initiate programs which will enhance student self-esteem and decision making skills to facilitate a decrease in students' substance use.

Eck (1982) stated that teaching styles is of primary importance for alcohol education. He further states that the key charcateristics we should look for is style which enables the student to have the freedom to make an informed decision.

According to Baker (1973) scare techniques are not effective in drug abuse. Rather, programs should deal with the psychological factors of drug abuse. These include peer pressure, alienation, and curiosity.

Social and environmental factors have been supported. Dembo et al. (1982) found an interactive relationship between perceived neighborhood setting and reasons for youth drug involvement. They state that the results imply that the processes by which youths become involved with drugs should be

the focus of future research to enhance and improve drug abuse prevention programs.

Family therapy and other systematic techniques have also been found to be necessary. Baither (1978) in a review of the literature concerning the current status of family therapy in the treatment of drug abusing adolescents found that by studying the family life of the young drug abuser a better understanding of the problem could be rendered to help direct treatment goals.

Wright and Moore (1982) found that male drug abuse problems were significantly related to perceived maternal emotional problems, parental rejection and angry parents, conflicts with parents, reported physical abuse by a parent, suicidal thoughts, delinquency and feelings of being bored, unappreciated, unrecognized, dependent, unstable, and dissatisfied. Female drug abuse problems were significantly found to be related to perceived parental emotional problems, maternal drinking problems, parental depression, parental anger and parental rejection, poor relationship with father, reported physical abuse by a parent, conflicts with and between parents, unhappy childhood, delinquency and feelings of being shaky, bored, unrecognized, troubled, unstable, dissatisfied, and unhealthy. It seems clear that many different opinions and speculations exist in the area of adolescent drug abuse prevention.

Present Evaluation Concept

There are a wide variety of drug education and prevention programs that have been in operation but none of them seem to

take into account the concerns and interest of the student drug users themselves, during the planning stage of program development.

This information seems to indicate a lack of knowledge that would indicate how programs and other environmental factors effect actual drug use among student drug users.

It has been reported (Graham & Cross, 1975; Blum, 1969) that there is a lack of reliable research information about illegal drug usage at the high school level.

Barter and Werme (1970) have reported that although the dangers of illegal drug use lie in social and psychological patterns of use, there is virtually no reliable data on the psychosocial factors underlying the use of drugs in the adolescent age range.

Graham and Cross (1975) have stated:

> ...we know so little about the underlying factors motivating adolescent drug users, yet have spent millions of dollars on drug education and rehabilitation efforts which may have been largely meaningless.

Boe (1971) stated that meaningful drug education programs must deal with the morals, values, and ethics involved in using drugs. Keniston (1966) stated:

> ...student drug users as a group are extremely knowledgeable about the possible bad effects of drug use; they can usually teach their counselors, deans, and advisors a good deal about the potential bad side effects of drugs.

Boe (1971) supported the necessity to understand the attitudes and values of adolescent drug users, by stating that it is imperative to know and understand the attitudes and

values of drug users because these attitudes influence decisions to use drugs.

King (1984) studied young people nine, twelve, and fifteen-years-old. A survey was given asking health knowledge questions to find out whether students were learning about health issues. Included in the survey were questions about alcohol and other drugs. They found that for every grade level tested, knowledge scores on drugs were lower than any other health issue. This result was found even though these students were given drug education from the time they first entered school.

Sheppard et al. (1985) conducted a follow-up investigation on the King et al. (1984) study, investigating why students who reported being involved with a drug education program knew very little about drugs. They studied 5,000 students attending junior high and high schools by issuing a questionnaire asking students specific questions about the nature of their drug education. The questionnaire also asked students what they would like most to learn about drugs and alcohol and how would they most like to learn about drugs and alcohol. Results indicated that students were mainly exposed to drug education that consisted of classes and movies which talked only about the negative effects of drugs.

The drug education classes were teacher-led discussions or lectures. When students were asked how would they most like to learn about drugs the majority of students indicated that they would prefer having an "expert" (doctor, pharmacist, nurse, etc.) tell them about drugs. Most of the students were

found to also prefer drug education classes that cover a variety of topics which discuss both the good and bad effects of drugs, legal issues, alternatives, and why people use drugs.

Bell (1980) discussed recommendations for drug education programs from the point of view of teenagers. Such information was obtained in a study that conducted 298 taped interviews with teenagers residing in East, Central, and West Harlem. Information obtained in this study was the following:

1. Respondents reported a lack of knowledge about drugs and drug abuse before starting to use them.
2. Respondents mentioned a need to inform parents and teachers although others insisted neither would understand why kids use drugs.
3. Respondents mentioned how they became disillusioned when they found out that drug propaganda was overexaggerated. This caused many to go on to harder drugs.
4. Respondents felt that youths themselves should operate drug education programs.
5. School drug programs should keep teachers and parent distant because they represent authority and distrust.
6. Some respondents felt that drugs represent a problem which the community must face and accept as its own responsibility.
7. Programs should focus on the effects of drug use.

8. Programs should attempt to destroy the image of the "Hip Drug User" as a role model.
9. Programs in ghettos should appeal to ethnic pride.
10. A variety of media should be used to present information in an interesting and compelling manner appropriate to the target age group.

Conclusion

It seems clear that there is much confusion concerning what constitutes an effective school drug prevention program. It seems that possibly the major reasons for this confusion is that past programs have failed in the following ways:

1. Pre-program needs assessments have been generally sparse in the area.
2. Students' opinions and suggestions for a school drug prevention program as a source of information in program development seems to be almost nonexistent.
3. Detailed information from identified student drug offenders regarding the motivational factors that caused their drug affiliation in school seems to have been overlooked as being relevant to program construction.
4. Lack of evaluative research on the effectiveness of present programs on students actual drug use.

Knowledge concerning student drug users and evaluative research is vital for the improvement of school drug programs. Neglect of these forms of research has added to the confusion that presently exists concerning what directional goals school drug prevention programs should pursue. Swanson (1978)

concluded that confusion about the goals of prevention and treatment had led some schools to define the nature of their drug abuse program in such a fashion that they cannot resonably expect success. He continued by stating that new models for evaluating such program's goals need to be developed.

Rationale for Present Research

Information from Lansing, Michigan school officials indicate the need for research into program development of an effectiveness drug prevention program that will meet the needs of student drug users in the Lansing area.

In view of information concerning the noneffectiveness of present programs, and the expressed need for effective programs that will meet the needs of identified student drug offenders, a confidential needs assessment interview with student drug users themselves seem to be a logical starting place for research to begin. The objectives of the interview were the following:

1. To obtain demographic data about the student drug users.
2. To assess perceived causes of drug use from the students themselves.
3. To determine the amount of current drug use.
4. To provide the opportunity for student drug users to express their own ideas for a school drug prevention program.

Demographic data. The following information on demographic characteristics was collected: age, sex, grade level, grade point average, length of time in Lansing area, and family members composition.

Perceived cause of drug use. Various questions were asked to ascertain students' opinions on the causes of their drug use (see Section II of questionnaire in Appendix B).

