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ABSTRACT

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

INTEGRATING PRIMARY PREVENTION INTO K-12 PROGRAMMING

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Introduction & opening remarks: the Scope of the Problem

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

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

By the early 1980's schools were contracting services with outside agencies or bringing treatment professionals in to provide services, especially for drug problems. When it became clear that schools could not control outsiders very well they began hiring their own staff. Pressured by the community, parents and finally their own administration, programs were slapped into place so that communities could say "we have a

program, we are dealing with the drug problem". This hastily organized, poorly planned response created as many problems as solutions, including:

-non-theory based programs
-unclear goals & fuzzy outcomes
-add-on programs which were "fringe" and subject to cuts
-an invasion by outside experts
-poor service delivery to students
-confusion, splintering and dysfunction among staff (SACs vs. Counselors)
-chaoas and conflict among professionals (turf & struggles over responsibility)
-lack of accountability
-little or no impact on the problem (drugs, sex, suicide,etc.)
-feelings of defeat, burnout, hopelessness
-a confused, distrusting public
(Mascari, 1989)

The Current "picture" in most schools

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

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

Some successful ventures are operating as evidenced by recent surveys indicating significant movement in drug use back to pre-1975 levels (Johnston & O'Malley, 1989). However, use of alcohol and cigarettes has remained constant and even increased, despite our best efforts (Class of 1989 survey). It is becoming clear that, just as there were several

mini-epidemics simultaneously involving different populations and substances, stemming the tide of student chemical use requires a range of services. These services must include prevention on the one end and treatment referral on the other. Unfortunately, most communities still remain focused on late stage chemical; they have no preventionprograms or are unsure of early identification techniques.

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

How to get started

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

Planning prevention programs has become a science. These activities "should":

-be based on a thorough planning process that is empirically validated
-be comprehensive enough to reach their target audiences
-be both internally and externally consistent (in messages)
-include thorough training for those conducting them
-be community owned
-engage in continuous public evaluation
(Lewis, Dana & Blevins, 1988)

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

*people are not programs-programs need structure so that they can survive after charismatic figure leave and the denial of people in power positions: WRITE POLICY & PROCEDURES

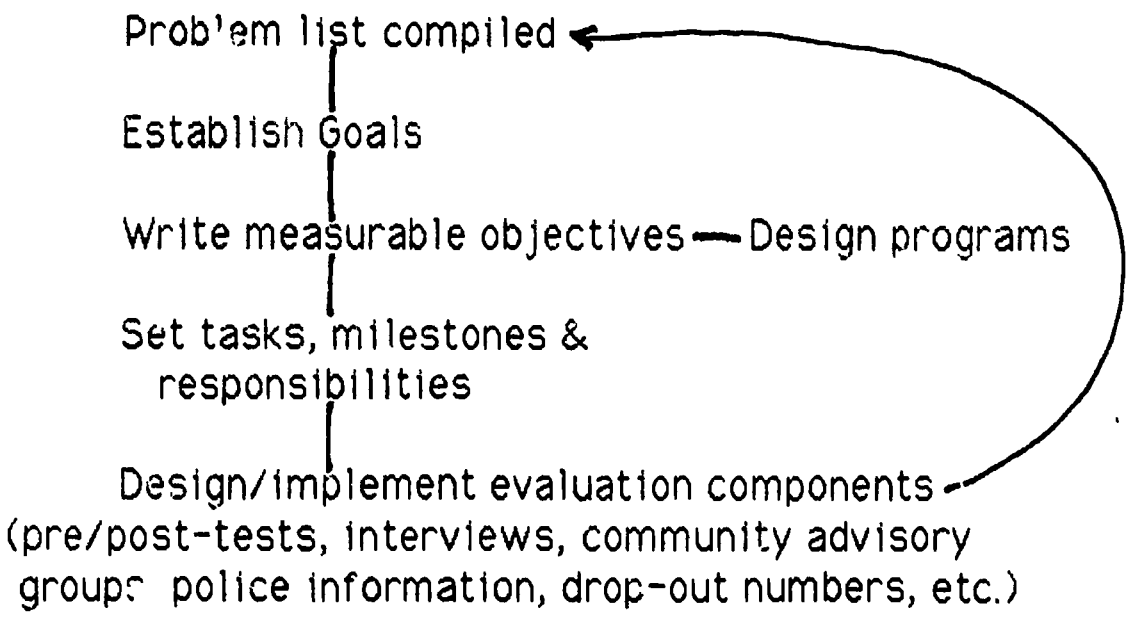
*programs without philosophies wander (i.e. poor social skils lead to drug use): ESTABLISH A PHILOSOPHY BASED ON EMPIRICAL RESEARCH

