The PREVENTION CONNECTION
NEWSLETTER

Drugs of the New Millenium

Alcohol, methamphetamine and ecstasy are obviously not the only drugs threatening Montana's youth. They are, however, drugs that pose significant danger to our youth. Awareness is the first, best, tool in our toolbox and one we can use to build prevention measures that will help Montana reverse trends and reduce demand.

In a report published in *On the Same Page: A Bulletin Board* (March 2001), Turning Point, an adolescent substance abuse treatment program operating in Missoula County, reported that alcohol remains the number one drug of abuse among the Montana youth they are seeing, followed by marijuana and amphetamines. The report goes on to state that many youth are also abusing heroin, acid and ecstasy. Given the statistics reported in the Prevention Needs Assessment, this rings true for year 2000, when a full 86.8 percent of 12th graders reported having used alcohol at some point in their lives; and 64.4 percent reported using alcohol within the last 30 days. Over half of 12th graders report having tried marijuana, and almost one in three kids has used some drug during the past thirty days. A full 56.9 percent of the Montana youth surveyed have used some drug during their lifetimes.

Though alcohol abuse isn't news in Montana, the data indicates that it *is* a growing problem among Montana teens. The impact cannot be overestimated. More than half of American adults have a close family member who has struggled with alcoholism and nearly 60 percent of 18-24 year old high school dropouts who drink started before the age of 16. Forty percent of children who start drinking before the age of 15 will become alcoholics at some point in their lives. If the onset of drinking is delayed by just five years, the risk of developing serious alcohol problems is decreased by 50 percent.

Methamphetamine hasn't overtaken alcohol as the primary addiction, but it is growing. A potent central-nervous system stimulant, methamphetamine is made of a combination of anhydrous ammonia, lithium from camera batteries and ephedrine or pseudoephedrin found in cold medicines. Other common components include acetone (found in paint thinner), ether, derived from engine starting fluid, sulfuric acid from drain cleaners, sodium hydroxide found in Red Devil lye, red phosphorous found in match heads, hydrous ammonia from farm fertilizer, iodine and sodium.

Continued on Page 4

Drugs of the New Millenium

Risk Checklist 6
Montana Board of Crime Control 7
Safe Schools/Healthy Students 11
4-H After School 14
Montana Turner Foundation 16
Gateway Recovery 17
Meth Task Force 19

Montana Prevention Resource Center
P.O. Box 4210
Helena, MT 59604
Web Site: www.state.mt.us/prc

Co-coordinators
Jan Lombardi
(406) 444-1928
jlombardi@state.mt.us *and*
Vicki Turner
(406) 444-5986
vturner@state.mt.us

Linda Schwabauer
Administrative Support
(406) 444-9772
mschulund@state.mt.us

Erin Jemison
VISTA Leader
(406) 444-3925

Aaron Lessen
VISTA
(406) 444-9654

The Prevention Connection

Sherrie Downing
Editor
(406) 443-0580
Fax: (406) 443-0869
E-mail: DowningSL@home.com

Karen von Arx Smock
KD Graphics
Freelance Design & Production
Phone/fax: (507) 894-6342
E-mail: KDVonArx@aol.com

The Jan and Vicki Column

This millennium ushers in deep shadows on the drug landscape—methamphetamines and ecstasy—even as our age old nemesis, alcohol, continues to haunt our backyards. Alcohol is offered in the home, hidden on school grounds and at teen dances, made available at the local grocery store, gas station and community 'watering hole.' In many cases, meth is being manufactured in our neighborhoods. Ecstasy is the drug of choice at many club dances touted as "alcohol free events."

This issue of the *Prevention Connection* provides insight into many worlds revolving around drugs and alcohol. We've solicited input from an ex-drug dealer, law enforcement, schools, media and the home front. We may never eradicate drugs entirely, but we can prevent our youth from using drugs and abusing alcohol.

What can we do? Learn the facts—kids have access to alcohol and drugs. Recognize that parents serve as the first line of defense by helping ensure that youth grow up in healthy environments and become competent and whole adults. Set ground rules and help our communities achieve a healthy vision.

The next time you are asked to support a community "kegger" for high school seniors, serve wine to kids at dinner, or consider when it is appropriate to offer kids a beer—think again.

Jan and Vicki

Notes From the Edge

By Jim Arneson

I'm not a cop or a counselor. I'm an ex-drug dealer and a recovering addict. I was involved with meth for fifteen years—and the truth is, I did meth once. The rest of the time it did me.

Meth took over after the very first time. I started using two-dollar lines 1/8 wide by 1 inch long, but after eight years, I was using fifty-dollar lines 8 inches long by 3/16 inches wide. It's still hard for me to realize how cunning this drug is, but it is cunning. A lot of kids—a lot of people—think if they don't get caught, they're getting away with it. What they don't know is that this drug steals from them every time they use it. I lost a fourteen-year marriage along with all my principles and morals, but I didn't even realize they were going because I was too busy doing the drug to notice. Meth took the love out of my relationship with my wife and turned it into lust. It took away my family, my health, my self-respect. Meth got everything I had.

My final wake-up call came when my friend killed himself. After the first two years, my teeth had started falling out. Toward the end, I was throwing up and my heart was going 200 beats a minute. Sometimes I'd snort and blood would come running out of my nose. I had scabs on my face and all over my body, but I was still doing the drug. The feeling I'd get from meth was so pleasurable, so intense that it would feel like even my hair was tingling. It's only a matter of seconds 'til you're off, and you can feel a chill moving through your whole body. You can smoke this stuff, snort it, shoot it or drink it, but it burns when you swallow. That's not a big surprise. Meth is made from toxic chemicals—paint thinner, Coleman lantern fuel—if it says *caution, warning or hazard*, they can make meth out of it.

Addiction is a family disease and you reap what you sow. One of my sons is 24 years old, and he just got out of prison for meth. Kids follow in your footsteps whether you want them to or not, but meth made me forget what it means to be a father. If you watch your kids play sports, you're setting an example. Give them hugs and let them know you love them, and you're setting an example. You also need to let them know who you are and where you stand. I have a 13-year-old son, and I haven't pulled any punches with him. I've told him *exactly* what this drug did to me.

Continued on Page 3

Notes From the Edge

Continued from Page 2

People think the schools should be keeping kids safe from drugs, but schools are there to educate. They can do their part, but they can't keep kids safe. The truth is, there's no place where a kid's completely safe. You can do everything right, but you can't be with them 24/7. It eventually comes down to free will. Of course, you can get lists of the things parents can do to keep their kids safe, and those lists will tell you that you need a close relationship with your kid, and that you'd better be on top of it by 6th or 7th grade, because those are dangerous years. You need to know who your kids are running with. You need to lead by example and be open with your kids. And you need to watch. If grades go down, if the kid is easily irritated, if he changes friends or changes appearance and starts looking greasy or unkempt, watch out.

A lot of parents go into denial— it's always easier to see a flat tire on your neighbor's car than on your own. But big changes are always danger signs. If someone is in trouble with meth, the symptoms and signs will be there. You might start noticing they're spending a lot of time in the bathroom. Your kid won't eat—he's always in a hurry to get somewhere. There will be rapid weight loss. Their looks go fast. Addicts are very sneaky and manipulative, and they're always very aware of what's going on around them. They won't look you in the eyes anymore. Their pupils will probably be dilated. If they're tweaking, they can't concentrate, it's like taking meds away—their minds are moving faster than their bodies can keep up. There's nothing restful about meth addicts. They stretch and twist, clear their throats all the time. They lick their lips, roll their eyes, chew their lips. They'll start smoking more cigarettes—crank and cigs seem to go together. And they may develop something that looks like acne, but these scabs will be all over their bodies. They can't leave the sores alone, either. They'll pick and pick at any imperfections until they bleed.

This drug works in a geometric progression—if one kid tries it, before you know it, it's spread like wildfire. That's because you're a user until you can't afford it, and then you're a seller. Meth grabs right hold of your soul.

Once meth is in the driver's seat, you're talking to the meth, not to your kid. You can't look at a little white line and tell it to leave your kid alone. If you suspect your kid is in trouble and he's under 18, my advice is to watch and make sure the activity is in full swing, then run drug tests. It doesn't stay in the urine and blood for long, but it stays in the hair for three years. Most people can't afford rehab—they're talking nine months for rehab, but you're going to need that long just to get them free of the environment. That's the key. I tell people to make sure their sons and daughters change their playthings, playmates and playground.

Prevention is hard, but it's the best we've got. Drug wars ain't working. We need to put the money into prevention and rehab, and help kids stop before they make the wrong choice, because we can't stop meth. Bust one dealer and there are five waiting to take his place.

These days I go into schools to talk, and I've started a chapter of Narcotics Anonymous for kids. My message is what methamphetamine did to me. I tell people what to expect because meth does the same to everybody, no exceptions. You either quit or it will kill you. The thing is, you don't have to go where I've been to figure that out.

Kids always know the truth from a lie. They know if somebody has been there or if they haven't been. So I tell them *here's what it takes from you—here's what you don't get back*. Kids need to know that before they try this drug. I haven't walked away from an auditorium yet where there weren't kids crying. When I see those tears, I'm hoping that what I've said has changed the life of one kid—that he's heard something that will either help him get off the drug or convince him not to start. Anyone can talk to a kid, but for him to hear, you have to touch his heart. When I finish talking and I see tears, I know I've gotten through.

—On May 31, Jim celebrated three years of sobriety.

Interagency Coordinating Council (ICC)

Mission: To create and sustain a coordinated and comprehensive system of prevention services in the state of Montana

Prevention Resource Center
P.O. Box 4210
Helena, MT 59604
(406) 444-1928
Fax: (406) 444-1970

Chair: ***DeAnn Thomas***
Director
Flathead CARE

Vice-Chair: ***Gail Gray***
Director
Dept. of Public Health & Human Services

Members

D.L. "Louie" Clayborn
State Coordinator of Indian Affairs

Bill Slaughter
Director
Dept. of Corrections

Mike Foster
Commissioner
Dept. of Labor and Industry

Linda McCulloch
Superintendent
Public Instruction

Mike McGrath
Attorney General

Jim Oppedahl
Executive Director
MT Board of Crime Control

William Snell, Jr.
Director
In-Care Network, Inc.

General John E. Pendergast
Dept. of Military Affairs

Dave Galt
Director
Dept. of Transportation

Dr. Richard Crofts
Commissioner of Higher Education

Vacant
Montana Children's Trust Fund

Staff

Jan Lombardi

Glossary of drugs categories and their slang nick-names:

Alcohol—*booze, sauce, brews, brewskis, hard stuff, juice.*

Amphetamines—*speed, uppers, black beauties, pep pills, copilots, hearts, benzedrine, dexedrine, biphetamine, bennies, benz.*
What it looks like: *capsules, pills, tablets.*

MDMA—*XTC, Adam, essence, ecstasy, E.X.*
What it looks like: *tablets, powder, capsules.*

Methamphetamine—*crank, crystal, meth, purple rock, speed, ice, glass, go.*
What it looks like: *white powder, pills, rock resembling a block of paraffin.*

From: http://www.ci.shrewsbury.ma.us/police/drugglossary.htm and ***Keeping Teens Drug-Free Monthly Planner and Activity Guide****, U.S. DHHS*

"Substance abuse is not just the responsibility of the federal government. All drug abuse problems are local by their very nature. Comprehensive strategies are needed at all levels." (J.Hendry, New York, Reuters Health).

