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P U B L I C H E A R I N G

before

SENATE COMMITTEE ON CHILDREN'S SERVICES

Substance Abuse Among Adolescents

September 23, 1986
Room 407
State House Annex
Trenton, New Jersey

MEMBERS OF COMMITTEE PRESENT:

Senator Catherine A. Costa, Chairwoman
Senator Leanna Brown
Senator Donald T. DiFrancesco

ALSO PRESENT:

Sharon D. Larmore
Office of Legislative Services
Aide, Senate Committee
on Children's Services

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Hearing Recorded and Transcribed by
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State House Annex
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Trenton, New Jersey 08625

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in
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New Jersey State Legislature
SENATE COMMITTEE ON CHILDREN'S SERVICES
STATE HOUSE ANNEX, CN-068
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MEMORANDUM

September 8, 1986

TO: MEMBERS OF THE COMMITTEE

FROM: SENATOR CATHERINE A. COSTA
CHAIRMAN

SUBJECT: NOTICE OF CHANGE IN DATE FOR PUBLIC
HEARING SCHEDULED FOR SEPTEMBER 24, 1986

(Address comments and questions to Sharon Larmore, Committee Aide)

The public hearing to discuss the problem of substance abuse among adolescents, scheduled for Wednesday, September 24, 1986 at 10:00 A.M., has been rescheduled for Tuesday, September 23, 1986 at 10:00 A.M. in room 407 of the State House Annex.



HERINE A. COSTA
Chairman
SEPH HIRKALA
Vice-Chairman
MONA M. LIPMAN
ANNA BROWN
DONALD D. DIFRANCESCO

New Jersey State Legislature
SENATE COMMITTEE ON CHILDREN'S SERVICES
STATE HOUSE ANNEX, CN-068
TRENTON, NEW JERSEY 08625
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August 22, 1986

NOTICE OF A PUBLIC HEARING

THE SENATE COMMITTEE ON CHILDREN'S SERVICES ANNOUNCES
A PUBLIC HEARING TO DISCUSS THE PROBLEM OF SUBSTANCE ABUSE
AMONG ADOLESCENTS, EXAMINE CURRENT STATE POLICY, AND CONSIDER
LEGISLATIVE INITIATIVES TO ADDRESS THIS PROBLEM.

September 24, 1986
Beginning at 10:00 A.M.
Room 407 of the State House Annex
Trenton, New Jersey

The Senate Committee on Children's Services will hold a public hearing on Wednesday, September 24, 1986 at 10:00 A.M. in Room 407 of the State House Annex. The purpose of this hearing is to discuss the problem of substance abuse among adolescents, examine current State policy, and consider legislative initiatives to address this problem.

Address any questions and requests to testify at the public hearing to Sharon Larmore, Committee Aide (609-292-1646), State House Annex, Trenton, New Jersey 08625. Persons wishing to testify are asked to submit eight copies of their testimony on the day of the hearing. The chairman may find it necessary to limit the number of witnesses or the time available for each witness.

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SENATOR CATHERINE A. COSTA (Chairwoman): Good morning. I appreciate all of you coming. This is the first of other public hearings on problems that affect children.

First of all, I'd like to introduce myself. I'm Senator Catherine Costa, Chairman of the Children's Services Committee. To my right is Senator Leanna Brown and following her is Senator Donald DiFrancesco. Two of our Senators could not be here today, although they apologize for not being here.

People have asked why are we holding this meeting? Is it because drugs is right up front in the entire nation on the severity of the problem? Actually, this has been on my agenda for many, many years.

As a former Freeholder, I use to visit schools and speak to children. I would stand before them and find they were stoned right in front of me. I tried to reach them and say, you know, "Why can't you get high on life, instead of these drugs?" And all they were interested in was, "Are you going to make it legal?"

These are the things that you come across, and right now this is a good time since we've never had a Children's Services Committee where we've had reference bills come to that committee until this year. I'm really delighted that we do have it, and of course, I'm ecstatic about it being its first year.

Today what we want to do is identify the problem -- identify where it's at, and how extensive it is. Is it in pockets? Is it the shotgun approach? Is it concentrated in certain areas?

The next thing we want to do is intervention. How could we intervene? How can we help our youngsters? What kind of help do we have here in the State of New Jersey? I know that a lot of our youngsters are sent for help to the

State of Pennsylvania at a quite an expense. Are those who can't afford it, able to get some help? These are the things that we are going to be looking at.

And the third, which I think is the most important, is prevention. As the old saying goes, "An ounce of prevention is worth a pound of cure." And never has it been more important and more true than in this case.

If we could find out how we could stop this scourge, how to keep our children from starting on drugs-- We're talking about an age group of 10 or 12 years old to 17 -- the young adolescents. This is what we're going to cover today.

We hope to hear from you -- those of you who are the experts in the field -- to give us the input that we need so we can be good legislators and come out with some legislation that can help the children of this State.

The first speaker will be Drew Altman, who is the Commissioner of the Department of Human Services. Drew?

COMMISSIONER DREW ALTMAN: Good morning to you all. I have with me Mr. Robert Nicholas, who is the Acting Deputy Commissioner for Operations in my Department and has been with these issues in the Department for many years.

Chairman Costa and members of the Committee on Children Services, I would like to thank you all for the opportunity to make these remarks here today about this tough, tough problem we all face in New Jersey.

As a brand new and very new father, I share the concerns of parents everywhere about this problem and the impact that it has on our society as well as on our children's future.

And I do, before I start, want to take the opportunity to commend you and commend the Committee for demonstrating your seriousness about this issue by holding these important hearings.

I'm here today because I'm personally committed as Commissioner of a department that reaches one out of every

eight New Jerseyans to participate in the development of an overall effort in New Jersey -- a renewed effort in New Jersey -- to take on this difficult problem. I think it's good news that this is a top priority of the Governor. It's a top priority for Attorney General Edwards and the Statewide Task Force, and we will be working closely with them.

I've submitted a somewhat more comprehensive testimony for the record, but for today in my oral remarks, I'd like to highlight the ways in which this problem impacts on my Department, and outline for you in some very general terms, some initiatives we have on the drawing board that might represent our contribution to an overall multi-department, statewide effort in New Jersey to do something about this problem.

I guess for starters, I would say to you that I believe that my department, perhaps more than any other department, deals with the underlining causes of substance abuse -- poverty, unemployment, mental illness, and the breakup of the American family.

And I believe that our welfare programs and our mental health programs, and our DYFS program, that help preserve families and help children, need to be strengthened and improved. We need to be smarter about them if we are ultimately to deal not just with the symptoms of this problem which we see on the streets everyday, but with some of the underlining causes as well.

I think secondly, just as my department deals with the underlining causes of substance abuse, we also are faced with, perhaps, more or as much as some other departments, with the fallout from this difficult problem. And that is the case across all of our divisions.

Let me give you a feeling for how that works out. Drug and alcohol abuse is a contributing factor in child abuse, elderly abuse, and domestic violence. I find it astonishing

that our studies show that 65% of the child abuse cases we deal with are related in some important way to substance abuse. That's a remarkable number to me.

Substance abuse also tears apart families and forces children into foster care. I think a similarly impressive number is that one-third of the families whose children enter foster care in our system have a significant substance abuse problem.

I think it's the case, too, that substance abuse contributes to the onset and severity of mental illness and to suicide. We know from a study at one of our psychiatric institutions that about 36% of the people in these institutions, particularly the adolescents, have some significant substance abuse problem.

And in the last year, there was another significant number. We've seen a 20% to 25% increase in the number of young substance abusers presenting for care at community mental health centers across the State. We know also that more than 30% of the suicides we deal with across the country and in this State have some substance abuse dimension, or related substance abuse problem.)

There are other ways, too, in which my Department deals with the fallout from the problem we're all here to talk about today. As I think you know, alcohol abuse causes fetal alcohol syndrome and leads ultimately to mental retardation. This affects about 1000 newborn babies in New Jersey each year.

Substance abuse also -- and this is something I'm very concerned about -- increases dependence on welfare programs and on Medicaid as well. One in five of the people on general relief in New Jersey has a substance abuse problem, and if you look more narrowly at the homeless, you will find an even higher percentage. Similarly, a very large share, perhaps 20%

to 30% of our Medicaid payments for inpatient hospital care can be tied to either a direct or indirect substance abuse related issue.

And just to mention two more which I think are important: Approximately 60% of the AIDS cases in New Jersey are the result of drug addicts sharing infected needles. You may hear more about that later on from the Health Department. But what I want to point out is that this is something that significantly impacts our Medicaid program which pays for the largest share for medical care for people with AIDS in this State. And lastly -- and I think somewhat in the news lately and very painfully-- Today in New Jersey we, as a State, see some 12,000 to 15,000 of our adolescents seeking residential services outside of New Jersey because we simply don't have the services they need in State at this time.

So, there are some statistics which give you a feeling for the way in which my department is impacted by and affected by the substance abuse problem. I think also in my department, we deal with substance abuse in very personal terms. We deal with the individual casualties of substance abuse on a day-to-day basis.

And I just want to give a feeling of how tough some of these cases are. A couple of examples: Both of these taken from our DYFS files, but could have been taken from my Division of Mental Health or from others in the Department as well. Just two quick examples.

One is a young woman, who I'll call Jill, 16 years old and currently is in placement. She has had two hospitalizations for drug treatment and suicide. She has experimented with alcohol, cocaine, marijuana, LSD, PCP, amphetamines, diet pills, and speed; in other words, with just about everything there was to experiment with.

She's attempted to kill herself by suffocating herself with a pillow, drowning herself, and stabbing herself with a knife. She's been diagnosed as being dependent on just about every drug you can name, as well as alcohol. And she has been formally classified as emotionally disturbed.

Just one other similar example. Joe is a 15 year old boy, obviously. He's currently in placement in a detention center. He has a history of drug and alcohol abuse and delinquent activities. He has experimented with alcohol, marijuana, cocaine, LSD, and mescaline. He has been charged with burglary and possession of stolen property. He has collected his friends' urine to change the testing results for his own drug tests. His older sister is currently in jail on drug charges. He's attempted to hang himself several times in the detention center; he's threatened other suicide attempts. He has a history of extreme violence in the schools, and he too, has been classified as emotionally disturbed.

And so this is as well as the numbers that give you a feeling for the human casualties we deal with on substance abuse, literally on a day-to-day basis in DYFS, in the Division of Mental Health, and as I said, throughout my department.

In our effort to make our contribution to what I hope will be, an overall statewide initiative, we have several -- I guess I'll call them only at this point -- ideas on the drawing board for the Governor to consider and also for the Statewide Task Force to consider. Some of them are fairly general, but would impact substance abuse, and some are more targeted. I'll just mention a few of them.

Because we know -- and I think this is an important point -- that troubled teen-agers today face multiple problems and because experience has shown us that they are a hard group to reach with fragmented categorical programs, I'm now working with the Governor's office on a comprehensive package -- a program with comprehensive services -- for troubled adolescents.

I think secondly, I would mention that in just a short period of time our Child Assault Prevention program, the so-called CAP program, has proven to be an effective vehicle for reaching communities, educators, and children across the State. We're considering the option of expanding that program to deliver a substance abuse message, as well.

I think it makes sense to consider reaching out to communities and supporting community wide programs, and we have a vehicle available through our Human Services Advisory Councils and our Youth Services Commissions which you know more about than I do. There is one in every county in New Jersey, and I think these represent an obvious vehicle and an effective mechanism for pulling together leadership groups at the community level and for funding and developing programs, and that's something we're looking at.

We're considering modifying our very popular, and I think successful, Kids on the Block program, which through puppets teaches children about the developmentally disabled, so that it too, as with the CAP program, can send a substance message.

Through an interagency agreement with the Department of Health, we are now adding substance abuse counselors in each of our DYFS offices around the State. We've been very much involved in training our community-based staff and our institutional staff so that they can do a good job of recognizing and dealing with substance abuse problems.

And lastly on this list, I will just simply mention that as you know, the Governor has made welfare reform a top priority for the State and for me. And I believe that as we move welfare recipients into jobs, we'll also deal with the idleness and the unemployment which is one of the underlining factors ultimately in substance abuse in our society.

I do want to emphasize that these are preliminary ideas that we have that may ultimately be integrated into the

Governor's efforts or the work of the Task Force, or the work that the Attorney General is doing at this point. But I think they underscore that my department is committed to renewing our efforts and our energies in this area and to working together with other departments as well.

In closing, I just want to thank you for the opportunity to testify and to say to you that I'm personally committed to working with you, with the Legislature, with the Governor, with the Attorney General, and the Task Force so that we can make some very special new efforts in New Jersey to do a better job in taking on this tough problem.

I will be happy to answer any questions you have, and you may ask some members of my staff to answer a few.

SENATOR COSTA: Thank you very much, Commissioner. I'd like to ask you just what do you do when you find out that there's a child that has this problem and they just come into the program? I've had experience with some youths that had drug problems and they kind of fall through the cracks with DYFS, and that's something I feel something that I feel very strongly about. As you know, I've expressed my opinion to you. What is there? How do you follow-up on them? How do you get them at the very beginning and start helping them?

COMMISSIONER ALTMAN: I think your point is exactly right. It's been a big problem in the past. They have fallen through the cracks. It's not an area where we've done as well as we should. For this reason, I think, now we've renewed our efforts to train our staff so that they can detect what may be primarily a substance abuse problem or a substance abuse overlay on top of a number of problems.

Adding the substance abuse counselors to our DYFS offices around the State represents, I think, a significant step to be able to cope more effectively with this. We've got to do a better job in my Department of coordinating between our Divisions so that children don't fall through the cracks of

DYFS, Developmental Disabilities, and Mental Health; but not just through my Department -- Corrections and the Department of Health. Coordination is a big problem.

And lastly, as you all know, we have to have the residential services available and the treatment in residential services available if we're to be able to ultimately do the right thing with these children, rather than just do our best through what in effect, is an improvisational arrangement.

SENATOR COSTA: Do you feel there are enough social workers in DYFS to take care of these young people? Because, it seems to me you have such a turnover because they get so burned out with so many cases that they are involved with. And that's where they lose the kids, and that's where the kids don't have that continuity of service and of trust that someone means well for them.

I think I expressed to you this case of this 11 year-old boy who when someone asked him, "Well, what do you want to be when you grow up? Don't you want to straighten out?" And he said, "By the time I'm 17, I'll be dead." That's a terrible thing for a young person to think that way.

COMMISSIONER ALTMAN: Yeah, we've all heard that.

SENATOR COSTA: But he was in a home where the mother was the child more so than he was. And we lost him. He had been in a JINS Shelter. He walked out, and the school never even knew that he was gone.

So there's something really lacking and that's where I need your help to work together with the legislators. Perhaps we can do something to help you.

COMMISSIONER ALTMAN: Yeah, we will. I think it's partly a matter of doing better with existing resources. Partly, that's my responsibility to show some leadership and pull together the Division so the kids don't fall through the cracks. But I won't pretend that it is a problem that can be dealt with effectively without new resources.

SENATOR COSTA: To what extent is there a coordinated effort between a department like your Department, the Department of Corrections, and Health and Education? Is there a coordinated effort?

COMMISSIONER ALTMAN: I think increasingly, but we're not doing as well as we as we should. And I hope this is one of the main trusts that will come, not only out of your own deliberations on this, but also out of the work of the task force and in the Attorney General's work because there is a big need for departments to work more effectively together -- Health, my Department, Corrections. It's still an area where we need to do a lot better.

ACTING DEPUTY COMMISSIONER ROBERT NICHOLAS: There are three major groups right now where department are cooperating -- the Governor's Committee on Children's Services Planning, Juvenile Delinquency Disposition Commission, and the Youth Service Commission -- all of which are looking at the issue of adolescent drug abuse and the integration of services between departments and divisions.

Obviously, there are very complicated issues and when you see so many multi-problemed children coming into the system who need the services of two or three different State agencies, how we get a system together to coordinate that is obviously difficult.

But there have, I think, been real good cooperative efforts in the last two or three years. At least you get agencies talking to each other.

COMMISSIONER ALTMAN: You know this is not a problem that's unique to this area. We face this in just about every area we deal with.

SENATOR COSTA: We know that. The thing is, how much effort is there as far as the family unit is concerned? Because it's not one individual alone; it concerns the entire family.

COMMISSIONER ALTMAN: Our philosophy on this is that one, you have to deal with the fact that this is a family, and deal with the problem in that way. Secondly, you have to recognize that troubled adolescents face multiple problems, and you've got to deal with their multiple problems as a whole. Simply dealing with one and then another in a differ geographic setting has not proven to be terribly effective in the past. So, that's our general thrust.

SENATOR COSTA: I'm pleased that the Governor is interested in welfare reform, because as you know I have a welfare reform bill in, and I need your assistance in getting that through. Senators, any questions? Senator Brown.

SENATOR BROWN: Commissioner, I'm very glad that you took time out of you busy schedule to be the lead off speaker today. I think it's very important that the Senate has formed this Youth Services Committee, and I'm very pleased that it took place this year.

A question for you. Needless to say, with some of the troublesome underlying uneasiness in our society today, we're going to have problems with our young people; whether it's crack, whether it's alcohol, or whether it's a new substance abuse that has to yet be devised in the laboratory. So, I am very much concerned about some of the grass root causes of this problem that we're having.

I think many of our young are very much pressured at the same time; I thing many of our young are very much neglected. I have put in a bill that would call for an ombudsman that would be in, but not of, your Department. And I was just wondering that as we look for having advocates for our young who are in trouble as well as for those who are not in trouble, whether you think that this might be a possibility that could work in your Department?

COMMISSIONER ALTMAN: Well, I do think that focusing on the underlying causes and on prevention in dealing with

children before they're in deep trouble, should be our first and foremost emphasis. There may be a variety of routes to that end. Yes, this does sound like a promising suggestion. It's not something that I've reviewed in detail. I'd be happy to look at it. It does sound promising.

SENATOR DiFRANCESCO: I have a question.

SENATOR COSTA: Senator DiFrancesco.

SENATOR DiFRANCESCO: Good morning, Commissioner. I also am appreciative of the fact that you took the time to come here today, and I think it's commendable that Senator Costa arranged this hearing, because it's certainly very timely. I am glad you have made this a top priority of your particular Department because it would take that kind of commitment to deal with this problem.

I have one specific direct questions that I would like a direct answer to, and that is: Would you support the creations of residential substance abuse treatment centers in New Jersey -- for adolescents, that is?

COMMISSIONER ALTMAN: Yes. I think we've got a big need for more-- There may be a number of routes to roam, but there is no question, that we've got a big need for more residential services for adolescents.

How many we need and just exactly where they should be, I would have to bow to the expertise in the Health Department which knows more about that than I do.

SENATOR DiFRANCESCO: I understand that. I'm also looking for some commitment from all the departments in this area. Thank you. That's all I have.

SENATOR COSTA: Senator DiFrancesco does have a bill calling for that which passed our Committee and is now in our RFA Committee. We hope to see that through. It's a good bill. No other questions? Thank you very much, Commissioner. We're pleased to have you here.

I'd like to call Commissioner Fauver, Commissioner of the Department of Corrections. Thank you. Good morning.

C O M M I S S I O N E R W I L L I A M H. F A U V E R:
Good morning Senator and members of the Committee. I've submitted the comments to you of my remarks today, and I'd just like to highlight some of these, and indicate, as Commissioner Altman has, that there are ongoing committees that have been set up among the departments to deal with juvenile problems; including drug abuse and alcohol abuse.

There are a couple of things I would like to highlight out of this. And the first one on the first page which talks about percentages-- These were startling to me when we did some research on this for our Training School for Boys at Skillman. And as you know, I've been around awhile. I'm not usually startled by seeing these kinds of figures.

But to indicate that 90% to 95% of all the admissions have experimented with alcohol and marijuana before their 12th birthday. And even more startling is that 95% to 99% of minority youth have admitted to trying marijuana at least once prior to the age of nine.

I think that this indicates that possibly in the past what we have been doing is that we've getting in too late. We've been interceding possibly in their lives, but at a point where they -- if not a commitment -- are already in experimentation and use.

These residents also tell us some of the reasons for the use, and one of the largest is peer pressure. Now that should come as no surprise to anybody with an adolescent that peer pressure is a major factor. The others are the kinds of things such as the hopelessness of their home situations where their situations in life and the fact of what they see it as an escape. But I would think that with most of these kids it would be the pressure that they feel from the others.

It's very difficult to be able to live in, for example, one of the projects and be on the floor where everybody else is using something or trying something and experimenting, and be able to say no. I mean, we go back to some of the old stories of people who all grew up in the same neighborhoods and some go to jail, and some become judges, and some are Senators, and other things like that -- and what's the difference?

Well, I think one of the differences is that there has to be agencies to help, if there isn't the family unit there to help. Those are the kinds of things I think Commissioner Altman was talking about.

One thing I would like to briefly comment on which I think will affect -- not so much the use, because these kids will use or not use as the situation arises -- but I think we're going to see more and more of these younger children getting pushed into sales of narcotics as the mandatory minimum sentences for adults become greater. I think you will see -- and we've seen this in the past with other kinds of things where kids are used as runners and so forth -- I think what you will see is a trickling down effect of the people trying to avoid prosecution themselves as adults by pushing onto the kids. And I think that's something that also should be looked at when we're talking about legislation.

The kinds of things that have to be set up, I think in conjunction with the programs that Senator DiFrancesco was talking about, where one of the things we see now-- We have group homes. We have some 40 group homes for juveniles throughout the State. Part of their day care programs, where they have children in them, are for substance abuse.

What we find is that we're getting people that are through probation departments, or through the courts, or just through agencies that intercede, because there are no other agencies to take care of them. I think that is an area that definitely needs to be expanded.

Whether there are treatment programs in the institutions, which there are, or whether these agencies are there, which they are and not to the extent that they should be. In either case, it's really, again, a sad commentary for the State that the child has to get into trouble to be able to get services. And I think we see that in the past we've seen it with education, and we see it now.

And analogous to this is the-- If you would think this child fell into a polluted stream and had to be pulled out and treated, and all the things were worked out -- he was physically brought back to health and psychologically helped -- because of the experience that he had gone through, you would not throw him back into the polluted stream after he had gotten out. And in effect and in many cases, that's what we're doing without support services.

I think this outlines the programs that happen in the juvenile institutions. I submitted that to give you some ideas of the kinds of things that I think can be done. But I really feel that the emphasis on this problem should be pre-incarceration and post-incarceration in the cases when people get out.

I think we need help in the fields of education, for example. I think there has to be money to set up programs where teachers and parents are educated to recognize drug and alcohol abuse symptoms at the earliest possible age so that they don't get caught up with it a lot later.

And I'm talking about intact families where it's not known until it's too late, until the person is already in trouble. I think there has to be things like that established in education. I think programs were done in the past and may have been overdone, but the kind of programs like we started at Rahway ten years ago with the Scared Straight program, show people what can happen to you if you get into trouble.

I don't know if it has to be that dramatic or if the children have to be brought into an institution, but I think we can work out with other departments the fact that people who are in jail now have gotten into trouble as kids with drugs and have moved up and progressively gotten worse, can be formed to talk to these kids so that there will be another type of peer group or at least socioeconomic group pressure brought on them.

But I think, although we could use funds for supporting the programs that we have and expanding the programs that we have and that's a need, I will give you the rare problem, and maybe the only time you'll ever hear a Commissioner sitting here saying that he thinks the money should really go elsewhere and to the preventative programs and the aftercare programs.

So on that note, before I get accused of being entirely insane and not asking for money, I will stop and try to address any comments or questions from the Committee. But I really think that the scenario has been neglected and has been talked about, but we really haven't done anything on a statewide level. Thank you.

SENATOR COSTA: Thank you so much, Commissioner. As I said before, you are so right, as far as going into prevention before they get there. And I think that is our only salvation. Right now, we're going to intervene and try to help those that are already there. But, if we can prevent it, that's when we've really made progress.

COMMISSIONER FAUVER: Yeah, and please don't construe my remarks to mean that we should give up on the kids that are in. But, I just think that we can reduce the numbers that are there, if we address it earlier.

SENATOR COSTA: But, you're not getting anywhere if you continue just treating and not stopping-- The group just keeps growing, I guess. So, I think that's one way to go. I appreciate you're being here today. Senators, any questions? Senator Brown.

SENATOR BROWN: Commissioner, I underscore the irony that maybe some of our younger people get more help when they're in the criminal justice system than when they're out of it, and certainly we've got to tackle that very difficult problem.

Of the 40 shelters that deal with some of the young people that have been in difficulties and so on, do you have any idea of what the recidivism rate is? In other words, the young people, for example, that have spent some time up in Greenfield in my district, in very nice and rural New Jersey, and then go back to Paterson, and so on, do you see them again, in your system?

COMMISSIONER FAUVER: Some we do. Overall, about half of the juvenile commitments are in the three institutions and the other half are in the group centers. The recidivism rate for the group centers, although I can't give you a figure on it, is lower. But I'm not sure that some of that isn't because they're getting the cream of the crop, as far as the kids anyway. But it is lower than those that are institutionalized.

SENATOR BROWN: Well, I've been very impressed by the Attorney General's comment that once we have somebody on drugs, it's very, very difficult to break the habit. I guess we can't expect miracles from you any more than from any other department. Thank you.

SENATOR DiFRANCESCO: Not to belabor anything, Commissioner, I want to thank you for coming also and I appreciate your commitment. I think it's great that you're here. You did mention something about young people selling drugs to other young people as opposed to adults selling drugs to other young people -- adults, I guess, being 18 or over, which kind of made me raise a question in my mind and maybe you can answer this question for me.

Assuming you have a mandatory penalty for distributing an illegal substance, whether it be crack, or whatever. Let's

say that you have a mandatory jail sentence for adults, in a situation where the child is 17 and is selling to another child, what would happen to that child? What would generally happen? I shouldn't say what would happen, what would generally happen to that child in terms of a penalty, if that child were found to be distributing drugs to other children?

COMMISSIONER FAUVER: I'm not sure of the proposed legislation, but there is even now the option to waive to adult court from 16 and up, and I think that would be, in a sense, a judgment call by the court unless the laws, that are specific, require it.

But, my opinion is, that is not going to happen too much. We're not talking about the fringe people that could be close to being adults. I think they're going to try to utilize much younger children on the basis of, if you pick up a 12 year old giving something to somebody, you know he hasn't been involved with the transaction. He's just the errand boy. You are going to be more empathetic with him and he won't get the kind of sentences-- And I think that will happen. That kind of pressure is there, and I think we have to look at it.

Probably what we should look at, if we're looking at mandatory sentencing, is the mandatory sentencing of people who exploit kids like that. Maybe the kids are not using it themselves, but are being exploited as being the courier to do the dirty work for the actual pusher.

SENATOR DiFRANCESCO: Good thought. Thank you.

SENATOR COSTA: I believe Senator Jackman has a bill that increases the penalties for the drug pusher. Are you familiar with that, Commissioner? He does have one.

COMMISSIONER FAUVER: There are number of bills in. I have not had the chance to review all of them.

SENATOR COSTA: Well, we were asking for some statistics from your department, and I believe this was told to us: that out of 800 juveniles that that are incarcerated,

60 are for drugs. Is that so? Is the portion that low compared to the 800 figure?