Family relations. Students attitudes toward their families have been found to be related to drug use. The less closeness in a family, the more willing students were to take risks and the more favorably they viewed drugs (Babst, Deren, Schmeidler, & Lipton, 1978). Two questions were asked to assess family relationships: On the average, how well have you been able to get along at home in the last six months and, is there a person with whom you can honestly discuss your feelings and concerns? It was predicted that poor family relationships would be significantly related to greater drug use.

Perceived well-being. Alternative prevention strategies which respond to social and emotional needs of the young substance abuser have been reported as being important in prevention (King, 1980). Thus it was predicted that students express no goal(s) (social and/or psychologically) or reported that there were things they could be doing that they were not doing to help themselves achieve their goal(s) would be significantly related to greater drug use.

Attitude toward school. Babst et al. (1978) also studied family affinity and how it affected youths (students 7th

through 12th grade) drug use, and also how family affinity effected other life areas of youths. They found that a negative relationship existed between family affinity and drug use. They also found that family affinity was also positively related to other life areas which were: 1) interest in school, and 2) who they would go to for help with a drug problem. This led to the prediction that low scores on school related variables (questions 12 and 13) would produce a positive correlation with a low score on question seven (family relations). It was also predicted that a response made by a student indicating that they did not have anyone to discuss their feelings and concerns, would be highly related to low scores on questions 12 and 13. Questions representing 12 and 13 were the following:

> Question 12: Indicate how much you like the following topics as they relate to your school: 1) Your school work (generally), 2) school rules and regulations, 3) your classes (generally), 4) sports team(s), and 5) school club and/or organizations.
>
> Question 13: Indicate how much you like the following people in your school: 1) teachers (generally), 2) your friends at school, 3) counselor(s) at school, 4) administrators (principal, assistant principal, and 5) hall monitors (security guards, etc.) (see family relations for questions 7 and 8).

Social conflict. Based on the findings by Scott (1972) that often drug use in adolescents started at ages 13 and 14 and that at age of puberty seems to trigger a rebellion

against parents and school, it was anticipated that students who have had problems at home that brought on "outside" help to solve the problem(s) would be more highly related to high drug use than students whose family did not have outside intervention. It was also predicted that low scores related to attitude toward school questions would be significantly related to high drug use.

Drug history section. The first part of this section (labeled Drug History Section 2) was constructed to define the very first drug "misused" (used for recreation rather than for medical purposes) by the student, their reason for using it, and how much the student knew about the drug before use.

The second part of this section attempted to define the student's opinion of their reason for first use. This was done by having the students rate how much they agreed or disagreed with the most common reasons for first use stated by students who participated in a pilot study (Summer of 1983). The pilot study was conducted by the present researcher in finalizing the present questionnaire.

The third part of this section attempted to define recent drug use (within last six months), reason for use, and situational preference for use.

The fourth part of this section (labeled Drug History 3) was constructed for two reasons:

1. to provide the students who use drugs the opportunity to express their own ideas for a school drug prevention program, and

2. to provide student drug users the opportunity to express their opinions on what elements of a school drug counseling program they felt would best facilitate a possible reduction in students drug trouble in school.

The students were asked to rate how much characteristics of various drug programs nationwide would possibly help them stay out of drug related trouble in school. This information was used for descriptive information only.

The following types of question categories were used to obtain information for descriptive purposes:

1. What type of group counseling do you think would be helpful?

2. How much would hearing an ex-drug addict talk about drug use be helpful?

3. How much would viewing various types of movies and pictures about drugs be helpful?

4. What type of characteristics should the counselor have to make him/her more helpful?

5. What type of confidentiality should the drug program have?

6. What should be the ultimate goal(s) of the drug program?

METHOD

Subjects

Participants were fifteen identified student drug users attending a middle school and nineteen student users attending a high school in Lansing, Michigan (N = 34). Students caught for the first time using and/or in possession of drugs by school officials or police on school property were eligible to participate in the study. The study included every student caught using and/or in possession of drugs (excluding two students at the middle school and three students at the high school)[1] from February 1984 to April 1985.

Participants' ages ranged from 12 to 19 years of age. The average age was 14 to 15 and there was 1 sixth grader, 5 seventh graders, 9 eighth graders, 7 ninth graders, 4 tenth graders, 4 eleventh graders, and 4 twelfth graders.

Ethnic representation of participants were 76 percent white, 15 percent black, 9 percent Latino. There were 26 males and 8 females participating.

Setting

The school system has widely been a popular site nationally to implement drug programs that attempt to prevent drug abuse among youth. Although many programs exist, drug use among youth continues (Goldberg & Meyers, 1980; Wepner, 1979; Goodstadt, 1980).

In the Lansing area school district for the 1983-84 school year, records indicated that there were 4,900 suspensions for school misconduct (truancy, striking a teacher, fighting, etc.), 10 percent of the total amount of suspensions were for smoking (cigarettes), drinking (alcohol), and illicit drug use.

The failures of present school programs to alleviate drug use in the Lansing area school district have been repeated in investigative interviews with junior high/high school students, teachers, administrators, and community residence members by the present researcher. Recent interviews in this area reveal that community school drug programs and resources have been sparse and have not been considered very effective. The programs that do exist are represented by occasional classroom presentations by either local police officers or visiting local crisis center representatives. These programs are usually directed to the general student population only. There are no present school programs for students who have been identified as illegal drug offenders. At the present time, student drug use offenses are only handled under the guidelines of District Wide Rules of the Lansing School District which states the following:

> The act of using drugs on school property or at any school sponsored event will result in a three day suspension and referral to an appropriate agency.

The appropriate agency is listed as either the Lansing Police Department, Fire Department, or the Pupil Personnel Office of the Lansing School District. The result of being sent to the Pupil Personnel Office is usually enrollment into a re-entry

program. This program is a one room school house with 20 to 30 students who represent disciplinary problems and cannot attend regular public schools. Students are sent to this school for discipline.

Presently it seems that there are no programs available for students identified as being illegal drug offenders. Information concerning motivational, environmental, and social situational factors obtained from these students seem to be nonexistent.

The present research was conducted at a middle school and high school in Lansing, Michigan. These schools were chosen because the student population represents a wide range of the Lansing area characteristics and because an estimated 30 to 50 students are identified yearly as being illegal drug offenders among the two schools not including those students suspected of using these drugs.

The middle school. The middle school had a population enrollment of 958 students. The ethnic representation was as follows: 55 percent White, 29 percent Black, 13 percent Latino, 2 percent American Indian, 2 percent Asian/Oriental.

Sixty-one percent of the students came from two-parent families, 33 percent came from one-parent homes, and 3 percent of the students lived in other arrangements.

The number of students whose family received AFDC (Aid for Families with Dependent Children) was 25 percent for the school. The proportion of parents of students who received at least a high school education was 66 percent.

The high school. The high school had a population enrollment of 2,536 students. The high school ethnic representation was as follows: 62 percent White, 14 percent Black, 15 percent Latino, 2 percent American Indian, and 3 percent Asian/Oriental.

Sixty-seven percent of the students came from two-parent families, 28 percent came from one-parent homes, and 5 percent of the students lived in some other arrangement. The number of students whose family received AFDC was 22 percent for the school. The proportion of parents of participating students who received at least a high school education was 73 percent.