Drugs of the New Millenium

Continued from cover

Known as speed, uppers, crank, poor man's cocaine and CR, methamphetamine is commonly distributed in powdered form. Depending on the recipe and the cleanliness of the procedure, the drug can be pink, brown, red, tan or white. It is most commonly snorted, but can be injected or smoked. "It is 100 percent addictive," according to Ray Malley, regional manager for the Southwest Montana Drug Task Force in a quote published in *The Montana Standard* (January 2000).

"I would guarantee any short-term use, you'll become addicted. It could be one time, could be three, could be five," Malley said in the same report. "If I could paint a plague on our society right now, it would be dangerous drugs, and the leader of that is methamphetamine." Meth eats away at addicts' bodies, altering their brain chemistry, disrupting sleep and appetite, and leaving the addict malnourished and severely ill. Since many addicts inject meth, Hepatitis C and AIDS are a growing problem among users. This drug impairs the brain's ability to produce dopamine, which means that it takes more and more of the drug each time to get high. As addiction grows, users often become aggressive, unpredictable and angry. Additionally, police officers report that drugs are at the root of many of the property crimes and assaults occurring in our communities.

MDMA (3, 4-methylenedioxymethamphetamine), which goes by street names such as Ecstasy, XTC, E, X, and Adam, is one of the "club drugs" just beginning to show up in Montana This drug is a synthetic, psychoactive substance with stimulant and mild hallucinogenic properties. Known as the "hug drug" or "feel good" drug, it reduces inhibitions and produces feelings of empathy for others, eliminates anxiety, and produces extreme relaxation. In addition to chemical stimulation, the drug reportedly suppresses the need to eat, drink or sleep, enabling users to endure all-night and sometimes 2 or 3 day parties.

Ecstasy is taken orally, usually in tablet form, and its effects last approximately 4 to 6 hours. Often taken in conjunction with alcohol, the drug destroys dopamine and serotonin cells in the brain. The drug often leads to severe dehydration and heat stroke, since it has the effect of "short-circuiting" the body's temperature signals to the brain. Overdose is characterized by rapid heartbeat, high blood pressure, faintness, muscle cramping, panic attacks, and in more severe cases, loss of consciousness or seizures. One of the side effects is jaw muscle tension and teeth grinding, which leads users to use pacifiers to relieve the tension.

The most critical, life-threatening responses are hyperthermia or excessive body heat. Recent reports of MDMA-related deaths were associated with core body temperatures ranging from 107 to 109 degrees Fahrenheit. The long-term effects are still under evaluation, but research by the National Institute of Mental Health in Bethesda, Maryland, measured the effects of the drug on the human brain. The study revealed that the drug causes damage to the neurons that utilize serotonin to communicate with other neurons in the brain. Recreational MDMA users risk permanent brain damage that can manifest itself in depression, anxiety, memory loss, learning difficulties, and other neuropsychiatric disorders.

Resources:

— How Does Alcohol Affect the World of a Child: Leadership To Keep Children AlcoholFree. leadership@cdm group.com

— HYPERLINK "http://www.us doj.gov/dea/pubs/intel/20005 intellbrief.pdf" http://www. usdoj.gov/dea/pubs/intel/20005 intellbrief.pdf

For more information about the Prevention Needs Assessment, see the Montana Prevention Web Site: http:/oraweb.hhs.state. mt.us:9999/prev_index.htm or call 406-444-3964

Traffic (R): *A Movie Review*

by Brent Northup

Rating: ☆☆☆☆

Although American action films contain nonstop violence, in the end, audiences tend to leave the auditorium light-hearted and happy. Why? Because more often than not, the violence has a comic-book quality that paints the hero as immortal and victims as somehow painlessly extinguished.

In short, there's no honest depiction of death or suffering in American mainstream cinema.

Enter "Traffic," a very different sort of action film in which pain actually hurts and death is a nosy neighbor who may drop in at anytime.

"Traffic" attempts to provide a multi-pronged view of America's drug problem. At the center is a family in which the dad is a federal official fighting the drug war and the daughter is a junkie who is inhaling drugs every day. The story of this family's anger and fear provides one perspective.

But the film does not stop there. Instead, director Steven Soderbergh widens his lens to examine drug cartels in Mexico. It's not easy to tell the heroes from the villains. The drug kings will kill anyone who steps in front of their carloads of drugs, but the Mexican cops are similarly ruthless in their willingness to torture anyone who could lead them to the cartel.

The film reaches into suburban America again when a "respectable businessman" is arrested on drug charges. At first, his wife is appalled by her husband's hidden lifestyle, but before long she sheds her moral inhibitions and hires a hit man to kill the witness against her husband.

Everywhere we turn, drugs are begetting violence - and the attempts to stop the violence only serve to increase the bloodshed.

"Traffic" is a relentlessly pessimistic view of the drug problem. The only hope offered is a sympathetic portrayal of Narcotics Anonymous, which manages to save a few of the souls who have been damaged through addiction.

"Traffic" is breaking the "happy ending" Hollywood formula, drawing crowds to see suffering.

As for me, the unmistakable conclusion is that drugs are as available in Helena as they are in El Paso. And, at some point, they will be offered to our children.

While I support an aggressive effort to stem the flow of drugs, I also believe that we are more likely to protect our children from the rain by giving them an umbrella than by waging war against the clouds. It's our job to provide our sons and daughters with the courage to protect themselves from this destructive temptation.

Then we must sit back and hope that our parenting is strong enough to influence a decision that will likely be made some afternoon when we aren't around.

And, as "Traffic" reminds us, there are no guarantees how the drama will end.

Reprinted by permission: Independent Record, Helena, on March 2, 2001

THE SCHOOL ZONE

As part of its efforts to promote a healthy, drug-free lifestyle, the Office of National Drug Control Policy (ONDCP) has created The School Zone, a web-based resource designed for teachers and kids of all ages. Youth can access information on safety issues, citizenship, and crime prevention. Younger children might enjoy the arts and crafts, games, and many innovative educational features. A library designed for teens features information on such topics as alcohol and drug abuse, HIV/AIDS, labor laws, and teen pregnancy. Teachers can find resources and activities to help them guide youth, including lesson plans and classroom-related materials.

Resource:

http:/www.whitehousedrugpolicy.gov/prevent/schoolzone/

Youth Drug Use Strongly Influenced by Friends

By Amy Norton

Dateline: Friday March 9, 2001

NEW YORK (Reuters Health)—Teens whose friends smoke marijuana are far more likely to try the drug themselves, and ''mild" drug warnings from parents are not enough to overcome this peer pressure, a government study shows. A nationwide survey of 7,844 adolescents aged 12 to 17 reveals that teens who have a few close friends who smoke marijuana are 39 times more likely than other teens to have used the drug in the past year. And respondents were far more likely to try pot if they thought their friends would not be bothered by it.

Among adolescents who said their friends would be "very upset" if they tried marijuana, just two percent had used the drug in the past year. That compares with forty-four percent of those who said their friends would not mind their marijuana use at all.

If you thought flea powder was something you used on the dog, bussing is a great way to get kids to school, and the Pepsi generation was all about caffeinated drinks, you aren't the only one. This quiz is a very small sample of the drug slang terms being used.

POP QUIZ

1. Bang
a. To get high
b. To inject narcotics
c. Sex for drugs

2. Big Man
a. Drug enforcement agent
b. Heroin
c. Supplier of drugs

3. Buss
a. To be high
b. Kiss
c. Transport a substance

4. Cartwheels
a. Drug cartel
b. Dodging a police officer
c. Amphetamines

5. Deck
a. A packet of drugs
b. A gun
c. The place where you go to buy drugs

6. Flea powder
a. Crank
b. Poor quality drugs
c. Observed by narcotics officers

7. Get off
a. Quit using drugs
b. Go to jail
c. Feel a drug's effects

Continued on Page 9

Risk Checklist for Your Child

1. Family history of alcoholism. If the biological father of a boy is an alcoholic, put down a point for that boy.
2. Early problem behavior. Add a point for boys who were aggressive and difficult to control when they were five, six or seven.
3. Family patterns. Give a point for each of the following that happens in your family:
   a. Your children don't share their thoughts and feelings regularly with at least one family member.
   b. You rarely let your child know in advance what kind of behavior you expect.
   c. You don't usually keep track of where your child is, the kinds of things your child is doing, and who your child's friends are.
   d. You rarely praise your children for doing well.
   e. When your child breaks family rules, you're not consistent and controlled in your punishment.
4. Family drug use. Add a point if household members use illegal drugs around children, if there is heavy recreational drinking in the home, or if adults in the family involve children in their drinking or other drug use, such as asking a child to get a beer or light a cigarette.
5. Poor school performance. Put down a point for each child who failed to achieve in school when that child was nine, ten and eleven.
6. Dislike of school. Add a point for children who strongly dislike school or who have a poor performance record.
7. Alienation from family and society. If your children have become isolated from the family and cynical about their own involvement in family and school activities, add another point.
8. Delinquent behavior/school misbehavior. Add a point if your child is involved in delinquent behavior or has been suspended or expelled for school misbehavior.
9. Friends who use drugs. Add another point for each child whose close friends use alcohol or other drugs.
10. Favorable attitudes towards drug use. Add a point for each child who expresses the view that it's okay for children to use alcohol or other drugs.
11. Early first use. Finally, if any children in your family began to use alcohol, marijuana or other illegal drugs before they were fifteen, subtract the child's age at first drug use from 15 and add the result to your child's total.

Total the number of points. The higher the number, the greater the risk of problems with alcohol or other drugs. This is not a scientific assessment of your family, but is designed to help you become aware of statistical probabilities. The presence of many risk factors doesn't condemn a child to be a drug abuser, nor does a low score mean freedom from problems. This risk check is simply intended to alert you to pay attention to these factors, and to make the extra effort needed to change patterns when necessary.

Source:
Preparing for the Drug-Free Years

Top Ten Prevention Tips for Parents

1. **Talk to your child about alcohol, tobacco and other drugs.**
2. **Learn to really listen to your child.**
3. **Help your child feel good about himself or herself.**
4. **Help your child develop strong values.**
5. **Be a good role model.**
6. **Help your child deal with peer pressure.**
7. **Make family rules.**
8. **Encourage healthy, creative activities.**
9. **Team up with other parents.**
10. **Know what to do if you suspect a problem.**

The Three Strategies of the Montana Board of Crime Control

By Al Brockway, Grants Planning Bureau Chief

Here in Montana, fewer than 900,000 individuals reside in 56 counties, and the border shared with Canada exceeds 500 miles. Three-fourths of our towns have fewer than 1,000 residents. Many jurisdictions cover hundreds of square miles. Low population densities coupled with huge space means that law enforcement manpower averages 1.5 officers per 1,000 population. Though Montana's population has been growing, there has been no parallel increase in law enforcement efforts. To the contrary, in the past few years, several federal drug investigation efforts have been scaled back. Many upper-level drug traffickers, who in the past have resided in metropolitan areas, are moving to rural areas and smaller communities, where law enforcement's presence is substantially reduced.

Statistically, Montana has grave problems with methamphetamine. Consider that:

— In 1998, the Office of National Drug Control Policy recognized Montana as one of eight states most seriously and actively threatened by methamphetamine.

— In 1996, Montana, along with six other states, led the nation for methamphetamine admission rates to state-approved substance abuse treatment centers at 50+ per 100,000 population.