COMMISSIONER FAUVER: I'm not sure. It doesn't ring a bell to me. The figures that I gave you today, or the percentages, were based on one place which was Skillman which is our youngest population. So, I would have to think that would have carried through--

SENATOR COSTA: That probably, a higher figure than that 60--

COMMISSIONER FAUVER: I think it would be a higher figure. The actual commitment for a drug use or abuse is probably maybe there or even lower, but the fact that they've used it is higher. They may be in for breaking and entering, which was caused by them trying to steal things to sell to buy drugs, but they were not convicted of a drug charge. That's, I think, the difference.

SENATOR COSTA: You spoke of the prevention and you said something about getting a program together where you have the families and the kids together in discussing prevention, because so many people from so-called, "good" families never are aware even that their children are on drugs and are not thinking about it. Would you say that the prevention would be something that PTAs of all schools would have some program for all children and all parents together to recognize the symptoms, as well as to speak to address the by-products of experimentation with drugs with drugs?

COMMISSIONER FAUVER: Yeah. I would think PTAs, as an example, would be a very viable group to do that with. I think at the colleges, particularly the teachers' colleges, in training that's the type of thing that they could be taught towards when people get into the classroom, and in-service training for people who are already in.

I think that education in general-- And I may just say that we have experienced among our adults the most severe

overcrowding in recent years and the greatest increase in the number of sex offenders coming in to Avenel-- And one of the reasons that I believe that it's true, is because of the campaign that's been on for the past several years about child abuse, sexual abuse of children, etc.

We've seen a different effect there. We've seen a lot of people coming in now who are sentenced on those kinds of charges. And these were things that were not really brought out before: incestuous relationships and sexual child abuse, and so forth.

I think that the educational programs, the TV programs, and the awareness in the newspapers are one of the causes for that increase, that people now report and go in and talk about it. And I think that is what's necessary -- that type of education and media blitz.

The media will stay on it for awhile, but I think a group like PTA will sustain it and the teachers' colleges and so forth could sustain that kind of direction.

SENATOR COSTA: Thank you very much, Commissioner. The next speaker will be Dr. Jack Rutledge, Deputy Commissioner of the Department of Health.

DEPUTY COMMISSIONER J O H N R U T L E D G E: Thank you. I'm Jack Rutledge, Deputy Commissioner of the Department of Health, and with me is Dick Russo, the Assistant Commissioner for the Division of Narcotics and Drug Abuse Control. We're testifying on behalf of Dr. Molly Coye, our Commissioner of Health, who is very concerned about this problem.

We'd like to again, compliment the Committee for tackling this problem. It's not an easy one, but one that greatly needs to be addressed in the State of New Jersey.

Several studies over the past few years have recognized the problem of drug abuse by youth in New Jersey. A survey conducted by the New Jersey Attorney General in 1980

indicated that 67% of high school students reported having used an illicit drug -- 67%. Seventeen percent of those interviewed had used an illicit drug regularly.

A study by the Attorney General in 1983, three years later, again found similar patterns of drug usage. Based on this percentage from the Attorney General's survey, it means that between 300,000 to 350,000 of New Jersey's youth, ages 12 to 17, have used alcohol or other drugs.

In 1983, a study by the United States Congress House Select Committee on Children, Youth, and Families, indicated that 7% of all teen-agers have serious drinking problems, and 7% to 8% of all teen-agers use marijuana daily. Based on this study, it is estimated that in New Jersey, 62,000 of our youth, aged 12 to 17 are problem drinkers, and 54,000 to 62,000 use marijuana daily.

The new Jersey State Department of Health, Division of Narcotic and Drug Abuse Control's client reporting system indicates that even though we have these 50,000 to 60,000 youths with problems, only 375 youths, aged 11 to 17 are currently being treated on a daily basis. Almost exclusively, these are being treated as outpatients, rather than in a residential treatment center. Approximately 1000 in this age group are currently being treated on an annual basis.

Annually, 1200 to 1500 adolescents in New Jersey go out-of-state for residential drug treatment due to the lack of residential drug treatment programs in the State of New Jersey. Most of these adolescents are covered by insurance coverage. Thus, the indigent and working poor are the ones that are excluded. They're the ones that cannot go out of the State for treatment, and they're the ones, unfortunately, that do not get treatment.

The 80 or more drug treatment centers -- residential and outpatient -- in New Jersey have historically and presently service primarily drug users 18 years and older. Ninety-five

percent of the dollars committed to treatment in New Jersey are used in providing services to older, long-term addicts.

Fifty-eight percent of the 7500 clients in daily treatment programs have a primary drug abuse problem of heroin, and an additional 21% have a primary drug use of cocaine. Because of the severity of drug addition amongst the 18 year old and older, the major effort for treatment in New Jersey has focused historically on clinical intervention with a seriously addicted population.

Unfortunately, because of limited funding, we've been unable to develop new and appropriate programs to treat youths who need it so badly. Our greatest need today is to establish new treatment aimed at servicing adolescent drug users.

The problem of treating youth is compounded by the fact that there are few programs with specialized clinical intervention to treat youths on an outpatient basis, and no residential treatment programs for youths. An additional problem is the lack of aftercare, that Commissioner Fauver has referred to, for youths returning to New Jersey from out-of-state residential programs. Especially with youths, it's essential that you have a program that includes the family and the youth in any type of counseling situation to be truly effective.

There are a number of bills currently pending before the Legislature that address many of these issues around education, prevention, treatment, and funding for drug programs. We in the Department of Health have a tradition of supporting any efforts by the Legislature that support what we consider to be a very serious problem -- among the highest priorities of the Department. What is needed is a coordinated legislative and policy strategy.

We look forward to working with the Legislature and the other departments that have testified today, including Commissioner Altman and Commissioner Fauver, to work out a drug use program. We would like to consider ourselves a

resource as you go forth in trying to develop your program and let us be an aid to you.

The Department has always felt that the Legislature has been innovative, creative, and supportive of not only public health issues, but all the issues that affect our youth and our communities. Thank you for allowing us to testify, and Mr. Russo and I will be glad to answer questions.

SENATOR COSTA: Thank you, Dr. Rutledge. I believe you covered what we are speaking of on intervention, and what you said here basically is that we don't have enough programs to intervene when there's a problem. Also, with those that do get treatment, when they are out of the treatment facility, there's nothing there for them -- no support system, so they go right back into it again.

And if you're looking at dollars and cents, that's quite a waste. Basically, you spoke of not enough money. That's always a problem. But is there more that we can do without only looking at the money aspect?

DEPUTY COMMISSIONER RUTLEDGE: I'll delineate a few things and then Dick Russo may want to hop in also. As it's been pointed out, drug abuse in society is a really difficult problem. It's not enough just to wait to treat it after it is already going. We've got to try to prevent it, and that means prevention programs and education programs. They truly are cost-effective.

It's difficult to measure those costs at times, but if anything is going to be cost-effective for society, they are going to be. Again, we have to intervene early. Most of the costs that we've incurred, as you can tell in drug treatment, are for the habituals -- users that have used for many years. It's getting at the people when they first use it and trying to have a treatment program that's effective in dealing with the youth, pulling in their families and their friends, and trying to go at it at that point rather than waiting until they become habitual users.

So, it's a multifaceted problem. Having residential treatment is going to be an essential component to it. It's really a tragic fact that many of our youth have to go out-of-state for residential treatment -- drug abuse beds. So, trying to develop some type of residential treatment program, I think, is essential.

SENATOR COSTA: How much has been spent for prevention for the adults that you have now, and how much for those under 18?

DEPUTY COMMISSIONER RUTLEDGE: Part of our prevention program, and this under Dick Russo's shop -- it's a multifaceted approach -- part of it is a scope program that trains them in neighborhoods to look at their own neighborhood and identify what needs to be done and what they can do. In other words, motivating the individual neighborhoods.

Part of the prevention messages are carried on by actually providing programs in the schools. Part of the prevention message is also related to AIDS on sharing of needles, and educating the addicts on how dangerous it is -- trying to get them off before they really have gotten into needles and sharing too much.

It's a really complex issue. I can't give you a dollar amount, and maybe Dick Russo can give you a better idea of how much is actually going into the prevention and education approach.

ASST. COMMISSIONER RICHARD J. RUSSO: To get back to your first question, Senator, I think it's a matter of, right now, funding, because every treatment facility in the State of New Jersey is overtaxed in terms of the number of clients that they're servicing. Some treatment facilities are servicing 50% to 80% more than they should in terms of clients/staff ratios. So, the system is overburdened, the system is breaking at the seams, and there really is at this particular point and time, a relief valve needed with some additional funds.

You know, we lost approximately \$5 million back in 1981 when the Federal government went from categorical grants to block grant funding, and we've never been able to pick that back up. And since 1981, the problem has blossomed out, as you know, throughout this country. The cocaine users that Dr. Rutledge mentioned-- The percentage of cocaine users coming into the treatment today was only about 2% or 3% back in the early '80s, now it's up in the high 20%.

So, it's a matter of providing some additional support to an existing system that just cannot take any more clients.

SENATOR COSTA: I understand you had about \$3 million spent in that direction. Was that the over 18 group?

ASSISTANT COMMISSIONER RUSSO: Primarily, most of the preventive education is geared to those under 18 in the prevention area. In the treatment that Dr. Rutledge mentioned, a large and greater percentage of it goes to treating adults, who are the hard-core heroin users, cocaine users, and so forth and so on.

But most of the prevention money -- because we work in the community with community groups and with school systems -- deals with the juvenile population, that exclusively under 18-- But most of it goes into that area.

SENATOR COSTA: You're working with the Department of Education and with schools?

ASSISTANT COMMISSIONER RUSSO: We work with the Department of Education, with the schools, and with the RCSUs, as you know which are part of the Department of Education system. We're doing a lot of combined programing. It's not adequate. I'd be the first to admit that what we're doing is not adequate and it's not enough.

But we've had a cooperative agreement with the Department of Education for almost six years now where we've been doing things cooperatively in the schools. It's not enough, though.

SENATOR COSTA: Does the Department plan to begin a program that -- like you had at Chelsea House that closed, I believe, in 1981 when the Governor cut out the funds for it?

ASSISTANT COMMISSIONER RUSSO: Well, the Chelsea House Program was an experimental program for juveniles. It was an excellent program. We had to close that at that point and time in 1981 when we did suffer a major \$5 million reduction.

That was a model program that we used as a demonstration. We would like to open new residential treatment centers now, exclusively for juveniles, relying very heavily on our experience out there. We've learned an awful lot at that program. And I think we can, and I'm sure we know much better today than we did back in the late '70s when that program was developed.

SENATOR COSTA: What was the cost of the Chelsea Program?

ASSISTANT COMMISSIONER RUSSO: The Chelsea Program was treating-- I think we had about 50 beds, and it was running over a million dollars. Now that was a little costly because it was experimental. You have to realize that what we did at the shelter school is that we were licensed as a high school. We gave diplomas to youngsters who graduated from there. And all of the counselors in that system at the Chelsea school were also certified teachers. That was a very expensive thing.

If we were to develop now -- and we have plans for developing residential programs -- we would not provide that heavy a concentration of educational components, because the kids don't stay in there that long. So, we could we could do a lot better today in short 5- or 6-month stays, treating youngsters and working out the educational component in cooperation with local school districts.

SENATOR COSTA: What was the effective rate with that program?

ASSISTANT COMMISSIONER RUSSO: I'm sorry?

SENATOR COSTA: What was the effective rate of that program?

ASSISTANT COMMISSIONER RUSSO: In terms of success?

SENATOR COSTA: Yes.

ASSISTANT COMMISSIONER RUSSO: We had never been in the substance abuse field, and I've been candid with you legislators and with others every day when I've repeated this. We've run about a 25% success rate from day one.

Now, if you hear programs or individuals talk about 80% or 90% success, challenge them, because they may be talking about after an individual is in treatment for 10-months or a year, it is 80% or 90%. But if you start your success quotient from day-one, we have 25% that we successfully treat, but that is-- In 1968 and '69, we were lucky if we dealt with 8% or 9%.

So, we have significantly improved the quality of services. Most of the counselors that we have throughout the 80 treatment systems are master's level people, so we know a lot more than we did 10 or 12 years ago.

SENATOR COSTA: And the recidivism rate from that 25% is what? Or are they followed through?

ASSISTANT COMMISSIONER RUSSO: I'm sorry?

SENATOR COSTA: The recidivism rate of the 25%?

ASSISTANT COMMISSIONER RUSSO: Twenty-five percent of them are successfully treated--

SENATOR COSTA: Successfully treated? They never again--

ASSISTANT COMMISSIONER RUSSO: --which means about 75% generically would go back to substance abuse treatment, and hopefully, we will get them back into the system.

And many of the people -- the youngsters and our old folks -- who are in the 25% success, are repeaters. Now they may have come back through the system more than once, but we realize as social service treatment that this is the most difficult population that you have to deal with. And when the

Commissioner spoke of the MICA client -- the mentally ill, chemical abuser which is clogging up our system and which we need residential beds for, it's even more difficult to treat that youngster.

SENATOR COSTA: Thank you. Senator Brown?

SENATOR BROWN: Yes. A couple of questions. You give us the statistics with the usage of drugs among the young. Are the figures about the same as with other age groups in the population?

What I'm trying to get the answer to is that do you find more substance abuse or more drug abuse among the under-21 as opposed to the other statistics?

ASSISTANT COMMISSIONER RUSSO: No. We still see the most serious problem in the middle 20s.

SENATOR BROWN: In the middle 20s?

ASSISTANT COMMISSIONER RUSSO: The middle 20s is where the largest percentage of individuals who come for services are. In the twenties. But that's usually when they have been addicted or severely using drugs for a long period of time. So they are older. But most of the individuals who come in for treatment services in their adult years in the mid-20s, have been using drugs for eight or nine years.)

So, that's a long time to build up a life style, and it's very, very difficult-- In fact, when you get a 25 year old in for treatment for the first time, he actually -- if he has been on the street using drugs for 10 years -- he's a 15 year old. He may be 25 years old chronologically, but mentally, socially, sexually, and educationally he's a 15 year old.

And you don't rehabilitate that 25 year old, because he didn't know what it was like in the first place. You have to "habilitate" him. So, you start from ground zero. You take that 25 year old and you deal with him as a 15 year old. And you slowly build up that kind of system that you and I, in a normal growing up, went through.

But the average person who comes in for treatment has had a number of years of serious drug use, and that is why it is so critical for us to get to the youngsters early through the school system, through community organization groups, and through the National Federation and the State Federation for Parents for a Drug Free Youth.

There are a whole variety of community action groups that we have been developing that try to get the communities to help themselves. It's a "help communities help themselves" concept. Because, we know that the government, whether it's the State or the Federal government, will never solve this problem without strong community support.

We have to do what we can, but we need strong community support. And we've put a lot of effort in the last six or seven years in developing strong community support and to develop programs for prevention activities around the particular need in that community, whether it's the inner city of Newark, or Westfield, or where ever it may be.

SENATOR BROWN: Some of us as up here go back many years in dealing with this particular problem whether it's been at the local, county, or State level. Do you see the problem with the young people being much worse today than it was twenty years ago? How has this problem changed?

DEPUTY COMMISSIONER RUTLEDGE: You'd better speak to that, Dick.

ASSISTANT COMMISSIONER RUSSO: We see a bigger problem. But we have to realize that the report-in today is so much better than it was-- We didn't have the kinds of surveys that Dr. Rutledge mentioned 20 years ago. So, we weren't really identifying substance abusers. But, I think -- and I think we all agree -- that maybe 20 or 25 years ago, the major problem was probably in the inner cities in the low or high impacted areas.

And we know that since then, it has reached all portions of our society in all levels of our socioeconomic ladder. And none of us, you know, your children or my children, are immune from the problems of substance abuse. If we are fortunate enough parents to get our youngsters through that stage, we're lucky.

SENATOR BROWN: Well, do you think it's very difficult to expect the young to act differently toward drugs when there is such an abuse with drugs in all ages, whether it's the grandparents that are over medicated or the mother or father that are, you know, combining substances?

My last question is an organizational one. Here in New Jersey, we have always had responsibilities for mental health -- or at least since I knew anything about it. In the Department of Human Services, alcohol and drugs come under the responsibility of the Department of Health. Does this continuing division makes sense? In other words, if we -- say for the sake of argument -- brought the responsibilities from mental health in our mental health institutions into the Department of Health and therefore, had a coordinated approach, theoretically, towards these problems-- Obviously, many of your drug abusers have mental problems, or they wouldn't be on the drugs for starters.

DEPUTY COMMISSIONER RUTLEDGE: One of the problems with drug abusers, especially that we've seen throughout the day already by having the Commissioners Altman and Fauver testify, is a difficulty in coordination.

And the absolute essential component of coordination, and no matter where any of the different programs are, it's going to be up to our involvement to make sure it's a fine tune coordination. We've worked very closely already with Human Services and the Mental Health Division historically to try to make as smooth a coordinated effort as possible. Whenever anything is in one department, coordination at time is always

easier, but you may have problems then with not being able to get at some of the population as easily.

So, that was a round-the-way of saying, "Whichever situation it is, we'll be glad to work with it." And let me see if Dick Russo wants to--

ASSISTANT COMMISSIONER RUSSO: Well, I'm sure you've seen and we've seen programs within organizational structure, whether it's the Health Department or the ABC Agency -- multiple programs within that same organization don't cooperate very well.

I don't think it's an issue of whether Mental Health is in a different department, and as Commissioner Altman mentioned, we do have a very close working relationship, and we are-- We have memos of agreement and we're working out our details.

One of the significant problems in the alcohol and drug abuse field, and I think it's critical, is visibility. Now, the alcohol and drug abuse field back in the late '60s started nationally with the National Institute of Mental Health. It was a mental health problem.

And it wasn't until 92-255 in 1971 when it was split out as a separate entity, an alcohol institute and a drug institute, and of course there's a mental health institute. And it's since that time, that nationally and in New Jersey, we have made tremendous strides in providing services for alcohol abusers and drug abusers.

I don't think would have happened if it were all under one organization. Because mental health is a very serious problem, and yet it's a huge problem. It's a very, very expensive problem and I wouldn't want that particular problem, but drugs and alcohol are also serious problems.

So, there's an advantage in having visibility. And this is the very reason why the Federal government still maintains a separate institute for alcohol, a separate

institute for drug abuse, and a separate institute for mental health to maintain that visibility.

The other critical issue which has happened numerous times in the past, is when you combine them you reduce the bottom line. And that would be catastrophic.

SENATOR BROWN: But you could still be a division within the same part?

ASSISTANT COMMISSIONER RUSSO: Oh sure.

SENATOR COSTA: Senator DiFrancesco?

SENATOR DiFRANCESCO: I have a question that maybe he can give me an answer to. I have a statistic here that was given to me some months ago -- I guess by Sharon -- that in 1983 over 400 young people were sent out-of-State, mostly to Pennsylvania facilities. I assume that number at least remains constant for '84 or '85?

ASSISTANT COMMISSIONER RUSSO: Dr. Rutledge-- In our testimony, our estimates are up to 1500.

SENATOR DiFRANCESCO: Oh, he did say that?

ASSISTANT COMMISSIONER RUSSO: Yeah. It's an estimate, Senator, because we don't have a good, sophisticated--

SENATOR DiFRANCESCO: Okay, 1200 to 1500. This was first brought to my attention and also to Senator Brown's attention by a local school district in our general area, though not in our districts, about sending kids to Minnesota and all of that.

Who are the various people involved or what entities are involved in paying for this residential stay? For example: If a school district sends a child to Minnesota, does the school district pick up the tab? Is that accurate or not accurate?

ASSISTANT COMMISSIONER RUSSO: In some cases, most states -- some 34 states -- have very decent mandatory insurance legislation for substance abusers. We do not. We have had mandatory insurance legislation for alcohol abusers since 1977 in this State.

And that's why we have an excellent, I think, treatment system for alcohol abusers, primarily because, any company that writes for insurance -- hospitalization insurance, medical insurance -- has to cover alcohol abusers. In New Jersey, we do not afford the drug abuser that same option. There are bills in the Legislature right now--

SENATOR COSTA: Senator Orechio has a package of five.

ASSISTANT COMMISSIONER RUSSO: --Senator Orechio and Assemblyman Otlowski have five bills and that would rectify that, and would significantly stabilize the funding base for the treatment of substance abusers.

Our projection in the cost analysis is that your policy and my policy, and I'm sure all of us in this room have a policy to cover us for mental illness and other physical illness. Our projection is that it would cost us about \$2.50 each more per year in our policies to cover substance abusers.

And I had just read in the paper last night that the Department of Civil Service, as you probably read, has estimated that government employees who have serious drug abuse problems are costing over \$180 million a year in lost productivity. So, it's a cost-effective way of supporting--

SENATOR DiFRANCESCO: Well, is it then the individual that pays the cost of that treatment in Minnesota or Pennsylvania? And if the policy doesn't cover it, it's out of their pocket?

ASSISTANT COMMISSIONER RUSSO: The critical important thing, I think, and the negative aspect of sending one out-of-state -- and we've mentioned it already -- is there are two critical issues in treating substance abuse, particularly with juveniles. And that's getting the family involved with strong family therapy from day one and developing a good, strong aftercare program from day one.

And when you send the youngsters to Oshkosh or somewhere else, you do not have family therapy, and you do not have a network. That's the most critical point and

that's the reason why we have to have one in New Jersey if we are going to be serious about our young children. We have to develop residential programs in New Jersey so that we can involve the parents immediately, and we can begin to develop an aftercare system. So, when they finish their residential, they're not thrown back out to a community with no support services.

SENATOR COSTA: Only to start again. I see.

ASSISTANT COMMISSIONER RUSSO: They come back from out-of-state and most of them fail.

SENATOR COSTA: Thank you. Just one more question regarding crack. I understand -- Dr. Rutledge, perhaps you can enlighten me further -- that once someone takes crack, that it gets into the system within eight seconds. Is that correct?

DEPUTY COMMISSIONER RUTLEDGE: I don't know the exact second, but it very rapidly goes into the system. Since it is smoked, it gets into the system much more rapidly than any of the other drugs.

So, it's an immediate high or very large rush, evidently which is the reason that it's so appealing initially.

SENATOR COSTA: Would that mean that in the young body, which is where they are selling it -- in the schools to these young kids; eight, nine, ten years old -- in that young body, does that mean with that first inhalation of crack that they become addicted?

DEPUTY COMMISSIONER RUTLEDGE: I don't think that you can say with the first inhalation. They've shown that crack is much more addictive. That is, people can become addicted to it in a much shorter amount of time than someone that has been on heroine or regularly snorting coke. But with one inhalation, I don't think you want to say that they are addicted.

But, it's so appealing, that people use it much more than they would a comparable drug. And so within a couple of

weeks, in the studies that I've seen, people can become addicted. But one time using it, I don't think, would be addictive.

SENATOR COSTA: I understand that what they are doing is giving it to the children free so that they get hooked, and then, of course, there's the problem right there in the schools. I guess we'll address that when we get to the Department of Education. Thank you very much for being here.

ASSISTANT COMMISSIONER RUSSO: Thank you.

DEPUTY COMMISSIONER RUTLEDGE: Thank you for having us.

SENATOR COSTA: I'd like to call our next witness, Rory Sparrow, who is a New York Knickerbockers member, and President and spokesperson of the Rory Sparrow Foundation and the Foster Parents Association.

Thank you so much for being here. How's your ankle by the way?

R O R Y S P A R R O W : My ankle is fine, and I'm ready to play, and we'll have a good season this year, I hope, if Bernard and Billy come back and everything works out that way. All should be well. It should be a good year.

SENATOR COSTA: I commend you for your work.

MR. SPARROW: Thank you. Good morning Chairman Costa and Committee members. Before I get into my talk that Cary Alleyne, my Executive Director, has prepared for me, what I want to do is to preface my remarks by saying that basically I'm going to be talking about a philosophy of prevention. It may be repetitive in some instances to what some other people have said. But, instead of intervention and aftercare -- because, you know, we have a drug policy in the NBA and other things -- and what's becoming more and more aware and as they learn more and more of drug usage is that the aftercare, the intervention -- yes, you need those particular elements to help stem the tide, but prevention is where you should be directing your money and your energies.

When we get into talking about prevention, the thing that I've noticed in just listening to the people is that you're not identifying most of the pressures or the causes. When we deal with the drugs in the NBA or in a professional basketball league, you identify the pressures. You identify the problems that may lead a player to have a tendency to go towards drugs. Why does he do it? Because you look at life styles and you say, "Well, he should be relatively happy, because his needs are satisfied."

So basically, what I'm going to try to do is identify problems and pressures in youths from dealing with my youth organization, and also with just dealing on a day-to-day relationship with you. Then we're going to just suggest some changes in just those pressure areas that we see.

What I have come to understand is that young people are attracted to drugs and like substances, because in the final analysis or the bottom line, they don't have other alternatives for the use of their time. What I mean is that they don't have outlets that they want to be involved with that are available.

The key is that they want to become involved with it, whether or not we as adults agree with it. Hence, a quick, easy, cheap alternative becomes drugs, and while the scourge of teen-age substance abuse has become to infect the entire society, it is and has been, most acute in the urban slums and ghettos in America's inner cities. We must begin to look at the problem from its broadest scope and devise a plan to combat the problem in its entirety; not just a single problem like drugs.

Why again, do young people turn their attention to drugs? School, in their eyes, is not a means to an end. Consequently, you have a staggering school dropout rate reaching a rate of 50% of high school seniors in urban areas. At the other end of the spectrum, the suburban middle

class youngster has nothing to earn, they are given everything. Both strata have the same problem -- lack of incentive, lack of goals, and lack of initiative. Along comes an alternative to reality -- drugs, at best, offering a buffer to reality; at worst, a killer.

Values are completely distorted. The media with its vast array of information feeds us "Dynasty" and "The Colbys", hunger, deprivation, and starvation in Africa, revolution in Chile, and indescribable lunacy to get you to buy "Obsession" perfume. Is it hip to have sex at 14? Is it square to be a virgin at 18?

Minds that are in the molding stage no longer have a set of values to use or a model during growth and maturation. So where do you place your values? If we adults have a problem seeing through the maze, the confusion for young people can only be greater.

Parents today are spending excessive, albeit necessary -- and I believe this is the major problem -- time working. Economics demand that wives and mothers work in these times. It means less parental input in the child rearing process.

Young people, with all their energy, curiosity, and vigor are turned on to drugs for stimulation that should be coming from family, extended family, and community. But drugs don't stimulate; drugs sedate. What begins as a high or a rush turns out to be a sedative of the mind and spirit. Where they are lost, confused, lacking in esteem or motivation, they find consolation, if only for a few moments. In drugs, they can hide from the teacher who punishes them, from the parent who ignores them, from confusion from media, from failure, and from lack of direction.

Today it is easy, quick, and cheap to escape. The available drugs, most notable of which is crack, are potent and cheap and everything is available. Where is it all coming

from? I don't mean Colombia or Iran or Cuba or any other places they say they import them from. I mean what we have bred as a people, as a nation -- that for money one would import, sell, or distribute such products to their neighbors? A significant part of the problem is in our adults' attitudes and priorities.