The Interview Instrument

The interview instrument (see Appendix B) asked for information about the following areas: biographical information concerning family relations, perceived well-being, attitudes toward school, social conflict and drug use history, and student preferred programs.

Drug History

The first section was constructed to define the students' age at first use, range of variety of drugs used, method of use and overdose and/or bad experiences with each drug used (emphases mainly on illegal drugs). The following explains the scoring process of the defined categories mentioned above.

The drug use variable. The drug use variable was constructed by summing the scores from the following areas: students' age at first use, extent of drug variety, frequency of use, method of use, and overdose experiences. All of these areas were trichotomized to assure equal contributions (score

ratings) that represented the final drug use score. The following describes the criterion for ratings in each area.

Age at first use. The rational for the age rating scale was derived from results of a national study (National Institute of Drug Abuse, 1984). Based on the potential hazards of early drug use the present study assigned a higher drug score for earlier ages of initial drug use over later initial drug use ages to allow for the potential increase in danger from longer life experiences with drugs.

The age range was identified after all interview data has been collected. The range of ages found in the data was the trichotomized in order to have consistent weight with the other variables that were used in this study to define the final drug use score. Ages 1 to 6 were assigned a score of 3, ages 7 to 10 were assigned a score of 2, and ages 11 to 19 were assigned a scores of 1. The ages were trichotomized into these ranges to produce categories that contained approximately one third of the reported first use ages. The scores represent age of first use such that the younger the first use age the higher the score. The higher the score the higher is the potential danger of use.

Variety of drug use. This score was obtained by counting how many different drugs the student had used, then using the total as the raw score. Raw scores for all students were then trichotomized (for consistency with the other drug use areas) into high medium and low groups based on how many drugs a student had taken. The range for each group was determined by assigning approximately the same amount of students to each

group based on the amount of drugs used. The categories were the following: low = used 1 to 3 different drugs (assigned a score of 1), medium = used 4 to 5 different drugs (assigned a score of 2), high = used 6 or more different drugs (assigned a score of 3).

Frequency of drug use. The frequency of drug use scores were obtained by the following procedure: students were asked to rate how frequently they used each drug (those drugs taken within the last six months of interview) by choosing one of the responses on a scale ranging from not at all (score of one) to daily (score of five). Scores for each drug were then totaled to get the raw score for "frequency of use."

The frequency of use range was identified after all interview data had been collected. The range of frequency of use found in the data was trichotomized (for consistency with other drug areas) into high medium and low groups based on assigning approximately one third of the total "frequency of use" scores to each group after all student scores were totaled. The group score ranges were the following:

1. Low - A total score ranging from 1 to 10 was placed in the low group and assigned an overall score of one.

2. Medium - A total score ranging from 11 to 21 was placed in the medium frequency of use group, and assigned an overall score of two.

3. High - A total score ranging from 22 to 42 was placed in the high frequency of use group, and assigned an overall score of three.

Method of use. It has been reported (Beschner and Friedman, 1979; Cohen, 1976; Platt & Labate, 1976) that many drugs can be taken in various ways. They can be injected directly into the blood stream, snorted through the nose, swallowed by pill or drink, etc., smoked, or inhaled by vapor. Although any of these methods could be dangerous depending on amount taken, or characteristics of the individuals taking them etc. (Smith et al., 1979), many studies (Graham, 1976; Platt & Labate, 1976; Smith et al., 1979; Beschner & Friedman, 1979) have shown that direct application of drugs to the blood vessels (via intravenous injections or snorting through the nose) can cause possible physical damage (damaged veins, septicemia, hepatitis, nasal problems etc.), along with more intense and rapid drug effects (this could in some cases increase the chance of a toxic reaction to the drug used). Because of these possibilities, application of drugs by injection or snorting was considered to be the most hazardous. Students using this method were assigned a score of three.

It has been reported (Landescan-Dwyer, 1982; Butters, 1982; National Institute on Alcohol Abuse and Alcoholism, 1982) that oral consumption of drugs can contribute to many problems in humans and animals. Alcohol has been shown (National Institute on Drug Abuse, 1984) to be the most widely used drug among high school students and younger youth (National Institute on Drug Abuse, 1982). Based on the potential dangers of alcohol combined with its widespread use among youth, oral application of drug use was rated second

most hazardous. For each drug used with this method, students were assigned a score of two.

Since marijuana use among youths has been found to be the second most widely used drug among youths (National Institute on Drug Abuse, 1984) and inhalents rated almost last in popular use among youths, smoking and inhaling (vapor) methods of drug use was rated third most hazardous. Students using this method were assigned a score of one.

After all research data was collected for every student raw scores from the "Method of Use" section for each student was totaled. This provided a range of scores from lowest to highest in this category for all students. The scores were then trichotomized (for consistency among all drug areas) into a low, medium, and high group. The range of scores within the categories were:

1. Low - A total score ranging from 1 to 5 was placed in the low group and assigned a score of one.

2. Medium - A total score ranging from 6 to 8 was placed in the medium group and assigned a score of two.

3. High - A total score ranging from 9 and above was placed in the high group and assigned a score of three.

Overdose/bad experience. Based on interviews with youths about their experiences with drugs, the youths' concepts of a bad experience seemed to generally classify in the following groups: no bad experience; experienced sickness, vomiting, dizziness etc.; experienced black-outs; unconsciousness; hospitalization.

In order to stay consistent with the other drug use areas, three levels of seriousness was constructed. Each level was given a score from one to three with one indicating least serious and three indicating most serious. The following groups and scores were used in the present study:

1. No overdose as defined in present study - (score of 1)
2. Experienced sickness, vomiting, dizziness etc., - (score of 2)
3. Experienced unconsciousness, black-outs, pass-outs, and/or hospitalization (hospitalized for a drug use related problem not mentioned in the other categories: example, hospitalized for a car accident that was drug related etc.) - (score of 3)

The range of scores in the "Overdose" groups were the following:

1. Low - A total score ranging from 1 to 4 was placed in this group and assigned a score of one.

2. Medium - A total score ranging from 4 to 6 was placed in this group and assigned a score of two.

3. High - A total score ranging from 7 or more was placed in this group and assigned a score of three.

Final drug usage score criterion. The total sums from each individual area (Age at First Use, Variety of Drugs Used, Frequency of Use, Method of Use, and Overdose) were counted and the result was used to respresent a students final Drug Usage score. Since the minimum score possible for a student to receive in any area was 1 and the maximum 3, the minimum final score that a student could receive was 5 and the maximum

was 15 (since there was a minimum of five areas for any one drug used, and all students used at least one drug who participated in the study).

Student preferred programs. Twenty-six questions were used to obtain information from students about what they thought would be helpful content elements for a school drug program. These questions containing content elements were selected because of popular use nationwide. Students were asked to rate the possible drug program elements according to how useful they thought they would be in alleviating their drug related problems.