*program design and implementation come only after homework: IDENTIFY PROBLEMS & DEVELOP GOALS (use 5 year plans, be flexible & formally assess progress)

*isolation breeds failure: INVOLVE COMMUNITY & STUDENT GROUPS, SEEK INPUT (develop vehicles such as Advisory Committee, Interagency Council, etc.)

(Mascari, 1989)

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



The research is clear: Why don't we use it ?

The National Institudes of Drug Abuse and Alcoholism, along with the newly formed Office Of Substance ABuse Prevention (NIDA,NIAAA, OSAP) have spent billions of taxpayer dollars to fund projects and study outcome effectiveness. Some of these studies go back into the early 70's and appear to build on each other and validate major conclusions. The High School Senior and Household Surveys which address actual trends in "use" provide us with very rich information. So why aren't we using this information to a great extent in developing our programs ?
While only speculation, it can be argued that in the age of over-information, we cannot read everything. In fact we seem to be so overwhelmed that if the information is not put in neat packages or scaled down to workable size. This paper will provide at least some of the essence of the literature however, it should not be considered a substitute

for reading information which is free from the National Clearinghouse on Drug and Alcohol information.. In fact, OSAP monograph #1 (DuPont, 1989) is a sort of "Cliff's notes" of recent prevention research. Since we know that change and infusion of new ideas occurs slowly enough you are encouraged to bring this information back to share with your staff !!

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

Basic Research

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

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

*90% of smokers began before age 21 (Surgeon General) and of the 12-17 year old smokers, 47% smoke marijuana as compared with7% of non-tobacco using pot smokers. Pack-a-day smokers are 20 times more likely to be daily marijuana smokers than those never using cigarettes. (Johnston, 1985)

*Cigarette smoking begins in grade six (21%)

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

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

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

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

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

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

Program Effectiveness

*knowledge only (information) programs are largely ineffective (Swisher, 1971; Faly & Sobet, 1983).

*values clarification and affective education are not effective in preventing AOD use (Hawkins, 1985; Chaps, 1983).

*problem solving, decision making, cognitive skills, as well as self-esteem/self-awareness activities and stress/anxiety coping, assertiveness, and interpersonal skill programs are effective (DeMarsh & Kumpfer, 1983 & 1988).

*skill training for early aggressive youngsters works (Garrett, 1985; Sure & Spivak, 1989).

*peer refusal skills are effective (Botvin & Willis '985).

*family skills training and improved family communication has led to refusal of gateway drugs (DeMarsh & Kumpfer, 1983 & 1986).

*multimodality programming aimed at different targets had measurable success (Edwards, US Dept. of Education Northeast Regional Center, 1989).

*emphasis at changing behavior rather than attitudes showed success.