For years, people such as Dave Winfield, Gary Carter, Nancy Reagan, myself, and others have cried out against the malicious killer. The problem of acceptance has not reached the turning point. The joint statement made by the President and Mrs. Reagan recently has brought home how critical the issue is, most especially where it involves our children.

This year I was asked by the New Jersey Foster Parents Association to be their spokesperson. I also sit on the Board of Directors of the Boys Choir of Harlem, Inner City Ensemble, Tigerball, Inc., Barnert Hospital, and I am President of the Rory Sparrow Foundation.

Everywhere I interface with youth organizations the solution is similar. If and when a child is given an alternative and direction, when shown leadership and guidance, when they are involved in life, their self-esteem is lifted and reinforced, and they don't have the time or desire for drugs. It is in keeping with the philosophy of my Foundation that if a person is endowed with strong self-esteem, motivation, and awareness, he or she has the inner strength to accomplish whatever their goals are and to say no to outside influences such as drugs.

We must attack the problem from many sides. One being our current educational system which was developed over 100 years ago. It must be changed -- overhauled. It worked well for an industrial age, but this is the information age and we must find the foresight, strength, and money to bring a new focus to the educational system for it to meet the needs of today and tomorrow.

The educational system needs to refocus from competitive learning to specialized, personalized learning. Flexibility should be given to young people by giving more attention to the interests of the young people and to give them the incentive. More pragmatic experience should be brought into the educational process.

More alternatives directed at and for young people should be available in media. In a sense, give them what they want. Anyone learns better when subject matter is fun and attractive. While overhauling the educational system may be a long-term process, we can begin immediately in another way that can have immediate measured effects.

That is through the extended family/community concept. As I've stated, when a person is involved and directed, he or she responds positively. In every community there are organizations which attempt to fill the voids in these young people's lives -- Boys Clubs, YMCAs, neighborhood youth organizations, scouts, Planned Parenthood, foster parents associations, after-school centers, and the list goes on and on.

These organizations, including the Rory Sparrow Foundation, especially in inner cities, create an alternative. What may just be a neighborhood basketball league to you or me, could be a life or death experience for a 12 year old who has nothing else through which he can build his self-esteem but that trophy from his local recreation center.

There are enumerable like programs that perform a clear, necessary purpose, but almost all have a common problem -- lack of funds. They cannot provide the manpower, the hours, or equipment to meet the demands, yet they are always asking for funds.

Heretofore it has been easy to say that these areas can always stand cutbacks; they are not vital. But, I submit to this Committee that we are witnessing the problem on our streets in the consumption of drugs. It would not be difficult

for me to line up program directors to testify, whose programs are suffering and have a clear need for help.

So I say to you, "Don't miss the trees for the forest." The solution is not simple, but the key is to redirect your focus, get out of the old patterns of thought, and see the solution before you. These are your children as well as mine who are at risk.

In closing, I want to bring forth two observations or thoughts: First, is that we learned through the poverty programs of the '60s and '70s that pouring money into programs with no clear goals is one for the conscience and is not a long-term cure. What I am suggesting is a cure process with the redirection of money and more importantly with spirit can cure our ills.

Secondly, is to make clear that the goal should be to develop a strong quality of self-esteem, self-awareness, and self-motivation, because it is self-esteem which ultimately will bring down and erase the need for the false realities of drugs and allow the young people affected to say, "No."

In essence, what we're trying to do is say that children need identity and through the various phases of their life right now, they're confused. They really don't have a good sense of direction of where they want to be, and so they can be easily influenced to get involved in drugs.

We advocate the use of community organizations to act as an extended family since the parents in most cases have to work to meet economic ends, to youth community organizations to redirect money and funds towards the organizations who can provide the moral support, the help, and the instruction and direction in a child's life to keep him away from drugs.

SENATOR COSTA: Thank you so much for appearing here. May I ask a personal question on what got you on drugs, and what motivated you to get off?

MR. SPARROW: I never was on drugs.

SENATOR COSTA: You weren't?

MR. SPARROW: No.

SENATOR COSTA: Oh, I thought you-- Well, I'm glad to hear that.

MR. SPARROW: In bringing up the priority of the NBA story, I've worked with developing a committee that helps identify that problem in the National Basketball Association.

SENATOR COSTA: You've seen it around you.

MR. SPARROW: Yes. I've seen it in close quarters, but no, I've never been involved and never had to come off of drugs.

SENATOR COSTA: Well, I'm pleased to see that, because you're speaking of role models and you are a role model for our children.

MR. SPARROW: Well, I try to be.

SENATOR COSTA: And I'm so glad that you are going around saying that you could be happy, you could lead a productive life, and not be on drugs.

Also, you touched on something that I think is very important, and that's the TV media and the movies. I think they have become role models of our youngsters and they see people drinking, on drugs, and high all the time; and that becomes to them the norm, especially when mommy and daddy have to be working and when they come home, that really doesn't look like a role model -- they're tired when they come home and everything. So that doesn't appeal to them.

I know in my efforts as a former Freeholder, what I did in the juvenile detention center was see to it that we had a farm for the kids to work in. When you're speaking of feeling good about yourself and learning something. I've always felt that if you work with the soil, that helps you to get a good identity on yourself -- a person who can make something grow.

These are the areas that, I think, you're addressing about having something for them to do. It's not only providing a fun time for kids; that's not what you are looking

at. It's something where they can feel productive. I'm still hoping one day we will be able to have a Girls' Town and a Boys' Town in the State of New Jersey. I think that would be very good. Senator Brown?

SENATOR BROWN: Yes. Congratulations on an excellent testimony that I think gets to the heart of the real problem out there. Following through on Senator Costa's line of questioning, work opportunities for our young people--

As a society, are we keeping many of our young, ineffective for too long? I mean, are we saying because they're under a certain age they're not capable of doing this? We look around and certainly you don't go by a gas station that doesn't need help. We don't go through a McDonalds that doesn't need help.

Is this an answer? Or should we be saying that the teen-age years are years for sports and for the school work and so on, and economic contribution should not be expected? Obviously, this is the philosophical question, but I was just wondering about your views.

MR. SPARROW: Well, it's sort of in line with what Senator Costa talked about, I think, as society and as civilization has progressed. We've had a tendency to lengthen the amount of time before you are out there in the work force and forming a sense of identity. Prior to that, you had to go to work on the farm or in the field to sustain life, and you had a sense of purpose at an early age.

And for a legislative body or government or anyone to dictate to the individual his rate of growth or how he perceives life and how he is to embrace life -- after grammar school you must go to high school, after high school you must go to college-- You set yourself up for a lot of failures because everybody doesn't have the same interest or can derive the same sense of identity to become those particular alternatives that you provide for them.

So, yes, I think that in terms of providing work experience, I think that's one of the key elements that you have to address. You have to provide a work environment so people can become involved and can go out and make money and have a sense of purpose and reason at a young age.

SENATOR COSTA: I go back to the years when we had the Conservation Core where young people who didn't have jobs joined the Conservation Core. They went out on farms and they did a lot of things: They learned to live outdoors; they got plenty of fresh air; there was discipline; they learned how to conduct themselves and their bodies -- to take care of it. I thought that was a marvelous thing, and maybe we should get back to that.

MR. SPARROW: I personally believe that we have to take a couple of steps back just to understand everything that is in society today and just slow our lives down and embrace it all before we go on further. I think that maybe we may have to go back to a little bit of a more rural life, as opposed to this urban, highly technical society that we embrace.

SENATOR COSTA: Even if we have to just take our children out of that environment for a while and just teach them the basics of survival.

MR. SPARROW: Very much so.

SENATOR COSTA: And I agree with you. I appreciate very much your coming here today.

MR. SPARROW: Thank you for inviting me. I appreciate it.

SENATOR COSTA: Thank you. Dennis Crowley, the Department of Law and Public Safety.

D E N N I S C R O W L E Y: Thank you Senator. I am Dennis Crowley, Director of Legislative Policy for the Attorney General's office and in the Department of Law and Public Safety.

On behalf of the Attorney General, let me extend to you his apology for not being able to meet with you this

morning. He had very much wanted to be here both because he is committed to this issue as well, and because he recognizes your long standing commitment to the need to identify and solve this problem for our society.

In terms of the problem, it's clear that we have one. And you are wise, as you are doing now, to begin your study of the problem by trying to determine as much as you can about the dimensions of the problem. The Attorney General, as Chairman of the Commission to Deter Criminal Activity, is involved in that same search for the dimensions of the problem.

I brought with me today Dr. Wayne Fisher, from the Department of Law and Public Safety's Criminal Justice Division. Dr. Fisher is the individual responsible for the creation and the implementation of the survey of drug use among school children that has been alluded to by several speakers prior to this.

We all thought that it would be also helpful to you as a Committee to hear from Dr. Fisher in some detail as to what the survey is, how long it's been conducted, and what it's yielding in terms of data; so that you can share that information just as the Commission to Deter Criminal Activity has shared that information at the beginning of your study.

So with that, let me introduce Dr. Fisher, who'll make a presentation to you based on the material that I've distributed to you -- it's the second of the two packets. It begins, "Drug and Alcohol Use Among New Jersey High School Students." That's a compilation of pages selected from a larger report. So the numbering sequence is not going to be strict. However, it's going to be informative. Dr. Fisher?

D R. W A Y N E F I S H E R: Senators, thank you.

SENATOR COSTA: How up-to-date is your data, Doctor?

DR. FISHER: Right now it's not up-to-date. The survey has been done twice. The project was a cooperative effort. It continues to be with not only this Department, but with the Departments of Education and Health as well.

The first survey was undertaken six years ago in 1980; the second in 1983. And being done in three year cycles, we are prepared now for next month to administer it for the third time. So, we speak at a time when the data is as aged as it can be and as outdated as can be.

Nonetheless, I don't think that that renders that data any less thought provoking or any less alarming in some respects, than it might be if it were up-to-date. Dennis said in considerable detail, that I always speak in moderate to light detail because, as you'll notice, there are many, many pages to it; not only to what you have, but to the report of the research project itself.

The research project, which has been going on for six years, is a rather extensive one which involves a carefully selected sample of 34 public high schools in New Jersey and involves the participation of over 2000 high school students each time it's administered. The sample was put together in order to generate for us in the participating departments and for anyone else as well, accurate information concerning -- at least on a statewide level and on a regional levels as well -- the extent of the problem.

Generally, the survey tries to cover two areas. Number one: it seeks to give us, as I mentioned, very detailed information about the scope or the range of the problems -- something which you, Senator, mentioned in your opening remarks. We ask in that section questions about what types of drugs are used by how many people, how much, and what combination are the substances -- questions of that nature.

The second major objective of the survey was to give us or to generate useful information concerning the attitudes or beliefs that our high school students have, regarding the use of chemical substances. We asked questions here about the time and occasion on which they used these substances, how available believe they believe the various substances are, what

are their perceptions concerning the harmful consequences of substance use, and perhaps most importantly, we asked a series of items concerning those factors which students feel might prevent them either from initiating their use on an experimental basis, or might persuade them from continued use once experimentation has begun.

With regard to the first portion of the survey or the one which goes after information concerning the scope or the problem: We try to measure the use of a number of different substances in three ways. We measure use with regard to how many times in one's life, a drug or alcohol has been used, how many times in the past year, and how many times in the past thirty days. The purpose here is to enable us to distinguish between those users who only experiment, those users in our high schools who go on to use it continually, and finally those who become habitual users of the various substances.

If you can just turn quickly to the second page to the addendum to the testimony, you see information about the lifetime prevalence of 12 substances which we mentioned. From alcohol which is used by virtually everyone down through heroin in which use is reported by just between 2% or 3% of high school students. The numbers, I think speak for themselves.

Beyond the numbers, though, it's important for us to get an idea of what research of this type tells us and I think it can be done very simply by looking at this chart. (Speaker displays chart) If we were to forget for one moment alcohol at the top of the chart and to focus only on illicit drugs which are contained in the chart that you have in front of you, what we find is about two-thirds -- about two out of every three of your high school students report that they have used one of these drugs at one time in their lives -- two-thirds.

Even if we strike marijuana from this chart -- marijuana is considered by some a lighter drug of, at least, a varying consequent from some of the other substances-- If we

were to strike marijuana, you will still find that almost half -- 46% -- almost half, report having used an illicit drug on this chart other than marijuana sometime in their life.

Beyond the obvious conclusion of the magnitude of the problem, which may be the initially the most formidable obstacle of any response that we may have to it, what did and what does this tell us? In 1980 when we first did this survey, it was evident to many from the survey that we needed to progress past the point of believing that the use of drugs was located only in certain schools and only in certain areas of our State, and this was five or six years ago when the survey was first done.

The results of this survey, when examined by region of the State, make it clear -- as well as by-- I should mention that when the sample schools are collected, they are collected in such a way that we can learn something about the north verses the central verses the southern parts of the State, and they're collected in such a fashion, that we can make some generalizations concerning the socioeconomical levels of districts involved in the study.

What we found is that the problem is not in fact, or what we found both times in the survey, is that the problem was not in fact relegated only to certain schools in certain areas. The problem was of very similar magnitude with only differences in detail as one goes from region to region throughout the State.

What we know after a second administration, is that within these schools virtually no student has the luxury of avoiding a very personal decision regarding substance abuse. With reported use to the extent that we have evidence in these surveys, the mandate for prevention, I think becomes very clear. The goal of prevention in this area is not to seek to avoid the serious consequences to a small portion of the students in our schools. But rather the goal or the mandate to

prevention is that it must direct itself to every single student, because if students report use in this number, then what the message should be very clearly is that virtually every student has had to individually make the decision regarding whether or not they're going to use substances, whether it be experimentally or on a continual basis.

Another series of questions we asked in the survey which I think further makes clear the importance of prevention in this area is that student were asked questions about their perception of the availability of the number of drug substances. What we found was that virtually everybody felt that alcohol and marijuana were very easily accessible.

Similarly, we found about half -- slightly more, slightly less -- saying the same thing that they were either easy to obtain or very easy to obtain with a number of other drug substances including barbiturates, tranquilizers, cocaine, amphetamines, and the like. Perhaps most alarming was that both three and six years ago, over one-quarter, about 28% of the high school students reported that they would have little or no difficulty in obtaining heroin if they so desired.

When this is compared with the rate of youth between 2% and 3% one sees that the potential for increase in this problem area specifically, between the proportion of who actually use it and the numbers who say that it's available is indeed large. The same was true for the rest of the substances that we asked about.

If this then is clear as to who must be targeted in prevention areas, I think the next logical question is, "When must the prevention start?" Also in the handout that you have, toward the back-- The page that's number 63 -- it's about the eighth page on the one that you have -- are some results concerning reported first use of a variety of drug

substances by the students in this sample. What has been done here, is to ask students to report the grade that they were in when they first used any of the substances listed down the left hand margin of the chart in front of you.

Reading across, we then have reports of the percent who began use before seventh grade, in seventh or eighth grade, in ninth grade, and then we add up all of those to come up with the total of students who report using the drug substance before 10th grade -- before they enter the confines of this survey or perhaps before they enter high school -- should it be a 10th through 12th high school.

What is important to note here is that for every substance that we sought to measure, with the exception of cocaine -- that's a very important exception -- of all the students who report ever having used the substance, more than half of them did so before they got to 10th grade. Cocaine is the substance which appears to be dissimilar in this respect. It appears that at least in 1983 and in 1980 as well, in fact, at least during that period of time, the onset of cocaine use beginning or experimental use of that drug relative to other substances occurred considerably later.

Now shifting back to the other substances, then the message is again clear. Not only can we not wait until high school to begin prevention efforts, but it appears as though waiting until seventh grade is too late as well. It appears from the data where 6% or 7% have already used marijuana, 2% to 3% a number of other substances -- and this is before seventh grade -- that preparation for these individual decisions concerning substance abuse must be begun before the seventh, and clearly must be begun long before students enter high school.

The final highlight that I would point out, is on the back page because it relates directly to some testimony already regarding the importance of families and family units

in this whole process. Series of questions are asked on the survey concerning factors that might prevent students from using drugs, what might persuade them from continuing their use, and also a series of questions are asked regarding what kind of trouble these student have gotten into, what criticism they have been the subject of as a result of their use of various substances.

Information of this nature can be quite useful in designing strategies for the preventive message that we know must be delivered. We'd certainly like to gear those messages to those areas which bear the highest probability for some success in terms of the prevention involved. Information like this can point out to us just such potential areas.

If you'll note that on the page that you have that's numbered 113, a clear majority-- About 60% of the students report that parental disapproval would prevent them from using drugs or marijuana or other drug substances -- about three out every five. Considerably later in the survey, we then asked these questions about with whom have you gotten into trouble or received criticism from, for using drugs? What we find is that looking at just those students who have used drugs or marijuana, only 15% report that they have been subjected to parental disapproval or criticism.

Well, I think you'll agree that the gap between the 60% that it might make a difference and the 15% that report that in fact that this attention has been paid or this criticism disapproval has been received from parents, is considerable. I point this out as only one area, but certainly an area in which I think a potential avenue of increasing preventive activities is quite evident.

Let me stop there because that just highlights some of the findings, and I think that brushes through what you have here. And let me repeat that the third administration survey will take place next month and we hope by the beginning of the next calendar year to have results on that.

SENATOR BROWN: We appreciate very much you taking the time to come here. Are there any questions?

MR. CROWLEY: I just want to close by saying that I've given you copies of the statement from the Attorney General and he would be most eager to meet with you at a future meeting to continue this dialogue, if that's possible.

SENATOR BROWN: Thank you very much. We appreciate that. I think maybe it is pertinent to have the New Jersey Parent Teachers Association, Jean Socolowski come and testify next so that this will follow well.

P H Y L L I S S C H E P S: Good morning. My name is Phyllis Scheps. I'm with New Jersey PTA. I think Jean has a little difficulty with her throat, and I would like to do the testifying, if it's okay.

I would like very much to say that I am proud to be here today representing New Jersey PTA -- New Jersey's oldest and largest child advocacy organization with some 215,000 members. We do appreciate the opportunity to testify on this important issue.

I'm going to confine our testimony to specific recommendations. The corroboration and rationale for these recommendations are based on information and experience of our membership and officers and the data and findings contained in the New Jersey's Action Plan for Children and the report of the Governor's Committee on Children's Services Planning. Please know that we urge the inclusion of a strong evaluation component for all of the following recommendations.

New Jersey must develop a broad continuum of care and services for substance abusing and/or addicted young people. We recognize that treatment for alcohol related problems differs from drug related problems, but we are not discussing treatment modalities. Therefore, when discussing the need for treatment facilities and the enactment of appropriate

legislation and the adoption of rules and regulations appropriate to dealing with treatment, we mean regardless of the substance abused.

The continuum of care which must be created must include an adequate number of residential, outpatient, and aftercare facilities. New Jersey's children should not have to go out-of-state to receive the kind of treatment they need. Nor should their treatment be sabotaged because there are not enough or appropriate aftercare programs in our State.

The use of programs and services should be based on the mode which is least intrusive, yet appropriate for the individual. Proposals, such as S-794 sponsored by Senator Donald DiFrancesco, would do much to begin the development of a network of care so badly needed in New Jersey.

A key to the establishment of an adequate number of treatment facilities and programs is the enactment of legislation that requires private carriers to ensure coverage for treatment of all substance abuse problems regardless of the substance abused or the age of the abuser.

Currently, New Jersey's private carriers only cover treatment for alcoholism. If coverage were extended to include treatment for all substances abused, a fiscal base adequate to stimulate the creation of treatment facilities could be provided.

The lack of a secure financial base has been one of the most significant barriers to the development of an adequate number and type of treatment facilities and programs. There is certainly not enough money in the public coffers to provide such a base, and families cannot afford the after tax expenditure of \$1800 to \$3000 per week for residential treatment.

While the cost of day treatment is significantly less, most families cannot afford extended outpatient treatment without insurance coverage. And it is extended treatment that is required for drug abusing young people.

Existing Medicaid provisions must be amended so that coverage for treatment of substance abuse problems can be provided at any recognized treatment program whether classified as a hospital or free standing treatment facility. It is unfortunate that the alcohol demonstration projects were terminated. These projects had been extremely successful and we are disturbed that they were terminated and that New Jersey did not request a waiver to continue them.

It is essential that insurance coverage for both alcohol and drug related problems be offered by both the private insurance carriers and Medicaid. We cannot successfully address the treatment of substance abuse if we limit access to appropriate treatment based on ability to pay.

Minimum program requirements must be established for the regulation of substance abuse treatment programs for youth. Insurance carriers must not be allowed to shape treatment programs by determining which services will or will not be covered.

Coverage and rate setting for treatment programs for youth should be separate from adult substance abuse coverage and rate setting. New Jersey should develop rules and regulations for licensing substance abuse treatment facilities.

The Division of Alcoholism and the Division of Drug Abuse should be merged into one division with regard to programs and services for children and youth. Substance abuse in young children and the response to it must be a coordinated effort. Fragmentation of services and divergent philosophies is at best an inefficient situation and it does not maximize State resources.

Additionally, poly-abuse and addiction are now the rule rather than the exception. Separate divisions are, therefore, no longer appropriate given the nature of the problems.

New Jersey should seek the inclusion of substance abuse training in the licensing requirements and require in-service training for those already licensed, such as physicians, nurses, paramedics, social workers, mental health professionals, educators, police, judiciary, court intake staff, and probation officers. New Jersey must facilitate the inclusion of substance abuse counselors in New Jersey's state school districts.

Appropriate training must be developed to ensure that substance abuse counselors have adequate training in both alcohol and drug abuse as well as counseling skills. Certification requirements should reflect such training.

The Department of Education must provide a mechanism that facilitates the entry of substance abuse counselors into the school system. The Department of Health and the Department of Education would work together to establish guidelines for the educational materials used and distributed in schools. All educational materials must be scrutinized for subtle "do drugs" messages, as well as references to responsible use.

Our youth cannot make a responsible decision to use alcohol when non-use is the only legal decision available to them. All educational materials must clearly state that it is against the law for anyone underaged to drink, or for anyone to use drugs not prescribed by a licensed physician. In addition, a mechanism should be established for the continuing evaluation and revision of materials and distinguishing between reliable and unreliable sources of educational materials.

Alcohol and drug education is often sporadic and haphazard. The ultimate goal must be how to make decisions; not about whether to drink or not, or use drugs or not; but how to say, "No." Curriculum must not contain mixed messages. For example, when students hear, "Don't drink and drive," they often come away with the message that it's okay to drink as long as you don't drive.

I'm just going to deviate from the testimony for a while. There are currently two such programs that have proliferated in our State that give this message to your underaged youth, starting at age 15. It's a safe ride program and these parent contract programs. It says, "It's okay to drink as long as you don't drive." This is confusing to our children.

And all the other testimonies that we're talking about here-- I'm hearing, "What do we need to do to educate our children?" If we don't come out with a consistent clear message, then we're just wasting our time and wasting our money and all of us are sitting here are wasting our time making recommendations.

We do have programs that we think are positive programs, for example, one of them is called "Safe Homes." This is a program which has been pushed and endorsed strongly by the New Jersey PTA. It's a simple program. Parents simply have to sign a pledge that they will not serve or allow alcohol or drugs to be served at their home, and are going to do everything in their power to be there to chaperon their youngsters at the appropriate time.

What we also need is a program that has more than good intentions. In addition to the Safe Homes, there are programs that are known as the "Teen Institute," there are programs that are called "Youth to Youth," and once again, back to the "Just Say No" programs.

New Jersey must enact legislation that would make it illegal to serve or sell alcohol beverages to underaged youth. Currently, I know it surprises some people, but serving alcohol beverages to underaged youth is prohibited only on public property. It's not prohibited on private property.

Oftentimes during prom season and many weekends our young children -- our kids -- are smart enough that they go out and rent motel and hotel rooms. And when they're having parties and there is a ruckus going on and the police are

called, we can not do anything to charge these youngsters. Now it's not a matter of wanting to take them and putting them in jail, but I think that they have to pay a penalty, and it was one of the oversights when we did pass the drinking age of 21.

Currently, the New Jersey PTA and a few groups are working with Senator Graves on his bill S-2224, and this will hopefully close that loophole. So, it's just one more loophole that we've learned about as we've progressed that we want to close up.

New Jersey should adopt legislation similar to a law recently enacted in Maine. Under the Maine statute, drivers under the legal drinking age who register a breathalyzer reading of .02, lose their driving privileges for one year. And sometimes people say, "Gee, how can you take their license away for one year?" We have to let them know that we're serious.

So, this is not legislation that's even pending now, but it's something that I think we should consider. Also, consideration should be given to administrative revocation of the license of your young people who are caught drinking and driving.

The County Alcohol Councils should be expanded to include substance abuse in general. Their work should be coordinated with every community within their jurisdiction. These councils should assist all communities with expertise and resources. Such councils should coordinate their activities with the County Human Service Coalitions in order to prevent duplication of services and inefficient use of public resources.

Coordination should strive to achieve parity of program and services between communities. Their charge should be to maximize the use of public resources as translated into public programs and services.

The Department of Education must ensure that school districts develop suspension and exclusion policies that promote the best interest of the students. The need for

suspension or exclusion from the general school population should trigger the need for evaluation by the district's substance abuse counselor.

In closing, we urge that New Jersey must be careful to fund both treatment and prevention. If we continue to prioritize our funding toward treatment, we will do nothing to reduce the need for those treatment services. We submit to you that this is fiscally and morally irresponsible.

Substance abuse is a terrifying epidemic. There are no easy answers and no magic bullets. And I'm going to tell you this, we're all very scared and very angry. We're looking to you, our government, for leadership. We hope in striving to adopt appropriate responses to this issue, that you will reach out to form a partnership with the community that you were elected to serve so that we may work together to develop the solutions.

And once again, I will just close by saying the philosophy of our New Jersey PTA for our youth is that it is necessary that we all concur with one voice and one message, "No use." And I thank you very much for your time.

SENATOR COSTA: Thank you very much. Any questions?

SENATOR BROWN: Thank you very much, Phyllis. We appreciate you taking the time to testify. We went out of order on purpose Madam Chairman, because we had had two groups testify about the challenges facing parents in this whole area of drug abuse; and needless to say, you are the Parent Teacher Association. There have been, again, two observations that 1): Parents are not coming with the disciplinary role that they should play which we just heard about, and the second thing is this whole role of families.

What is your organization doing at the grass roots level to strengthen the role of parents?

MS. SCHEPS: We do have various chairmanships on the State level. We have chairmanships of parenting groups. We

have a very, very competent young lady who just became the president of the Morris County league.

But, we do have very adequate programs. We have seminars and workshops throughout the State several times a year through our own legislative bulletin and through our own "New Jersey PTA Magazine." We are constantly sending out information to 215,000 members about how they can even obtain further more specific information on the various parenting programs.

In other words, as we progress through each year-- Coming this next October, we're having our annual convention. We have many, many good seminars and workshops that will encourage parents from all over the state to come in and learn about parenting.

But once again, going back to the basic thing that I was trying to say and the basic message that I'd been trying to give out: parents can do their job, but if we're getting a message from the schools and if they're not getting the right education message from the schools, it can be very, very confusing, and we see forces, you know, that are really working opposite against each other.