— Montana's larceny rate exceeds the national average and is increasing, even as the U.S. rate is decreasing. In a related category, juvenile drug offenses are increasing geometrically in Montana at a rate five to six times that of the U.S. average. Data analysis suggests that juvenile drug use is associated with the larceny problem in Montana[1].

The long-term strategy employed by the Montana Board of Crime Control (MBCC) is designed to counter disturbing trends in our crime rates using a three-pronged approach[2]:

1) prevention & education;
2) law enforcement & criminal justice enhancements; and
3) corrections & treatment.

Prior to 1987, Montana had no institutionalized or organized drug enforcement effort. The MBCC has administered a formula grant program since Congress created the Edward Byrne Memorial Act in 1987. Sixteen drug task forces were funded with the inception of the Byrne Act; several have combined into the eight multi-jurisdictional units presently funded. The Byrne funds are also used for treatment and prevention. Funds are distributed through sub-grants, consistent with federal guidelines.

Over the past ten years, the Montana Board of Crime Control has consistently dedicated Byrne funds to a broad spectrum of areas, which reflect the needs of the drug strategy board and local communities. The bulk of funds have gone to narcotics enforcement, community corrections, prevention, and technology improvements. Continued use of funds directed toward prevention and early intervention are the first, best, strategies we have for addressing the serious and growing threats drugs are imposing on our state.

For more information, see bccdoj.doj.state.mt.us.

Resources:

[1] "Report to Montana Board of Crime Control Regarding Planning and Strategy Development Assistance Meeting" by Community Research and Associates. http://bccdoj.doj.state.mt.us/mbccpubs/index.shtml

[2] Montana 2000-2002 Drug Strategy: Montana Board of Crime Control Strategies. http://bccdoj.doj.state.mt.us/mbccpubs/index.shtml

Average Daily Population (ADP) at the state correctional facility in 1990 was 1,097. The actual count on January 5, 2000 was 1,939, representing a 76.75 percent increase. Just under a quarter of the population (480) were registered for treatment during FY 1998. Offenders in the single male juvenile correctional facility in Miles City have significant problems, including early-onset substance abuse and Fetal Alcohol Syndrome/Fetal Alcohol Effect. At intake, over 85 percent report issues with drugs and/or alcohol.

Source:
bccdoj.doj.state.mt.us.

Drug	Number of Arrests*
Cocaine	146
Heroin	31
LSD	36
Marijuana	2,58
Methamphetamine	1,112
Other	205

**July 1, 1996 - June 30, 2001*

Arrests for offenses including distribution, possession, manufacture, cultivation, transportation, or using.

MOST Of Us™ Web Surveys

The Montana Social Norms Project, home of the MOST OF US™ Campaign, is focused on promoting healthy behaviors among Montana's youth and young adults. The Montana Youth Norms Web Survey is a cutting edge technology being offered to schools as a way to create positive, subtle and effective prevention campaigns.

The survey asks questions about students' substance abuse and safety behaviors, as well as their perceptions of the behaviors of other students. Asking students about their perceptions of fellow students provides data that inevitably shows a drastic disparity with actual reported behaviors. Looking at this disparity allows schools to see where potential problems exist, and allows them to target a population with a social norms campaign.

The web survey offers several benefits to schools. First, it is provided through funding by the Montana Department of Transportation—Traffic Safety Division. Schools may purchase campaign materials at a very low cost from the Montana Social Norms Project, or create their own. The survey takes only ten minutes to administer on the Internet. This means no paper shuffling for administrators. Finally, the school receives school-specific data within one week of administering the survey and can have campaign materials within a month of receiving the data.

Several schools have already administered the survey to their students. Jackie Mavencamp at Gardiner schools said, "The survey was easy for us to administer. The data was sent to us promptly and the professionalism demonstrated by the Montana Social Norms Project staff has been appreciated." Alison Counts from Belgrade Middle School said, "I found administering the Social Norms Youth Web Survey online to be very efficient and fun. The students enjoyed being on the computers and found the survey easy to complete. Saving paper is also a great benefit."

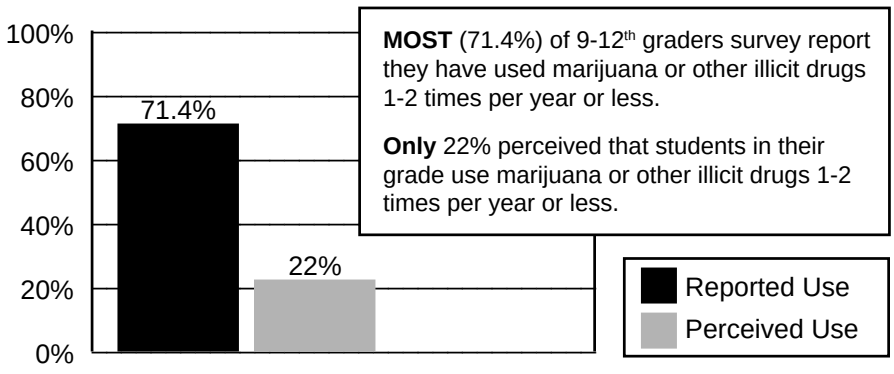
Interest in the survey is growing and the Social Norms Project continues to field calls from prospective schools. There is still room to include several schools in the survey this spring. By administering the survey in April, schools will be able to compare their data with the PNA and YRBS results (this survey is not meant to replace the PNA or YRBS). The main difference between the Norms Web Survey and the others is that the Norms Web Survey matches students' reported behaviors with their perceptions of norms among their peers.

By participating in the survey, schools will be able to incorporate an individualized school message into positive, high-energy materials that engage students. Providing students with the truth in a positive manner will empower them to see that not everyone is "doing it" and realign their perceptions of other students' behaviors. The end goal is to reflect healthier norms or behaviors by showing students that the majority of their peers are engaging in healthy behaviors—that **for MOST OF US™,** *health* is already the norm.

For more information contact Kim Adams of the Montana Social Norms Project at: Kimadams@montana.edu.

Answers to Pop Quiz (Page 6 & 9)

1. *Bang: b. To inject narcotics*
2. *Big Man: c. Supplier of drugs*
3. *Buss: a. To be high*
4. *Cartwheels: c. Amphetamines*
5. *Deck: a. A packet of drugs*
6. *Flea powder: b. Poor quality drugs*
7. *Get off: c. Feel a drug's effects*
8. *Get on: a. Use drugs for the first time*
9. *Gun: c. Equipment for injecting drugs*
10. *Heeled: b. Having plenty of money*
11. *Kickback: b. Relapse into drug usage*
12. *Lemonade: a. Poor-quality drugs*
13. *Monkey: b. Drug dependency* or *c. A kilogram of a narcotic*
14. *On ice: a. In jail*
15. *Pepsi habit: c. Occasional use of drugs*
16. *Tweaking: b. Drug-induced paranoia* or *c. Peaking on meth*



Example of data from the Montana Youth Norms Web Survey that shows reported compared to perceived use of illicit drugs in 9-12th graders in surveyed schools.

Example of data from the Montana Youth Norms Web Survey that shows reported use compared to perceived use of illicit drugs in 9-12th graders in surveyed schools.

Heads Up on Ecstasy

The 2000 Monitoring the Future Survey marks the fourth year in a row that use of illicit drugs among teenagers stayed level or declined. On the other hand, for the second year in a row, there was an increase in the use of MDMA (ecstasy) among 10th and 12th graders. For the first time, there was an increase in use among 8th graders.

"The recent increases in MDMA use are of great concern," said Dr. Alan I. Leshner, Director of the National Institute on Drug Abuse. "Our research shows that ecstasy is a dangerous drug. It is not a 'fun' drug. Serious consequences include dehydration, hypertension, hyperthermia, and heart or kidney failure."

As per the chart below, a recent survey (1998) of drug use among University of Maryland, College Park (UMCP) students showed dramatic differences between students who did or did not use ecstasy. Students who *had* used ecstasy in their lifetime were substantially more likely to have low grades and to have used cocaine, heroin, LSD, and other drugs.

These findings were obtained at the beginning of the upswing in ecstasy use in 1998 and may not apply to today's larger and potentially more heterogeneous population of ecstasy-using college students. Clearly, though, ecstasy users appear to be at a much higher than average risk.

Resources:

— Center for Substance Abuse Research (CESAR), unpublished analyses of a 1998 survey of University of Maryland College Park students. For more information, contact Dr. Eric Wish at ewish@cesar.umd.edu or 301-403-8329.

— Monitoring the Future Survey. http://www.hhs.gov/news/press/2000pres/20001214.html)

Demographic Charactertistics and Drug-Using Behaviors of Students, by Lifetime Ecstasy and Marijuana Use

	Never Used Marijuana or Ecstasy (n=557)	Ever Used Marijuana, but Never Used Ecstasy (n=444)	Ever Used Ecstasy 2 (n=108)
Demograhic Characteristics			
Male	48%*	52%*	63%*
White	48%**	75%**	68%**
Mean age (years)	24.3	23.0	22.6
Grade Point Average (GPA) Below 2.5	4%**	8%**	14%**
Past Year Drug Use			
Alcohol	78%**	96%**	99%**
Marijuana	n/a	57%**	83%**
Cocaine	0%**	2%**	46%**
Inhalants	<1%**	10%**	38%**
LSD	0%**	2%**	26%**
Other Hallucinogens (e.g. PCP)	0%**	2%**	26%**
Heroin	0%**	<1%**	17%**

1 Ns may vary because of missing data 2 Regardless of marijuana use
*Chi-square significant at the p<0.05 level.; **Chi-square significant at the p<0.001 level;

Pop Quiz

Continued from Page 6

8. Get on
- *a. Use drugs for the first time*
- *b. To be high*
- *c. Locate a supplier*

9. Gun
- *a. Someone who collects money owed for drugs*
- *b. A weapon*
- *c. Equipment for injecting drugs*

10. Heeled
- *a. Withdrawals*
- *b. Having plenty of money*
- *c. Down and out*

11. Kickback
- *a. Relaxing*
- *b. Relapse into drug usage*
- *c. Money for services*

12. Lemonade
- *a. Poor-quality drugs*
- *b. Bad luck*
- *c. A drink laced with drugs*

13. Monkey
- *a. Someone addicted to drugs*
- *b. Drug dependency*
- *c. A kilogram of a narcotic*

14. On ice
- *a. In jail*
- *b. Using methamphetamines*
- *c. Going to rehab*

15. Pepsi habit
- *a. Selling alcohol or drugs to minors*
- *b. Going off drugs*
- *c. Occasional use of drugs*

16. Tweaking
- *a. Twitchy*
- *b. Drug-induced paranoia*
- *c. Peaking on meth*

Facing Change

*By Natalie Roberts, AmeriCorps*VISTA, Stephen's Youth Center*

Every community has an intricate web of factors that creates its culture. Part of my job as a VISTA is to investigate and learn about the culture of White Sulphur Springs. Here's what I have found. Two years ago, White Sulphur Springs began Communities That Care (CTC) training. Because CTC participants lived in the community, they knew the culture and the problems, but didn't have the data necessary to document those problems, so they performed a Meagher County prevention needs assessment. The first step was surveying 8th, 10th and 12th graders. The results identified three risk factors: (1) Favorable adult attitudes toward problem behaviors; (2) Low neighborhood attachment and community disorganization, and (3) Availability of drugs.