The research information synthesized into a visual developed by the author (Mascari, 1989) would look like this:

Prevention Programming By Grade Level

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

*from Edwards, Northeast Regional Center

A comprehensive model in process: Clifton Public Schools

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

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

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

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

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

(1988) Residential Training with Northeast Regional Center for Drug Free Schools and Communities and subsequent "superteam" projects (critical mass increased to 65)
Social Problem Solving program established grade l
Assessment of all counseling services and presentation of Long Range Plan for student services
Local Advisory Committee on Substance Abuse formed

(1989) Department formed as umbrella for general education support services and prevention programs (Counseling & Student Services)
School Resource Committees established in all buildings
Quest Skills for Adolescence added to middle school curriculum
Student Assistance Counselors added to middle school Counseling & Guidance program
Survey conducted by the Northeast Regional Center

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

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

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

Appended handouts:

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

SUPPORT SERVICES PLAN - K-12
CLIFTON PUBLIC SCHOOLS

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

1989-90 staffing:

:SC- 1 Psychologist
2 LDTCs
1 LDTC (3 days)

tudent Assistance Program-
3 Counselors (HS)
2 Counselors (MS)

School Counselors-
11 Counselors (HS)
4 Counselors (MS)

THE SCHOOL RESOURCE COMMITTEE & THE PRE-REFERRAL INTERVENTION PROCESS

CLIFTON PUBLIC SCHOOLS
Clifton, New Jersey

PROCEDURES FOR THE SCHOOL RESOURCE COMMITTE MEETINGS

Purpose

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

Organization

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

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

The SRC should include the following members:

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

Operational Details

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

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

Resolving disputes among SRC members

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

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

Referral to the Child Study Team for an Evaluation

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

1. When the SRC determines that a referral to the Child Study Team is planned, a member shall consult with the Director of Counseling & Student Services prior to obtaining a parent signature.
2. The Director shall review the Summary of Pre-Referral Interventions form and will either sign the designated space in agreement, or return the request with additional considerations before getting parent permission to obtain an evaluation.

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

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

Obtaining parental/guardian permission is the responsibility of the building principal however, any member of the SRC having a working relationship with the parent/guardian may obtain the signature. This should be decided at the SRC meeting.
3. When a request is approved, the following documents shall be returned to the Director of Counseling & Student Services for referral to the Child Study Team:

a) Child Study Team Referral "Cover sheet"
b) Parent/guardian permission form
c) Summary of Pre-referral Interventions form

4. The Department of Counseling & Student Services shall keep a log indicating:

a) dates reviewed by the Director

b) date of parent signature

c) date delivered by the Director, or designee to the Department of Special Education.

At this point Pre-Referral Intervention strategies shall cease.

Parent/guardian refusal to give permission for a referral

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

Table 5. Summary of study findings on effectiveness of prevention programs

PROGRAM TYPE	INVESTIGATORS	FINDINGS
Targeted		
Primary prevention	McAlister et al. 1980.	Peer-resistance training found to prevent initiation of tobacco, alcohol, and marijuana use by junior high school students.
	Evans et al. 1981.	Peer-resistance training found to prevent initiation of tobacco use by adolescents.
	Botvin et al. 1983, 1984.	Life-skills training, involving training in personal and interpersonal skills as well as peer resistance, reduced use of tobacco and marijuana up to 1 year after training for fourth to eighth grades.
	Perry et al. 1983.	Use of both teachers and peers employing peer-resistance, health education, and social skills training led to reduction in smoking with high school students.
	Schinke and Gilchrist 1983, 1985.	Skills enhancement, emphasizing peer resistance, reduced tobacco use and intention to use.
Early intervention	Kumpfer and DeMarsh 1983; DeMarsh and Kumpfer 1986.	Skills training program for children of drug abuse clients and their parents led to improved family communication, diminished problems in children, and reduced intention to use alcohol or tobacco.

	Spivak and Shure 1982; Bry 1982; Shure and Spivak 1983.	Skills training in interpersonal skills at fourth and fifth grades decreases impulsiveness and delinquency and increases interpersonal effectiveness.
	Hawkins et al. 1988.	Classroom management program using teachers t teach skills in interpersonal behavior and self-control in the classroom setting to low achievers led to improved school-related behaviors, attitudes.
Large-scale		
Media	Hanneman et al. 1977, 1978.	Media campaign plus community mobilization led to greatest behavioral change when target was prescription drug use by women.
	Flay and Sobel 1985.	Coordinating classroom and home/family assignments with televisio programming led to lessened initiation of smoking by junior high school students.
Communitywide	Berrueta-Clement et al. 1983, 1984.	Skills-training program for preschool youth and parents led to lower rates of antisocial behavior and greater academic succes. than was shown by a control group in late adolescence.