Procedure

The researcher used the following procedure in acquiring student participation. All students caught using and/or in possession of drugs for the first time by school officials or police on school property were eligible to participate in the study. These students were asked if they would like to voluntarily participate in the research interview, during a mandatory conference involving the school vice principal, the students' parent(s), and the student concerning the illegal drug incident. At that time the parent(s) and student were informed of the research interview and asked for their consent to allow the student to participate. Once consent was obtained, the student's name was referred to the project's active list. The researcher then summoned the student from class (within one week of referral) by asking a student office monitor or staff member to contact the student's teacher (this procedure reduced potential student embarrassment since

students were often called out of class in this manor for a variety of reasons).

All research interviewing took place confidentially in a private office or vacant classroom. Interviews at the middle school were conducted in a private office located in the student teacher corps area of the school. This area was selected over the regular counseling area because student traffic and other school distractions were reduced in this area, making it possible to maintain a confidential environment. Interviews at the high school were conducted initially in a vacant classroom (with the first six students interviewed) but later interviews were done in a private counseling room in the school counseling center because of limited classroom selection for privacy.

Upon arrival the student was again briefed on the purpose of the interview and asked to honestly answer a series of questions. All student responses were recorded on the interview form by the researcher to assure completeness an accuracy. The interview lasted approximately one hour.

RESULTS

Family relations. Two items were utilized to test the predictions that self-reported drug use would be negatively correlated with family relationships. Specifically, greater drug use would be correlated with less positive family relationships. Item 1 was: On the average how well have you been able to get along with people at home in the last six months. A Pearson correlation between item 1 and self reported drug use was not significant (r = -.11, p > .05). However, the negative direction of the relationship between these two variables was consistent with the prediction. Item 2 was: Is there a person with whom you can honestly discuss your feelings and concerns? (The response scale was: 1 = yes or 2 = no.) A t-test between item 2 and self reported drug use was also not significnt (t (32) = .58, p > .05).

Perceived well-being. There were two items used to test the prediction that students who expressed no goal(s) (social/psychological) or means of achieving their goal(s) (Questions 9 and 10, page two of questionnaire), would be correlated with high self-reported drug use scores. However, responses to question 9 (Item 1) and question 10 (Item 2) were distributed so unequally between response categories that a test of a significant correlation would have been meaningless. Specifically, frequencies for the responses to the categories

were: (Question 9) Do you presently have career goals? Twenty-six students said yes, while only 8 said no. Question 10 was partly contingent on the response indicated on question 9.

Attitude toward school. Two questionnaire items were used to test the prediction that family/affinity would be correlated with attitudes toward school. Specifically, item 1 asked how much do you like your school work, school rules and regulations, your classes, sports team(s), school clubs and/or organizations. Item 2 asked how much do you like teachers generally, your friends at school, school counselors, school administrators, hall monitors/security guards. Both items are shown in Table 1. Both items were correlated with question 7 which represented family affinity by asking: How well have you been able to get along with people at home in the last six months?

Pearson correlations between variables in item 2 with question 7 indicated that only one variable in the item 2 group; (attitude toward) teachers generally (r = .47, p < .05) was significant. This finding supports the prediction that the more positive the students perceived their home relations the more positive their attitude was toward school teachers (generally). There were no significant differences found when correlating each variable in the item 1 group with question 7 (see Table 1).

Variables in items 1 and 2 were also tested with question 8 (see page one of questionnaire). Question 8 asked: Is there a person with which you can honestly discuss your

Table 1

Relationship Between How Well Student Perceived Home Situation with Attitude Toward School Variables

How much do you like:	How well have you gotten along at home in the last 6 months? Pearson Correlation
Your school work	.30
School rules and regulations	-.10
Your classes general	-.10
Your school's sport teams	.20
School clubs and/or organizations	-.20
Teacher generally	.40*
Your friends at school	.22
School counselors	.30
School administrators	.14
Hall monitors/security guards	-.14

*Significant at .05 level.

feelings and concerns? T-test between all variables in item 1 and 2 groups showed only one variable that significantly supported the prediction that if a student did not have anyone to honestly discuss their feelings and concerns with the more likely the student would be to have negative attitudes towards school. The one variable found to significantly support the prediction was found in the item 1 group. The variable was (attitude toward) your classes (t (32) = 2.87, $p < .01$).

Social conflict. Two items were used to test the prediction that students who showed rebellious opinions toward their parent(s) and family, would be more likely to have high self-reported drug use scores. Item 1 was represented by question 15 (see questionnaire, page 3) which asked: Have you or your parent(s) ever received any counseling or participated in any program that was aimed at helping you and your parents get along better at home? A t-test was used to test the relationship between item 1 with the self-reported drug indicating score. There was no significant relationship found (t (32) = .95, $p > .05$) that would support the prediction that students who came from families that had outside counseling would have more drug involvement than students whose families did not receive such outside help.

A Pearson r correlation between each attitude toward school variable, with self-reported drug use scores was used to test the relationship between item 2 (attitude toward school scores) with self-reported drug used scores. Results showed (see Table 2) that greater self-reported drug use was negatively related to the following "Attitude Toward School"

Table 2

Relationship Between Extent of Drug Use and Attitude Toward School Variables

How much do you like:	Extent of Drug Use Pearson Correlation
Your school work	-.20
School rules and regulations	-.60**
Your classes generally	-.20
Your school's sport teams	-.50**
School clubs and/or organizations	-.40*
Teachers generally	-.20
Your friends at school	-.21
School counselors	-.20
School administrators	-.63**
Hall monitor/security guards	-.60**

*Significant at less than .05 level.

**Significant at .001 level.

variables: School Rules and Regulations, School Sports Teams, School Club and/or Organization Participation, Opinion Toward School Administration, Hall Monitor/Security Guards.

Student preferred programs. Students were asked to rate the possible drug program elements according to how useful they thought they would be in alleviating their drug related problems.

The following shows the results of how students rated the possible school drug program content elements. This was done by indicating what percentage of students responded to each possible rating concerning each possible content element (see Table 3).

Results showed that nine content elements presented to students were perceived as possibly being "somewhat helpful" or "would help a lot" by over 50 percent of the students (if they were given a chance to experience them in a school program). These 9 content elements along with percentages were the following:

1. Counseling sessions held in groups (79 percent)

2. Counseling sessions involving all boys or all girls (65 percent)

3. Counseling sessions involving both boys and girls (71 percent)

4. Private counseling sessions between just you and the counselor (79 percent)

5. A combination of group and individual counseling sessions (79 percent)

Table 3

Percent of Student Ratings in Response Categories Concerning Possible School Programs and Issues

		% Scale Values*				
		1	2	3	4	5
1.	Counseling sessions held in a group	5.9	2.9	11.8	41.2	38.2
2.	Counseling sessions with all boys (girls)	5.9	8.8	20.6	44.1	20.6
3.	Counseling sessions with both boys and girls	2.9	2.9	23.5	55.9	14.7
4.	Private counseling sessions	2.9	5.9	11.8	52.9	26.5
5.	A combination of individual and group sessions	8.8	2.9	8.8	50.0	29.4
6.	Hearing an ex-addict	5.9	2.9	17.6	29.4	44.1
7.	Counseling by students your age	20.6	8.8	20.6	38.2	11.8
8.	Showing frightening results	11.8	8.8	8.8	32.4	38.2
9.	Viewing movies and pictures about drugs	8.8	2.9	5.9	58.8	23.5
10.	Talking about good things in your life	11.8	0.0	20.6	47.1	20.6
11.	Having a counselor who works in your school	17.6	5.9	23.5	32.4	20.6
12.	Having a counselor who is an outsider	5.9	5.9	11.8	47.1	29.4
13.	The counselor should have experience	2.9	2.9	2.9	64.7	26.5
14.	No information given to parents etc.	0.0	11.8	8.8	41.2	38.2
15.	No information given to teachers	14.7	35.3	14.7	17.6	17.6
16.	Information given to friends	32.4	32.4	17.6	14.7	2.9