The numbers tell the story: 62% of the kids knew of two or more adults who had used marijuana in the past year; 80% knew of two or more adults who got drunk in the past year; 57% knew of one or more adults who had sold drugs in the past year; 86% of students felt they would not get caught by the police for smoking pot; and 89% percent felt they would not get caught by the police for drinking alcohol.

It's evidently pretty simple for minors to get cigarettes and alcohol as well: 64% reported that it was very easy to get alcohol; 68% percent reported that it was very easy to get cigarettes. A few more than one third of the students felt that it was very easy to get marijuana.

As VISTAs, our job is to help communities provide prevention programming designed to help lower these numbers. In White Sulphur, as in many communities, that means creating a cultural change. The first step is identifying and evaluating the negative factors inherent in the culture. Making the entire community aware of local problems is the next step, even though people may not care or want to admit that there is a problem. Once the community has become aware of the problems it faces, it can begin moving toward positive change. It was through this process that White Sulphur Springs, with the help of VISTAs, created the Meagher County Prevention Coalition.

The Prevention Coalition is comprised of community members working toward creating programs that will impact risk factors. They are also spreading the "prevention word" in hopes that these ideas will eventually be assimilated into the culture. The assimilation process takes years and *may* take generations, yet we retain hope. This hope comes from the realization that the necessary cultural change will not happen in one year, but will come from knowing that along with my help and the help the previous and future VISTAs, the community of White Sulphur Springs is headed in the right direction.

Substance abuse plagues our nation as the number one health problem, or so says a recent press release by the Robert Wood Johnson Foundation (March 9, 2001). As per the Comprehensive Substance Abuse Report, of the more than two million U.S. deaths each year, one in four is attributable to alcohol, tobacco, and illicit drug use.

A FEW GOOD SITES:

Koch Crime Institute HYPERLINK "http://www.kci.org/" www.kci.org

Life or Meth HYPERLINK "http:/www.lifeormeth.org/" www.lifeormeth.org

Billings Gazette Series, March 1999 HYPERLINK "http://www.billingsgazette.com/" www.billingsgazette.com (archives)

ClubDrugs.org

The Antidrug www.theantidrug.com

Glossary of drugs categories and their slang nick-names:

Alcohol—*booze, sauce, brews, brewskis, hard stuff, juice.*

Amphetamines—*speed, uppers, black beauties, pep pills, copilots, hearts, benzedrine, dexedrine, biphetamine, bennies, benz.* **What it looks like:** *capsules, pills, tablets.*

MDMA—*XTC, Adam, essence, ecstasy, E.X.* **What it looks like:** *tablets, powder, capsules.*

Methamphetamine—*crank, crystal, meth, purple rock, speed, ice, glass, go.* **What it looks like:** *white powder, pills, rock resembling a block of paraffin.*

From: http://www.ci.shrewsbury.ma.us/police/drugglossary.htm and Keeping Teens Drug-Free Monthly Planner and Activity Guide, *U.S. DHHS*

Safe Schools/Healthy Students Initiative

Missoula County Public Schools

By Marianne Moon, Project Director

Missoula has always been a progressive community and we are proud to continue this legacy. We are addressing significant mental health issues that will help our population perform in school and in life. The Safe Schools/Healthy Students Initiative is an innovative project conceived by a group of Missoula community members and professionals, all of whom wanted to improve mental health services, violence, drug and alcohol prevention and intervention services to students and families. The initiate was funded by a federal grant from the departments of Education, Justice and Health and Human Services. Missoula's site was one of 54 chosen from a pool of 477 applicants. Our project is a collaborative effort designed to allow ten local agencies to provide comprehensive school-based services to Missoula students (preschool through high school) as well as to families.

The Safe Schools/Healthy Students project has completed the first of three years in its implementation cycle. There are currently eight mental health workers serving ten elementary buildings and two middle schools. This is significant because prior to this, the elementary buildings had not had counseling staff. Through this program, mental health workers have completed over 300 assessments and continue to provide therapeutic services to students and families.

Access to services is universal in all domains of this project. This program is unique because services are provided to all students regardless of income or handicapping condition. This is the first time a program has been available to the total Missoula student population, which includes about 10,000 children and youth.

This program takes a holistic approach to families, teaching pro-social skills from preschool through adulthood. A recent publication summarized the Montana Needs Assessment statewide survey measuring chemical use and resiliency factors. According to this data, Missoula students showed remarkable improvement in student resiliency characteristics in the school sites that have had Flagship programs and Family Resource Centers in place for over five years. We predict that the mental health program will add to these numbers. Additionally, through the Safe Schools Initiative and the Community Incentive Program, we are offering students and families five of the top ten blueprint curriculums rated by the University of Colorado, Boulder.

The 25 staff members employed by Safe Schools are a fine example of commitment to healthy families and proactive intervention. In January 2001, Safe Schools/Healthy Students received the *Outstanding Program Award* from the Montana Mental Health Association, the Montana Department of Public Health and Human Services (Addictive & Mental Disorders Division) and the Montana Council of Mental Health Centers.

A major strength of this initiative has been its ability to bring the necessary partners and services together to build and maintain the collaborative spirit of this community. For example, the issue of confidentiality, a potential barrier, has been explored and resolved with an Interdisciplinary Child Information Team Agreement. School administrators and faculty have been gracious and open, welcoming the partners and helping integrate their efforts with existing school programs and culture. All agency partners have been willing and motivated to work together on common referrals and goals. There is much to be proud of. This initiative has shown how a community can work together to build and maintain safe, orderly, drug-free learning environments.

Safe Schools/Healthy Students Initiative in Action

Family Resource Centers have been added at one elementary and one middle school, bringing the district total to ten.

Even Start has expanded to a full-time program at Lowell Elementary. This is our second Even Start Program, providing childcare through Head Start, Adult Basic Education through MCPS, and parenting skill enhancement tools through the Family Resource Center.

The Public Health Department has provided a neighborhood nurse to Franklin Elementary.

A Bullying Prevention Program is being piloted in Lowell Elementary and Rattlesnake Middle schools.

A Youth Court Officer serves all of the middle and high schools through District Court.

Conflict Resolution and Peer Mediation is provided by Montana Mediators to all the middle and high schools.

The Flagship Program has expanded to Washington Middle School, Sentinel High School, and Rebound, an alternative site in the Missoula County Public Schools.

Big Brothers Big Sisters provides the mentoring for the Flagship Program.

Safe Passage:
A Parent's Guiding Influence

By Patty White, M.Ed., CCDC

All kids will be exposed to drugs at some point because our culture is filled with them. All kids are at risk. Socioeconomic status, religion, culture, ethnicity, gender—no one factor keeps us safe: use, abuse and dependency are equal opportunity diseases.

We do know that the kids who safely navigate this culture have parents who have spent time with them, helped them develop their interests, and made them a priority. The more parents invest in kids, the better kids do. It's also important to become—and remain—involved in children's schooling. We know that when there is parental and community involvement in the schools, kids do better in school—and in life. By getting involved, parents also have the opportunity to see for themselves how their children are getting along with others. If necessary, they can help their children learn conflict resolution skills or better their social skills. This can be a terrific chance to help a child who has been following to take the lead, or a child used to taking the lead to become more collaborative. It helps children, too, if parents create a relationship with their teachers from day one. In school and out, parents can make their children aware of their gifts and talents. Ultimately, study after study shows that these are the kids who do best.

Developmentally, children begin separating from their parents at age two. They open every door, want to touch—and taste—everything. Their curiosity is boundless. The parents' job at this point is to keep the child safe. But when the second separation comes during adolescence, it is no longer possible to protect the child from every danger he or she will encounter, so parents need to learn how to guide their children. The overarching theme of the guidance has to be toward safe passage.

Frontal lobe development starts around the age of thirteen or fourteen, at which point the brain is under construction. In addition to hormonal changes, the frontal lobe—which gives the ability for formal operational thought—is undergoing neural development. These changes make the brain more susceptible than ever before to external influences. Drug use during these periods of hormonal change can inhibit frontal lobe development.

The younger the age of first use, the greater the chance of addiction. Starting drug or alcohol abuse early furthers the chance that the child will continue to make poor choices. Parents from the 1960s and '70s may not deliver clear anti-drug messages because they, themselves, have histories that include experimentation. Having used marijuana themselves, they may take a kids will be kids view, and see this as essentially harmless experimentation. The trouble is, twenty years ago the THC content of marijuana was 1-3 percent. Now many strains contain 21 percent THC.

Addiction, too, is very different among adolescents than it is among adults, particularly in terms of the progression of the disease. With kids, six months of steady use can mean addiction. Six months to a year of use, and children/youth will begin experiencing every consequence of addiction. One of the primary tasks of adolescence is building identity. Adding a chemical at this crucial juncture creates a harmful relationship with the chemical. Normal development is stalled and developmental delay results. The younger a child starts using, the greater the chance of addiction. Even given a genetic predisposition, the effect will not be same if the age of onset is twenty years of age or older.

Because the brain is undergoing physical and hormonal change, and because identity isn't yet established, it is very difficult for children and youth to evaluate internal change. Additionally, adolescents are, by nature, risk takers. They are also extremely altruistic. Risk taking is healthy and normal, as is altruism. The best alternative is to take those drives and channel them into healthy choices.

We have three good models that tell us how to protect our children from drugs and alcohol: Peter Benson's Asset Model, as used by the Search Institute; Bonnie Bernard's Resiliency Model; and Hawkins' and Catalano's Risk and Protective Model.

All three say much the same thing: parents have to give clear, no use messages, starting when the child is very young. Schools, communities, the faith community, and local law enforcement must all take a strong position about delaying use. Fines work if the child has to pay them himself and if they're stiff enough to hurt. It works best if community service is a component and if consequences are consistent. We can create safe communities.

The bottom line is that even when everything is working, kids can still make bad choices. The most important thing to remember is that even when a young person is struggling with addiction, these are not bad kids who need to get good. These are kids who are addicted and need treatment.

It can be extremely difficult to see beyond the addiction, and yet at all stages of use, abuse or dependency, it is crucial that kids get the proper help—just as they would with cancer or any other disease. It's difficult to understand that this is a disease, because all that may be visible is unacceptable behavior. When children have been given chance after chance, and there's been violation after violation, parents can finally become so tired and overwhelmed, so frustrated and angry that they give up. After all, if a child is lying, robbing, violating every parental value there is, parents begin to feel helpless, hopeless, and completely powerless. At that point, it is not uncommon for parents to start blaming one another, schools, friends, society . . . to begin looking in every direction. The truth is, the only right direction to look is toward the addictive process itself.

The difference between adolescence and dependency is the child. Do you recognize your child? Is this the same person you've always known? If

Continued on Page 13

Safe Passage

Continued from Page 12

you suspect drug or alcohol use, go to a CDC counselor or someone who has a strong reputation for working with adolescents. Once parents recognize addiction or abuse, the next step is to get professional help. Parents should go to the counselor and create a plan with the professional. From there, with luck and hard work, it is a matter of building the bridges and structuring the journey that will allow safe passage.

Difficult as it may be, we must let our children know that our actions rise from love and that we love them enough to create a safe passages within our communities and within our hearts.

Patty White has been offering parenting classes for the Helena Public Schools for 15 years. Currently she provides training throughout Montana geared to helping parents at every level of a child's use, abuse or dependency. For more information, contact Patty at 443-5121 or pjwhite@quest.net

Know a parent who would enjoy these articles?