SENATOR BROWN: But I would like to stress that the other thing is also true; that if the schools are giving one message, with all due respects, and they go home and there's not the support from parents, whether it's a male parent or a female parent or both, that's a problem too.

J E A N S O C O L O W S K I: Let me see if I can help answer for a minute too. Probably the first thing that we needed to address is the change in the adult population and those who care for our children -- and we understand that the term "parent" may mean a variety of things.

And it certainly has not been the resolve of the adult population to keep children from drugs, especially when many are using them themselves. And they are setting an example. Children take our world literally. They don't have the ability

to see the differences in the messages that are being given to them. And if their idols -- and frequently, they are on the athletic field, on television, and on the movies -- are showing them one pattern; the guardian in the home is often not as acceptable to them as a model as the people they are watching.

And the gentleman here from the Health Department said already that the children say it's peer pressure in 99% of the cases that causes them to use a substance which they have been told is not good for them.

So we start with that premise and then we work to keep the children out of things. We've brought into this State the Child Assault Prevention Program which has been so graciously accepted by everyone, and that is where we will work with the children rather than with those who care for them.

SENATOR BROWN: Just one last thing on behalf of parents. It is the parent or the parents who has given the child self-confidence at the age six months or a year or whatever, who is in the stronger position to resist the peer pressure. So, I guess the thrust that I'm saying to representatives of Parent Teachers Association is, "Bravo" and support the parents.

SENATOR COSTA: I'd like to ask what is your attendance at PTA meeting? Do many parents come out? Do they show an interest?

MS. SCHEPS: Yes. Well, it depends on the individual community, obviously. In a town of West Orange, we happen to have 12 schools and all have PTAs. When they have their PTA meetings, in other words, you get a respectable turnout. I'm not going to say that you get 200 or 300 people coming out. When the subject is alcohol and drugs, we do get a higher turnout, to be honest with you. But when it's repeated each year, sometime the membership does fall off. They are perhaps looking for new areas.

One of the problems that you have heard here is that parents are working, and when they put in an eight hour day, it is a little difficult at night to come out and hear the kind of things that they should be hearing. So, we're living, as Jean said, in different times now. But we continue, frankly, to have the PTA meetings on local levels as well as county and State. We are constantly sending out messages, networking with other organizations, and I think that we're doing as much as any organization possibly can to correct the situation.

MS. SOCOLOWSKI: We worked with chemical people, with Mrs. Reagan, and we will work again with chemical people number two which will be coming out after the first of the year. This will be the third year in 1987 that the national PTA's Drug and Alcohol Abuse Week-- Those kits were ordered and sent out to more than 10,000 local units and interested parties across the country. The supply was completely gone and unfortunately, we had no more money to reprint.

So the message is out, and as Phyllis said that it's one of cooperation. When the media, you, the Federal government, and everybody works together, we seem to be able to work much better than when it's just one voice in the dark.

SENATOR COSTA: Thank you so much for being here. We appreciate it. Mr. Phillip Brown, Division of General Academic Education, the Department of Education.

MS. SCHEPS: Could I just say one more thing before Mr. Brown takes my head off publicly? We are working together with the Department of Education and I also served on our State's Drunk Driving Commission, and we are making efforts to upgrade the alcohol and drug reputation information with the one consistent message.

SENATOR COSTA: Thank you.

PHILLIP BROWN: Senator Costa, other members of the Committee on Children's Services, I'm pleased to be here this

morning representing Commissioner Cooperman in the Department of Education.

I want to focus my testimony on the causes of substance abuse among young people -- that's, obviously, something very important in gaining an adequate understanding of what we're trying to combat -- and then focus on the roles of schools in the Department of Education in the prevention arena which is obviously an arena that the schools have a strong obligation in.

First of all, in terms of context, I think it's important to look historically, even for a minute, because the problems that we're dealing with are not new. For example, opium addiction was associated with both the Civil War and the Vietnam War, cocaine dependency was common in the early 1900s when it was common to use it for medicinal purposes, and it's a problem in the 1980s as a recreational drug.

Alcohol use has been a source of problems from the colonial period through prohibition to now. It's really only been during the last 20 years approximately that drug and alcohol abuse among school age children has been one of the most prominent and troublesome signs of the changing face of American society.

A couple of other people who have testified have made reference to that. There's one way of looking at that, to me. It needs to be reinforced in terms of the changing face of American society. In the course of the last 30 years, the face of American society has changed this way:

In 1955, about 60% of American families were characterized by what we might think of as the Norman Rockwell image of the American family -- a father who works, a mother who stays home and raises the children, the children who share a common household. Only 30 years later, by 1985, the 60% figure is down to 7% of American families that share that kind of portrait. And of course, what that means is that schools get

in their doors what society produces in terms of its characteristics of the families and the children. And I think we're all struggling -- all institutions are struggling to deal with this common change.

In New Jersey there have been four themes that I would like to identify that have reoccurred consistently since the late 1960s, and to me, would define the context in which the Department operates in this area.

First of all, awareness building. There's been a growing awareness of the epidemic proportion of the problem on the part of the media, the public, the Legislature, both Federal and the State, which is committed, I think recently in the attention that we've seen.

Unfortunately, frequently this awareness has been focused on a particular drug, such as marijuana, PCP, or cocaine, in lieu of a comprehensive approach to the problem which would reflect longer range planning in the commitment which I think we need if we're really going to make a difference in the long run.

The second thing I think has recurred is our attempt to understand the problem. There's been an effort by the government social scientists and practitioners to attempt to determine the actual extent and nature of the problem and to establish responsibility for its cause and amelioration.

Because of the frustration often involved in understanding and dealing with the complexity of the substance abuse problem, institutions, including schools, law enforcement, and parents, have all been blamed for not doing enough. And attempts to evaluate the effectiveness of our efforts to combat the problems has been generally inadequate.

This is particularly important, I think when you compare the level of funding that's going to an area of research, such as cardiovascular disease. And some of the strides that we've made in recent years are directly

attributable to the research effort that has been going on for a period of years. That same level of effort has simply never occurred in this area.

Third: policy initiation. The Federal and State legislative initiatives and court decisions which mandated specific responses from the education establishment have had a real and meaningful impact on encouraging the adoption of sound policies, procedures and instructions, but had failed to address the issue comprehensively.

And an example of this which I think you might find interesting in New Jersey is the existence of separate drug and alcohol constituencies which, in my view, fostered separate statutes, and made local school board policy formation cumbersome and difficult.

For example, for the first time the State Board has just passed a few weeks ago an Administrative Code dealing with what a school district's responsibilities are, regarding procedures and policies for evaluating and treating school students. And that code, of course, is based on statutes.

The difficulty is that if you are a principal in a school that has that code in front of you, you must follow one procedure if a student is suspected of being under the influence of alcohol, and a different procedure, if the student is suspected of being under the influence of drugs other than alcohol.

In fact, of course, the principal would be ill-advised to presume that he or she knows what drugs might be influencing a student's behavior, but the distinct procedures are necessary in the Department's Code because of the existing statutes which are separate and distinct for drugs and alcohol.

The fourth theme which I think you also heard reiterated this morning, is the attempts of interagency cooperation and collaboration. You've heard Dick Russo mention the interagency agreement which has been going on for more than

seven years with the Department of Health which is really the foundation for what the Department is doing in the way of preventive education. But these efforts have also suffered from the lack of sufficient resources and inconsistent planning over a period of time.

I want to go back to the second theme that I identified -- the causes, and look at some of the research, that you might find interesting, that has gone on and is beginning to bear fruit now in terms of the longitudinal studies that follow kids over a period of time and look at what factors seems to be involved when the kids become involved in drugs.

And the following 11 factors summerize this research. First of all, it's important that you understand that these should be viewed as risk factors. These are all factors which the more any of these are present in any individual child or family, the more likely that child will subsequently become destructively involved with alcohol or other drugs.

First a family history of alcoholism. The presence of an alcoholic family members doubles the risk that the child will have a problem with alcohol or other drugs.

Second: a family history of criminality or anti-social behavior.

Third: family management problems. And the interesting finding here is that both families that have a laissez faire or permissive attitude and families that have a very restricted repunitive (sic) atmosphere in terms of how they manage their children-- Both of these management styles are risky in terms of kids later becoming dependent on drugs or alcohol.

Fourth: early anti-social behavior and hyperactivity in school. A consistent relationship has been found between such disorders as aggression and shyness in early elementary school and later drug use.

Fifth: parental drug use and positive attitudes on the part of parents towards use which Phyllis Scheps and Jean Socolowski have mentioned. This is a very important factor.

Sixth, and I think this may be news to you and it's a very interesting finding -- academic failure. It is low and failing grades in mid to late elementary schools by themselves independently increase the use of latter adolescence drug use.

Seventh: a low or little commitment to school on the part of the parents and/or the children. Students who are not committed to educational pursuits are more likely to engage in drug use.

Eighth: the alienation and rebelliousness and lack of social bondings to society. By middle or junior high school, students who do not adhere to dominant values of society and who rebel against authority, particularly parents and school officials, and have low religiosity, tend to be at higher risk for drug abuse than those who are bonded to those institutions.

Ninth: friends who use drugs. Association of friends using drugs during adolescence is among the strongest predictors of adolescent drug use. The evidence is clear that initiation into drug use happens most frequently through most friends.

Tenth: favorable attitude towards drugs. This sounds like something that's self-evident but, it's important to hear because what it tells us is that if kids have attitudes that are likely to predispose them towards use, they will use it. It's not just a matter of, "If I had the chance, I might." If a child says that he or she is likely to use it in a situation, they are using it.

And last, and in some ways the most important in terms of directing where our efforts should be, early first use of drugs. Alcohol and other drugs abusers tend to begin their use of the gateway drugs -- cigarette, alcohol, and marijuana -- at an early age.

Early initiation into drug use increases the use of extensive and persistent involvement in the use of other drugs later on. The onset of alcohol or other drug use prior to age 15, is an especially consistent predictor of later drug use. Initiation of drug use after the age of 18 significantly lowers of the risk for subsequent use and the use of multiple substance.

So, the context of these themes in this information is what is the role that the Department of Education should have in fulfilling our obligation to help prevent drug and alcohol abuse. I wanted to identify three themes for you which, to me, have a number of components, but I'll address the broad themes right now.

First of all, the school should provide sustained current instruction in drug and alcohol abuse prevention in the context of a comprehensive health education program. The ideal drug and alcohol curriculum emphasizes developmentally appropriate knowledge and skill acquisition from kindergarten through 12th grade in the areas of information, decision making, and coping skills. They should be nested in the comprehensive health education structure.

Current statutes are explicit regarding the minimum level of effort required for drug education at the secondary level, but less prescriptive regarding the requirements of the elementary grades. In that regard, I want to mention that we are collaborating with Senator Gagliano in a bill that would attempt to address that deficit.

Secondly, the school should provide intervention services based on a consistently administered school district policy structure. Schools should simply be drug-free zones. We're not going to stop drug use by pushing drugs out of the school, but it's very important that we send the message that this predominant institution of socialization is not a place

where kids can use the drugs and get away with it. And at the same time we're able to offer help for kids that have that type of problems.

If this job is well done, and policies effectively administered more students who are abusing alcohol and other drugs will be identified and helped. In Ocean County, for example, the number of students who were identified for assistance between 1984 and 1985 increased from more than 700 to more than 1200 because adequate intervention centers were in place.

Third, the schools have to be capable of responding with information, training, and assistance when new issues or crisis of program intervention come about. The Department bears a special responsibility in assisting the school districts in that regard.

There are a number of things that we have been doing, and are doing, and are planning to do. To leave time for your questions, let me just mention two of the most recent, and to me, the most important measures that we have taken.

The first I've already mentioned which is for the first time, we have an Administrative Code on drugs and alcohol. The second occurred last March, when the State Board adopted for the first time a State plan for the prevention of drug and alcohol abuse. The plan is essentially a blueprint for Department activities for the next couple of years, and the first item on that plan was the code that was then passed September 3rd.

In summary then, drug and alcohol abuse are health compromising behaviors with both developmental and social roots. Clear social norms and sustained educational efforts at home, at school, and through the media have proved successful in modifying specific aspects of this cluster of behavior in the cases of marijuana use and drunk driving.

Something no one has mentioned is that the one positive note has been the decrease between 1978 when marijuana

use peaked and the year before last when it reached its significant level of decline. And the surveys, including the one we cooperated on with Law and Safety, have indicated the most significant factor in adolescents' reports on why that use has decreased, is their perception of its harmfulness.

So, this doesn't mean that we're going to get to all the kids through educational messages, but it is encouraging that for a certain group of kids, adequate education can make a difference in lessening their use.

The Department of Education welcomes the interest that your Committee is showing by having this hearing. We look forward to working with you and other governmental agencies in a renewed commitment to reducing the consequences of alcohol and drug abuse. I'll be happy to respond to any questions that you may have.

SENATOR COSTA: Thank you very much. I'll probably make everybody angry at me for what I'm going to say, but I really don't think that churches and schools are really doing the job they could be doing to help all kids.

First of all, our society is changing, yet we still maintain a nint to three school system, or whatever it is. Now, I think that should change too. Most of what we hear is that kids don't have anything to do, and that's how they get into trouble.

Well, we have buildings that stay vacant for a large part of the day. You have the latchkey kids. You can take care of that problem by keeping them there after school. Physical education -- you're right there. You should be getting them used to that. Homework -- why wait until they get home where they're not going to do it? You've got the schools there. Let them do it there where they can get the access to some help that they need in doing their homework. I think that we're missing the boat.

I really think that they should have crafts. They should have music taught. Kids that learn an instrument -- they can lose themselves in playing an instrument. And in artwork too you can get lost -- and in painting.

These things should be available to our children and I think the Department of Education has to change its thinking as far as "nine to three" and that's it -- that's school. The schools have to be -- as well as the churches -- have to be the focal point of the community. Our society has changed; parents have to work; both parents have to work. It's not that there's a mother home that's going to watch the kids when they get home, and society has to change its way of doing things.

I really hope that you can get that back throughout the Department of Education. Maybe they can come up with something that's constructive where we're utilizing the schools at the utmost capacity and we're really keeping the kids off the street and teaching them about drug abuse, and alcohol abuse, etc. You can have the movies there. If they're not doing sports and if they're not doing arts and crafts, they can be watching a movie.

Anything just to keep them busy and growing and learning in a healthy atmosphere. That's my attempt. Senator Brown?

SENATOR BROWN: I am appalled that in 1986 we're talking about making schools drug-free zones, considering this has been a problem for many, many years and this is still going on. Can you give me specifics about how you're going to fulfill this objective of making schools drug-free zones?

I would rather have my child at home in the neighborhood to follow through on what Senator Costa is saying than in a school that wasn't a drug-free zone. You know, I do think that having the neighborhood enlarge upon the resources

out there is a very buyable alternative -- having been a latchkey myself.

MR. BROWN: First let me tell you how bad the problem is, if you haven't already understood it completely. And this comes Dr. Fisher's data as well, of students -- and we're talking about something like 46% of high school students -- report that they've used marijuana. Of that 46, more than half said that they had used marijuana while at school at some point.

SENATOR BROWN: Let me just tell you-- Can I interject for a moment? Because in my district they're talking about children smoking on school buses. You know, this has gone round and round and round and round. To me it's very simple. If I'm a bus driver, I absolutely don't drive the bus if kids are smoking.

I sounded off at a superintendent's meeting about how with all the problems that are coming into my office, I really did not think that this was one of the more impossible ones. And very frankly, we've had no complaints about this. Somehow the message must have gotten across and we're having no smoking in this particular district.

But again, it's appalling that some of these things that, you know -- we've got the figures, so you're telling me again that it exists. What's the mandate that's going to go through that says, "Absolutely No Trafficking in Drugs in Schools!"?

MR. BROWN: Well, the existing statutes are already clear. I'm not sure that legislation, for example, in itself is the answer. The code that was just passed by the State Board needs to be fully implemented, and I think while it is based on statutes that have been around for awhile, what we've found is the level of implementation has fallen far behind the attempts of legislation to create an effective mandate.

SENATOR BROWN: We could pass a piece of legislation that would have the Treasury refuse to give the local districts

any money if there was any drug discussion going on in schools. That would be an interesting piece of legislation-- (Laughter) No money for running the schools. I mean, it's just, to me, appalling.

MR. BROWN: Well, the bottom line of the problem is that what you find in the schools is what we find in the community, and what you have to do to change the situation is to do a number of things at the same time.

I'll give you an example of what I mean. One of the first positive signs that you're doing things right, is that you start identifying more kids who are using it. Okay?

SENATOR BROWN: Don't go around and around on me. You're the one who brought up the objective of a drug-free zone. That was your terminology. So don't bring it back. We realize that everything is interrelated, but you were raising the possibility that the schools could be drug-free zones. I was just asking how you were going to do it.

MR. BROWN: I think it's a position that we all have to take. Secretary Bennett is taking it. The President is taking it. I think it's part of our responsibility as parents and as school administrators to do everything that we can to make that real. There is no simple-- If I had an answer, I would give it to you.

SENATOR BROWN: But you're not giving me a specific answer, like you're strengthening relationships with prosecutors offices, that you're building bridges with local police, and that you're, you know, telling the parents that the child will return at 12 o'clock if there's been any problems with this. I mean, you're not giving me a game plan to fill out the statement that you've just made.

MR. BROWN: Well, I could go into the details of both the State plans and the code, if you wish.

SENATOR BROWN: All right. Through the Chairman, so there is time for the other people, I would like the specific

ways that the Department is going to fulfill making schools drug-free zones. Is that fair?

MR. BROWN: I think we have that immediately available for you. Yeah.

SENATOR BROWN: Super. I appreciate it.

SENATOR COSTA: Thank you very much for coming. I would like to call Ciro Scalero, Cecilia Zalkind, and Susan Conti, Association for Children of New Jersey.

C I R O A. S C A L E R O: Senator, thank you very much. Cecilia Zalkind and Susan Conti of my staff are here today. I'm going to vary from my comments for one brief comment.

I am both angry and elated just sitting here this morning. I'm elated that the Committee, I think, is asking the hard questions and beginning to, as a Committee, focus in on some of the important issues. And quite frankly, I find the responses that have been coming forward to be really inadequate and lacking.

If our State departments collectively have been doing such a good job in terms of everything that they do for kids, why is substance abuse is such a problem in our State? I think that somebody has to say that enough is enough and that some of the things that, frankly I have been hearing for five years about the interdepartmental coordination and planning-- It's a lot of hogwash, because none of it is being done.

And so, I would say, you know, my statement -- in terms of what we said, many of the agenda items are identical to what the PTA said, and I'll tick through them in a minute. But the most important thing is that it's time to stop the rhetoric and we have to see that it get's done.

Now, quite frankly, I've also come to another conclusion. I don't think that it's within the capacity at this point of the State Department to meaningfully impact on this. The most I think at this point that I want is for them to step aside and stop being a barrier to problems in this area, and to frankly, enable local communities to do something.

I think Rory Sparrow was right on point when he said that we have to develop programs to promote positive youth development, build the self-esteem in our young people, and that if we're to come up with mechanisms--

And I think that on the Committee, there are bills -- there are three concrete bills -- that would allow some of that. I want to get into how, I think, just some of the bills that you have could get to that. I think we could go a little further.

In terms of your suggestion about the-- Department of Education does not want latchkey kids. Well, let me rephrase it. They would like to see latchkey programs in our schools, but they initially opposed and then decided that they were not going to promote them, because they didn't want the responsibility for it.

In the end they decided not to be a barrier to a bill that would house it in the Department of Human Services. You said it, and I think you saw a lot of heads nod, but why is it that we have to continually bang on some heads to get the cooperation?

Well, I'll tell you what a number of us are doing as statewide and local advocacy groups. We're going to start bypassing the departments. We're going to go to local communities, and we're going to start doing things and hopefully carry some other departments along with us. Because, all I can ask for you as a Committee is to continue asking those hard questions that I think you were asking this morning and not getting the answers to.

In terms of my statement, and I'm sorry if sound a little strong, and it's not normally my style--

SENATOR COSTA: We get just as angry, Ciro.

MR. SCALERO: --but it's just upsetting to me to see that we're not getting meaningful answers to a lot of serious problems.

There were really nine points outlined in the testimony. The first one is that we have to take efforts to promote positive youth development. Senator, you have a bill in, creating Youth Service Commissions. I think that that bill could be modified to make a linkage. You've heard Commissioner Altman and you've heard other people refer to the Human Services Advisory Council. I think there could be a linkage with that, and I think that could be--

And if there were additional language that targeted community program approaches to substance abuse and other problems, that that bill could be modified to provide a vehicle for some funding to community-based groups -- be they PTAs, be they YMCAs, or be they local organizations -- at a community-based level that would want to begin to do things.

To combat the problems in juvenile justice or substance abuse, we don't necessarily have to take a treatment approach. In a prevention approach we could target things to develop self-esteem, recreational programs, and positive youth development programs. I think that could be a vehicle for doing that.

A second kind of concrete thing-- Senator DiFrancesco has a bill in. He began to ask one department, I think, in terms of a direct answer of whether there will be support for that. I think that we need to look at that particular bill and see that that residential need that does exist, gets addressed.

And finally, Senator Leanna Brown has a bill in that she mentioned -- the ombudsman bill. There is a crying need for what I call case advocacy. At our Association, we get calls all the time from people who are having problems in the system. I think we need to look at that proposal now and see whether or not we can move forward on something, so that in a rough basis you would have sort of a treatment approach -- a prevention approach, and an advocacy component to sort of link

all of those in. And those are just three measures that are right in this Committee itself sponsored by the Chairs.

Additionally, Assemblywoman Ogden has a bill dealing with trained counselors in the schools, and Senator Orechio has the Medicaid bill. That alone can form the nucleus of a package that we should look at very carefully, make any needed changes, and then try to move forward in terms of a concrete effort that this Committee could put forward.

The second point I had, related to our frustration in terms of dealing with the Department of Education.

Third, a concern over the lack of balance in terms of this whole present inquiry in the drug abuse area.

In terms of six kinds of policy issues or things that we felt need to be addressed, many of them have been covered already. There is a need for an interdepartmental effort, but it's a need to move it from a planning-planning, discussion-discussion phase and into a concrete phase.

The second point is that we do feel the divisions should be merged in the Department of Health. Right now they have a Division on Alcoholism and a Division on Drugs, and it just doesn't seem to-- Frankly, many of the people we talk to will not tell you, but people in those Divisions, they see the need for the merger, but somehow, somehow we haven't broken through the bureaucracy to get this accomplished.

Third, we need a regulatory and licensing system. Right now, it's pretty much other than the residential programs in New Jersey. It's pretty much a free environment in terms of setting up a "treatment program," or doing what you want to do in terms of substance abuse or alcohol abuse. There really are no standards for qualification of staff, training of staff, or ratio of staff. We really haven't even set a minimum level of a threshold for how these programs should operate. And if we're going to have that, we need to look at that.

SENATOR COSTA: I think Title 26 regulates those programs.

MS. LARMORE (Committee Aide): With the exception of outpatient alcoholism treatment facilities.

MR. SCALERO: Right. The residentials are covered. And I think we need--

MS. LARMORE: Outpatient drug treatment facilities are regulated by Title 26.

MR. SCALERO: Well, I'll check on that.

MS. LARMORE: They are regulated.

MR. SCALERO: You say they are regulated. That's fine. I would then say from our experience, the regulation does not seem to address some of the set standards that we feel would be needed in terms of who and how these programs are operating, and there may be a need to enhance that regulatory base. I'll certainly look at that, but it's my understanding that the regulatory base is not adequate in terms of the basic minimum protections.

In terms of the balancing of the insurance reimbursement, I think that that issue has been covered already. We need to look at the inequities that come from having one system of reimbursement push one set of issues or treatment, and a lack of reimbursement in the others.

And finally, we need to look at a broad treatment spectrum and insure that that broad treatment spectrum exists. I think that we need to promote a lot of different things that have been covered -- everything from initial assessment and evaluation through transitional care and support groups.

Well, that wasn't the final point. The final point that did come up earlier in terms of the family involvement being crucial to positive outcomes. Too often, that is not an active component.

I wanted to respond to one thing Senator Brown raised. I think that we have seen, and I don't like it -- it's not a popular term, but I like to use the word, "parental responsibility." I think we have seen, for various reasons, a certain manifestation of a decline in parental responsibility at the same time that we see certain parents crying out in many avenues or ways for tools and approaches.

So, I would support very much what you were saying in terms of need. And when I called for community-based approaches and programs to instill self-confidence and positive youth development-- As part of that, we should have programs for parents and should strongly encourage programs that are designed to teach in many cases parents, and give parents the confidence and the tools so that they can better relate and understand, to work with their child.

I don't know how we could make, frankly, many of the parents who don't love their children -- many of the parents who don't spend time with their children-- Which I think fundamentally, if you come back to it, has a lot to do with why a child might begin-- If they're not getting love and attention from the parent, then I don't know if we could legislate that or do anything.

But I think for those parents who want to spend the time and energy with their children, I think we at least should be there in some community way or through some community presence to give them an opportunity to be able to do that, should they be so inclined.

So, I think that was a very important point that you made. And with that, I'm willing to answer any questions.

SENATOR COSTA: You have a point that I just love. And that's love. I think if more people loved their children, especially when they are the most unlovable, that's what's needed. I think that would help in the home situation.

It's unfortunate. I don't know what happens. When you think about animals, they have their babies, and my God, how they care for them. What happened to our society? All of a sudden so many people have forgotten how to love their children. It's very sad. Senator Brown.

SENATOR BROWN: Thank you. This whole problem with the -- let's leave it this way -- with the unattended child. This obviously is where trouble can take place -- whether it's the parent is away, or the drug abuse parties that still proliferate in the State of New Jersey, or going back to this whole idea of encouraging the child to take some responsibility.

I was interested in a survey that came out recently about latchkey kids which again has been a negative term and a term I think we have been using to sort of blame the working woman, because the woman is working, therefore, the latchkey thing arises. I think the whole problem of instilling in the little ones from age zero, practically, how to deal with time alone, is just terribly, terribly, important.

And I do think that it is perfectly legitimate in some situations to have it structured with backup from a neighborhood group like we have Neighborhood Watches and so on. The young people can come home under a structured situation with phone calls and so on, and play in the neighborhood between three and five with other people in the neighborhood from three to five.

But I did that as a child, and mother didn't have to work. My mother very frankly had certain afternoons in the course of a month where she would have her own recreational facilities.

And again, it gets back to how we're treating our young people as viable members of society. I don't think we can solve the whole problem by having one program here and another program and another program if we're missing dealing and instilling the proper behavioral values in the child, period.

MR. SCALERO: Well, I agree exactly with what you're saying, and I think that we have to take as many creative approaches as we can come up with to deal with the problem. I think in terms of the latchkey or as many of the people who really work specifically in that area, they call it the "school age child care."

There's a conference this Thursday of that group. There's going to be an all-day session on just that issue alone -- the third one in a row. I think that if you ask people, you find that they're not locked into any way of doing it.