(table continues)

		% Scale Values*				
		1	2	3	4	5
17.	No information given to other students	32.4	38.2	23.5	2.9	2.9
18.	The program should try to scare students	17.6	41.2	8.8	26.5	5.9
19.	The counselor should answer drug questions	0.0	2.9	5.9	64.7	26.5
20.	The counselor should stop your drug use	2.9	11.8	11.8	58.8	14.7
21.	Should prevent drug related trouble	0.0	2.9	0.0	76.5	20.6
22.	Should allow talk on any problem	0.0	0.0	11.8	70.6	17.6
23.	Movies, video tapes, books don't tell the truth	5.9	35.3	17.6	35.3	5.9
24.	Shouldn't worry about drugs you use	11.8	52.9	8.8	20.6	5.9

*Note. For questions one through twelve, scale values represent the following: 1 = would not help at all, 2 = would be somewhat unhelpful, 3 = don't know, 4 = would be somewhat helpful, 5 = would help a lot. For statements thirteen through twenty-four, scale scores represent the following: 1 = strongly disagree, 2 = disagree, 3 = don't care, 4 = agree, 5 = strongly agree.

6. Hearing an ex-drug addict talk about drugs and drug use (74 percent)

7. Counseling sessions that show frightening results of drug use (71 percent)

8. Viewing movies and pictures about drugs and their effects (82 percent)

9. Being able to talk to the counselor about good things you are doing (68 percent)

Results also showed that eight other drug program elements were in agreement with student views. The following statements give the percentages for drug program elements which over 50 percent of the student agreed with:

1. Having a counselor who is someone that already works for the school (53 percent)

2. Having a counselor who is an outsider (does not already work for payment at your school) (77 percent)

3. The counselor should have experience working with young drug users (91 percent)

4. Absolutely no information given in group sessions should be given to parents (79 percent)

5. It is important that the counselor answers your questions about drugs (91 percent)

6. The counselor should try to help you stop taking drugs (74 percent)

7. The counselor should try to help you stay out of drug trouble in school (97 percent)

8. The drug program should allow you to talk about any problem no matter what it is (88 percent)

Based on results, over half of the students agreed with/or thought many possible drug program elements would be helpful. Although this was found, a few elements seemed extremely popular among students. Ninety-seven percent of all students interviewed agreed that the counselor should try to help them stay out of drug related trouble in school. Ninety-one percent of the students agreed that the counselor should have experience working with young drug users. Also ninety-one percent of the students agreed that it would be important for the counselor to answer their questions about drugs. Eighty-eight percent of the students agreed that the program should talk about any problem they might have no matter what it is. Finally, eighty-two percent of all students interviewed indicated that viewing movies and pictures about drugs and their effects would at least be somewhat helpful.

DISCUSSION

Family Relationships. Previous research (Babst et al., 1978) found that the less closeness there is in a family, the more willing the students (7th through 9th graders) were to take risks and the more favorable were their attitudes toward drugs. Thus it was anticipated that low family relation scores would be related to a high level of self-reported drug use. No significant results were found in the present study. However, the negative direction of the correlation does indicate some support for the prediction. Although no significance was found, it may not necessarily mean that lack of family closeness does not affect student drug use. The present study was only interested in investigating students who were caught using drugs in school. This group of students was not representative of all students in the schools. Babst et al., (1978) included all consenting students from various schools without concern about the participating students' prior drug use affiliation. Since the present study was only interested in opinions of identified student drug users, this study may not have been sensitive to correlational relationships that might include other types of students, that possibly would result in support of Babst et al., (1978).

Perceived well-being. The small size of the present sample of identified student drug users may have contributed

to the unequal distribution which prevented a Pearson r correlational analysis of scores on the item concerning perceived well-being.

Attitude toward school. Babst et al., (1978) found that a positive relationship existed between family affinity and interest in school. Thus it was predicted that lower scores on "attitude" toward school questions would be related to a lower score on the question, "How well the student got along at home in the last six months." Results showed that only one attitude toward school question, significantly supported the prediction. The significant "attitude toward school" question asked the following: How much do you like teachers generally? Although only one "attitude toward school" question was found significant, examination of Table 1 indicates two other strong relationships although not significant. It can be seen (Table 1) that poor relationships at home have a high correlation with poor attitudes toward school work. Also it can be seen that a fairly strong relationship was found between relationships at home and opinions toward school counselors. Possibly a larger sample size may have resulted in a significant difference between these variables.

In examining the present results, there seemed to be a contradiction present concerning the results found for the attitude toward school item "How much do you like your school work"? Results showed that when the student's opinion of their school work was correlated with "How well the student got along at home," a negative correlation was found. However when the student's opinion of their school work was correlated

with responses to the question stating: "Is there a person in which you can honestly discuss your feelings and concerns," a significantly positive relationship was found. Since both of these questions were trying to measure family affinity it was assumed that if the student stated that they got along good at home, they would state that the person they could honestly discuss their feelings and concerns would be related to them (or family member living with them). A frequency distribution indicated that although most students (71 percent) indicated that they did get along positively at home, only 41 percent of the students stated that the person who they could honestly discuss their feelings and concerns with was related to them. Further only 27 percent stated that the person lived with them. These frequency results might possibly explain why negative and positive relationships were found on the "attitude towards school" item stating students opinion on "your school work."

Social conflict. Scott (1972) found that often drug use in adolescents started at ages 13 and 14 and the age of puberty seems to trigger a rebellion against parents and school. In the present study it was predicted that students who have had problems at home that brought on "outside" help to solve the problem would have higher drug use scores than students' whose families did not have outside intervention. Results showed no significant differences between students whose families received outside help and students whose families did not. Thus, no support for the prediction was indicated. However, the criterion for parent/family

rebelliousness in the present study was defined as having counseling or some kind of program participation aimed at helping the student and his/her parents get along better. This criterion may have been too extreme, thus reducing statistical sensitivity to other less extreme indications of rebellion, which may have shown support for the Scott (1972) finding.

Scott (1972) found that the age of puberty not only triggered rebellion against parents but also against school. Thus it was predicted that attitudes toward school would be negatively correlated with self-reported drug use such that students with poor attitudes would have high self-reported drug use. Results showed support for this prediction to a significant degree; when students were asked how much they liked school rules and regulations, school sports teams, school clubs and/or organizations, school administrators, and hall monitors/security guards. A possible explanation for the students' negative attitudes toward school administrators and hall monitors/security guards, is that both at the middle school and high school in which students attended, it was observed that administrators and hall monitors/security guards were responsible for student disciplinary action. It was noted that when a student was caught or identified with a drug the school discipline inforcers were hall monitors and/or security guards (who caught the students and reported the incident). Usually as a result of the hall monitors/security guards report, a school administrator (principle or assistant principal) would then choose the appropriate disciplinary

action (usually the student was suspended from school and parents were notified). Thus in most cases these school staff members were not well liked by most identified student drug users.