Be a copy cat!

Is This Normal? And How Do I Know?

By Ann Bullis, M.A., CCDC

Mood swings, conflicts with family members, and spending more time with friends can all be normal adolescent behaviors. Unfortunately, these behaviors can also serve as indicators that an adolescent is having problems that may include alcohol and drug abuse. Determining when behavior is normal and when it has become a problem requires parents to take an objective look. That can be harder than it sounds, particularly when it comes to our own children.

Parents of infants and young children are given a wealth of information, which gives them a good idea of what to expect from their children. At that stage, parents eagerly share their triumphs and problems. Unfortunately, the flood of information slows to a trickle during adolescence. As children move into middle childhood, visits to the doctor become infrequent and parents stop exchanging stories. Much of our information about adolescent behavior may come from the media, which sensationalizes adolescent crimes and distorts adolescent behavior.

The good news is that research indicates that the majority of adolescents are happy, productive members of their families (Carnegie Report, 1990). Though adolescent development almost invariably creates ups and downs, most families deal with day-to-day issues, and ultimately launch their teens into healthy, well-adjusted adult lives. On the other hand, if you are having problems with your adolescent, the first step is to read up on adolescent development. Parents of adolescents need a clear understanding of what is normal before they can evaluate what is not.

The next step is to document what's going on. An adolescent's life consists of three or four spheres—family, school, friends and possibly employment. Carefully consider each sphere and write down incidents that concern you. These may include such behaviors as refusing to participate in family activities, lying, changing peer groups, dropping out of school activities, or frequent arguments with other family members. After writing down current behavior, reflect back six months or a year and do the same thing, then compare lists.

Within the context of normal development, it is normal to see ups and downs. When behavior has become problematic, there will be a growing intensity and/or frequency of conflicts—in *all* aspects of the child's life. Generally, the spiral is downward, with the downs becoming more frequent and the ups lower and more infrequent. Problem behavior does not always mean your child is abusing alcohol or drugs, but it can tell you that *something* is going on. At that point, it is time to take steps to intervene.

If you suspect alcohol and drugs are playing a part in your child's life, get educated. Find out what is going on at the national, state and community levels relative to adolescent use. In today's climate, it is particularly important *not* to use your own adolescent experience with alcohol and or drugs as a reference point. Most Montana communities have drug and alcohol counselors, mental health workers or counselors knowledgeable in this area. Contact one, and work out a treatment plan.

Contrary to what your child might want you to believe, everyone is *not* doing it. You will find other parents who are setting clear standards. Above all, don't be afraid to convey a strong, clear message that makes it very clear that *no use* is not only your hope, but your expectation.

Parents continue to be the strongest influence in the lives of their adolescents. In national polls that ask students why they do not use alcohol or drugs, the number one reason is consistent. "*My parents do not want me to*."

4-H After School:

The importance of quality out-of-school activities

By Kirk Astroth, Ph.D.

Montana kids who participate in organized out-of-school activities are better off in several ways than kids who aren't involved in such activities, according to a recent Montana State University study. A research team led by Kirk Astroth of the MSU Extension Service and George Haynes of the MSU Department of Health and Human Development surveyed 2,500 Montana youth in fifth, seventh and ninth grades. The youth were from 21 randomly-selected counties and nearly 50 schools. Survey results indicated that youth who are involved in structured out-of-school activities reported that they are less likely to get drunk, shoplift or steal, purposely damage property for the fun of it, use drugs to get high, smoke cigarettes, skip school without permission, or engage in other at-risk behaviors.

Though the difference for fifth-graders was minimal, the risks grow steadily as students get older. Ninth grade students who do not participate in any out-of-school activities reported that they are:

— twice as likely to smoke cigarettes;

— seven times more likely to have carried a gun to school;

— twice as likely to report that they have driven while drunk;

— nearly three times as likely to use drugs; and

— twice as likely to have shoplifted.

The researchers also found that young people who participate in the 4-H youth development program for a year or more fared better than their peers, including those participating in other after-school activities. The survey showed that 4-H members:

— are more likely to give money or time to charity;

— are more likely to help the poor, sick or others;

— get more A's in school than non-4-H'ers;

— are more involved as leaders in school and community; and

— are more likely to be looked up to as role models by other kids.

The MSU research also indicates that Montana 4-H kids are busy making contributions to improve the quality of life in their families, neighborhoods and communities. While about 17% of Montana kids are not involved in any out-of-school activities or programs, 4-H kids are very involved. Nearly three-fourths of all 4-H members (75%) are involved in up to four out-of-school activities.

The 4-H program is the largest youth development program in Montana. Participants learn practical skills and responsibility through hands-on projects such as photography, woodworking, raising livestock, aerospace and cooking. This research shows that how kids spend their time out of school is critical to their development. Kids who aren't involved in constructive out-of-school youth development programs like 4-H are more likely to experience problems in school, get lower grades, cheat on tests and experiment with drugs. After all, a lot can happen in the out-of-school hours. Four-H makes sure it's positive.

For more information about 4-H in Montana, contact your local county Extension office; call the State 4-H Office at MSU: (406) 994-3501; or visit their Website: www.montana.edu/www4h

Download the full report at: www.montana.edu/www4h/4hsurvey.pdf [case sensitive].

Alcohol-abusing Teens Risk Long-term Problems

New research suggests that most teens who are problem drinkers are not simply going through a phase. Instead, kids who abuse alcohol often see their drinking problems and mental health worsen as they age. In a study of 940 high school students who were followed until age 24, researchers found that those with diagnosed alcohol problems were at increased risk for further drinking problems, other substance abuse, depression and personality disorders as they got older. These risks were elevated among kids with symptoms, but no diagnosis, of problem drinking.

Researchers led by Dr. Paul Rohde of the Oregon Research Institute in Eugene reported the findings in the January 2000 issue of the Journal of American Academy of Child and Adolescent Psychiatry. *While surveys show drinking to be common among American high school kids, some develop drinking problems early on. In fact, Rohde's research has shown that more than 35 percent of adults with an alcohol problem developed symptoms by age 19.*

	4-H	Others
Mostly A's	33.4%	19.6%
About half A's and B's	37.5%	37.7%
Mostly B's	9.7%	9.1%
About half B's and C's	13.5%	20.8%
Mostly C's	2.0%	4.2%
About half C's and D's	2.4%	5.6%
Mostly D's	0.7%	1.3%

Making a Difference in Missoula

By Detective Sgt. Gregg Willoughby, Missoula Police Department

A lot of news articles and public discussions have recently addressed the rise in the use of illegal drugs such as methamphetamine and ecstasy, as well as the illegal use of legal drugs like alcohol and oxycodone pharmaceuticals. The rise in concern about how these drugs of abuse are affecting our youth has caused a number of public health and public safety agencies to search for programs and interventions to help deter people from getting involved, or to provide a means for people to get rid of the burden of substance addiction.

In this information age, knowledge and information move between people and locations at a rate faster than ever before. People can obtain information about how to manufacture methamphetamine or learn how to get other drugs easily and cheaply. No longer is Montana off-the-beaten-path where urban difficulties can't get a good hold.

The relative cheapness of methamphetamine makes it the single largest concern of health care and law enforcement professionals. Methamphetamine can be manufactured using easily obtained chemicals and sold for as little as $4.00 a hit.

In Missoula, the Missoula Police Department has actively developed and participated in several projects and programs designed to educate people to the dangers of substance abuse, and to attempt to curb the growth in the use of illegal drugs among young people. Programs such as the Youth Drug Court, employee training at retail businesses, School Resource Officers, training for residence hall assistants at the University of Montana, and presentations for employees of hotels and motels are all examples of officers' regular efforts to improve community awareness. Ongoing programs involving the Health Department and the Montana Department of Revenue in cooperation with the Missoula Police Crime Prevention Unit seek to educate employees of businesses that sell alcohol about alcohol abuse among teens, and to solicit the help of these employees to check IDs and encourage them to notify police when someone attempt an illegal purchase of alcohol.

The Missoula Police Department participates in the Youth Drug Court, along with the District Court, Youth Court, Missoula County Sheriff's Department, and health care professionals. Together we identify and track at-risk youth who have some history of substance abuse. The program has received acclamation from across the country for its effectiveness in reducing the incidence of recidivism among youth who have been involved in illegal drug activity. Participants examine cases of kids who have been referred by Youth Court. When law enforcement comes in contact with a youth in the program, Drug Court personnel reviews the record of the youth and the reason for contact. The Drug Court then examines the incident to determine if further action or intervention is necessary.

Missoula Police narcotics investigators have developed an educational presentation for businesses that legitimately sell such agricultural products such as iodine, or businesses that sell matches (for phosphorous), as well as those that sell ephedrine or pseudoephedrine. The program provides information about how legal chemicals can be used to manufacture methamphetamine. The program also seeks to develop a cooperative approach in identifying individuals who attempt to purchase large quantities of these chemicals, especially in quantities far greater than could ever be used for legitimate agricultural purposes. While investigators appreciate information about these individuals who are believed to be manufacturing methamphetamine, this program is designed to stop the sale of these chemicals, thereby curtailing manufacture.

Narcotics investigators are also in the process of refining a presentation for employees of hotels and motels. Because meth manufacturers sometimes use motel or hotel rooms to set up temporary labs, investigators hope

Continued on Page 16

Interactive glossaries:

http://www.cesa7.k12.wi.us/atod/2000-2001_directory/drug_glossary.htm

http://www.lec.org/DrugSearch/Documents/slangterms.html.

http://www.lec.org/DrugSearch/Documents/slangterms.html
A pretty long list of drug terms, in alphabetical order.

http://www.addictions.org/slang.htm
A very long list I saw referenced a few times.

http://www.whitehousedrugpolicy.gov/streetterms/
From the White House Office of National Drug Policy Control. This is a HUGE interactive glossary that includes a couple of lists and a .pdf document of 2,300 drug terms in alphabetical order.

http://www.drugfreeamerica.org/druginfo/default.asp
From Partnership For a Drug Free America. Interactive glossary of slang terms, definitions, pictures.

http://www.tcada.state.tx.us/research/slang/
A pretty thorough online interactive slang dictionary with lots of terms, and related information.

http://www.drugs.indiana.edu/slang/home.html
Another good interactive glossary with lots of terms — searchable.

Online interactive drug quizzes

http://members.aol.com/sarahhisted/quiz.htm
A quiz about drug slang terms.

http://www.health.org/gpower/adultswhocare/cool/slangdrugcoolquiz.asp
A quiz for parents on drug terms and slang.

http://www.theantidrug.com/drug_info/drug_information_quiz.html
Quiz on drug information. Not just slang.

Making a Difference

Continued from Page 15

to educate employees about the dangers of the chemicals involved as well as to identify those actively producing methamphetamine.

In the past year, Missoula has had to deal with the difficult task of identifying and removing portable drug labs from motel rooms. The least expensive of these labs cost more than $2,000.00 to clean up, and some cost taxpayers upwards of $10,000.00. The cost to businesses and individuals for latent medical effects or lost business is something that has yet to be calculated.

In the last year, the painkiller oxycodone, marketed as OxyContin or Tylox, has risen to the top of the list of abused pharmaceuticals. The pharmacological effects of oxycodone make it a suitable substitute for heroin; therefore, it is attractive to the same abuser population[1]. Heroin abusers are obtaining OxyContin because it provides reliable strength and dosage levels. A 40 mg tablet legitimately obtained costs an average of $4.00, but will sell illicitly for between $25.00 and $40.00.