Whether it should be a model that's a school based model, whether it's a YMCA based model, whether it's a neighborhood based model, or even a block model, I think what they're saying is that we need a small amount of technical assistance and a small amount of support from this system. But if given some technical assistance and support, we will come up with creative ways of doing it.

I think as we look around at our State, we see a lot of different approaches. So, I think you're right that we can take a different approach and it doesn't have to be one model for doing it. And in some communities it might work better the way you're suggesting and in others it might work better with a wide basis system or a school basis system.

But I think that the point that I'm trying to make is that somehow, somehow we have to find -- you know, our President has referred to unleashing the creative energies of business; well, I think somehow we have to find a way of stimulating and creating an environment to unleash the creative energies of community people and the fundamental concerns that come from parents in a community about some of these needs and their desire to want to do something.

Too often, it's just too difficult for them to organize it and do it, and that's part of the barrier. If we look as a State system, to making it easier for them to get to

some of those goals, I think we would do well. Thank you very much. I appreciate the opportunity to speak today.

SENATOR BROWN: Moving right along, next on the list, I believe, is Gail Larkin from the-- (Negative response) Gail is not going to do it. Okay, Sue for the New Jersey Foster Parents Association? (Negative response) Okay, Mia Anderson and John Higgins.

I'd just like to interject here that I'd like to think the most important thing I've accomplished since being a Senator is that I let my colleague over here know that if he wants to drop everything and watch his children in swim meets, that's what comes first. Right Don?

SENATOR DiFRANCESCO: That's correct.

M I A A N D E R S O N: While John is handing that out, (Indicating statement) let me say that in the interest of time and everybody's mental health, I'm going to condense as much of this as I possibly can. People do reach the saturation level and I don't want us to get past saturation into blithering idiot time.

First just let me make a broad, general statement about how grateful we are at the Committee that you have held these hearings, and focus specific legislative interest with the intent of moving pragmatically to address this issue. It is our conviction that the mandate in which the Governor's Committee was charged, that is to act as a catalyst and an impetus for the coordination of activities with regard to children's services, has in fact been happily met.

Since the release of this report, there has been a great deal of energy dedicated to the issue of substance abuse. And just a little thing on the side; when you say, "adolescence substance abuse," I wish we would rephrase it and say, "substance abuse in children and youth," because it doesn't start at age 13. We've got kids who are addicted at age nine and are dealing at age eight, and I think we need to realize that.

Putting that aside, you are holding these hearings to move forward pragmatically on this issue, and I think it is essential. We're grateful for it. We're grateful that the Action Clinic for Children can act as a kind of catalyst.

Please recognize that the Committee, as a whole, prioritizes substance abuse as one of its highest concerns. It is the largest piece in the action plan, and I don't want to spend time going through those individual recommendations.

But there is one particular problem that really has surfaced in the past six to eight months that threatens a coordinated approach and an appropriate approach, and I would like John Higgins, who is the staff person responsible for all of the research, the digesting of, and support to the substance abuse subcommittee in this area and to the Committee as a whole-- I'd like him to share with you this problem before we continue.

J O H N H I G G I N S: Well, I think before I start, I guess I'm a little dismayed that Riley Regan isn't here. I think that the Division of Alcohol has done a lot of stuff in the youth end and I haven't seen any representatives from them.

I guess I have more of a personal reason for that. Going to these hearings, and I guess sitting here for a few hours, I hear all these State level people talking about this stuff. Riley, at least is recovering, and sometimes I think we need that kind of perspective. If Riley was here, I wouldn't have to say what I'm going to say.

SENATOR BROWN: He's had pneumonia, you know.

MR. HIGGINS: I understand that. I was addicted for about 11 years, and I've been off it for 4 years. I think if we don't keep in mind that there's an addict in me who kind of laughs at some of the things that are being put forth today-- I don't know.

I was very good in school. I didn't have what half of what people are trying to stop. If I had to say what was

important, it was probably having a significant adult that was trustworthy in my teen-age years. I think all these other programs, whether you going to do them on a community-based or State level, that unless you can really get that through, I don't think anything really is going to occur here.

Now, we've got a lot of numbers; I'll go into that. I think there is a problem between the alcohol and drugs end. It is important to keep it in mind, although the latest media blitz in governmental activities are wonderful -- and let's be careful not to ignore the problem of alcohol abuse.

The first intoxicant that children are exposed to is alcohol, and a researcher will explain later that alcohol is the key substance in the chain which leads to marijuana and other illicit substances.

In addition, and perhaps more importantly, alcohol abuse resulted in approximately 100,000 deaths, while those attributable to cocaine, amounted to 563. Further, alcohol has remained our number one problem in terms of social cost. And this was stated by the head of the National Institute on Drug Abuse. We cannot, therefore, ignore the issue of alcohol abuse and addiction while focusing while the latest drug craze.

Then in terms of early use, the problem of alcohol and drug abuse has surged in the past 20 years with greater and greater numbers of young people becoming involved. In addition, the age of children who begin using alcohol has become younger and younger. It is not uncommon for the children in the grade schools to be involved in substance abuse.

Depending upon the specific definition of abuse, the numbers of young people involved, range from 62,000 to 350,000. Studies conducted by the Department of Law and Public Safety have discovered that more than 34% of high school students reported use of alcohol before the seventh grade, and 25% reported use of marijuana before the ninth grade.

The dangers of early abuse are fourfold. First, the earlier the onset of abuse, the greater the chances of developing alcoholism or an addiction. Secondly, a young person's body, as well as coping strategies, are not as well developed as those as an adult, which results in a greater damage to organs and thwarts emotional development.

Thirdly, research has shown a pattern of stages in the use of substances which include the use of beer and wine, hard liquor and cigarettes, then marijuana, and finally other illicit drugs. Fourthly, children who begin to use it at an early age have a greater risk of becoming absent, becoming school dropouts, and becoming involved in criminal activity.

Let me give you an important thing to remember. If you have a kid who is dealing with crack, they've already dealt with the other stuff. You just don't experiment with that. You're deep into it.

Another important thing is the children of alcoholics and drug abusers. Somewhere between 20% and 40% of New Jersey's children are living or growing up in the care of an alcoholic or drug abuser. These children are at a high risk of child abuse which includes severe physical abuse, emotional harm, and sexual abuse.

In touring throughout the adolescent residential programs this summer, all three reported that at least 60% of the clients that they were seeing had been sexually abused. These children are also at higher risk between three and eight times that of other children of becoming substance abusers themselves. These children also suffer with problems in self-concept, peer relationships, home life, and school life. As a result, it's no wonder that these children suffer from a greater incidence of depression and higher rate of suicide.

In patterns of abuse -- nearly 18% of high school students surveyed reported regular use of alcohol -- that's 10 or more occasions within the last 30 days. And over 10% used marijuana in a similar fashion.

In addition, over 36% reported the combined use of either alcohol and drugs other than marijuana, or marijuana and other drugs. Another 11% reported the combined use of two illicit drugs other than marijuana.

From my experience, most of the people that I knew that were involved, never used one substance alone. That seems to be in a later stage when somebody develops that kind of addiction. In the early years -- in the teen-age years -- for the great part for what is known as garbage heads -- they'll take anything they can get their hands on.

People don't seek out PCP. If PCP is available, that's what they do. Again, I'm going to repeat that. If you're just focusing on crack, PCP was around five years ago and that was the big craze. Before that it was the DMT treated smoker, heroin, or whatever. But those numbers really are not anywhere as near as with the alcohol problem. Until we really start focusing in on dealing with the idea of intoxication in our society, we're just going to have stopgap measures.

MS. ANDERSON: Yeah. One thing I wanted to say about numbers, and you correct me if I'm wrong -- and he does all the time-- Some of these numbers are dangerously low. For example, the Attorney General's survey that was done in '80 and '83 dealt with grades 11 and 12. That didn't hit the kids that had already dropped out, many of whom for substance abuse reasons.

So, the numbers that are here that are reflected in those kinds of studies are low, given the whole adolescence and drug abusing population in youth. We have to keep that in mind.

I want to go to the general recommendation. But given time and trying to be pragmatic and helpful, last night -- it ain't gorgeous, but it's all I had around-- I've made a chart to try and make our point and the Committee's point about needing, very badly, to have a coordinated approach -- noisy, too -- to the whole issue of substance abuse.

Also trying to recognize that we can deal with substance abuse issues and the problems of substance abuse without spending new dollars. We have to spend new dollars, too, otherwise we're never going to develop the kind of continuing care and prevention efforts -- the programmatic approach -- that is necessary.

But if we don't have a three tier approach, giving equal emphasis on all three tiers, we're not going to be successful by just throwing money at something in a programmatic way. So, to try to put these recommendations in context, I have a little show and tell here.

First of all, we feel very strongly and the Committee feels strongly that there are three equal areas of prioritization. There's policy -- if you don't have a statewide policy, how do you respond to substance abuse? Nothing that you do is going to band together.

Then you need a departmental policy. Then you need to recognize, for example, that here in New Jersey you've got about six departments who deal with kids; therefore, substance abuse. You've got more divisions within the departments. And on the one hand, you've got the Department of Health that treats substance abuser as people who are sick.

On the other end of the scale, you've got Law and Public Safety that treats substance abusers as criminal activity. Now, how do you reconcile the two? When you don't have an overall coordinated policy, what you develop -- whether it's programmatic or organizational, which is the next tier -- it's not going to band together. It's not going to be coherent and it's not going to be done with integrity.

The second tier is your administrative response -- our organizational response. This doesn't necessarily require new dollars, but that hits the coordination issues between departments, within departments. As an example, it doesn't

cost more dollars to coordinate the prevention efforts between the Division of Alcoholism and the Division of Drug Abuse, but it certainly needs to be done.

Then you have your coordination between the State and the county efforts so that we can develop a plan that is coordinated and that delivers services without duplication and therefore maximizing resources. This is something the Committee feels -- and I know you do -- very strongly about.

Guidelines is another administrative organizational thing that needs to be hit. We need to develop the kind of guidelines that are recommended here and that you've heard here today from a number of people -- not the least of which was the Department of Education.

Training is an organizational administrative approach. It needs to be hit with equal emphasis. If we don't train our teachers, if we don't have appropriate training for substance abuse counselors, then whatever we enact in terms of a programmatic response that requires the use of these teachers or these substance abuse counselors, etc., they're not going to do us a whole lot of good. Certification is something also that we need to hit.

Now, programmatic -- the new dollars, is only one of the three, but certainly a very important one. And in that, the Governor's Committee felt very strongly that you must prioritize prevention and you've heard that today a lot. I don't know that it's possible to hear it enough. And treatment -- under there, as you see, I have a few of these things written down.

I want to emphasize-- Can I go on? Are there any questions? I want to emphasize how much the Governor's Committee and the Subcommittee on Substance Abuse wants to be an asset and a help to all sectors of government, and hope that, in fact, you will reach out to us for the research that

we've collected. I hate to see people reinvent the wheel. That can happen when there's great energy that is put to a subject.

I wanted to share with you in closing some of our present priorities, because although this report was issued a year ago, life did not stop at that time, contrary to popular opinion, and we have still been working.

I think that John can share with you best what our present priorities are, and where, in fact, we are going.

MR. HIGGINS: One of them is the statewide plan and we feel that it's important to have a statewide plan for prevention and early intervention for treatment efforts that should be developed and modified as needed on an annual basis.

At present, six major State departments along with county and local agencies are involved with dealing with adolescence substance abuse. In addition, each of these agencies uses the substance abuse differently. I'm repeating what she repeated. I'm going to try to skip that.

I think one of the things we didn't have mentioned is the establishment of appropriate license and standards for adolescence treatment. I know you mentioned Title 26, but I can cite the example of a treatment program in Bergen County where the Department of Health could not go in and stop the allegations of child abuse.

What's happened is they don't have the behavior modification protocol that stop these treatment facilities from depriving these children of sleep, privacy, and sometimes corporal punishment. You'll notice in reports in the newspapers about Riley and Russo speaking about them not being able to go in there and control what's going on.

In other cases, some parents have had difficulties seeing their children in these facilities and getting them released from these programs. This isn't a new event. This has gone on for the last four or five years at least.

I think another thing that maybe I should bring up is some of the other activities that we're involved with, and that we've been working in consultation with the Governor's office in developing a package of bills. As soon as that's done, I guess, it'll be released.

In addition, we're cosponsoring a conference with the New Jersey Association of Student Assistance Professionals. We're also involved in putting together and participating on panels at a number of other conferences during the next couple of months; for example, Carol Ann Kane's group.

MS. ANDERSON: Okay, in closing, I wanted to reiterate that the recommendations that are contained in the Governor's Committee Report on Substance Abuse are a good beginning statewide plan.

What John was referring to on our ongoing work in developing a statewide plan is in addition to that -- the more finite people pieces -- filling in the gaps. Do you really have a really pragmatic approach? What kind of insurance coverage is appropriate, recognizing that mandating insurance coverage for treatment services is one of our top priorities?

I just want to say thank you for holding these hearings again, and if there are any questions, Sandy Larson, who is our Executive Director, is also here. Can we answer any questions?

SENATOR BROWN: A quick question. Obviously a complicating factor in life since World War II has been television -- MTV. Your operation has been instrumental in working with MTV to get some anti-drug commercials that will be starting at some point shortly.

MR. HIGGINS: We're speaking about having a press conference in the next few days on that. That's why I really didn't mention it at this point.

SENATOR BROWN: Well, obviously, it's good to have some, you know, positive images come across on the screen.

What is happening? I really spend a lot of time watching television, but I don't do Channel 12 that often. Is there any change in the overall impression in messages that are coming across on some of our programs that the young watch? I think there is a little drinking on Dallas. (Laughter)

MS. ANDERSON: I think there is beginning to be, in reaction to great concern, some programs that follow the Bill Cosby image. I think that's a healthy response. I think that given the advertising perspective of Madison Avenue, you're not going to see a change in using sex and a drink in your hand to promote products including toothpaste. You know, it doesn't matter. So, I don't see that kind of change.

I see more of a change, believe it or not, on MTV and with the music that the kids are listening to. There are more and more superstars, and even great big ones, that are coming out anti-drug, and are talking about self-growth, and things like that. It's, you know, a spit in the whirlwind, but if you ask do I see any change? --minimum.

MR. HIGGINS: I think all the major networks are pretty much committed to changing that. And I know that the writers' group in California-- There's an association of writers, they've basically made pledges that they are going to try to screen that kind of stuff out.

I think also in the last few months there's been a lot more of a focus on the substance abuse issue. I know CBS had something on "Crack Street" and I know that NBC has been working very diligently in trying to do community-based kinds of things, but I don't know if their program is all together at this point.

I know that The White House is working on a major initiative with an advertising agency in New York as Lois and I have met with them. I think one of the dangers in all of this though is that quite often they don't consult with the people who have already done the work, and we keep doing the same thing over and over again. It just doesn't make it.

Kids don't get scared. If you tell a kid that a chemical is going to do something to them, they may or may not jump on that, especially if your information isn't very well-founded. I even think in the positive youth development end, I think we have got to be real careful that we have to make those programs attractive to the kids, otherwise the kids just think it's very nerdy and they won't be involved. So, you can be right back to where you started from.

MS. ANDERSON: Well, thank you very much for your time and just one more plug for doing a coordinated response, both in terms of encouraging the appropriate policies to be developed, the appropriate organizational response, so that the State can maximize their resources -- both people and money, and that when you look at programmatic issues, to please use the Governor's Committee's recommendations as an asset to your determinations. Thank you.

SENATOR COSTA: Thank you. Carolann Kane-Cavaiola, New Jersey Association for Prevention and Treatment of Substance Abuse.

C A R O L A N N K A N E - C A V A I O L A: Thank you, Senator Costa. I have a prepared statement which I'll leave with you, and rather than read it, I'd like to make a few points.

I am first, a director of an outpatient treatment agency primarily for adolescents and young people in Woodbridge, New Jersey. I've been doing this for 12 years. In addition to that, whom I represent today are 45 of the drug treatment agencies across the State of New Jersey. We respond to adolescents in varying degrees. And what that has most to do with, is the fact that there has never been a solid funding base for adolescents and young people, and there has never been a coordination or a clear-cut jurisdiction over the adolescent substance abuser.

What you've heard here today are a number of departments that say, "We can handle it. We can handle it. We

can handle it." The reality is that the only people who are handling it, are the front line professionals and the experts in drugs and alcohol who work in a community-based way.

We work with the parent groups, we work with the community groups, we work with law enforcement, and the rest of them. But we are on the front line combating the problems of drug and alcohol abuse on a daily basis among adolescents as well as adults.

I think what's dangerous is-- Excuse me?

SENATOR COSTA: Who funds you? Where is your funding from?

MS. KANE-CAVAIOLA: Part of our funding comes through the Department of Health, Division of Narcotic and Drug Abuse Control. Much of our funding also comes through the Division of Alcoholism. But essentially, we respond to a community need. We are not puppets of that organization.

SENATOR COSTA: You're not a county organization either? You don't work in counties?

MS. KANE-CAVAIOLA: No. We're usually private/non-profit. Some of us are public/non-profit, but we all have a common thread.

What I think is dangerous and what I hear here today is that many times drugs and alcohol abuse in adolescents is seen as a symptom of poverty, a symptom of divorce, or a symptom of any other number of things. Substance abuse is not a symptom. It is a primary problem, and must be dealt with as such, because until you hit the denial where it lives which is individual families as well as institutional -- the fact of the matter is that alcohol and drug abuse can happen anywhere to anybody and it does.

The choice of poison is really irrelevant. If alcohol is first, if marijuana is second, and if cocaine is third, it's all irrelevant, because in 20 years before and 20 years to the future we're going to see those change. It's important that

you begin to recognize that there are people who have been out there for 25 years, that we don't make headlines very often--

We're the ones that are doing the work when the headlines come and go. We've worked in cooperation with all the other groups, but there is no easy answer. There is no community organization or parents' group or TV messiah that is going to answer this. It's taken us 25 years to get where we are today and it is going to take us another 25 years, I feel, of slow, steady struggle, but uphill.

You have never really funded us appropriately. The funding goes to Education one year then it become appropriate to send it over to DYFS the next year, and you know, things just kind of get lost. I venture to say that you need to bite the bullet and make the Department of Health, Division of Narcotic Drug Abuse Control-- And you can make them do whatever you want to make them do. You need to make them the lead agency. They are the experts.

The Department of Education does the education best, Human Services does child advocacy best, but when you're dealing with drugs and alcohol abuse, you have to see it as the primary problem. It coexists with all these other problems. We need experts in all these other fields to help us, but this is the primary problem. It has to be seen as a primary problem.

SENATOR COSTA: How much do you need, to be adequately funded?

MS. KANE-CAVAIOLA: We need to at least begin to have enough beds in New Jersey, once we've identified the children, to put them into beds. I think that what we're talking about to even begin making a dent in this process is to -- and we asked the Appropriation Committee for this money -- is to talk about another \$1.5 million immediately to start funding. Essentially, reimbursing the treatment programs for doing what they know how to do with the kids who have no money.

SENATOR COSTA: This is just speaking about treatment in-house. You have beds. You speak of beds.

MS. KANE-CAVAIOLA: There are beds in New Jersey.

SENATOR COSTA: But you said treatment for outpatient?

MS. KANE-CAVAIOLA: Outpatient as well. You cannot have a good treatment system unless you have a continuum of care. You need to fund the motivational counseling as well as the residential beds as well as the aftercare, and as well as outpatient just for the kid who may never need a residential bed. The majority of children will not need a residential bed.

SENATOR COSTA: Just discussing Senator Orechio's package of bills that he has regarding the insurance taking care of it, if we have that insurance, if those bills are signed into law, then that figure would change, would it not?

MS. KANE-CAVAIOLA: No. I think that--

SENATOR COSTA: That 1.25 million?

MS. KANE-CAVAIOLA: One point five million. No, because what happens is that you're increasing the ability for people to identify. We talked about the number of kids that are out there. We're only treating the tip of the iceberg. Kids that are being sent to Minnesota are just the tip of the iceberg. Kids that are in the programs now, are the tip of the iceberg.

If the front line people begin to learn correctly how to access early on, we're going to need a lot more than that.

SENATOR COSTA: What is so great about this treatment place in Minnesota? I keep hearing people saying--

MS. KANE-CAVAIOLA: There's nothing great about it. I'm going to tell you what's great about it. They have insurance coverage for private insurance, they have public insurance coverage, and they have a huge amount of dollars just from the State Legislature to take care of all the kids that fall through the cracks. The Legislature also, in Minnesota, funds its aftercare, group homes, and halfway houses.

SENATOR COSTA: But isn't that for their own people?

MS. KANE-CAVAIOLA: It is for their own people. We only get to use part of it. People here in New Jersey with insurance only get to use a piece of it because they paid for it.

SENATOR COSTA: By being able to pay a large sum. So, that means only those who can afford it can go.

MS. KANE-CAVAIOLA: Exactly. So, the body of knowledge--

SENATOR COSTA: So, they are so much more advanced.

MS. KANE-CAVAIOLA: They're advanced because they've made the commitment many years ago. That body of knowledge is available to you in New Jersey. It's not new.

Our Association has supported the mandatory insurance legislation. In fact, we were part of the impetus of getting it written even prior to Senator Orechio picking it up. That has to be done to pick up a piece of this.

There will always be children whose parents can pay. But we need to pick up also the piece of the Medicaid legislation. It's inadequate. Van Wagner has a bill now that, I think, looks, at least at my first glance, looked good. Orechio's bills we support wholeheartedly.

But we do need funding just for the kids who fall through the cracks. We also need jurisdiction over those kids. People, educators, child-study teams, whoever is on the front line-- Sometimes it's the police departments. They need to be trained appropriately, not a 10-hour training program in drugs and alcohol.

We need to have specialists that are credentialed in a variety of fields. It's more expensive to treat an adolescent than it ever is to treat an adult, and it's harder. It's much harder work, because you've got to know something about child development as well as drugs and alcohol, and as well as a variety of other things. We've always given children the least amount of money. It's always been the first thing cut.

Prevention efforts -- we've heard a lot about prevention efforts. Prevention efforts need to run the full spectrum. They need to be funded just as well. You cannot expect parent groups and community groups to do this on their own, with no money.

First of all, they're only a piece of it. They are an awareness piece. We're there after all the marches and things, and commercials have come and gone.

SENATOR COSTA: What would you suggest as a prevention measure?

MS. KANE-CAVAIOLA: I think that we need, first of all, education that not only talks about what's a drug and how it affects your body, we need education from preschool right through that talks about refusal skills, that talks about alternatives, and talks about developing a healthy life style.

This is not something that school systems or teachers are trained to do. This is where you need a coordinated effort. Teachers are trained to give education and they've done that, but that has not solved the problem. There are many books and the kids all get that in their curriculum. That is not the beginning or the end of the problem.

I think we need to realize that as much as it's very nice to, and we hope kids are going to just say, "No," that it takes an awful lot to get a kid to say, "No." It isn't easy and it isn't simple, and I don't mean to be facetious about the First Lady's intentions, but it's not the beginning and it's not the end, and certainly, we've got to put our money where our mouth is -- a lot of money.

I don't want to take up any more of your time. Thank you.

SENATOR COSTA: Thank you very much. We appreciate it. Please work with us, with this Committee, okay?

MS. KANE-CAVAIOLA: I would enjoy that.

SENATOR COSTA: We have Carolyn Hadge, Alcohol/Substance Abuse Program of the Toms River School District.

C A R O L Y N H A D G E: Good afternoon. I want to thank you for the opportunity to present to this Committee. I'd like to relate, first of all to two of the prior speakers.

First of all, John Higgins spoke about Riley Regan. As an alcohol/drug professional. I have been working with schools for seven years, and certainly was supported, very strongly, by the Division of Alcoholism. They called me and said, "Please go to this hearing, Carolyn, because you have something to offer them and we would like you to represent us there." So, in a sense, Riley is here through his efforts for our program.

Secondly, I would like to refer to Carol Ann Kane, and I know Carol Ann and I respect her highly. I have learned a great deal from her about outpatient and aftercare and service to back up our students. However, I would like to differ from her in the fact that the front line is also represented in schools. We do have alcohol/drug professionals in some of our schools. That's what I'm here about.

As a professional, I am certified New Jersey Alcoholism Counselor, a New Jersey Department of Education social worker. I have a master's in counseling, a bachelor's in psychology, and an associate's in alcohol studies. I mention that to you because credentialing of the people who work in schools is right now a very current and hot issue. I would assume you would want to be aware of that.

Hopefully, through the New Jersey Department of Education Administrative Code that was passed on September 3rd which Phil Brown mentioned, we will be allowed to do what we're doing. Right now, even though I bring to the school those degrees, they have said to me that I am not allowed to counsel, because I am not a guidance counselor. So, that leaves us with some controversy going on.

I coordinated the first New Jersey Student Assistance Program which originated in Ocean County in 1979. It was originated throughout the National Council on Alcoholism. I feel that the Council on Alcoholism were the first ones who began to see that the schools were the place to address this problem and the alcohol/drug professionals were the ones who could begin to address it in conjunction with the school staff.

During August of 1983, Toms River Schools -- which is the fifth largest school district in New Jersey, we have over 16,000 students -- their superintendent, Al Dietrich, wanted to develop a comprehensive primary and secondary prevention program which started with a peer education program called, "T.E.A.M." He hired me as an alcohol/drug professional.

I mention that again, because it was the first time in New Jersey that I am aware of that a school had reached to the alcohol/drug field and said, "We want a marriage between education and alcohol and drugs." And I think that marriage is really important for all of us. We bring to the schools our expertise in substance abuse; the people in the schools bring us their expertise in children and learning and adolescent growth and development. Together, hopefully we can achieve something.

From the four years of ASAP, which is the program in Toms River, I brought some of our data, because I think we have something to offer in the patterns that we've seen developed. First of all, students affected by substance abuse-- For so long we thought that it's one-to-one counseling that is going to do the trick with these young people -- that it's going to help turn them around. We have found that it isn't.

Where it's really at is building bridges in those young people's worlds. You've heard it mentioned all this morning. When you send a young person away to a treatment program and they come back to the same family, the same school, and the same neighborhood, it's like setting them up.

If we don't begin to build the bridges in the school community and develop some understanding with teachers, guidance, and administrators, and if we don't do something about their family systems and developing understanding there, and if we don't do something about resources for aftercare, you know, the child's chance of success is almost null.

One of the directors of a local New Jersey treatment center gave me 20% as the "success rate," of his treatment program, and I can't even begin to tell you how long a period that is. When we look at children in our school district, I never talk about who stays sober or straight. I talk about school performance, because I would lose in the eyes of the school board if I talked about how many children returning from treatment stay straight. It is a very, very difficult task.

We also have found out one other thing. Wayne Fisher, who spoke to you about the Attorney General's report, is the head of the Attorney General's research department, and we've gone to him. We want to know if our programs work. We have a peer education program, we have an intervention program, and sometime I wonder, are they doing anything? So, he is assisting us in setting up a computerized evaluation system to see if they do have an outcome.

As part of this, we let Wayne-- Well, I shouldn't say we let him, but we agreed to have the Attorney General's staff run a survey in one of our high schools. Now, it's not for publication; it was for our internal use. But I want to share a bit of that survey with you, because what we found was that 10% of the children in that school are seriously affected by alcohol and drug abuse.