Student preferred programs. Results showed that many of the possible program content elements and issues were perceived by student drug users as possibly being helpful in alleviating future drug related trouble in school. But it was noted that five program issues were shown to be extremely popular among students. First, 97 percent of all students interviewed stated that the counselor should try to help them stay out of drug related trouble in school. This might possibly indicate that student drug users may value a drug program that promotes various drug prevention techniques aimed at alleviating behavior that might lead to school drug trouble (example: a program that stresses the importance of drug-free school behavior and explores possible ways to accomplish this with students and their peers who use drugs).

Second, 91 percent of the students agreed that the counselor should have experience working with young drug users. This might indicate that students might feel more comfortable and willing to discuss drug related issues with a person whom they perceive as being knowledgeable to the unique concerns and interests of young drug users.

Third, 91 percent of the students also agreed that the counselor should be able to answer their questions about drugs. In order to be helpful in answering the students' questions about drugs, the counselor must have knowledge in

the general area of drugs and drug use. In addition to having general drug knowledge the counselor must also have knowledge related to the local drugs used among the students who receive the counseling. Both kinds of drug knowledge would be essential in attempting to answer student drug related questions.

Fourth, 88 percent of the students agreed that the program should talk about any problem they might have. This might indicate that the counseling program should be diverse enough to be able to address a wide variety of concerns and/or problems that the students might have. Since reasons for using drugs are often different among those who use them, a diverse program may be likely to help alleviate student drug use.

Fifth, it was shown that 82 percent of responding students indicated that viewing movies and pictures about drugs would be helpful. This might suggest that students who use drugs seem to basically believe the drug information that may be shown to them in movies and pictures to the level of possibly being helpful in keeping them out of drug related troubles in school.

LIMITATIONS

Several limitations of the present study need to be noted. First, the sample for the study was small. This was the result of lower school reported drug incidents than expected based on reported use in previous years.

Second, the small sample size may have also effected the statistical conclusions found in this study. The number of students participating in the study may not have been sufficient to generalize their reported opinions to other schools and/or settings.

Third, only two public schools were selected to obtain data for this study. Although the two schools in this study seemed to represent other public schools in the same school district, the study may have included many unknown biases that may have influenced the results of this study in unknown ways.

Fourth, in regard to family relations, a larger representative student sample may have possibly clarified some of the vagueness and problems found in trying to interpret results from a small sample.

Fifth, in testing the finding that a positive relationship exist between family affinity and interest in school, the concept of family affinity must be more specifically defined. This might reduce the vagueness of interpreting results in the future.

The sixth limitation was in the area of social conflict. A follow-up study may have been helpful to clarify speculation summary statements made in this section of the study. A follow-up asking students specifically why they responsed the way they did could have possibly helped to clarify and explain the findings.

The seventh limitation involved student preferred program criteria. No follow-up investigation was attempted to find out specifically from students why they preferred or agreed with various criterion for a possible school drug program. Lack of follow-up in this area resulted in speculation in interpreting results found in this area.

FOOTNOTE

FOOTNOTE

The middle school. One youth's (female) parent would not let her participate because of the possible embarrassment participation in the study might produce, after she was told about the confidentiality of the study procedure. Another youth (male) moved away from the area after his referral to the study, but before he could be formally interviewed.

The high school. One student (female) was given the opportunity to participate in the study by the school vice principal. But when the student continued to be disagreeable (using aversive language toward the vice principle) during the initial drug incident conference the student was permanently expelled from the school before being officially referred to the study. In addition there were two youths (male) who were officially referred to the program but because of frequent truancy (and later dropping out of school) the students could not be contacted for research participation.

APPENDICES

APPENDIX A

Departmental Research Consent Form

Michigan State University
Department of Psychology

DEPARTMENTAL RESEARCH CONSENT FORM

1. I have freely consented to take part in a scientific study being conducted by: Robert Clark

   under the supervision of: Dr. Robin Redner

   Academic Title: Assistant Professor of Psychology

2. I understand that the research is an interview that will ask general questions about my perceptions of the causes of drug use, knowledge about drugs, current drug use, and ideas about a school drug prevention program.

3. The study has been explained to me and I understand the explanation that has been given and what my participation will involve.

4. I understand that I am free to discontinue my participation in the study at any time without penalty.

5. I understand that the results of the study will be treated in strict confidence and that I will remain anonymous. No information from my interview will be given to parents. Within these restrictions, general findings of the study will be made available to me at my request.

6. I understand that my participation in the study does not guarantee any beneficial results to me.

7. I understand that, at my request, I can receive additional explanations of the study after my participation is completed.

Signed: _____
(student)

Date: _____

Signed: _____
(parent or guardian)

Date: _____

TITLE OF RESEARCH PROJECT: Needs Assessment of Identified Student Drug Users in a Middle School and High School Environment

APPENDIX B

The Interview Instrument

DATE ADMINISTERED:_____ CODE NUMBER:_____

GENERAL INFORMATION

1. Date of Birth _____

2. Sex Male _____ Female _____

3. Grade _____

4. Grade Point Average _____

5. How long have you lived in Lansing?

   (number of years) _____

6. What are the names, ages, and relationship (what relationship are they to you) of the people living in your home in the last six months?

NAME	AGE	RELATIONSHIP

7. On the average how well have you been able to get along with people at home in the last six months?
   (Indicate which ONE of the following responses BEST describes your feelings)

Very Badly (1)	Somewhat Badly (2)	Neither Good Nor Bad (3)	Somewhat Good (4)	Very Good (5)

8. Is there a person in which you can honestly discuss your feelings and concerns? Yes ___ No ___
   If yes are they related to you? Yes ___ No ___
   Does this person live with you? Yes ___ No ___
   How long have you known this person (if they are not a relative) ?_____

9. Do you presently have career goals? _____ Yes _____ No

If yes, what are they? _____

_____

If yes, what are you doing now to prepare yourself to reach your goals?

_____

10. Is there anything you feel you should be doing now to help yourself achieve your goal(s) that you're not doing?
(Indicate the response that best represents your feelings.)

Yes _____ No _____

If yes what do you feel you should be doing?

_____

_____

11. Do you have a job? Yes ___ No ___ If no would you like a job Yes ___ No ___

If yes, what is your job? _____

If yes, indicate which response best represents how much you like your job:

_____	_____	_____	_____	_____
Don't Like At All	Don't Like Most of the Time	Neither Like Nor Don't Like	Like Most of the Time	Always Like

12. Indicate how much you like the following topics as they relate to your school. Indicate one response to each topic. The responses are:
1 = Don't like at all
2 = Don't like most of the time
3 = Neither like nor dislike
4 = Like most of the time
5 = Always like

_____ Your school work (generally)
_____ School rules and regulations
_____ Your classes (generally)
_____ Sports team(s)
_____ School clubs and/or organizations

13. Indicate how much you like the following people in your school. Indicate only one response to each person. The possible responses are the same as in the previous question.