Table 6. Summary of study findings on risk factors and correlates to alcohol and other drug use

FACTORS	INVESTIGATORS	FINDINGS
Genetic and family		
Parental AOD use	Cotton 1979; Vaillant 1983; Goodwin 1971, 1985; Goodwin et al. 1973; Goodwin et al. 1974; Barnes et al 1986.	Heightened susceptibility to alcoholism in children with alcoholic parents.
	Johnson et al. 1986.	Heightened susceptibility to nonalcohol drug abuse in children of alcoholics.
	Kandel et al. 1978; Kandel 1982; Kim 1979; G.M. Johnson et al. 1984.	Parental drug use associated with initiation of drug use by children.
	Rachal et al. 1982; Zucker 1979.	Frequency of children's AOD use associated with parental use.
	Thorne and DeBlassie 1985.	Parental use of illicit drugs associated with AOD use in children.
Parental discord	Baumrind 1983; Penning and Barnes 1982; Robins 1980.	Parental divorce and separation associated with drug-using and delinquent behaviors.
	Simcha-Fagan and Gersten 1986.	Parental conflict associated with drug abuse.
	Wolin et al. 1979, 1980; Bennett and Wolin 1985	Family rituals more largely absent in homes of AOD abusers.
Parental supervision	Kumpfer and DeMarsh 1986; Kumpfer 1987.	Disorganization, home/family management skills less evident in homes of AOD abusers, less time with children, less evidence of support.

	Dishion et al. 1985; Patterson and Dishion 1985.	Less monitoring and parental involvement in homes of alcohol abusers.
	Vaillant and Milofsky 1982.	More family moves, lower cohesion in families of AOD abusers.
	Bachman et al. 1981.	AOD use strongly correlated with number of evenings per week outside the home.
GENETIC	Schuckit et al. 1972.	Half-siblings of alcoholic parent or parents disproportionately alcoholic.
	Kaij 1960.	Rates of alcoholism higher in monozygotic twins (71.4 percent) than in dizygotic (32.3 percent).
	Gurling et al. 1981.	Alcoholism concordance rates higher in male twins (33 percent monozygotic, 30 percent dizygotic) than in female twins (8 percent) monozygotic, 13 percent dizygotic).
	Loehlin 1972.	Greater concordance for heavy drinking in monozygotic than dizygotic twins.
	Pickens and Svikis 1986.	Nonalcoholic drug abuse concordance rates in male twins: monozygotic, 55 percent; dizygotic, 31 percent. In female twins: monozygotic, 27 percent; dizygotic, 23 percent.
	Jonnsson and Nilsson 1968.	Greater concordance for quantity of alcohol regularly consumed for monozygotic than dizygotic twins.

	Partanen et al. 1966.	No differences in alcoholism concordance rates between monozygotic and dizygotic twins for uncontrolled drinking; differences for quantity consumed.
	Cadoret and Grath 1978; Cadoret et al. 1980.	Adoptees with alcoholic biological parents have greater tendency to alcohol abuse.
	Cloninger et al. 1981.	Children without alcoholic biological parents raised in alcoholic adoptive families showed no tendency to alcohol abuse.
	Bohman et al. 1981.	Adopted sons and daughters with biological parents who were alcoholics were more likely to become alcoholic than adoptees without family histories of alcoholism.
Peer		
Drug use and delinquent behavior	Kandel 1978, 1985.	Peers' attitudes toward drug use and use of drugs related to adolescents' own use.
	Robins and Ratcliff 1979; Jessor and Jessor 1978.	Beliefs about drug use by peers and orientation to peers associated with own use.
	Johnston et al. in press; Elliott et al. 1985; Jessor et al. 1980; Kaplan et al. 1982; Norem-Hebeisen et al. 1984; O'Donnell and Clayton 1979.	Associations with drug-using peers associated with own use.