That means that at least 10% of them are using alcohol and/or other drugs on a regular, consistent basis -- 10 or more times per month. This coincides with exactly what Wayne was finding with rest of the survey. That gave me a perimeter to

know am I identifying young people -- how many of them am I identifying? I'm only identifying 3% and the program has been in effect for four years.

Where are we at fault? What do we need? We know we need much more networking in the school district. We need in-servicing with the administrator, with the guidance counselors, and with the child study teams, so that they can help in this process of identification and intervention.

The other thing that we found from this is that Alcoholics Anonymous, as a community support group provides a philosophy that allows young people to identify and to grow. It is a wonderful philosophy. However, it needs to be perpetuated and expanded. Adolescents are not adults.

When you put them into an adult support group their needs are not always met. Some of them certainly are, but they have many other needs because adolescents are unique. They haven't had the experiences of an adult. They don't have a point of reference to go back to. They've never succeeded in anything. They don't know how to have fun.

And in order to meet those needs, we desperately need aftercare programs, and programs that talk about how do you enjoy yourself and how do you cope with interpersonal relationships. Here they are at the greatest time of their emotional development, and they're reaching out to each other. They want to have boyfriends and girlfriends, they want to be accepted, they're questioning their own self-image, and when you add alcohol and drugs to that, it really negates it.

On the other hand, if you have a young person who's scared about asking that girl for a date, or a girl who thinks she's a little bit too chubby or a little too skinny, you give them a drink or you give them a joint, and for a short time they feel that they are okay. I'm sure that maybe you can identify with that.

So, I think those are the kinds of coping and developmental skills that we need to address and that aren't being talked about in treatment programs very often. I'm sure Carolann Kane does, but not all of them do. So, once we get drug free, so to speak, in treatment, we need to address those issues.

I would also like to mention briefly about choice of chemicals. Yes, in the past four months in our school district we have seen a rise in cocaine. Now we used urine testing with those student who are suspended for substance abuse. Only when we have reasonable cause do we suggest urine testing.

One thing that it's done for us is to help clarify their drug use. And one of the drugs that have popped up in the past four month is cocaine. We would never have known those kiddos were using cocaine if it hadn't been for the urine testing, so that has helped.

However, the drug of choice and the drug that is by far preferred by all of our young people that are abusing it is alcohol. When we talk to the overt abuser, alcohol is always the paired drug. Their other drug of choice may be marijuana or LSD, but we always see alcohol in there. I think it's real important that we remember that and we don't get distracted. You know, it's so easy to look at cocaine and say, "big, bad, evil cocaine," and forget about legal alcohol.

Again, we're not anti-alcohol, but we're certainly anti-alcohol abuse. It's not a clearly defined issue. It's a kind of fragile topic, you know, because lots of people use alcohol and don't get into trouble. I think we need to see that.

Thirteen percent of our young people who weren't using substances used alcohol, 7.8% used marijuana, and 2.6% used cocaine. Now those are the groups of students who were in serious trouble.

Lastly, I'd like to mention the fact of high risk student. Those come into our focus, you know, who are in the courts, who have suicide threats, who come from families of alcoholic homes, who are abused, who are in the DYFS system, and you know all of them, because we've mentioned it all here today. We need a networking with those outside agencies.

As a student assistance professional, I think that's one of our roles -- to network the outside agencies so we can work together. When I need leverage over a child to get him into treatment and if I can go to their probation officer and get help from the courts, that is a real asset to me. So that helps us.

And lastly, I would like to mention primary prevention efforts. We have found that these are threefold for us in Toms River. We use the "Here's Looking at You" curriculum, we use teacher and staff in-service, and we use peer education programs that help us to build an aware community. But a fringe benefit of all that is that it helps to identify young people.

In other words, in the elementary grades, children surface that come from chemically dependent homes. Children surface who are beginning to experiment. And so it's a two-pronged fork.

Our peer education program uses all of these strategies. We are beginning to use that concept of bonding positive young people. We take high school students who are willing to make a commitment to not abuse substances and to give us two days of in-service training and we use them to work with our younger students.

We're also now building that same type of program with our athletes. I'm sure you're aware of what's happening at the professional level, and we feel this is an area that needs identification.

So, we're going to bond our positive athletes. Both of those groups of high school kids become role models, and as you've heard mentioned again here, role modeling is so important. The young people look up to them, the rest of the peers in the high school group look up to them.

We feel that this is a prevention tactic that will be working for us. That also, by the way, has some research on it to give it credibility.

I am going to ask you for support for our prevention efforts and for our intervention efforts. We need people of your caliber to speak up for us. For so long we've been the illegitimate child out there -- those of us in the drug and alcohol field. No one wanted to recognize us. We weren't very popular. And now we need your help in getting some recognition so we can help our young people. Thank you.

SENATOR COSTA: What kind of support are you asking?

MS. HADGE: We need your verbal support, most of all. Your support saying that prevention is an issue that needs to be addressed.

SENATOR COSTA: We've said that today. We agree with you.

MS. HADGE: We certainly have heard you say that.

SENATOR COSTA: One thing I wanted to ask you, do you have any support from the churches?

MS. HADGE: Churches and parents-- You've said that before. One of the two women said that. Churches and schools, rather, can offer us so much. We're trying to work with the schools. Churches I don't get much support from at all, and parents, we don't get much support from. We have tried over and over again to develop community family programs, parent programs, and I'm sure you can ask any school person here -- they are just not well attended. Parental denial is probably one of our biggest problems with adolescents substance abuse.

SENATOR COSTA: I think that's a place that we really should look into, because that's suppose to be their business, saving people -- not only souls, but in order to save people. And I don't see them doing the job. It distresses me greatly. Maybe if we say it enough, maybe we'll get some help.

MS. HADGE: Thank you.

SENATOR DiFRANCESCO: I have a question. You came all the way from Toms River, so I thought I should ask you a question. How do you, specifically -- quote Senator Brown -- how do you determine the difference? How do you gauge the difference between a child who's abusing alcohol and one who is using alcohol but not abusing it? What criteria do you use for that?

MS. HADGE: Well, we use behavioral standards. First of all, if their substance is alcohol and drug use -- and I must say, and I'm sure you know this, that it's very rarely that anyone just uses alcohol. Most are a combination of substances.

If their substance use is interfering with their school performance, i.e. attendance, grades, cuts; with their family relationships; with their interpersonal relationships, then that is a problem.

SENATOR DiFRANCESCO: Well, on a survey -- when you talked about surveys -- how are you going to determine when whether someone is abusing alcohol or whether someone just uses it?

MS. HADGE: In the survey?

SENATOR DiFRANCESCO: Yeah.

MS. HADGE: We're going to look at those who are using it on 10 or more occasions.

SENATOR DiFRANCESCO: Well, that's what I wanted to ask you. Are you talking about 10 or more uses of alcohol in some fashion per month constitutes an abuser in your eyes?

MS. HADGE: Certainly. That's an adolescent. An adolescent is--

SENATOR DiFRANCESCO: An adolescent. How old is an adolescent?

MS. HADGE: An adolescent is from 12 to 18. If a young person in that age group, who is also growing emotionally and physically -- that's their greatest age of emotional and physical growth -- is using alcohol on 10 or more occasions a month, we would say that is abuse, because that would certainly interfere with that emotional and physical growth.

SENATOR DiFRANCESCO: The second question is-- It's not really a question. I wanted to clear up something. It's not necessarily something that you raised, but a reference has been made to residential care facilities for adolescents as opposed to outpatient care on a number of occasions today.

A reference was made to a bill that I'm sponsoring that provides strictly for residential care facilities in New Jersey. I've gone round and round on the issue of whether or not that money should be designated for the residential care and outpatient care. I had drafted a bill specifically in response to a specific need based upon what I heard from other people.

The bills, obviously, address only a very small part of the big pie. You made reference that the former person who spoke before you, Carolann, made reference to that. And so has everyone else.

There are a number of pieces of legislation that address almost every phase of the problem as far as I could see. We have 6000 pieces of legislation introduced already in the Legislature.

But I would think there is great support for what you're talking about. There are other school districts that do similar things that you're doing. I was looking at your folder. I know that. I think that this Committee and the Legislature is very aware of the need for outpatient

facilities. I understand, quite well, the problem with having enough money to address all of the various problems: residential, outpatient programs, schools, etc.

And so, I want you to understand that we understand that. We also have great demands upon us by all kinds of various groups for money. And, yes, if you're looking for commitments, I'm think, certainly, Senator Costa today has made it clear that she has a commitment. She has in the past.

So, I appreciate your statement and I hope you understand from our perspective some the problems that we have to deal with in listening to everybody speak on this issue.

MS. HADGE: Certainly. I think you have wonderful patience listening to all of us speak. I was personally reinforced when I heard your responses and I thank you for them. I think you are right on, so to speak.

SENATOR DiFRANCESCO: Thank you.

SENATOR COSTA: Thank you very much. Bruce Stout, Assistance Director of the Juvenile Delinquency Disposition Commission.

B R U C E S T O U T: Thank you for the opportunity to speak with you this morning. I've submitted to you a written copy of my statement and rather than reiterate that, I think what I'd like to do is just highlight some of the key findings that the Commission has uncovered with respect to substance abuse and juveniles in New Jersey's new family court system.

We know that the juveniles who are brought to the court on drug or alcohol charges offenses, be they illegal consumption, use, possession, or distribution, represent only a small subsidy of all juveniles in the court system who have substance abuse problems. Yet given that, I think looking at those juveniles provides an interesting measure of the level of the substance abuse difficulties of juveniles in the court system.

Presently, one out of every ten charges brought before the court system is for drug or alcohol offense. This is the second most frequent category of offenses brought towards the family court for juveniles -- second only to larceny thefts. The trends in these documenting of charges are not encouraging. When we compare figures for the first seven months of this year to comparable figures for 1985, we find an 11% increase in drug possession charges and a 28% increase in distribution charges.

Clearly, despite the problem of measurement, this is a problem of some magnitude. Realizing these problems of measurement, also have gone in and surveyed the records of juveniles in the three primary out-of-home placements that family court judges have available to them: Department of Corrections institutions, Department of Corrections residential facilities, and DYFS residential programs.

We find that in both Department of Corrections' programs, a quarter of the records indicate that the juveniles' parents have substance abuse problems. For the DYFS residential juveniles, over a third of their parents have substance abuse problems. On an individual level, in both of the Department of Corrections programs, half of the juveniles' records indicate that they have substance abuse problems, and for the DYFS juveniles, a quarter of those.

You've heard a lot of figures this morning about the magnitude of the problem and I've just added to those figures. I think they're frightening. What is more frightening for us was the gap which existed between these incidences of those problems and the levels of services these juveniles had received to address them.

Of all the three groups of juveniles, fewer than 16% of any of them had any drug counseling or therapy prior to their current sentencing. Fewer than 10% of any of the three groups of juveniles had ever had any alcohol counseling or

therapy. These were not juveniles who were new to the system. The DYFS juveniles, who were newest to the system, had been an adjudicated delinquent twice previously. The Department of Corrections committed juveniles had been adjudicated on an average of five time previously.

So, these are juveniles who've somewhat repetitively been through our juvenile justice system and yet there existed this gap between the services they had received towards their substance abuse problems and the levels of those problems. I think the reasons for this are complex and varied. We've heard a lot about insurance this morning. One of the difficulties in the juvenile justice system is that many juveniles who are under the system aren't covered by insurance policies, and they don't have third party payments available to them.

Many of these juveniles are also not in school, and it certainly hampers the ability of school officials to act as a primary preventative agent. At the court level I think there is a definite need for training both to aid in identification and in identifying what an appropriate treatment strategy ought to be.

Across the State, our family court system lacks a comprehensive diagnosis and evaluation capacity. What we have out there are 21 unique systems for determining what should be done with a juvenile who has been an adjudicated delinquent, and some of these systems are inadequate. When we can't diagnose, identify, and evaluate a juvenile's needs, we can't provide the appropriate intervention.

Lack of resources is also a problem. But in conjunction with that, I think the family court also faces significant obstacles to using resources which currently exist.

The family court system is a service user that relies on a fairly autonomous and independent service provider network. This network can unilaterally define who it will and

will not work with. Delinquents who face a multiplicity of problems in addition to substance abuse and delinquency are frequently excluded from these programs.

The Commission has made two recommendations which touch on these issues. The first is the establishment of mechanisms to improve the court's diagnostic capacity and to more closely align the court system with the service provider system that it must rely on. There are a variety of mechanisms that would accomplish this. Multi-disciplinary review teams are one approach. They would be responsible for gathering diagnostic information, for making sentencing recommendations, for aiding the court in procuring services, and for following up on cases once they've been disposed.

SENATOR COSTA: You don't have any of that right now? Any of that assistance?

MR. STOUT: There are youth advocacy projects in a small number of counties which work only with kids who have been potentially sentenced to the Department of Corrections. You have released the bill from your Committee which would strengthen that effort. I think that's a step in the right direction. I think we need to go further and more comprehensively in addressing the problem of not only juveniles who would be sent to Corrections, but all juveniles coming out of the court system.

Secondly, the Commission has recommended the establishment of a system of aftercare for juveniles who are leaving a correctional program. We have a juvenile parole system now. I think admittedly that from the parole side, it is not equipped to handle the kinds of kids who are coming out of institutions. The burden is on the adult side, and the juveniles don't get the majority of resources.

I think these types of approaches in conjunction with increases in education, prevention, and treatment will start us in the right direction. Thank you.

SENATOR BROWN: Thank you, Bruce, very much. Have you noticed or do you have any observations on what effect the 21 year old drinking age has on this whole problem of substance abuse with drugs? It's interesting that we need a definition of what is substance abuse and alcohol abuse in teen-agers. You know, the bottom is that it's illegal.

MR. STOUT: We have found that -- and we haven't looked specifically at impact given the change in the age -- we've found a fairly steady rate of alcohol offenses coming into the court. Now whether that rate has been impacted by the change in the age, I really couldn't say.

SENATOR BROWN: But it has increased?

MR. STOUT: It has not increased over time.

SENATOR BROWN: It has not increased. Okay. Are there any other questions? (No response)

MR. STOUT: Thank you.

SENATOR BROWN: Thank you very much. Okay. Dr. Robert Stuckey from Future Health Systems, Summit, New Jersey, next to Chatham, New Jersey. So we are neighbors and you have your own Senator here, Donald DiFrancesco.

D R. R O B E R T F. S T U C K E Y: I am Dr. Stuckey, a deaf psychiatrist. I assure you that it is not a bad thing. I don't have to listen to all the people's self-pity any more, and I can absorb whether they are getting better or not.

I am a certified psychiatrist. I'm going to talk for about 10 minutes at best. I wrote a 30 minute speech. I hope to stimulate you to read it. But I'm going to make about 10 points and quit.

I am a certified psychiatrist with a public health degree. My medical and psychiatric training were done at Columbia University in New York. I've lived and practiced in this State for 26 years. I am the senior developer of 28 addiction and psychiatric centers, nationally and internationally.

For two years, I chaired the New Jersey Committee on Youth, Alcohol, and Drugs in the Health Department. For three years, I chaired the Governor's Committee on Alcoholism. For two years I chaired the National Committee on Addiction for the National Association of Psychiatric Hospitals; and for four years, I was the National Treatment Chairman of the Trustees of Alcoholics Anonymous. I am a consultant at Harvard.

Since 1969, I have been the senior developer of eight New Jersey addiction programs and senior clinician for the more than 10,000 addicted residents of this State. It is my guess that I have treated more adolescents than any professional in the private sector of New Jersey today.

This number of treated addicts was made possible primarily by the support of New Jersey Blue Cross at the suggestion of Riley Regan, Richard Russo, former Health Commissioner Richard Goldstein, whom you all know.

Twenty-seven years ago -- and I'm just going to read one more paragraph, then I'm going to make some comments. Seventeen years ago, I was designing and establishing the alcohol and drug addiction program now known as "New Hope." Well, it was known as New Hope then. This was accomplished by removing patients from Marlboro State Hospital. I was told then that the patients there were psychiatric, not addicts.

I noticed, however, that many of the adolescents there had been excellent students and had originated in stable families. In the therapy that the juveniles had received, the addiction had unfortunately been seen as only secondary. The incorrect treatment for these adolescents, as it turned out, destroyed not only their childhood but the joy of living for the entire family.

Now the things that I cover are the nature of treatment and addiction. I talk about alcohol and drugs being the same thing. I talk about why there is so much denial and how serious it still is in the schools in the Education

Department. I talk about why adolescent addicts are sent out of the State.

There are five reasons for that. Why should we have mandatory insurance? What is the program for the decade ahead? This Committee is listening about what should have been done in the last decade. I beg you to be aware that changes have occurred in the last two years, and there are programs superior now, to the residential programs. And then a conclusion about what I hope this Committee will do, and this is all for your reading.

I apologize. I typed this, I put it on a computer, and I printed it this morning. I do not spell well, and my ribbon was gone, and I was in Cape May, and there was nowhere I could but one. So, you do the best you can with it. They don't sell computer parts in Cape May.

Now, the New Jersey Education Department, at this point, has no label for addicts or alcoholics. There is no such thing. They are lumped and it will not come, in my experience, until parents sue that their children were handled misappropriately. The children that are in these public programs have histories of being good students up to about age 13. They get their addiction, they are misdiagnosed in a school system where the school system itself through the years--

By the way, this is a 15 year-old crisis. For any of you who have been around looking at this honestly, you do know that the only thing that's happened is that the crack has more glamour on TV. If all we had was all the shuffling around, violent drunks going to Staten Island, as we had 15 years ago, television would not have not picked this up.

The kids are getting around faster than they were when they were just on pot and booze. They are more motivated. They are not as (Inaudible). So, from our point of view, thank God, people are listening. But the situation certainly was worse 10 years ago than it is today.

Now, with all of that, the school education system has never put in a staff assistance program. In the school system of the State, the teachers and the principals all go still for the suppression treatment, and they send the janitor for alcohol treatment. The kids know there's a double standard in the schools. I myself had a patient that was in Marlboro. I was asked to see him. He was from a very affluent family. The kid is now a young physician in Union County.

This school system -- the superintendent got sober that time and called me up and said, "When that kid was missed, the principal of that school, his primary teacher, and I all had drinking problems. In the school system, we would be fired if the school board knew about it." In fact they were, even after they got sober, all three were fired.

So, in the school systems you have a situation. If I treat an airline pilot, I can put it down honestly that it is alcohol or cocaine. If I treat a school system person, I have to lie. So, that is why you have so much denial about this problem for the last 15 years in kids, because I've been on to the school grounds and had the kids in my hands with the pot, and the school people wouldn't want me to report it to the local juvenile authorities. The suppression starts at the top. There is no label in this State for addiction. Period.

Now, the next point is why do we send them out of the State? This will be very brief. Because there is no return on investment. You can talk about the public sector and the ones that the State now is responsible for. But if you take a history, you will find that most of those had a shot at the private sector and did not get the right diagnosis and the right treatment.

I am talking about the 90% of people in the State who are in a situation with a somewhat typical suburban life. They do not have facilities in Union, New Jersey like a prison in other States. There is a reason for that, and there are five

reasons in this paper. One of the reasons is that an investor-- I've had three health corporations come to me within the last 24 months offering to do a joint venture with me on adolescent addiction. I myself have invested my life savings in this process and slowly lost it because of the following situation.

It's subtle. It's so subtle that it's like if the whole world were blue, you couldn't conceptualize blue. The problem that we've got in this State starts right at the bottom. There is a prejudice against the capitalistic world. I came into this State and put in the Perth Amboy and Raritan Bay Mental Health Center in 1967.

Governor Hughes had me in his office with arms on me, and put up the Perth Amboy Comprehensive Alcoholism Program. I was asked to come in here and testify. I went over to the private system in 1973, and nobody's invited me here to this day. And I had to call up to get myself invited because I'm in the private sector.

Now, if I go into a school system, that teacher, that principal, and that parent seek out help from the private sector, but they want their kids, somehow, to go to a public or nonprofit program. Why is that? You tell me. I don't know.

But in the State Department and in the entire State area it follows right up the line. There is, in this State, an anti-capitalistic, subtle, unspoken, anti-capitalistic approach to health care.

Now, I say three people have come and volunteered several million. One came done and plunked down \$3 million and said, "I want to start--" This was a corporation. And I said, "Okay, go do your homework with the insurance company." Then over the dinner table, all three of them decided their money was better off in the bank. Enough said on that subject.

Now, there are four other reasons that the kids leave the State -- and good ones. But that's the one that's going to

stop it. The term, substance abuse, is atrocious. It shows that people do not understand what addiction is. The man who wrote the book "Diagnostic Manual III" is a classmate of mine from Columbia. His name is Bob Spitzer.

They still conceive of the person as having a weak character somehow, and addiction is a symptom of that. Nobody's going to make any progress in this field until it's learned that it's just a program written squarely on the instinctual region of the brain. It's permanent, it's biological, and it's not affected by good intentions or money.

Now, I wonder why in this State so much health-- Why, for instance I noticed on the program, the one person not on the program is the Insurance Commissioner. The one thing that is needed in this program, I didn't see it. What we need is for the Insurance Commission to have more to say. What we have now is the Health Department not wanting kids in hospitals -- committed to not letting them into the hospitals. But at the same time, they are backlogged two or three years with their licensing standards, so they don't have time to get residential centers in either.

Now that's all because of all of the work dumped on the Health Department in this State. The Legislature, in their wisdom, sees that the Health Department should do everything and the Insurance Commissioner should have a little bitty office with a little bitty staff and not do much. He's not even on the program, as I can see. Now, why is that?

I mean, go check around the other states. If you want to deal with addiction as a biological and health insurance thing, you get the Insurance Commissioner in and you deal with insurance.

Now, why is the rate of addiction so low in certain communities historically? It gives a clue to what treatment is. I know I don't have time to talk about that. If you study why the Greek and Jewish communities had power in their

community and addiction was kept so low traditionally, and what happened in this society when we took on the attitude of, "I'll do it my way," then you will understand how addiction, although biological, is not controlled by society anymore. It's always been biological, but it's controlled by covenant communities that draw their strength from each other.

You draw your strength from other people, that's called dependency. This society is hostile towards dependency. So they become dependent. It's weird. But if you study how people recover, it will be the same reason that there were strong bonds in Greek and Southern Italian and so forth in the communities that have had a lot of incidents.

I say finally, why should there be mandatory insurance? Because if you take any one alcoholic or any one addict, they've used up 400% of their share of insurance before they get diagnosed. If you check on why the beds are getting empty in the hospitals today, because there are not many more 40, 50, 60 year old drunks with prostatitis, and pancreatitis, and gastritis, and so forth.

We didn't have insurance for drug addicts? Right. Now what have we got -- Hepatitis-B epidemic, AIDS epidemic-- You either deal with an issue or it eats you alive. And the point is the addicts are using more than their share of insurances. It's not a matter of whether you are going to answer them, it's whether you're going to be honest or not. It's whether you're going to put them in a program that's got a chance of dealing with the addiction or whether you're going to keep paying for the infectious diseases. I'm finished. Thank you very much.

SENATOR COSTA: Thank you so much Doctor. Any questions for the Doctor? I think you covered it all, Doctor. Thank you very much. We appreciate you being here.

DR. STUCKEY: No questions?

SENATOR COSTA: No. I think you covered it all.

DR. STUCKEY: All right.

SENATOR COSTA: Thank you very much. May we call on Connie Cohen and Myrna Zito from the State Association of Student Assistant Professionals of New Jersey. I think that's going to be the end of our program. Correct? And we thank you for being so patient.

C O N N I E C O H E N: I've been sitting here for the last four and a half hours trying to find a rationale for why being last is a positive thing as opposed to a negative thing. And what I came up with was that it is good being last because you will remember what I had to say when you have already forgotten what my predecessors had to say.

Myrna and I are here today representing the State Association of Student Assistant Professionals; and what I would like to do briefly is to tell you that organization is and what that organization is.

The State Association is an organization of school based professionals working with students in areas of high risk behaviors, particularly alcohol and drug abuse. Carolyn Hadge, who spoke about the Toms River program, is a member of that Association. She's an example, and we're an example of the types of people that have involved themselves in this very new Association which is having a conference in October.

We're working closely with the Department of Education and the Department of Health to get the message that we heard today across to the schools, to the administrators, and to the school people because we're looking to them for a lot of focus and a lot of direction in the area of addressing youth and adolescent drug and alcohol needs.

But what I'd like to do in speaking to you is be a little bit more specific about the agency that I work at and a little bit about my background which lends itself to an explanation of how we see the needs in our State today.

I spent 10 years in the educational community. About nine years ago I left because of my frustration of working with young people, seeing dysfunction take place, seeing kids come in under the influence, not being able to get families involved, and not being able to diagnose kids appropriately. That has been brought up today, too. Oftentimes these kids have fallen through the cracks in the system.

So, out of my frustration in not being able to address this problem within the classroom setting and within the school setting I left teaching. Nine years ago I entered the treatment field because that's where my real interest lied -- in working with these kids that had drug and alcohol problems.

I came to the Discovery House, and you have that brochure in front of you. Discovery House is one of the few residential programs in the State of New Jersey that treat a population of, right now, 18 years old and up. In the past we treated 16 years old and up.

What I began to recognize in working in the treatment community which was an 80 bed program, was that many of the people that were coming into treatment, they were coming in 10 years after their alcohol and drug history had already provided such dysfunction that they lost their jobs, they lost their families, and they could no longer cope with life. That's what brought them into treatment -- rock bottom. The rock bottom came too late. It came too many years after drug abuse and alcohol abuse had started.

I began to see something very interesting that there was a place for the treatment community in the schools. I had just left the schools, out of frustration. I was serving on the board of education along with the Chief of Treatment for the Department of Health. And the two of us in the six years that we were on the board of education were not able to bring in one prevention and education program into the schools.

What we noticed and what the frustration was, was that we were seeing kids in treatment who had either quit school or fell through the cracks in the system and made it through without being diagnosed, without having their problems addressed.

We were seeing kids in treatment who had a family history of chemical dependency and no one knew about it, kids who were involved with vandalism and illegal activities, and again, let me reiterate, that they would be coming to treatment very, very late. Statistically, treatment does not work as well as prevention.

We decided some years ago that we would take a piece of the treatment modality and bring it into the school setting. If we can get the kids at an early point in time, we would not have to respond to the overwhelming need for treatment that we saw happening.

And what we also saw happening in the treatment modality was that the population was changing. We were getting kids from more middle and upper-middle class homes and we were getting referrals for younger aged individuals that we would not treat in a residential facility.

So, what I want to talk to you about now is what we began to do some six years ago and what the State Association is strongly recommending and endorsing in working with the Department of Health and the Department of Education.

Might I add that I'm not sure if you people sitting up here today needed to hear from us, because it seems to me that you really understand the problem and you've already outlined some of the answers. I think, perhaps, you can give us some information, and we should reverse the seating arrangement.

But the thing that the State Association is recommending and what those professionals in the field are doing, is working with school districts to, number one: develop policy that reflects the philosophy of the school district.