_____ Teachers (generally)
_____ Your friends at school (generally)
_____ Counselor(s)
_____ Administrators (principal, assistant principal)
_____ Hall monitors (security guards, etc.)

14. Have you ever been arrested? Yes _____ No _____

If yes, how many times? _____

If yes, how many of these arrests were related to drugs? _____

If yes, what was the outcome of the drug related arrest(s)?
(Check the following outcomes that apply.)

	(First Arrest)	(Second Arrest)	(Third Arrest)
Warned and Released	_____	_____	_____
Probation	_____	_____	_____
Juvenile Lock-up	_____	_____	_____

Other (Explain Specifically) _____

_____

_____

15. Have you or your parent(s) ever received any counseling or participated in any program that was aimed at helping you and your parent(s) get along better at home?

Yes _____ No _____

If yes, who received the counseling? _____

If yes, what was the counseling for? _____

_____

If yes; what kind of counselor did you/they have?
(Check the appropriate category.)

_____ Psychiatrist
_____ Psychologist
_____ Social Worker
_____ Drug Counselor
_____ Other (Explain specifically) _____

_____

If yes, how helpful do you feel the counseling was? (Indicate which response best represents your feelings.)

_____	_____	_____	_____	_____
Didn't help at all	Helped very little	Don't know	Somewhat helpful	Very helpful

Drug History Section I

16. Now I would like to know every drug that you have ever taken or experimented with, even if you used it only once. I'd like to remind you that your answers are confidential, and your name will not appear on this interview questionnaire.

See next page and answer only the questions to the drugs that you have tried.

Of these drugs mentioned which drug(s) do you prefer most?

_____

17. Are you presently taking any drug(s) prescribed by a doctor for a health related problem?
Yes _____ No _____

If yes, what drug or drugs are you taking and why?
(List drug and reason for taking it in the space provided below.)

Drug	Reason
_____	_____
_____	_____
_____	_____

Check which of the following drugs that you ever used, even if it was only once. Then answer the following questions to each of those drugs chosen.

Substance	Age at First Use	How Frequently Used Last 6 Months	Method of Use	Overdose or Bad Experience
Marijuana				
Cigarettes				
Beer/Wine				
Liquor				
Amphetamines (Speed)				
Cocaine				
Barbiturates (Downers)				
Tranquilizers (Librium) (Valium)				
Quaaludes				
PCP (Angel dust) (Crystal-T)				
LSD (Acid)				
Psilocybe (Mushrooms)				
Mescaline				

Substance	Age at First Use	How Frequently Used Last 6 Months	Method of Use	Overdose or Bad Experience
Hash Hash Oil				
Rush Oil				
Opium				
Morphine				
Heroin				
(R) Demerol				
(R) Percodan				
Paint Thinner				
Gasoline				
Lighter Fluid				
Glue				

Drug History
Section II

In this section, I just want to ask you about the first drug or drugs you took the very first time that you tried drugs.

18. What drug(s) did you take the very first time you ever tried any drug(s)? (Limit discussion to one drug if possible.)

---

19. Now I'd like you to rank how important the following reasons were in getting you to use this (these) drug(s). (Use only one rank for each reason.)
The ranking scale is the following:

1 = Most important reason for use
2 = Second most important reason for use
3 = Third most important reason for use
4 = Fourth most important reason for use
5 = Absolutely not a reason for use

_____ Curiosity; just wanted to try it.
_____ Friends wanted you to try it.
_____ Relatives wanted you to try it.
_____ Everyone else was doing it.

20. How much did you know about the drug(s) before you tried it(them)? (Rate how much you knew about each of the following items. Use only one rating for each item.) The rating scale is:

1 = Didn't know anything
2 = Knew a little about the drug
3 = Don't remember how much you knew at the time
4 = Knew a lot about the drug
5 = Knew everything about the drug

_____ Chemical content
_____ Physical effects
_____ Negative effects
_____ Positive effects
_____ How to take the drug
_____ How much it cost

21. If you knew the things that you know now about this (these) drug(s) before you tried it(them) the first time, do you think the knowledge would have stopped you from using this(these) drug(s)?

Yes _____ No _____

How much do you agree with the following statements in relation to the first drug you ever used.

1. You like the way it makes you feel.

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree

2. It helps you get along better with people at home.

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree

3. It helps you sleep/or stay awake.

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree

4. It helps you get along better with friends.

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree

5. You don't know why you like to take/or use it, you just do.

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree

6. It gets you tired.

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree

7. It could lead to other things.

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree

8. It creates problems with your family.

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree

9. It creates problems with other people you care about.

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree

10. It gets boring after a while.

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree

11. It makes it harder to relate to your relatives.

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree

12. It makes you lose interest in things you care about.

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree

13. People waste too much money on it.

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree

14. After trying it, I found out that it was no "big deal."

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree

Now I just want to know what drug(s) you have taken in the last 6 months.

Which of the following drugs have you taken in the last six months?

1. Marijuana
2. Cigarettes
3. Beer/Wine
4. Liquor
5. Amphetamines (speed)
6. Cocaine
7. Barbiturates (downers)
8. Tranquilizers (librium, valium)
9. Quaaludes
10. PCP (angel dust) (crystal-T)
11. LSD (acid)
12. Psilocybe (mushrooms)
13. Mescaline
14. Hash
    Hash oil
15. Rush oil
16. Opium
17. Morphine
18. Heroin
19. Demerol
20. Percodan
21. Paint thinner
22. Gasoline
23. Lighter fluid
24. Glue

Drug: _____

What caused you to use _____, the very first time? (Indicate the order of importance the following possible reasons were in causing you to use this drug for the first time.)

Use only one of the following numbers to define how you feel about each of the following reasons.

1 = Most important reason for use.
2 = Second most important reason for use.
3 = Third most important reason for use.
4 = Fourth most important reason for use.
5 = Fifth most important reason for use.
0 = Not relevant as reason for your drug use.

_____ Curiosity; you just wanted to try it.
_____ Friends wanted you to try it.
_____ It was a holiday or special occasion.
_____ A relative offered it to you.
_____ To help you cope with problems at home.

Was there any reason not mentioned that caused you to use this drug for the first time? _____

_____

Using the same numbering method, indicate the order of importance the following reasons were in causing you to continue using this drug?

_____ It helps you have a good time.
_____ It makes you feel good about yourself (more confidence).
_____ It's easy to get.
_____ Friends want you to keep using it with them.
_____ It's just a habit.

Is there any reason not mentioned that causes you to continue using the drug?

_____

_____

Which of the following situations do you like to use this drug most? Indicate how you feel about each of the following situations by placing the number below that best represents your feelings. The numbers are:

1 = Most often
2 = Second most often
3 = Third most often
4 = Fourth most often
5 = Fifth most often
0 = Never use in this situation

_____ Alone
_____ With your friends
_____ At school
_____ At parties
_____ At concerts

Is there any other situation not mentioned in which you use this drug?