Psychological		
Temperament	Zuckerman 1979; Penning and Barnes 1982; Spotts and Shontz 1984.	Sensation-seeking related to marijuana use and to number of drugs used in adolescence.
	Ahmed et al. 1984.	Risk taking by child associated with expectations to use and later use of tobacco and alcohol.
	Tarter et al. 1985.	Decreased attention span associated with alcoholism.
	Rosenberg 1969.	Decreased ability to return to emotional homeostasis in alcoholic.
	Cantwell 1972; Morrison and Stewart 1973.	Hyperactivity in children with alcoholic parent(s).
	Goodwin et al. 1975.	Emotional lability and hypersensitivity associated with alcoholism.
	Aronson and Gilbert 1963.	Depression, low frustration tolerance and emotional immaturity in sons of alcoholic fathers.
Deviance	Wechsler and Thum 1973; Johnston et al. 1978; Kandel et al. 1978; Robins 1978; Elliott et al. 1985.	Early antisocial behavior associated with later adolescent drug use.
	Bachman et al. 1981.	Rebelliousness associated with later drug use.
	Kellam and Brown 1982.	Early (first-grade) aggressiveness in males, particularly in combination with shyness, associated with adolescent drug use.
	Kandel 1982; Kaplan et al. 1986; Robins and Przbeck 1985.	Early use of drugs associated with later regular use.

	Brunswick and Boyle 1979; Kleinman 1978; O'Donnell and Clayton 1979.	Early use of drugs associated with later criminal activity.
School behaviors	Kumpfer and DeMarsh 1986.	Alienation from school, school peers, and decreased attendance associated with later AOD abuse.
	Anhalt and Klein 1976; Johnston 1973; Robins 1980; Annis and Watson 1975.	School dropout related to adolescent drug use.
	Catalano et al. 1985; Johnston et al. 1986.	Low commitment to school associated with AOD abuse and delinquency.
	Herjanic et al. 1977; Rimmer 1982.	Academic problems and behavioral difficulties in early grades associated with drug use.
	Holmberg 1985.	Tardiness and truancy associated with later drug use.
	Johnston et al. 1985.	Plans to attend college associated with lower levels of drug use.
	Bachman et al. 1981; Brooks et al. 1977; Kandel 1982; Kim 1979.	Absenteeism, cutting class, and poor performance associated with drug abuse.
	Jessor and Jessor 1977; Johnston 1973; Kandel et al. 1978.	Low academic performance in early grades associated with initiation of drug use.
	Friedman 1983; Johnston and Bachman 1980.	Attitude toward school and time spent on homework associated with drug use.

	Smith and Fogg 1978, 1979.	School failure associated with subsequent use and level of use.
	Spivak 1983.	Aggressive, antisocial behavior in early grades associated with later delinquency and drug use
Biological		
Neurological-cognitive	Propping et al. 1980, 1981; Pollock et al. 1983.	Deficiency in alpha slow wave capacity distinguished children of alcoholics from others.
	Sowder and Burt 1980.	Lower IQ, greater behavioral problems in children of heroin-using mothers.
	Schuckit and Bernstein 1981.	Less time sleeping by children of alcoholics.
	Begleiter et al. 1984; Porjesz and Begleiter 1985.	Differences between sons of alcoholic fathers and matched ones in evoked potentials findings.
	Bloom et al. 1982; O'Connor and Hesselbrock 1985.	Differences in evoked potentials in sons of alcoholic fathers after administration of alcohol.
	Gabrielli and Mednick 1983.	Lower verbal ability and IQ associated with family history of alcoholism.
	Noll and Zucker 1983.	Lower abstraction concept-forming abilities associated with family history of alcoholism.
Neuroendocrine	Goodwin 1985; Kent et al. in press.	Differences in serotonin levels in children of alcoholics compared to others.