Oftentimes the policies -- and that is drug and alcohol policies -- in a school district are archaic and very punitive, and only talk about what will we do when we find a child either under the influence or in the possession? It's very clear; we suspend or expel. There has been no other intervention that would provide service to these young people.

We're working with school districts to develop policies that reflect a different philosophy. I guess that philosophy is concurrent with what's going on in society today -- that kids need intervention services.

What will schools now do in conjunction with treatment facilities in other resources in the community to meet the need of this population of students that we're losing? That policy should outline intervention services and support services with student assistance personnel in the school that understand drug and alcohol addiction and know how to address that problem with young people.

The other piece of student assistance program would have developed curriculum on a K-12 basis. Right now, the mandate is for 10 clock hours in grades 7 through 12. That's too little too late.

The recommendation, and I think Gagliano's bill, is talking for education in K-12. What is that curriculum in education all about? It's not the physiological effects of drugs. It's more than that; it's more than that. It's building self-image, understanding interpersonal relationships, learning about making decisions.

Our youth is turning to drugs because they're not feeling very good about themselves. Many of them don't have support systems in the family. We have to help kids to understand that there are alternatives to a high. The recommended curriculum will do that, will give kids a whole new basis in a frame of reference as to how to deal with life.

Another piece of student assistance programs would be in-service training for school personnel. How do you acknowledge and respond to a kid who is at risk early on? What are the indicators that tell you that there's a kid in trouble and that kid needs an intervention, and an early intervention, before it's too late?

The worst kind of referral for treatment for a student is self-referral, because when a kid refers themselves, it's because they are completely out of control and desperate, and that comes very late in the addiction. The best type of referral is from either parents or teachers because it comes a lot earlier than the kid's recognition of the problem.

So, our school people need in-service training in understanding the curriculum; and in understanding what is an addiction, how do I recognize an addiction early on, what are the resources within my community, and how do I refer within my school setting? Is there support for me?

Most often we hear from teachers that say, "I know this kid's in trouble, I know this kid is abusing, but I'm turning the other cheek because I don't have the support system to help me move this kid through our system. So our teachers and our front line people need more support and that will be done with clear cut policies within our schools.

In-service training is also essential for parents. There's been a lot of talk today about parents. Well, let me say that over the years that we have been continuously frustrated with the turnout of parents when we offer all types of services -- parenting groups, communication groups, and information groups. Schools can't get parents out any more. We're hearing that all across the State and probably all across the country.

I understand that families have all types of other issues that are taking priority to them coming out at night. But the bottom line is if we don't get parental involvement and

if we don't get families to respond to the needs of adolescents, whatever legislation takes place and whatever type of programs we begin to see in schools, we're still going to be spinning our wheels. We're not going to change the course of a kid's life if they're coming home to the same dysfunctional family. I don't know what type of legislation could be recommended to bring parents out, but that's certainly a very grave concern on our part.

The fourth piece of the student assistant program would be counselors in the school. I know the Ogden bill is addressing that the high schools in New Jersey have student assistant counselors that can address the drug and alcohol problems of our youth.

Let me just add one thing that I think would be an interesting piece of information. In my treatment facility, Discovery House, we pre-test all of the individuals that come into treatment, no matter what their age is. If they don't have a high school diploma, we provide a high school equivalency program for them. So all of our people are tested in reading and math.

We find, almost without exception, that the reading grade of an individual -- and for example, that would a 19-year old, 20-year old, 25-year old coming into treatment -- their reading grade is always synonymous with the age at which abuse took place. So that a 20-year old reading on the seventh grade level when we do the psycho/social, we find that around the age of 12 that individual was abusing drugs.

What that says to us and what that says to all of you is that abuse and learning can no longer go hand in hand. When someone is abusing, they are not learning and they are not growing, either physically or psychologically. And there certainly is that indication with the type of testing that we're doing.

But we also find that when we start responding to the emotional needs of this person and helping them build a self-image and understand who they are and start to work with the family, their reading level often increases about four years in a ten month span of time. That's an important message to our school community.

We're not going to increase reading scores and math scores by bringing in new types of reading programs; we're going to increase the academic achievements of kids by responding to their emotional needs. Obviously, by responding to drug and alcohol dysfunction, because again, as soon as the kid starts to abuse, they cease to learn.

I guess the last thing I would like to leave you with as recommendations from our State Association is something we feel very strongly about. There are not the types of residential programs in the State of New Jersey for adolescents, and you've heard that all morning. Too many kids are being sent out-of-state. That's one problem.

The other problem is that I'm not quite sure that all of the kids that are being sent out-of-state are in need of residential treatment. That should be the last step.

Our goal is to keep kids in their communities, and certainly with the many community-based programs that we have, there are services available to kids.

Again, insurance has continued to be a problem and there are long waiting lists. This crack epidemic has brought a lot of people out of the woodwork. Last year Myrna was working in a school in Monmouth County and she called our office at Discovery to ask us if we had heard of crack because the kids were starting to talk about it. I hadn't heard of crack last January and most of the people in our treatment agency had not heard of crack. So we see how fast this happens.

Again, I want to applaud you for some of the legislation that's already pending. I think what you have out on the floor right now is what's needed to address some of the

problems: curriculum in all grades in the schools, student assistance counselors in the high schools and certainly recommended for the lower grades, and the other piece was the residential services. We should not ever have to send one kid out-of-state. And what happens when we send them out of state is we return them to the same school, the same dysfunctional family, the same peer relationships?

The insurance industry is wasting millions and probably billions of dollars. And what happens when we get this kid home from residential treatment is that the treatment agency has exhausted the medical insurance and now there is no money for family therapy in aftercare. So that's another issue that down the road should also be addressed.

I want to thank you and--

SENATOR COSTA: Ms. Cohen, we want to thank you for your work and for your feeling of responsibility in this field. You've done a marvelous job and we appreciate you being here. Do you wish to address us, Ms. Zito?

M Y R N A Z I T O: No. Connie said it all.

SENATOR COSTA: Thank you so much. I found it very interesting. If there are questions here -- Senator Brown?

SENATOR BROWN: Could you clarify for me the difference between a student assistance counselor and a drug abuse counselor?

MS. COHEN: I'm glad you asked that question because that's now being addressed on the State level with the different departments. For somebody providing drug and alcohol treatment or substance abuse services in a treatment facility comes under the auspices of the Department--

SENATOR BROWN: Let's stick with the school situation because there are people that came here today saying that it should be mandated that there be substance abuse counselors in school. And then there is the Ogden legislation and you're

recommendation that there be the student assistant person in the school. I'm a little confused as to what's the difference?

MS. COHEN: Between a student assistance person and a substance abuse person?

SENATOR BROWN: Of course.

MS. COHEN: It's the same. A schools-based person is a person who's considered a student assistance counselor providing substance abuse counseling.

The question right now is what should be the credentials of that person? Right now the Attorney General, and the NJEA, and the State Association is trying to determine what will be the credentials and the criteria for that position.

What we've had up until now is different people assuming those responsibilities in school. Depending upon the school district, some hire guidance counselors, some hire certified alcoholism counselors, some hire teachers who have some background in chemical dependency. There is no criteria.

One of the things the State Association is doing in conjunction with the NJEA and Department of Education is establishing criteria for those substance abuse counselors that will work in the schools as student assistance people. So it's really one in the same.

SENATOR COSTA: Don?

SENATOR DiFRANCESCO: No.

SENATOR COSTA: Thank you very much. Is there anyone else here before we close this that would like to testify. (No response) I see you've stayed here and I appreciate that very much. With that the public hearing is over. Thank you so much, Senators, for being here. That's very nice of you.

(HEARING CONCLUDED)

APPENDIX

New Jersey Foster Parents Association

P.O. Box 220, Middlesex, NJ 08846 • (201) 356-0667



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Recruitment Assistant

SENATE COMMITTEE ON CHILDREN'S SERVICES

Honorable Catherine A. Costa, Chairman

Public hearing to discuss the problem of substance abuse among adolescents, examine current state policy, and consider legislative initiatives to address this problem.

September 23, 1986
State House Annex
Room 407
Trenton, New Jersey

Testimony of:
New Jersey Foster Parents Association
Sue Dondiego, President

Our testimony today contains documented facts, many questions and few, if any solutions.

It is a fact that substance abuse is becoming, if it is not already, the number one problem in the United States. It is a leading cause of child abuse and neglect, a primary reason for teenage pregnancy, contributes to adolescent suicide, accountable for an increase in serious juvenile crime and responsible for the death and injury of hundreds of thousands of teenagers, each year.

The New Jersey statistics are staggering. It is estimated that:

there are 36,000 adolescent alcoholics

91% use alcohol before the 10th grade

44% of adolescents between the ages of 12-17, abuse drugs or alcohol, or both substances

almost 3,000 adolescents are sent out of state for alcohol abuse treatment

approximately one/sixth of the adolescents under DYFS supervision are pregnant now or are already parents

over 10,000 babies are born each year to mothers under the age of 19

Drinking alcoholic beverages and taking or selling drugs has become attractive. Have a drink - relax, make friends and find romance. Use drugs - be one of the "in" crowd, be invincible. Sell drugs - get rich, only the stupid get caught.

Compounding the problem of substance abuse is the lack of adequate programs - for prevention; for the occasional user; or for those who are addicted to drugs or are alcoholics and are a serious threat to themselves or to others in the community. We believe, in spite of the seriousness of the problem, that children, adolescents and teens should remain in their communities. Once they leave the community, we are only adding to the problem.

Many children are placed in foster care because of abuse, neglect or family difficulties resulting from substance abuse. The primary goal for every foster child is return home, when at all possible. How are foster children going to return home if there are no appropriate treatment programs for their parents?

Adolescents and teens, who are not serious users of drugs or alcohol, could very well be kept in the community in foster care - the least restrictive form of out of home placement and the most cost effective. Pregnant teens and teens with babies would also benefit by remaining in their communities. But how are we going to find foster parents to take on this responsibility when there are no programs for these young adults, no supports for foster parents or no specialized training to acquire the skills foster parents will need to provide the proper care and motivation to prepare these young people for independence?

JX

Every effort should be made to keep even serious substance abusers in the community. If this is not possible, we must at the very least, keep them in New Jersey.

It is unfortunate, that much of what we do in human services is crisis oriented. Serious situations must exist before concern or support is found.

We must find a way to address the immediate need of those ready using drugs and alcohol. More importantly, we must make an exerted effort at prevention.

We urge the Departments of Health, Education and Human Services to work together on this problem which crosses departmental lines.

We urge the support and expansion of existing programs which work and the development of new, inovative programs where they are needed.

We urge this Committee to support those testifying today who have offered viable solutions to the present crisis.

If we do not address this serious problem today, we can all be sure we will be addressing a far greater problem tomorrow.

TESTIFY

Senator Costa, committee members, my name is Gail Larkin. I am speaking to you today on behalf of Senator Thomas Gagliano.

The SENATOR CANNOT BE WITH US TODAY BECAUSE HE IS APPEARING BEFORE THE BOARD OF DIRECTORS OF NJ TRANSIT ON ANOTHER PRESSING MATTER. HE HAS ASKED ME TO APPEAR ON HIS BEHALF.

SENATOR GAGLIANO HAS INTRODUCED LEGISLATION, Senate Bill 2559 THAT WOULD ESTABLISH CURRICULUM GUIDELINES FOR THE TEACHING OF DRUG AND ALCOHOL EDUCATION PROGRAMS IN THE ELEMENTARY SCHOOL, AS WELL AS IN THE UPPER GRADES, WITH SPECIAL EMPHASIS ON GRADES FOUR THROUGH EIGHT. THE LEGISLATION WOULD PROVIDE FOR IN-SERVICE TRAINING FOR TEACHERS AND WOULD PROVIDE GRANTS TO LOCAL SCHOOL DISTRICTS FOR THE ACQUISITION OF INSTRUCTIONAL MATERIALS NEEDED TO SUCCESSFULLY IMPLEMENT THESE PROGRAMS.

I AM SPEAKING HERE TODAY TO LET YOU KNOW THAT SENATOR GAGLIANO HAS A DEEP PERSONAL CONVICTION, AS A SENATOR AND A FATHER, TO ELIMINATING SUBSTANCE ABUSE FROM OUR CHILDREN'S LIVES. SENATOR GAGLIANO URGES QUICK LEGISLATIVE ACTION ON HIS LEGISLATION TO GIVE US AN EFFECTIVE TOOL TO FIGHT DRUG AND ALCOHOL ABUSE.

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ALL OF US HAVE SEEN THE HEADLINES. WE HAVE SEEN THE PICTURES OF DRUG
PUSHERS SELLING THEIR DEADLY WARES TO SCHOOL CHILDREN. BUT THERE IS ONE
GLARING STATISTIC THAT HAS RECENTLY BEEN PUBLICIZED THAT CLEARLY
ILLUSTRATES THE MAGNITUDE OF THE DRUG ABUSE PROBLEM WE NOW FACE. ONE
HUNDRED AND FOUR DRUG SALES TOOK PLACE ON THE GROUNDS OF A PASSAIC
ELEMENTARY SCHOOL IN ONE DAY. THE DRUG DEALERS WERE UNKNOWINGLY SELLING
TO UNDERCOVER POLICEMAN.

WHILE PUBLIC SCHOOLS PLAY A MAJOR ROLE IN OUR EFFORTS TO COMBAT THE
USE OF DRUGS AND ALCOHOL BY OUR YOUTH, CURRENT DRUG AND ALCOHOL PROGRAMS
IN SCHOOLS ARE PRIMARILY DIRECTED TOWARD INTERMEDIATE AND HIGH SCHOOL
STUDENTS. THERE IS CLEAR AND CONVINCING EVIDENCE THAT IF WE ARE TO CURB
THIS GROWING EPIDEMIC, IT IS ESSENTIAL TO REACH THE CHILDREN IN THE
PRIMARY AND LOWER ELEMENTARY LEVELS AS WELL.

WE MUST NOT ONLY GIVE THEM INFORMATION ON WHAT DRUGS CAN DO TO THEIR
GROWING BODIES BUT WE MUST ALSO PROVIDE THEM WITH THE COPING SKILLS
NECESSARY TO RESIST PEER PRESSURE TO EXPERIMENT WITH DRUGS. SENATOR
GAGLIANO'S LEGISLATION IS ONE WAY TO DO THIS.

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COMMISSIONER DREW ALTMAN

NEW JERSEY DEPARTMENT OF HUMAN SERVICES

SENATE COMMITTEE ON CHILDREN'S SERVICES

SEPTEMBER 23, 1986

Chairman Costa, members of the Senate Committee on Children Services, I would like to thank you for the opportunity to make some remarks today on the problem of substance abuse. As a very new father, I share the concerns of parents everywhere about this issue; one which has such a critical impact on our society and our children's future. I want to commend you for demonstrating your commitment to this issue through these important hearings.

I am here today because I am personally committed as Commissioner of Human Services - a department which touches one out of every eight people in our state - to participate in the development of an overall effort in New Jersey to fight substance abuse. This is a top priority for our Governor, who has a strong record in this area, and for Attorney General Cary Edwards and the statewide Task Force on Substance Abuse.

In my testimony today I would like to highlight the many ways in which substance abuse impacts on my department, and outline a series of initiatives we have on the drawing board to play our part in a renewed effort in New Jersey to tackle this problem.

Substance abuse is indeed a serious problem. It is one that has far reaching economic, social and health consequences. Recently, the following has taken place:

- o "Crack", a cheap, deadly and highly addictive form of cocaine, has exploded on the scene as the new middle class drug of choice.

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- the use of marijuana has nearly doubled among youngsters age 12 to 17 in a recent 10-year period.

- the use of cocaine among high school seniors has almost doubled between 1975 and 1985.

- 5,000 teenagers die each year in alcohol-related auto accidents, which are the number one killer of our young people.

The picture in New Jersey is much the same. Substance abuse affects more of our children than any other single problem. 350,000 of our youngsters between the ages of 12 and 17 use drugs or alcohol. Worse, experts say, our young people are turning to drugs at even younger ages. Many are addicted before they even reach seventh grade. The average age when a child begins to drink is 13. We must begin to change this picture.

My Department, perhaps more than any other, deals with the underlying causes of substance abuse. Substance abuse is, first and foremost, a symptom of deeper problems plaguing our society, including poverty and unemployment, the breakup of the American family, mental illness and others. Our welfare programs, our initiatives for the homeless, our DYFS programs aimed at helping children and families, and our mental health programs will have to be strengthened if we are to deal not just with symptoms but with the underlying problems that breed substance abuse.

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Just as my department is striving to address many of the underlying causes of substance abuse, we must also cope with the fallout from substance abuse across all of our divisions.

- Drug and alcohol abuse is a contributing factor in child abuse, domestic violence and elderly abuse.

- up to 65% of child abuse cases are related to substance abuse.

- Substance abuse tears apart families and forces children into foster care.

- 1/3 of the families whose children enter foster care have a substance abuse problem.

- It contributes to the onset and severity of mental illness and can lead to suicide.

- 36% of clients in a hospital study of the mentally ill showed histories of substance abuse.

- in the last year, there has been a 25% increase in the number of substance abusing youth who seek treatment in our community mental centers.

- more than 30% of suicides are substance abuse related.

- Alcohol abuse by pregnant women causes fetal alcohol syndrome and mental retardation in newborns. This affects almost 1,000 babies in New Jersey each year.

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° It increases the likelihood of dependence on welfare and medical assistance programs (Medicaid).

- one in five of those on general relief have had a substance abuse problem
- as much as twenty to thirty percent of all medicaid hospital costs can be tied to drug and alcohol abuse.

° Approximately 60% of the AIDS cases in New Jersey are the result of drug addicts sharing infected needles. Beyond the human tragedy, this significantly impacts our Medicaid program which pays for the largest share of AIDS medical care.

° Most painfully, we as a State see 1200 - 1500 adolescents annually go out of state for residential treatment services that are not now available in New Jersey.

We deal with the consequences of substance abuse and its related problems in my department in personal as well as statistical terms. Let me give you two examples of the casualties of drug abuse we deal with.

1. Mary is a 16 year old female currently in placement. She has had two hospitalizations for drug treatment and suicide. She has experimented with alcohol, cocaine, marijuana, LSD, PCP, amphetamines, diet pills and speed. She has attempted to kill herself by suffocating herself with a pillow, drowning herself and stabbing herself with a knife. She has shown aggressive and violent behavior toward her

11x

mother. She has been diagnosed Alcohol Dependence-Continuous; Cannabia Dependence-Continuous; Unspecified Substance Dependence-Continuous; Cocaine Abuse and she has been classified Emotionally Disturbed.

2. Another example is Joe. He is a 15 year old youth currently in placement in a detention center. He has a history of drug/alcohol abuse and criminal/delinquent activities. He has experimented with alcohol, marijuana, cocaine, LSD and mescaline. He has been charged with burglary, possession of stolen property and disorderly conduct. He has collected his friend's urine to change the testing results for his own drug tests. His older sister is currently in jail on drug charges. Joe attempted to hang himself in the detention center, has threatened to commit other suicide attempts, he has displayed aggressive behavior to the staff and and he has destroyed property. School history includes pulling a knife on other students, fighting, attention-getting behavior, inappropriate comments and walking out of the classroom. He has been classified Emotionally Disturbed.

Joe and Mary are just two of the many youths that our department is trying to spare from a dismal future.

In our effort to make a contribution to an overall statewide initiative, we have several new initiatives on the drawing board for the Governor and the Task Force to consider as part of an overall substance abuse program. Several of these are general strategies and some are more targeted.

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° Because we know that troubled teenagers today face multiple problems that are not always dealt with effectively through fragmented programs, I am working with the Governor's Office in developing a package of integrated services for troubled adolescents.

° In just a short period of time, our child assault prevention program has proven to be an effective vehicle for reaching communities, educators, and children in schools across our state. We are considering expanding this program to send not just a child abuse but a substance abuse message as well.

° We are considering the development of a statewide substance abuse awareness, education, and prevention effort implemented through the Human Services Advisory Councils and Youth Service Commissions which exist now in each of the twenty one counties in our state. These organizations are natural vehicles for pulling together community leadership and for developing programs.

° We are considering modifying our very successful "Kids on the Block" program (which through puppets teaches children about the developmentally disabled) so that it also sends a substance abuse message to children. This is a very popular and effective program and this modification could be readily achieved.

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° Through an inter-agency agreement with the Department of Health, we will be locating substance abuse counselors in each of our DYFS offices around the state. We are also training staff in our institutions to recognize and deal with substance abuse problems.

° As you know, Governor Kean has made welfare reform a top priority for the State. Our efforts through welfare reform to move welfare recipients into jobs cannot help but alleviate the idleness and unemployment which is a major cause of substance abuse in our society.

I want to emphasize that many of these are preliminary ideas on our drawing board which may or may not ultimately be integrated into the Governor's initiatives or the work of the statewide task force. They do serve to indicate, however, that my department is committed to addressing an effective, coordinated approach to serve the child and adolescent with substance abuse problems.

There are also several bills before this legislature dealing with substance abuse which, as Commissioner of the Department of Human Services, I support. Some of these deal with early prevention and education programs for children; school and community based programs; pilot projects for the mentally ill and mentally retarded chemical abusers; studies of childrens' needs; residential facilities for the adolescent substance abuser who now, too often, we are forced to place out of state; mandated insurance coverage for alcohol and drug treatment; and others.

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In closing, I want to thank the Committee for giving me the opportunity to speak to you today. I look forward to developing a close relationship with you, the legislature and the Governor on this important issue. I will also look forward to reviewing any recommendations this Committee may compile in the areas I have discussed.

SENATE COMMITTEE ON CHILDREN'S SERVICES
PUBLIC HEARING - SEPTEMBER 23, 1986
SUBSTANCE ABUSE AMONG ADOLESCENTS

Remarks by: William H. Fauver, Commissioner
Department of Corrections

Senator Costa and members of the Committee, I am pleased to participate in today's hearing and to provide information concerning the Department of Corrections' experiences with, and response to, the problem of adolescent substance abuse.

While this is by no means a new problem, its scope is everbroadening and its consequences far reaching.

At the Training School for Boys at Skillman, which houses our youngest offenders, 90-95% of all admissions have experimented with alcohol and marijuana before their 12th birthday and 95-99% of minority youth have admitted to trying marijuana at least once before the age of 9 years. Equally alarming is the range of substances which the youngsters admit to using on a regular basis. These include alcohol, marijuana, cocaine, crack, PCP, mescaline, LSD, amphetamines, barbituates and heroin.

While substance abuse is prevalent among all adolescents in our system, I have highlighted Skillman to demonstrate that even the youngest among us are not exempt from the danger.

The causes of the problem, and possible solutions to it, have been under investigation for as long, or longer, than I have been involved in Corrections. In spite of this, the only thing of which I am certain is that the problem is worse now than it has ever been. The overriding theme, reported by young people in our system, is that substance abuse begins in response to peer group pressure, as well as a need to get high to escape from whatever problems and pressures appear to have no other solution.

And once one becomes addicted, one needs money to support the habit. Therefore, it is not surprising that the crimes related to substance abuse center around selling drugs to get money to buy drugs or committing other crimes to obtain money or merchandise that can be sold to buy drugs.

It is imperative to mention here that we are witnessing an alarming increase in the number of young people who are involved in the sale of controlled dangerous substance. According to our residents, younger and younger children are being recruited by older youths and adults so that the latter can avoid lengthy incarceration.

To date, the response to the problem, within the Department of Corrections, has been diverse. Within the Division of Juvenile Services, the following approaches have been taken:

Skillman employs the services of a New Jersey State

certified Substance Abuse Counselor one day per week to provide drug education and treatment. In addition, each cottage has daily group counselling sessions which address behavioral problems, social issues, as well as, the problems of substance abuse.

The Juvenile Medium Security Unit, since its inception, has provided the services of Alcoholics Anonymous and Narcotics Anonymous.

Each Monday the Alcoholics Anonymous Program is conducted under the direction of a volunteer coordinator. The agenda for these sessions usually includes guest speakers, films and general group discussions regarding individuals participation with alcohol abuse. These meetings also provide an avenue for individuals, in a confidential setting, to discuss personal experiences that led to addiction.

The Narcotics Anonymous Program, is also conducted on a weekly basis. The program's format is augmented by films, guest speakers, books and general group discussions. Specifically, an attempt is made to have the juveniles involved in this program understand why drug dependency is such a paramount enigma.

Both programs also provide follow-up in terms of after-care once an individual is released from the facility. They direct and support program continuance in the community.

In addition to those programs, the Staff Psychologist provides individual therapy on a regular basis to those

chronic substance abusers. The actual therapy includes needs assessment, causation, value clarification and possible deterrents and foreseeable avenues for follow-up upon re-entry into the community.

At the Training School for Boys at Jamesburg there are substance abuse programs located in two cottages. Each cottage houses forty residents. The treatment program consists of academic, vocational training and group and individual counseling. Referrals are made to psychologists, psychiatrists and the Child Study Team in addition to peer-group counseling sessions and weekly Alcoholics Anonymous meetings.

Lastly, there are forty-four residential and day treatment programs within the Juvenile Division, all of which employ regular group counseling sessions to address problems which led to incarceration. Additionally, two programs, with a capacity of 60 beds, have been created for youth whose primary problem is Substance Abuse.

To more adequately address the problem of substance abuse among adolescents the Department of Corrections would require additional funding for an increase in the number of certified Substance Abuse Counselors, staff training programs geared specifically toward substance abuse, the development of substance abuse education programs and an increase in the number of substance abuse treatment programs within the institutions. Added to this is a dire need for better after

care and for more and better integration with community based treatment groups.

Even more important than the foregoing is the need for every concerned citizen to understand that this insidious problem can not be beaten by the sole efforts of any single group or agency. The cancer of substance abuse is all encompassing at all levels of our society. The pervasiveness of the problem is such that those entering the correctional system are only being temporarily removed from what they came from and what they are going back to. Therefore, even if we had all the money we needed to develop the most comprehensive of programs, any efforts and gains would only be neutralized if society in general does not band together to fight the disease at all levels. We do not need a superhuman effort by one group alone, we need a cooperative, long term attack by all groups, agencies and individuals throughout our society.

SENATE COMMITTEE ON CHILDREN'S SERVICES

PUBLIC HEARING

TO DISCUSS THE PROBLEM OF SUBSTANCE ABUSE
AMONG ADOLESCENTS, EXAMINE CURRENT STATE
POLICY, AND CONSIDER LEGISLATIVE
INITIATIVES TO ADDRESS THIS PROBLEM

September 23, 1986

Room 407
State House Annex
Trenton, NJ

Testimony Presented By:

John H. Rutledge, M.D.
Deputy Commissioner of Health
New Jersey State Department of Health

I AM JOHN H. RUTLEDGE, M.D., DEPUTY COMMISSIONER OF HEALTH. MOLLY JOEL COYE, M.D., STATE COMMISSIONER OF HEALTH, HAS ASKED ME TO TESTIFY BEFORE THIS COMMITTEE TO ADDRESS THE NEEDS OF YOUTH IN THE STATE OF NEW JERSEY SUFFERING FROM DRUG USE.

1. HISTORY

SEVERAL STUDIES CONDUCTED OVER THE PAST FEW YEARS HAVE RECOGNIZED THE PROBLEM OF DRUG USE BY YOUTH IN NEW JERSEY.