The Missoula Police Department is still refining its strategy of proactive intervention through community programs and law enforcement. While rehabilitation and incarceration of abusers and suppliers still remain the most frequent methods of curtailing these problems, it is obvious that the prevention of drug and alcohol abuse is by far the preferable response.

[1] U.S. Department of Justice, National Drug Intelligence Center

Montana Turner Foundation:

Community Youth Development Initiative

How fortunate we are in Montana to have the Turner Foundation investing in our youth. The Turner Foundation is a private family foundation created in 1990. The Turner Foundation's Community Youth Development Initiative provides grants to seven Montana communities: Alder, Bozeman, Dillon, Gallatin Gateway, Helena, Sheridan, Townsend and Lima. The grants are earmarked for youth development in communities located near properties owned by R.E. Turner, president of the Turner Foundation and vice chairman of Time Warner, Inc. Montana is just one of six states receiving grants.

As part of the initiative, each of 23 towns was asked to identify priorities for local youth and given the opportunity to determine how funds should be spent. Programs funded address not only recreational activities but also education, job training, and self-esteem. The Turner Foundation's philanthropic interest in helping Montana make systemic changes that benefit our youth commendable.

The Montana Community Foundation helps manage the grants locally, and holds an annual retreat bringing together youth and adult representatives from the communities involved.

Besides the things we might expect—like affordable and accessible recreation and job opportunities—most kids really want to be heard and respected. This initiative provides the opportunity for their voices to be heard and to earn respect as they work successfully on community projects. The initiative has been most successful in the communities where youth have been most empowered and have, therefore, taken the most responsibility.

A significant factor in success has been the addition in several communities of VISTA or AmeriCorps* workers. These young leaders are mature enough to help guide youth, but young enough to relate in a way that parents and teachers cannot.

The **T**urner Foundation Community **Y**outh **De**velopment Initiative (TYDE) has been very successful in Bozeman, where a number of projects are underway. The *Blue Iguana Teen Center* opened in an annex provided by the United Methodist Church. One of the most inspiring aspects of the Center is that the forty-five youth involved run and "police" it. Youth and adults serve on the Executive Board, and the older teens facilitate participation of younger kids.

Bridging the Gap, a call-in teen radio show, began as a one-hour, Saturday morning slot, which expanded to two hours.

TYDE's Job Shadowing project, *A Day in the Community*, has involved over 400 kids from Bozeman and the outlying rural schools.

RAVES—*Recreational Awards for Volunteer Service*—offers kids the chance to decide what kind of volunteer work they'd like to do, then rewards hours with incentives such as ski or movie passes or guitar lessons.

TYDE-Pool—the fund for young ideas—is growing, and has included the *Youth Law School* and the *Take a Judge to Lunch* programs, which allow kids to talk to professionals in the legal system.

TYDE programs are also in effect in Dillon, Gallatin Gateway, Helena and Townsend. Each community has expressed its individuality, but all are working toward empowering kids, increasing communication, and enhancing community capacity.

For more information, contact Sidney Armstrong, Executive Director, Montana Community Foundation (443-8313) or MTCF@MT.NET.

Visit the TYDE website created by kids at: www. tyde.org

A.S.A.P. at Gateway

By Judy Kolar-McGovern, MHS, CCDC Executive Director; Gateway Recovery Center

Most clinicians have had the experience of working with a patient who comes with multiple consequences of drug/alcohol related behaviors, yet does not meet the DSM-IV criteria for substance dependence. Programs such as the ACT curriculum have been designed for patients charged with specific offenses, but there are many patients who present a myriad of other problems that are usage-related. Several years ago, Gateway Recovery Center designed the Substance Abuse Group (SAG) in response to this need. The program is targeted toward adults, and has been used for two purposes:

1) to provide an educational format for persons with a clearly defined substance abuse diagnosis and who are considered high-risk for developing a dependence diagnosis should their usage continue; and

2) to provide a period of protracted evaluation for a patient whose bio-psychosocial process results in inconsistent, or contradictory information that does not lead to clear diagnosis. In the second case, the group education/process time may give the clinician additional information that clarifies the abuse diagnosis. In some instances it may also reveal more detailed experiences on the part of the patient, indicative of a dependence diagnosis. If a dependence diagnosis is established, the patient can be further referred to a structured treatment program appropriate to their needs.

The availability of such a group is also paramount for the adolescent population. Our Adolescent Substance Abuse Program (ASAP) was originally designed for multiple Minors in Possession (MIP) offenders who had attended the structured MIP program one or more times, and presented an obvious need for further education/evaluation. Often these youth would present an inconclusive picture for substance dependence, but it was obvious that repeatedly offering them the same information in the MIP program was not resulting in a change in behavior. ASAP was designed to expand the information as well as the total number of hours of interface and intervention with this high-risk population. When the opportunity to attend training regarding implementation of a Youth Drug Court became available, the program was redesigned to include approaches and information that had been proven successful with this population throughout the United States.

ASAP incorporates a variety of approaches that assist high-risk youth in drawing their own conclusions about the potential consequences of continued substance use. They are walked through the process of identifying problematic emotions, thought patterns, and/or situations that were precursors to usage. Subsequently, they move toward understanding how use became a further problem rather than a solution. Skills are taught relative to dealing with anger and stress, identified by youth as common factors resulting in use. In identifying how their emotions, thinking patterns, and subsequent irresponsible behaviors are related, youth are empowered to change their behavior by focusing on internal factors that may have been used as an excuse for continuing unacceptable behavior.

It is extremely important to assist youth in identifying the strengths that exist within, as well as those that exist within the family unit. All youth have strengths that they can learn to build on, and which will help reduce further risk. Because many youth come from unhealthy environments due to parental usage or other dysfunctions, it may be necessary for them to look beyond the home environment to find other people who can assist in identifying values important to a healthy living style.

Every attempt should be made to have the parent or primary caregiver involved. Parents/caregivers often do not understand the importance of consistency in setting clear behavioral

Continued on Page 18

Teen Risk-Taking: Promising Prevention

Urban Institute researchers have identified six core elements of successful programs after studying over 70 of them.

Successful Programs:

— Attempt to modify teens' knowledge, attitudes, and behavior so that the perceived rewards of engaging in a healthy behavior outweigh the perceived costs.

— Target specific behavior goals with a clearly delineated plan.

— Are designed to teach skills, not just information, using student-to-student or instructor-to-student methods.

— Include a written curriculum and instructor training and feedback.

— Last weeks or months and involve multiple sessions.

— Use a variety of techniques and instruction methods, including, for example, combinations of formal instructors, parents, and peers.

***Teen Risk-Taking: Promising Prevention Programs and Approaches** by Urban Institute researchers Marvin Eisen, Christina Pallitto, Carolyn Bradner, and Natalya Bolshun. is available from the Urban Institute Web site, www.urban.org, by calling the Office of Public Affairs at (202) 261-5709, or email: paffairs@ui.urban.org*

Substance Abuse

Continued from Page 17

standards for youth as critical factors to change in the youth's behavior. Mentoring becomes critical especially when family members are not available as a result of dysfunction or absence. Positive bonding with extended family members, friends, teachers, or other caregivers has been identified as protective factors. That can outweigh some risk factors. Teaching leadership skills and assertiveness is also extremely important in assisting the youth with instances in which peer pressure becomes the precursor to use. Identifying goals, short- and long-term, can be used to illustrate how continued usage will interfere with achieving goals. The young person also needs to learn problem-solving skills, resiliency in dealing with the *life is not fair* concept, and to develop support systems that will enforce a non-using lifestyle.

Some information was presented during the Youth Drug Court training that indicated 12-step programs are not successful with adolescents, but the graduates of these programs often cited the 12-step process as being significant in their success. Our program includes a weekly 12-step meeting, facilitated by a young adult. Because many communities struggle with the existence of 12-step groups that may be targeted toward a younger population, one of successful technique has been for youth to identify an adult (or adults) who are active in the 12-step community as role models for the type of adult the youth would like to become.

Our original ASAP design has been modified within our agency to service dependence-diagnosed youth needing outpatient or intensive outpatient programming. We have expanded on the subject material and increased the hours of interface time with the patient. We have also utilized the format for a prevention program that we introduced in to Paris Gibson Middle School in the Fall of 1999. In the Fall of 2000 the program was modified to meet the specifications of the Best Practices Program, the Bry Model, and has been instituted as a program of the Community Incentive Project in all three Great Falls Middle Schools.

Judy Kolar-McGovern, MHS, CCDC is the Executive Director of Gateway Recovery Center. She can be reached at judy@gateway recovery.org.

AlcoholScreening.org

Join Together, a project of the Boston University School of Public Health, announces the launch of AlcoholScreening.org, a website that provides information on the effects of alcohol on health and well being and provides a self-evaluation tool. The confidential and informative self-test can help assess drinking patterns and provide personalized feedback. AlcoholScreening.org also features answers to frequently asked questions about alcohol and health, links to support resources, and a database of 12,000 local treatment programs throughout the United States.

Join Together is a national resource supporting community-based efforts to reduce substance abuse and gun violence. Primary funding comes from the Robert Wood Johnson Foundation. More information about Join Together is available at www.jointogether.org/about.

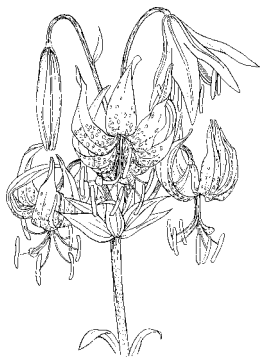
Drug Demand Reduction

The Drug Demand Reduction Program (DDR) by the Montana Army National Guard is designed to make a positive difference in local communities. Focused on educating high school and middle school students on the physical, psychological and social effects of drug use, this program empowers students to make better life decisions helping them understand the effects of drugs on the whole person.

DDR presents informative, quality training on drugs such as smokeless tobacco, cigarettes, alcohol, methamphetamine and various club drugs. The program also covers poisons (inhalants). The program is normally conducted during one-hour class periods over a period of 3-4 days.

As a DDR Instructor, I am convinced that "just saying no" isn't good enough, and am very excited about the content and quality of this program.

For more information about the DDR Program, contact John C. Stuart, Northern Area Team Leader at 406-841-1260 or Garth Scott, State Coordinator, at 406-841-3179.



Regional Methamphetamine Task Force

By Dustin Rolfsness, LCPC, CCDC

Billings, Montana, "*Meth Capital of the World.*"

This headline rocked the boat in Billings back in 1998. The average citizen was shocked . . . and the police chief denied that the problem was 'that big.' But many people working in treatment were relieved that they could finally talk about the elephant in the living room.

Methamphetamine was not only in Billings, our biggest urban center, but it had also hit the Northern Cheyenne Reservation with a vengeance. Bonnie Pipe, CCDC, then a counselor at the Northern Cheyenne Recovery Center, was at her wits end trying to understand what was going on. People were having psychotic breaks . . . violence and crime were prevalent . . . and treatment was not helping. Indian Health Services recognized the problem and invited Jeanne Obert from the MATRIX Institute on Addiction to train their treatment providers back in June of 1997. This training began to help us understand why conventional residential treatment was not working.