_____

Which one of the following reasons best describes the reason why you use this(these) drug(s) and not some other drug(s)?
(Indicate by placing a "check" next to the reason that best describes your feelings.)

_____ The drug(s) is(are) more available than other drugs.
_____ The drug(s) is(are) safer than other drugs.
_____ You tried other drugs and didn't like them.
_____ You trust the person who gives you this(these) drug(s).
_____ You think other drugs are stupid.

Is there any other reason not mentioned for why you use this(these) drug(s) most often and not some other drug(s)? _____

_____

What drug have you used the longest time even if you don't use it now?

_____

What particular reason was there for your using this drug for this time period? (Indicate which one of the following responses best represents your feelings.)

_____ You like the effect of the drug.
_____ It helps you get along with others.
_____ It helps you have a good time.
_____ You like the taste of it.
_____ It's easier to get.

Is there any other reason not mentioned for why you used this drug the longest time? _____

_____

Of the drugs you presently use, which of these do you like most? _____

_____

DRUG HISTORY
SECTION III

In this section, I would like your opinion on what type of school program you think would be useful to help keep students in this school from getting into drug related trouble.

1. What do you think this school should do to help keep students out of drug related trouble? _____

_____
_____
_____
_____
_____
_____
_____
_____

How much do you agree with the following statement?

2. All students caught using drugs in school should be given the option to attend a program aimed at getting students to stop their school drug use rather than to be suspended from school.

_____	_____	_____	_____	_____
Strongly Disagree	Disagree	Don't Care	Agree	Strongly Agree

Now I would like to know your opinion on what type of school counseling program you think would be useful to help you stay out of drug-related trouble in school.

How much do you think the <u>following</u> ideas for a school counseling program would (possibly) help you stay out of drug trouble in school if you were given a chance to participate:

1. Counseling sessions held in a group?

_____	_____	_____	_____	_____
would not help at all	somewhat would not help	don't know	would somewhat help	would help a lot

2. Counseling sessions involving all boys (girls)?

_____	_____	_____	_____	_____
would not help at all	somewhat would not help	don't know	would somewhat help	would help a lot

3. Counseling sessions involving both boys and girls?

would not help at all	somewhat would not help	don't know	would somewhat help	would help a lot

4. Private counseling sessions between just you and the counselor?

would not help at all	somewhat would not help	don't know	would somewhat help	would help a lot

5. A combination of group and individual counseling sessions?

would not help at all	somewhat would not help	don't know	would somewhat help	would help a lot

6. Hearing an ex-drug addict talk about drugs and drug use?

would not help at all	somewhat would not help	don't know	would somewhat help	would help a lot

7. Counseling sessions conducted by other students about your age?

would not help at all	somewhat would not help	don't know	would somewhat help	would help a lot

8. Counseling sessions that show you frightening results that happen to some people using certain street drugs?

would not help at all	somewhat would not help	don't know	would somewhat help	would help a lot

9. Viewing movies and pictures about drugs and their effects?

would not help at all	somewhat would not help	don't know	would somewhat help	would help a lot

10. Being able to talk to the counselor about the good things that are going on in your life, like accomplishments in school, achievements in sports, better relations at home with your family etc.?

_____	_____	_____	_____	_____
would not help at all	somewhat would not help	don't know	would somewhat help	would help a lot

11. Having a counselor who is someone (teacher, counselor, administrator etc.) in this school?

_____	_____	_____	_____	_____
would not help at all	somewhat would not help	don't know	would somewhat help	would help a lot

If applicable, who specifically?_____

12. Having a counselor who is an "outsider" someone who does not teach or work (for payment) at your school?

_____	_____	_____	_____	_____
would not help at all	somewhat would not help	don't know	would somewhat help	would help a lot

Now I would like your oppinion on the following questions:

13. How old would you like your counselor to be?

_____	_____	_____	_____	_____
19-25	26-32	don't care	33-40	41 or older

Which one of the following descriptions best represents what you feel would be the best choice of attire (clothing) for the counselor to wear while talking with students who use drugs in this school?

_____ T-shirt and jeans

_____ slacks and shirt

_____ whatever he/she wants to wear

_____ slacks, shirt and tie

_____ suit and tie

How much do you agree with the following statements:

14. The counselor should have experience working with students your age who use drugs.

_____	_____	_____	_____	_____
strongly disagree	disagree	don't care	agree	strongly agree

15. Absolutely no information given in individual or group sessions should be given to:

A) Parents or Relatives:

_____	_____	_____	_____	_____
strongly disagree	disagree	don't care	agree	strongly agree

B) Teachers:

_____	_____	_____	_____	_____
strongly disagree	disagree	don't care	agree	strongly agree

C) Your friends:

_____	_____	_____	_____	_____
strongly disagree	disagree	don't care	agree	strongly agree

D) Other students:

_____	_____	_____	_____	_____
strongly disagree	disagree	don't care	agree	strongly agree

16. How necessary do you think it is for someone to teach the following people what drugs "really do" (because they seem to know nothing about them).
Give only <u>one</u> of the following ratings to each person:

1= very necessary
2= might be necessary
3= don't care
4= might not be necessary
5= not necessary

_____ parents

_____ other relatives

_____ teachers

_____ friends

_____ other students

17. How do you think showing you another person's bad experience with drugs will effect your drug use?

Rank the following responses by choosing the order that best represents how you are most likely to respond.

1= most likely to happen
2= second most likely to happen
3= third most likely to happen
4= fourth most likely to happen
5= least likely to happen

_____ It might prevent you from using drugs.

_____ It might prevent you from using the particular drug(s) shown to you.

_____ It might not effect your drug use behavior.

_____ It might make you curious about trying the drug(s) shown to you.

_____ It might cause you to start using the drug(s) shown or help motivate you to continue using the drug(s) shown.

How much do you agree with the following statements:

18. The program should try to scare students away from using drugs.

_____	_____	_____	_____	_____
strongly disagree	disagree	don't care	agree	strongly agree

19. It is important that the counselor answers your questions on drugs and their use.

_____	_____	_____	_____	_____
strongly disagree	disagree	don't care	agree	strongly agree

20. The counselor should try to help you to stop taking drugs.

_____	_____	_____	_____	_____
strongly disagree	disagree	don't care	agree	strongly agree

21. The counselor should try to help you stay out of drug-related trouble in school.

_____	_____	_____	_____	_____
strongly disagree	disagree	don't care	agree	strongly agree

22. The drug program should allow you to talk about any problem you may have no matter what it is -- if you want to.

_____	_____	_____	_____	_____
strongly disagree	disagree	don't care	agree	strongly agree

23. People in group sessions should only talk to each other about drugs because movies, video tapes, books, etc. don't usually tell the truth about drugs.

_____	_____	_____	_____	_____
strongly disagree	disagree	don't care	agree	strongly agree

24. The counselor shouldn't worry about what drugs you use as long as you don't bring or use them in school.

_____	_____	_____	_____	_____
strongly disagree	disagree	don't care	agree	strongly agree

Thank you very much for your cooperation

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REFERENCES

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