	Schuckit 1983.	Lower levels of dopamin associated with family history of alcoholism.
	Schuckit et al. 1983.	Higher levels of prolactin after alcohol consumption in sons of alcoholics than in sons of nonalcoholics.
Metabolism of AODs	Schuckit et al. 1981.	Decreased muscle tension consequent to alcohol consumption for males with family histories of alcoholism.
	Schuckit 1980.	Lower report of intoxication by sons with family histories of alcoholism than other males at same alcohol blood levels.
	Schuckit 1985.	Decreased static ataxia in males with family histories of alcoholism.
	Wilson 1982.	Differences in psychomotor functioning after alcohol ingestion between sons of alcoholics and males without family histories of alcoholism.
mmunity		
privation	Schlossman et al. 1984; McCord and McCord 1959.	Community disorganization related to higher levels of delinquency.
	Blumstein et al. 1985; Farrington 1985; Robins 1979; West and Farrington 1973.	Poverty, inadequate housing, and living conditions associated with delinquency and drug use.
Neighborhood involvement	Catalano et al. 1985.	Residential stability associated with lower rates of initiating drugs and lower frequency of drug use.

	Kaplan et al. 1984.	More mobile adolescents felt more alienated from family and school and were more likely to have friends using drugs.
	Sampson et al. 1981.	Delinquency and crime associated with low stability of neighborhood population.
Religious commitment	Bachman et al. 1981; Johnston and Bachman 1980.	Adolescents attending religious services more frequently and rating religion important in their lives less likely to use any substance.

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Johnston, L., Bachman, J., & O'Malley, P., *1989 National High School Senior Drug Abuse Survey* press kit. Rockville, Md.: Ann Arbor, Mi.: University of Michigan, 1990.

Lewis, J., Dana, R., & Blevins, G., *Substance Abuse Counseling: an Individualized Approach*. Pacific Grove, Ca.:Brook-Cole,1988.

Mascari, J.B., *Integrating Primary Prevention into K-12 Program Development*. Ann Arbor, Mich.: ERIC Clearinghouse on Counsleing & Personnel Programs, 1990.

Domicile/Attendance Investigations

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

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

Additional Departmental Activities

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

CLIFTON PUBLIC SCHOOLS

DEPARTMENT OF COUNSELING & STUDENT SERVICES

MAXIMIZING STUDENT POTENTIAL...

Mr. William C. Liess,
Superintendent of Schools

Dr. Osborne Abbey,
Assistant Superintendent of Schools

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

About the Department of Counseling & Student Services

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

Director:
J. Barry Mascari, MS,CCMHC,CDC
Secretary:
Gloria LaBruzza
470-5697

Department Goals

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

About the School Resource Committees

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

AVAILABLE PROGRAMS...

The Educational Support Team (Grades K-8)

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

Educational Support Counselors:
Bernadette De Simone, MA-LDTC
Marlene Kroel, MA-LDTC
Sharyn Pasternack, M.Ed.-LDTC
Joanne Shapiro, MA,NCSP
470-2291

The Student Assistance Program (Grades 6-12)

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

Student Assistance Counselors:

Christopher Columbus Middle School-
Linda Lis, MS 470-2364

Woodrow Wilson Middle School-
Jan Stauber, MS,CAC 470-2347

Clifton High School-
Florence Calise, MA 470-2318
Anne Friedland,MA,NCSP 470-2453
Peter LoRe, M.Ed. 470-2424

The Counseling & Guidance Program (Grades K-12)

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

Supervisor (Grades 6-12):
Christine Belli,MA 470-2324

Counselors

Christopher Columbus Middle School-
Janet De Benedett, MA 470-2366
Dennis Zahorian, MA 470-2363

Woodrow Wilson Middle School-
Elizabeth Maguire, MA 470-2347
Richard Prunk, MA 470-2346

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