Ms. Obert opened our eyes to the extremely addictive properties of meth as well as some relapse and recovery factors that do not exist with alcohol or many other drugs. Because of the lack of resources available and the rural location of the reservations, the Native American Chemical Dependency Directors Association decided to form a task force. In 1998 after directors meeting at MCDC the Northwest Regional Methamphetamine Task Force was born.

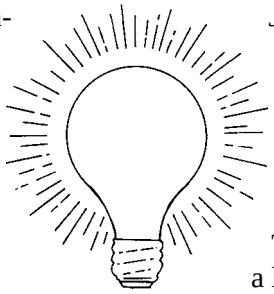
The Task Force began to bring treatment providers together, Indian and non-Indian, to help us find appropriate ways to treat these clients. Treatment center personnel were invited to attend meetings to explain how they were treating meth addicts. Clinicians were asked to share their successes and failures with the group. Legislative, educational, treatment and research committees were formed and letters were written to local and national legislators telling them of our problems. Some of the committee members met with legislative delegates from the state senate and the house. Additionally, meetings were held across the state in order to get people involved. Speakers were invited to talk on the impact of meth on the brain, babies, social services, the environment and a variety of other topics. Local people talked about the specific effects on their communities.

The Task Force meets at 10 a.m. the 3rd Friday of every month at the Probation & Parole Building in Billings. The address is 2615 4th Avenue South. Anyone interested is welcome to attend. For more information on the Task Force call Pam Bunke at Probation & Parole (896-5400), Rhonda Stennerson at the Mental Health Center (245-1314) or Dustin Rolfness at the Indian Health Board of Billings (245-7318).

Making the Connection

Missoula County Public Schools and the Safe Schools/ Healthy Students Initiative are encouraging parents and students to use an anonymous hotline in order to report issues concerning student safety. They encourage reports about mental health issues and potential violence. Sample messages run along these lines:

It only takes one phone call. If you know of a situation or a person that might cause potential harm at your school, show you care and call the Safe Schools Hotline. You donít have to give your name. Just show you care. Help us keep our schools safe!



For more information, call Marianne Moon at 728-2400. This program could be a lifesaver!

Juvenile Justice: How Communities Respond to the Mental Health and Substance Abuse Needs Of Youth in the Juvenile Justice System

More than two million youth under the age of 18 are arrested each year. On any given day, more than 100,000 of these youth will be placed in juvenile detention and correction facilities.

Research indicates that approximately twenty percent of all youths entering the juvenile justice system experience serious mental disorders, with a much higher percentage experiencing some level of mental health problems. Studies have consistently found the rate of mental disorders higher among the juvenile justice population than among youths in the general population. There is also a growing recognition that 50–75 percent of these youths have serious substance abuse problems.

www.nmha.org/infoc.tr/factsheets/index.cfm

The opinions expressed herein are not necessarily those of The Prevention Recource Center and the Addictive and Mental Disorders Division of the Montana Department of Public Health and Human Services.

The Prevention Resource Center and the Addictive and Mental Disorders Division of the Montana Department of Public Health and Human Services attempt to provide reasonable accommodations for any known disability that may interefere with a person participating in this service. Alternative accessible formats of this document will be provided upon request. For more information, call the Prevention Resource Center at (406) 444-5986.

Let's Get Practical:
Clarifying the Prevention Continuum

By Ken Taylor, Prevention Officer, Chemical Dependency Bureau, AMDD

Economist John Maynard Keynes allegedly said that practical men are captives of theory developed by men long dead, typically economists. On the other hand, Kurt Lewin, one of the fathers of American psychology was very clear that nothing was so practical as a good theory. So, which is it: do theories entrap or enable? Or is it our use and understanding of theory that entraps or energizes?

Whether we recognize it or not, prevention is guided by theory. When I started working in prevention eleven years ago, there were two models or theories in common use. One talked about the relationship between prevention and treatment, and identified a continuum that led from primary prevention to early intervention to treatment. The second model talked about a continuum that led through three tiers of prevention: primary, secondary and tertiary.

In all honesty, I was never too clear about how these models related to each other. It seems obvious that because we used different terms within the first model—prevention, early intervention and treatment—that we were talking about discrete though related processes. Along these lines, prevention tries to keep something from happening. Early intervention takes place after something has happened but before there is serious damage. Treatment takes place to correct or address an evident problem. The confusion came in when we started talking about primary prevention, secondary prevention, and tertiary prevention. Following is a current discussion of those terms:

— *Primary prevention measures* prevent the onset of a targeted condition. (pp xli)

— S*econdary prevention measures* identify and treat asymptomatic persons who have already developed risk factors or preclinical disease, but do not have clinically-apparent. (pp xli)

— *Tertiary prevention activities* involve the care of established disease, with attempts made to restore to highest function, minimize the negative effects of disease, and prevent disease-related complications. (pp xli)

These definitions are very useful for physical diseases, as one would expect. Using these definitions, it is possible to describe the course of a disease in simplistic terms: *I'm healthy . . . I don't feel well . . . I've got the bug . . .* and finally, *I'm better now*.

In this model, the distinction between prevention, early intervention and treatment is not clear. Early intervention targets people beginning to "show some signs of the disease of addiction." Given this model, how is that different from secondary prevention? And if tertiary prevention involves care of an established disease, how is that different from treatment? The model is useful for some purposes. Its shortcomings lie in the difficulty it presents when those of us working in the fields of behavioral health—particularly substance abuse addiction—need to plan our activities in useful ways.

If this seemed confusing to me, apparently it did to others as well. In a 1994 report on prevention research, the Institute of Medicine (IOM 1994) proposed a new framework for classifying prevention. The IOM Model divides the continuum of care into three parts: prevention, treatment, and maintenance. The prevention category is divided into three classifications, as well: universal, selective and indicated prevention interventions. These replace the confusing concepts of primary, secondary, and tertiary prevention.

Universal

Universal prevention strategies address the entire population (national, local community, school, neighborhood) with messages and programs aimed at preventing or delaying the abuse of alcohol, tobacco, and other drugs. All members of the population share the same general risk for substance abuse, although the risk may vary greatly among individuals.

— The mission of universal prevention is to deter the onset of substance abuse by providing all individuals the information and skills necessary to prevent the problem.

— Universal prevention programs are delivered to large groups without any prior screening for substance abuse risk. The entire population is assessed as at-risk and capable of benefiting from prevention programs.

Selective

Selective prevention strategies target subsets of the total population who are deemed to be at risk for substance abuse by virtue of their membership in a particular population segment. Selective prevention targets the entire subgroup regardless of the degree of risk of any individual within the group.

— Risk groups may be identified on the basis of biological, psychological, social, or environmental risk factors known to be associated with substance abuse (IOM 1994).

— Targeted subgroups may be defined by age, gender, family history, place of residence such as high drug-use or low-income neighborhoods, and victimization by physical and/or sexual abuse.

The selective prevention program is presented to the entire subgroup because the subgroup as a whole is at higher risk for substance abuse than is the general population.

Indicated

The mission of indicated prevention is to identify individuals exhibiting early signs of substance abuse and other problem behaviors associated with substance abuse and to target them with special programs.

Continued on Page 21

Let's Get Practical

Continued from Page 20

— Indicated prevention approaches are used for individuals who may or may not be abusing substances, but whose behavior exhibits risk factors that increase their chances of developing a drug abuse problem.

— Indicated prevention programs address risk factors associated with the individual, such as conduct disorders or alienation from parents, school, and positive peer groups.

The aim of indicated prevention programs is not only the reduction in first-time substance abuse, but also reduction in the length of time the signs continue, delay of onset of substance abuse, and/or reduction in the severity of substance abuse.

As far as I am concerned, the IOM Model is a useful theory! This continuum suggests how to think about, identify and—most importantly—how to work with those populations. It also suggests ways to think about goals and outcomes. For example, one of the ICC goals involves increasing the age of onset – the age of use beyond a few sips of alcohol or the puff of a cigarette. The IOM model suggests how we can accomplish this goal. Does early initiation relate to membership in the *selected* or *indicated* groups? If so, why is the average age of initiation in Montana as early as it is?

There are, of course, ways to address this question by looking at available data, including the Prevention Needs Assessment. Let us think for a minute, what this might look like. We do a data run to find if there is a correlation between number of risk factors, use and reported age of first use. This is part of the risk and protective factor theory, and should be born out by the evidence. We could then look at programs targeting common risk factors. Suppose, however, we discovered that the correlation existed only for a certain age range, for example, between ages 11 and 14. Or suppose we found that after age 14 or 16, use was not correlated with risk factors. This might suggest that different strategies are needed for different age groups. It might also suggest that while the legal age for use of alcohol is 21, the social norms support use at an earlier age.

To have an impact, we need to use appropriate strategies in appropriate situations. We can only make those choices if we have a good theory telling us what to look for and what actions to take. The continuum employed by the IOM Model allows those of us working in behavioral health to distinguish prevention activities from early intervention and treatment activities. It also provides a means to plan and evaluate. In short, the IOM model of Universal, Selected and Indicated Prevention has all the hallmarks of what Kurt Lewin would consider a good theory.

(Note: The discussion of the Institute of Medicine Model was taken from material prepared by Kristen Reed Gabrielsen on the WestCAPT web page: www.open.org/~westcapt/bptype.htm)

Resources:

1. The U.S. Preventative Services Task Forces' Guide to Clinical Preventive Services (2nd edition, 1996)
2. "Drug Abuse Prevention: What Works" by National Institute on Drug Abuse (1997).
3. Institute of Medicine. New directions in definitions. In: Mrazek, P.J., and Haggerty, R.J., eds. Reducing Risks for Mental Disorders: Frontiers for Preventive Intervention Research. Washington DC: National Academy Press, 1994.
4. Building a Successful Prevention Program: Western Center for the Application of Prevention Technologies: www.open.org/~westcapt/
5. Primary, Secondary and Tertiary Prevention: Important in Certification and Practice. Fitzgerald Health Education Associates: www.fhea.com/level_prevention.htm

Propaganda 101: *Avoiding the Influence*

By Charles Horesji, Ph.D.

Most of us assume that we are careful thinkers and that our beliefs and decisions are rooted in facts and logic. In reality, many of us—perhaps most of us—are rather careless in how we think. In order to be responsible to those we serve, we need to cultivate the habits of critical thinking—the process of deliberately and continually examining the assumptions, beliefs and logic that affect our reasoning. All of us are susceptible to the information bombarding us from all directions—including that of the propaganda distributed through the media.

Propaganda refers to deliberate and systematic efforts to influence perceptions, alter thoughts and influence behavior. Propaganda is inevitably one-sided, and utilizes the tactics of persuasion. A classic example is advertising. To avoid being taken in, consider the following tips.

1. Always keep in mind the central questions: What conclusion does this material want me to accept? What kind of evidence is presented in support of that argument?
2. Be aware of emotional appeals (e.g., a presentation by a strikingly attractive person, background music chosen to set a mood, or a pleasant or shocking context).
3. Keep in mind that editors can present materials (text, film, video) to support favored views. For example, they may juxtapose events to suggest a causal relationship, include only material that supports a particular conclusion, or delete countervailing evidence.
4. Beware of how you can be influenced by the style of the presentation: the presenter's sincerity (which suggests truthfulness); a well-prepared presentation (which invites confidence); the presenter's attempts to appear similar to the audience; and the use of anecdotes and humor that entertains, but does not inform.
5. Beware of the effect of the presenter's status on how you respond. Pay more attention to the substance of the argument than to the person presenting the message. The display of degrees, titles (e.g., professor or doctor), affiliations with respected organizations, and/or introductions by someone familiar to us.

Media Literacy

By Ken Taylor, Prevention Officer, Chemical Dependency Bureau, AMDD

We remember stories . . . stories that scare us, stories that make us laugh, stories that make us feel important. Stories teach us what is right, what is good, and have the power to caution us about people and behavior to avoid. A good story is an enchantment, a spell that transports us to a heightened reality. Because they are so powerful, stories can be used to deceive and to mislead, or even to persuade us to act against our best interests. Among the Greek philosophers, it was the Sophists who specialized in persuasive stories. Most of them concluded that truth and morality were essentially matters of opinion. Thus, they tended to emphasize forms of persuasive expression.

Today we gather around television sets rather than campfires or in village squares, but we are still hearing the stories that will shape our lives. The trouble is, the best-planned, most studied, and carefully-manicured stories are those preceded by the phrase, "And, now a word from our sponsor."

The measure of success for any commercial is; "How much product did it sell?" A commercial may be funny, sexy, or exciting. It can be stupid or clever, but the underlying truth is that there are no accidents in a commercial. Even when the mind doesn't consciously register the image, every frame serves a purpose. Ironic, isn't it? The purpose of these carefully-crafted productions is to incite us to act on impulse.

Given the power of stories, it is important to find ways for the audience to disengage, to become critical of the message and of the medium. This is especially true when that audience is young, seeking excitement, and not given to impulse control. Peter DeBenedittis, Ph.D., a nationally recognized expert in media literacy, identifies five characteristics of a media literacy program:

1. Media literacy is the ability to "read" television and mass media, to see the tricks of the trade.
2. Media literacy education teaches people to *access*, *analyze*, *evaluate*, and *produce* media.
3. Media education represents an important approach to protecting children and adolescents from the unhealthy effects of media.
4. Media education is an approach that is not dependent on the willingness of Hollywood or Madison Avenue to accept accountability for its programming and advertising, beyond providing ratings points and product sales for their advertisers.
5. Children who understand the motivations and production techniques of mass media are less likely to adopt the destructive attitudes and behaviors depicted in the media.

> "Media literacy seeks to empower citizenship, to transform citizens' passive relationship to media into an active, critical engagement capable of challenging the traditions and structures of a privatized, commercial media culture, and thereby find new avenues of citizen speech and discourse." Wally Bowen, Citizens for Media Literacy, Asheville, NC, U.S.A, 1996.

Understanding how commercials are constructed and how each scene contributes to the story can reduce the impulse to purchase. Even children know that commercials are not real. What is harder to understand is just how "not real" commercials really are. Not only are there no mistakes in commercials, there is no everyday life in them, either. The Irish have stories about the land of eternal youth, Tir na nOg, where the days are perfect, the people are beyond beautiful, and the hunting is always good. The food is always the most delicious, the wine the finest and the fruit the freshest. Tir na nOg is a land of ideals. Commercials take those ideals and put them to a new use.

Continued on Page 23

Links & Resources

Media & Culture:
- *New Mexico Media Literacy Project*
- *Jean Kilborne—The First Lady of Media Literacy and Health Promotion*
- *Media Literacy Online Project*
- *AdBusters*
- *BADvertising*
- *Entertainment Industries Council*
- *Teen Health and the Media*
- *TV Free America:*
- *Media Literacy Clearinghouse*
- *Eating Disorders Awareness and Prevention*
- *Center for Media Literacy—Features the most complete on-line catalog of media literacy resources.*
- *Media Awareness Network*

Prevention & Activism:
- *National PTA Common Sense*
- *ONDCP Project Know*
- *Media Matters (American Academy of Pediatrics)*
- *Safe & Drug-Free Schools*

Tobacco Prevention:
- *TIPS-Tobacco Information and Prevention Resources*
- *Kids Campaign*
- *Kickball Action Center*
- *Great American Smokeout*
- *Smoke Free Youth Tobacco Sold to Kids*
- *Center for Tobacco Free Kids*
- *SmokeScreen Activists Network*
- *Get Outraged!*
- *ALAC Shoplifting Project*
- *S.W.A.T. — The Whole Truth*
- *SmokeSignals*

Alcohol Prevention:
- *Marin Institute*
- *J.A.Y.D.N.*
- *NCADI College Drinking and Prevention*

Violence Prevention:
- *CampusSafety.org*

Media Literacy

Continued from Page 22

With some of the commercials today, it is hard to say what ideals are being promoted. Consider two well-known television personalities. Bozo the Clown and Ronald McDonald. Bozo was originally developed as part of an idea to combine records and books in order to teach children to read. The books contained the same stories as the records. Later in his career, he became a "franchised" character, appearing on local television stations around the country in children's shows that featured Bozo cartoons. Today Bozo has his own show on cable. Bozo the Clown may or may not have been your friend. But Ronald McDonald it definitely more interested in your pocket book than in your well-being. For Ronald, happiness begins with a hamburger, continues with French fries, and remains incomplete until you have a soft drink.

We all recognize advertising as a permanent part of our lives. Our sources of news and entertainment will inevitably include television, radio and magazines. Just as we must be able to use our critical thinking skills when we read an article in a newspaper, so we must be able to critically watch a program or a commercial on television. The cascade of images from magazines to newspapers is a permanent part of the information age.

Media literacy is an important tool in the prevention tool kit. This past year the Addictive and Mental Disorders Division, in cooperation with Peter DeBenedittis, better known as Dr. D, has begun to raise the issue of media literacy. This past September, AMDD sponsored a presentation at the Montana ED conference. During Red Ribbon Week last October, Dr. D. made thirteen presentations to middle and high school students and parents in five communities. In April, we will be working with communities participating in the CIP process to provide more in-depth training in teaching media literacy in the classroom.

If you are interested in further exploring this topic, an extensive set of links can be found at: www.media literacy.net

"[Media Literacy] moves from merely recognizing and comprehending information to higher order critical-thinking skills implicit in questioning, analyzing and evaluating that information." David Considine, Telemedium*: The Journal for Media Literacy*, Strategies for Media Literacy Inc. and the National Telemedia Council, Madison, WI., U.S.A., Vol. 41, No. 2, 1994.

Lost Boys: Why Our Sons Turn Violent and How We Can Save Them

A book review by Kirk Astroth, Ph.D.

James Gabarino, Co-director of the Family Life Development Center at Cornell University, has written a book that goes to the heart of the recent violent tragedies involving boys. He is in a position to offer an informed opinion: he works directly with youthful offenders at a treatment facility. His book, *Lost Boys: Why Our Sons Turn Violent and How We Can Save Them* makes specific recommendations about dealing with boys and violence. He offers examples of successful programs around the nation and appeals to our sense of hope and optimism, pointing out that in 1995, 84 percent of U.S. counties recorded NO youth homicides.

There is no single factor that can explain "why kids kill," but there *are* identifiable predictors that lend themselves to prevention. Unfortunately, Gabarino states, there are no guarantees that violence will not occur, no matter how hard we try. He maintains that youth violence is an aberration that must be approached through comprehensive, committed approaches at the community level, geared to helping parents learn how to parent.

In *Lost Boys*, Gabarino does an effective job of helping the reader understand that a violent 16-year-old doesn't just appear, but was16 years or more in the making. As he points out, many troubled boys come from backgrounds that include family abuse, neglect and troubled households. Gabarino's solutions go back to beginnings—prenatal programs, early home visiting, early childhood education and care, parenting support and education.

On the other hand, I was troubled by Garbarino's portrayal of youth violence as a "disease" and an "epidemic." Characterizing youth violence as some sort of virus medicalizes the diagnosis and the solutions. Despite his earlier comments about the rarity of youth violence, he falls back into the mantra of youth violence as rampant and pervasive.

On the other hand, I was troubled by Garbarino's portrayal of youth violence as a "disease" and an "epidemic." Characterizing youth violence as some sort of virus medicalizes the diagnosis and the solutions. Despite his earlier comments about the rarity of youth violence, he falls back into the mantra of youth violence as rampant and pervasive.

In his book, Gabarino also discusses how to reclaim lost boys, and is a proponent of "Multi-Systemic Therapy." This book also lists a number of prevention resources for those who wish to find more out about some of the programs he recommends. All in all, I highly recommend *Lost Boys* as a practical book, and one you will return to on numerous occasions. Despite some weak points, I found the book a useful companion and reference that I will be glad to keep on my shelves.

Garbarino, James. *Lost Boys: Why Our Sons Turn Violent and How We Can Save Them.* (New York: Anchor Books, 1999). 274 pp. $13.00

DAY MINDER

July 19-21

6th Annual Rocky Mountain Mental Health Symposium: Teens and Drugs 2001
Grouse Mountain Lodge, Whitefish
Contact: Kalispell Regional Medical Center Education Dept. (406)752-1775 for more information

August 7-8

Community Building Institute
Jorgenson's Inn & Suites, Helena
Sponsored the Montana Commission on Community Service, the Office of Public Instruction, the Montana Campus Compact, and the Corporation for National Service State Office. *Geared primarily to non-profit entities working with volunteers.*
Contact: Sherrie Downing at 406-443-0580 or DowningSL@home.com

September 10-12

Montana Public Health Association Fall Conference
Holiday Inn, Billings
Contact: Joyce Burgett at 406-444-0065 or email jburgett@state.mt.us.

September 13-14

Methamphetamine Conference
Holiday Inn, Billings
Contact: Pam Bunke at 406-896-5400; Rhonda Stennerson 406-245-1314; or Dustin Rolfness at 406-245-7318.

September 19-21

13th Annual Conference on Services to Children and Adolescents With Emotional Disturbance
Colonial Inn, Helena
Contact: Mary Bowman at 406-444-7924 or email mbowman@state.mt.us.

October 18-19

Montana Educational Association Conference
Belgrade
Contact: Debbie Hanna at 406-442-4250.

October 23-25

Indian Child & Family Conference
Holiday Inn Grand, Billings
Contact: Mick Leary at 406-444-1677.

November 6-8

Resource Development Conference
Holiday Inn, Bozeman
Sponsored by the Montana Commission on Community Service, the Office of Public Instruction, the Montana Campus Compact, and the Corporation for National Service State Office. *Geared primarily to non-profit entities working with volunteers.*
Contact: Sherrie Downing at 406-443-0580

CSAP Center for Substance Abuse Prevention
Substance Abuse and Mental Health Services Administration

*A joint publication of the **Prevention Resource Center** and the **Addictive and Mental Disorders Division***

MONTANA Department of Public Health & Human Services

Be a Copy Cat

You may make copies of articles in the Prevention Connection for noncommercial, educational use. No reprint of this document or articles contained herein should be used in a way that could be understood as an expressed or implied endorsement of a commercial prod service or company. To use this document in electronic format, permission must be sought from the Prevention Connection and tl individual author. Please be sure to include acknowledgement of the author and the Prevention Connection in any reproductions. All other rights remain the property of the Prevention Connection and the author.

1,500 copies of this public document were published at an estimated cost of $2.57 per copy, for a total cost of $3,854.00, which includes $3,441.00 for production and printing and $413.00 for distribution.

Montana Prevention Resource Center
P.O. Box 4210
Helena, MT 59604

PRSPT
STD RATE
U.S. Postage
Paid
Permit No. 246
Helena, MT