A SURVEY CONDUCTED BY THE NEW JERSEY ATTORNEY GENERAL IN 1980 INDICATED 67% OF HIGH SCHOOL STUDENTS REPORTED HAVING USED AN ILLICIT DRUG; 17.5% USED ILLICIT DRUGS REGULARLY. A STUDY BY THE ATTORNEY GENERAL IN 1983 FOUND SIMILAR PATTERNS OF DRUG USAGE. BASED ON THE ATTORNEY GENERAL'S SURVEY, IT IS ESTIMATED THAT 300,000 TO 350,000 NEW JERSEY YOUTH, AGES 12-17, HAVE USED ALCOHOL AND/OR OTHER DRUGS.

IN 1983, A STUDY BY THE UNITED STATES CONGRESS, HOUSE SELECT COMMITTEE ON CHILDREN, YOUTH AND FAMILIES INDICATED 8% OF ALL TEENAGERS HAVE SERIOUS DRINKING PROBLEMS AND 7-8% USE MARIJUANA DAILY. BASED ON THIS STUDY, IT IS ESTIMATED THAT 62,000 YOUTH IN NEW JERSEY, AGES 12-17, ARE PROBLEM DRINKERS AND ANOTHER 54,000 TO 62,000 USE MARIJUANA DAILY.

THE NEW JERSEY STATE DEPARTMENT OF HEALTH, DIVISION OF NARCOTIC AND DRUG ABUSE CONTROL'S CLIENT REPORTING SYSTEM INDICATES THAT 375 YOUTH AGES 11-17 ARE BEING TREATED ON A DAILY BASIS.

APPROXIMATELY 1,000 IN THIS AGE GROUP ARE BEING TREATED ON AN ANNUAL BASIS.

2. EFFECTIVENESS OF PRESENT POLICIES AND SERVICES FOR TREATING YOUTH IN NEW JERSEY

ANNUALLY, 1,200 TO 1,500 ADOLESCENTS GO OUT OF STATE FOR RESIDENTIAL DRUG TREATMENT DUE TO THE LACK OF RESIDENTIAL DRUG TREATMENT PROGRAMS IN THE STATE OF NEW JERSEY. MOST OF THESE ADOLESCENTS ARE THOSE WITH INSURANCE COVERAGE. THUS, THE INDIGENT AND WORKING POOR ARE EXCLUDED.

THE 80 OR MORE DRUG TREATMENT CENTERS (RESIDENTIAL AND OUTPATIENT) IN NEW JERSEY HAVE HISTORICALLY AND, PRESENTLY, SERVICE PRIMARILY DRUG USERS 18 YEARS AND OLDER. 95% OF THE DOLLARS COMMITTED TO TREATMENT IN NEW JERSEY IS USED IN PROVIDING SERVICES TO OLDER LONG-TERM ADDICTS.

58% OF THE 7,500 CLIENTS IN DAILY TREATMENT HAVE A PRIMARY DRUG ABUSE PROBLEM OF HEROIN AND AN ADDITIONAL 21% HAVE A PRIMARY DRUG USE OF COCAINE. BECAUSE OF THE SEVERITY OF DRUG ADDICTION AMONGST THE 18 YEAR AND OLDER GROUP, THE MAJOR EFFORT FOR TREATMENT IN NEW JERSEY HAS FOCUSED

ON CLINICAL INTERVENTION WITH THE SERIOUS ADDICTED POPULATION.

BECAUSE OF OUR LIMITED FUNDING, WE HAVE BEEN UNABLE TO DEVELOP NEW AND APPROPRIATE PROGRAMS TO TREAT YOUTH. OUR GREATEST NEED TODAY IS TO ESTABLISH NEW TREATMENT PROGRAMS AIMED AT SERVICING ADOLESCENT DRUG USERS.

THE PROBLEM OF TREATING YOUTH IS COMPOUNDED BY THE FACT THAT THERE ARE FEW PROGRAMS WITH SPECIALIZED CLINICAL INTERVENTIONS TO TREAT YOUTH ON AN OUTPATIENT BASIS AND NO RESIDENTIAL DRUG TREATMENT FACILITIES FOR YOUTH. AN ADDITIONAL PROBLEM IS THE LACK OF AFTER-CARE FOR YOUTH RETURNING TO NEW JERSEY FROM OUT-OF-STATE RESIDENTIAL PROGRAMS.

3. LEGISLATIVE EFFORTS TO ESTABLISH SPECIALIZED PROGRAMMING FOR YOUTH WITH DRUG PROBLEMS

THERE ARE A NUMBER OF BILLS PENDING BEFORE THE LEGISLATURE THAT ADDRESS A NUMBER OF ISSUES AROUND EDUCATION, PREVENTION, TREATMENT, AND FUNDING FOR DRUG PROGRAMS. WE IN THE DEPARTMENT HAVE A TRADITION OF SUPPORTING ANY EFFORTS BY THE LEGISLATURE THAT SUPPORT WHAT WE CONSIDER TO BE A VERY SERIOUS PROBLEM AND AMONG THE HIGHEST PRIORITIES OF THE DEPARTMENT. WHAT IS NEEDED IS A COORDINATED LEGISLATIVE AND POLICY STRATEGY.

WE LOOK FORWARD TO WORKING WITH THE LEGISLATURE AND OTHER DEPARTMENTS THAT CURRENTLY HAVE DRUG PROGRAMS AND WOULD LIKE TO CONSIDER OURSELVES A RESOURCE AS YOU GO FURTHER IN DEVELOPING A COMPREHENSIVE LEGISLATIVE PACKAGE.

THE DEPARTMENT HAS ALWAYS FELT THAT THE LEGISLATURE HAS ALWAYS BEEN INNOVATIVE AND SUPPORTIVE OF NOT ONLY PUBLIC HEALTH ISSUES, BUT ISSUES THAT EFFECT OUR YOUTH AND OUR COMMUNITY.



Rory Sparrow Foundation Inc.

Rory D. Sparrow
President

Cary P. Alleyne
Executive Director

Good morning Chairman Costa, Committee members!

To begin, I would like to thank this committee for the opportunity to testify on an issue which I spend a great deal of time and resources combating--that of substance abuse. What I have come to understand is that young people are attracted to drugs and like substances because, in the "final analysis" or the "bottom line" they don't have other alternatives for the use of their time. What I mean is that they don't have outlets, that they want to be involved with, available. What is key is--what they want to be involved with whether or not we as adults agree with it.

Hence a quick, easy, cheap alternative becomes drugs. And while the scourge of teenage substance abuse has begun to infect the entire society, it is and has been most acute in the urban slums and ghettos of America's inner cities.

We must begin to look at the problem from its broadest scope and devise a plan to combat the problem in its entirety not just a single problem like drugs.

Why, again, do young people turn their attention to drugs? School, in their eyes, is not a means to an end. Consequently, you have a staggering school dropout rate reaching up to a rate of 50% of high schoolers in urban areas. At the other end of the spectrum the suburban middle class youngster has nothing to earn, they are given everything. Both strata have the same problem--lack of incentive, lack of goals, and lack of initiative.

Along comes an alternative to reality--drugs--at best offering a buffer to reality, at worst a killer.

Values are completely distorted. The media with its vast array of information feeds us "Dynasty" and "The Colbys," hunger deprivation and starvation in Africa, revolution in Chile and indescribable lunacy to get you to buy "Obsession" perfume. Is it hip to have sex at fourteen (14)? Is it square to be a virgin at eighteen (18)?

Minds that are in the molding stage no longer have a set of values to use or a model during growth and maturation.

So where do you place your value? If we adults have a problem seeing through the maze, the confusion for young people can only be greater.

Parents today are spending excessive, albeit necessary, time working. Economics demands that wives and mothers work in these times. It means less parental input in the child rearing process.

~~Young people, with all their energy, curiosity and vigor are turned on to drugs for stimulation that should be coming from family, extended family and community. But drugs don't stimulate, drugs sedate. What begins as a "high or rush" turns ^{out} to ^{be} a sedative of the mind and spirit. Where they are lost, confused lacking in esteem or motivation they find consolation, if only for a few moments. In drugs they can hide from the Teacher that punishes, from the parent who ignores, from confusion from media, from failure, from lack of direction.~~

Today it is easy, quick and cheap to escape. The available drugs, most notably "crack," are more potent and cheaper than anything available before.

Where is it all coming from? I don't mean Columbia or Iran. I mean what have we bread as a people, as a nation, that for money one would import or sell or distribute such products to their neighbors. A significant part of the problem is in our adults' attitudes and priorities.

For years people such as David Winfield, Gary Carter, Nancy Reagan, myself and many others have cried out against this malicious killer. The problem of acceptance has not reached the turning point. The joint statement made by the President and Mrs. Reagan recently has brought home how critical the issue is most especially where it involves our children.

This year I was asked by the N.J. Foster Parents Association to be their spokesperson. I also sit on the Board of Directors of Boys Choir of Harlem, Inner City Ensemble, Tigerball, Inc., and Barnert Hospital and am President of the Rory Sparrow Foundation. Everywhere I interface with youth organizations the solution is similar. If and when a child is given an alternative and direction. when shown leadership and guidance, when they are involved in life, their self-esteem is lifted and reinforced, they don't have the time or desire for drugs. It is in keeping with the philosophy of the Rory Sparrow Foundation that if a person is endowed with a strong sense of self-esteem, motivation and awareness he or she has the inner strength to accomplish whatever their goals are and say no to outside influences such as drugs.

We must attack the problem from many sides. Our current education system was developed over a hundred years ago. It must be changed...overhauled. It worked well in an industrial age but this the information age and we must find the foresight, strength and money to bring a new focus to the educational system for it to meet the needs of today and tomorrow. The education system needs to refocus from competitive learning to specialized, personalized learning. Flexibility should be given to young people by giving more attention to interests of the young people, to give incentive. More pragmatic experience should be brought in to the educational process.

More alternatives directed at and for young people should be available in media. In a sense, give them what they want. Anyone learns better when subject matter is fun and attractive.

2Tx

While overhauling the education system ^May be a long term process, we can begin immediately in another way that can have immediate measurable effects.

That is through the extended family--community concept. As I stated, when a person is involved and directed he or she responds positively. In every community there are organizations which attempt to fill the voids in these young people's lives. Boys Clubs, YMCA's, neighborhood youth organizations, scouts, planned parenthoods, foster parents associations, after-school centers and the list goes on and on. These organizations, including the Rory Sparrow Foundation, and especially in inner cities, create alternatives. What may just be a neighborhood basketball league to you or I could be a life or death experience for a 12-year old who has nothing else through which he can build his self-esteem but that trophy from his local recreation center. There are enumerable like programs that perform a clear, necessary purpose but almost all have a common problem--lack of funds. They cannot provide the manpower or hours or equipment to meet the demand yet they are always begging for funds.

Heretofore it has been easy to say that these areas can always stand cutbacks, they are not vital. But I submit to this committee that we are witnessing the problem on our streets in the consumption of drugs. It would not be difficult for me to line up program directors to testify, whose programs are suffering and have a clear need for help. So I say to you, don't miss the trees for the forest. The solution is not simple but the key is to redirect your focus, get out of old patterns of thought and see the solution before you. These are your children as well as mine who are at risk.

In closing, I want to bring forth two observations or thoughts. First, is that we learned through the poverty programs of the sixties and seventies that pouring money into programs with no clear goals is only for the conscience and is not a long term cure. What I am suggesting is a cure process that with redirection of money and more important spirit...can cure our ills.

Secondly, is to make clear that the goal should be to develop a strong quality of self-esteem, self-awareness and self-motivation because it is self-esteem which ultimately will bring down and erase the need for the false realities of drugs and allow the young people affected to say "no."

Trends (1980-1983)

- . The past three years have witnessed an appreciable decline in the use of marijuana. Significant decreases are observed in the lifetime prevalence (61.4% to 56.6%), annual prevalence (51.8% to 47.2%) and monthly prevalence (36.1% to 28.9%) rates for this substance. 2, 3, 4
- . While the proportion of students reporting lifetime or annual use of alcohol has remained unchanged, there has been a significant decrease in the proportion of students reporting use in the past month (70.2% to 65.9%). 4
- . Although there has been a moderate increase in the number of students reporting use of amphetamines at some time in their lives (30.2% to 33.6%), use in the past year and past month have remained stable. 2, 3,
- . The use of cocaine has remained relatively stable between the 1980 and 1983 surveys. 2, 3,
- . A general decrease can be observed in the overall use of hallucinogens and barbiturates; of particular note are the declines in the annual prevalence of barbiturates (10.2% to 7.4%) and the monthly prevalence of barbiturates (6.1% to 4.4%). 2, 3,
- . A marginally significant decrease is evident in the use of tranquilizers with lifetime prevalence down from 13.4% to 10.9%, and annual prevalence declining from 8.3% to 6.2%. 2, 3

- . Reported use of heroin by high school students has remained unchanged over the three year period between the two surveys. 2, 3, 4
- . There has been a significant increase in the proportion of students who report sniffing glue at some time in their lives (10.3% to 13.4%). 2
- . No change is evident in the past three years regarding the use of cough syrups, methadone or aerosols as intoxicants. 2
- . Little overall change is evident in the number of students reporting illicit drug use at some time in their lives (67.3% in 1980; 64.9% in 1983). 13
- . The proportion of students reporting substance use other than marijuana at least once in their lifetime has increased from 42.7% in 1980 to 46.1% in 1983. 13

TABLE 2.

Trends in Lifetime Prevalence
of Twelve Substances (Percent)

	<u>1980</u> <u>Survey</u>	<u>1983</u> <u>Survey</u>	<u>Change</u> <u>1980-1983</u>
Alcohol	91.2	91.8	(+0.6)
Marijuana	61.4	56.6	(-4.8) <i>ss</i>
Amphetamines	30.2	33.6	(+3.4) <i>s</i>
Cocaine	16.6	17.8	(+1.2)
Hallucinogens	15.8	14.6	(-1.2)
Barbiturates	14.4	12.4	(-2.0)
Tranquilizers	13.4	10.9	(-2.5) <i>s</i>
Heroin	2.2	2.4	(+0.2)
Glue	10.3	13.4	(+3.1) <i>ss</i>
Cough Medicine	5.7	4.5	(-1.2)
Methadone	4.5	3.9	(-0.6)
Aerosol	3.7	4.0	(+0.3)

Levels of significance: *s* < .05; *ss* < .01

TABLE 3.

Trends in Annual Prevalence
of Eight Substances (Percent)

	<u>1980</u> <u>Survey</u>	<u>1983</u> <u>Survey</u>	<u>Change</u> <u>1980-1983</u>
Alcohol	87.6	86.9	(-0.7)
Marijuana	51.8	47.2	(-4.6) <small>ss</small>
Amphetamines	23.6	23.6	(0.0)
Cocaine	12.6	14.7	(+2.1)
Hallucinogens	12.3	10.4	(-1.9) <small>s</small>
Barbiturates	10.2	7.4	(-2.8) <small>ss</small>
Tranquilizers	8.3	6.2	(-2.1) <small>s</small>
Heroin	1.1	1.3	(+0.2)

Levels of significance: $s < .05$; $ss < .01$

TABLE 4.

Trends in Monthly Prevalence
of Eight Substances (Percent)

	<u>1980</u> <u>Survey</u>	<u>1983</u> <u>Survey</u>	<u>Change</u> <u>1980-1983</u>
Alcohol	70.2	65.9	(-4.3) ^{ss}
Marijuana	36.1	28.9	(-7.2) ^{sss}
Amphetamines	14.4	12.4	(-2.0)
Cocaine	6.4	7.5	(+1.1)
Hallucinogens	6.3	5.0	(-1.3) ^s
Barbiturates	6.1	4.4	(-1.7) ^s
Tranquilizers	4.0	3.0	(-1.0)
Heroin	0.7	1.1	(+0.4)

Levels of significance: $s < .05$; $s < .01$; $s < .001$

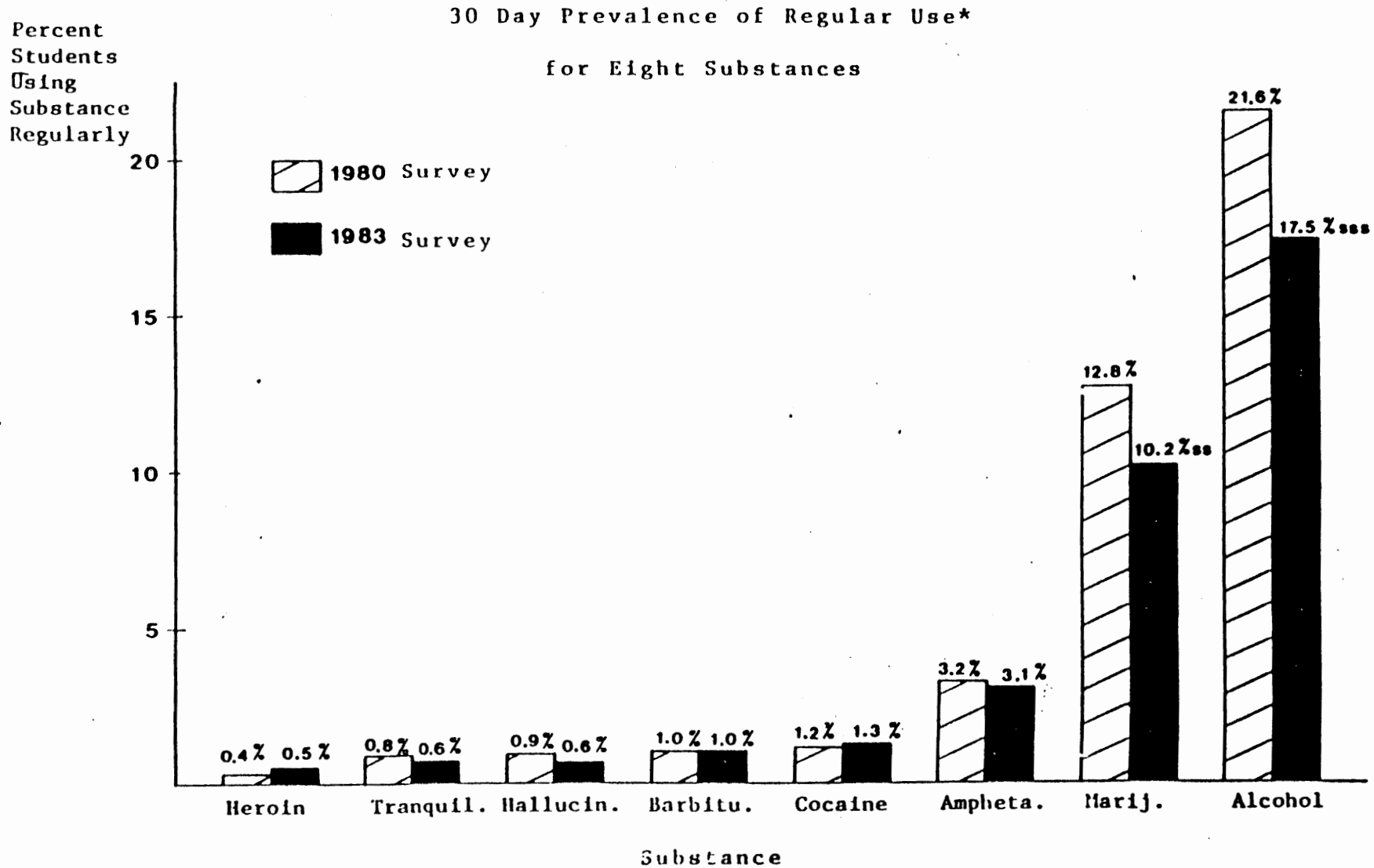
TABLE 5.

Trends in Recency of Use(Proportion of Students Ever Using Who
Have Used in the Past Month)

	<u>1980 Survey</u>	<u>1983 Survey</u>	<u>Change 1980-1983</u>
Alcohol	77.0	71.8	(-5.2) sss
Marijuana	58.8	51.1	(-7.7) sss
Amphetamines	47.7	36.9	(-10.8) sss
Cocaine	38.6	42.1	(+3.5)
Hallucinogens	39.9	34.2	(-5.7)
Barbiturates	42.4	35.5	(-6.9)
Tranquilizers	29.8	27.5	(-2.3)
Heroin	31.8	45.8	(+14.0)

Levels of significance: sss < .001

GRAPH A.



*Regular use defined as use on ten or more occasions in the last 30 days.

Source: Office of Drug Abuse Control, 1984

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FIRST USE

A series of survey items were included to obtain information concerning students' first use of drugs and alcohol. The students were asked to report the grade in which they first used each of eight substances. The data are presented in this section to indicate the proportion of students reporting substance use prior to entering tenth grade. Table 10 displays the number of students reporting first use of each listed substance before the seventh grade, during seventh and eighth grades and during ninth grade. The table then compares the total proportion of students reporting use prior to the tenth grade with the number of students who have ever used (lifetime prevalence) each substance. It is recognized that information regarding the age at which students begin substance experimentation is of key importance in determining the content of prevention efforts as well as the age or grades to which they are directed.

Four of every five students (81.9%) report some use of alcohol prior to tenth grade.

Two out of every five students (41.1%) report use of marijuana before entering tenth grade, while one in every five (20.1%) report the same for amphetamines.

Table

10

10

Table

- . The proportion of students reporting initial use of hallucinogens, barbiturates, cocaine and tranquilizers before tenth grade ranges from 6.9% to 8.7%, while 1.9% first used heroin during that period. 10

- . When considering only those students who have ever used each substance we find, with the exception of cocaine, that more than half have done so before entering tenth grade. 10

- . Almost all of the students (89.2%) who have ever used alcohol report first use prior to tenth grade, as do three-quarters (72.6%) of the students who report use of marijuana at some time in their lives. 10

- . A clear majority (59.6% - 63.3%) of the students who have ever used hallucinogens, amphetamines, barbiturates or tranquilizers report initial use before entering tenth grade. 10

- . Only with regard to cocaine do we find that less than half (42.1%) of those who have ever used report first use earlier than tenth grade. 10

- . Although the absolute numbers are small, we observe that four-fifths (79.2%) of those students who have ever used heroin have done so prior to tenth grade. 10

TABLE 10.

First Use of Eight Substances by Grade (Percent)

<u>Substance</u>	<u>Grade</u>			<u>Total Before 10th Grade</u>	<u>Ever Used</u>
	<u>Before 7th</u>	<u>7th-8th</u>	<u>9th</u>		
Alcohol	34.3	30.6	17.0	(81.9)	91.8
Marijuana	6.6	18.6	15.9	(41.1)	56.6
Amphetamines	1.9	7.3	10.9	(20.1)	33.6
Cocaine	1.0	2.1	4.4	(7.5)	17.8
Hallucinogens	1.0	2.9	4.8	(8.7)	14.6
Barbiturates	0.9	3.4	3.5	(7.8)	12.4
Tranquilizers	1.0	3.0	2.9	(6.9)	10.9
Heroin	0.6	0.4	0.9	(1.9)	2.4

TABLE 14.

Annual Prevalence by Self-Reported Academic Performance (Percent)

	<u>Alc.</u>	<u>Mar.</u>	<u>Amph.</u>	<u>Coc.</u>	<u>Hal.</u>	<u>Barb.</u>	<u>Trq.</u>
Total	86.9	47.2	23.6	14.7	10.4	7.4	6.2
Mostly A's	84.4	30.2	16.6	8.1	7.5	4.4	6.4
Mostly B's	86.2	40.7	20.3	11.3	7.6	5.6	4.4
Mostly C's	88.3	60.2	29.3	20.1	19.6	10.2	7.5
Mostly D's and F's	96.8	77.8	44.4	33.3	27.0	20.6	23.8

TABLE 21.

Trends in Factors Preventing Substance Use (Percent)Would prevent from
using drugs or marijuana:

	<u>1980</u>	<u>1983</u>	<u>Difference</u> <u>1980-1983</u>
Fear of Physical Harm	77.1	81.3	(+4.2)
Fear Trouble w/Law	66.2	71.7	(+5.5)
Parent Disapproval	55.5	59.5	(+4.0)
Fear Bad Grades	47.1	51.7	(+4.0)
Friends Disapproval	39.0	47.7	(+8.7)
Religious Values	29.7	30.7	(+1.0)
Nothing	11.9	11.2	(-0.7)

Would prevent from
using alcohol:

	<u>1980</u>	<u>1983</u>	<u>Difference</u> <u>1980-1983</u>
Fear of Physical Harm	62.8	65.9	(+3.1)
Fear Trouble w/Law	51.3	58.8	(+7.5)
Parent Disapproval	43.2	46.2	(+3.0)
Fear Bad Grades	38.9	43.0	(+4.1)
Friends Disapproval	23.8	30.3	(+6.5)
Religious Values	19.6	20.9	(+1.3)
Nothing	18.7	14.9	(-3.8)

TABLE 24. Substance Users - Trouble/Criticism

Those Who Have Used Marijuana (Percent)

Have you ever gotten into trouble with _____ for using marijuana?

	<u>1980</u>	<u>1983</u>
Friends	22.2	21.0
Family	19.8	15.1
Police	5.5	5.2
School	3.8	4.8
Have never gotten into trouble as a result of marijuana use.	72.9	78.7

Those Who Have Used Alcohol (Percent)

Have you ever gotten into trouble with _____ for using alcohol.

	<u>1980</u>	<u>1983</u>
Family	25.5	25.8
Police	9.9	10.0
Friends	9.8	12.5
School	4.1	4.3
Have never gotten into trouble as a result of alcohol use.	64.2	63.1

NEW JERSEY PTA

900 Berkeley Avenue
Trenton, New Jersey 08618
(609) 393-6709, 393-5004

September 23, 1986

TO: Senate Committee on Children's Services

FROM: Jean Socolowski, President

RE: Substance Abuse

I am proud to be here today to represent New Jersey PTA, New Jersey's oldest and largest child advocacy organization with 215,000 members. We appreciate the opportunity to testify on this important issue.

In the Interests of time, I will confine our testimony to specific recommendations. The corroboration and rationale for these recommendations are based on information and experience of our membership and officers and the data and findings contained in New Jersey's Action Plan for Childre, the report of the Governor's Committee on Children's Services Planning. Please know that we urge the inclusion of a strong evaluation component for all of the following recommendations.

1. New Jersey must develop a broad continuum of care and services for substance abusing and/or addicted young people. We recognize that treatment for alcohol related problems differs from drug related problems but, we are not discussing treatment modalities. Therefore, when discussing the need for treatment facilities and the enactment of appropriate legislation and the adoption of rules and regulations appropriate to dealing with treatment, mean regardless of the substance abused.

The continuum of care which must be created must include an adequate number of residential, out-patient and aftercare facilities. New Jersey's children should not have to go out of state to receive thekind of treatment they need. Nor should their treatment be sabotaged because there are not enough or appropriate aftercare programs in the state.

The use or programs and servicie should be based on themode whichis least intrusive yet appropriate for the individual. The individual should not be placed in the next more intrusive level of service without in depth evaluation

44x

If someone can be treated within the community in an outpatient program, do not put him in a residential program. These kinds of constraints must be built into the legislation or regulations creating and licensing these programs and facilities.

Proposals such as S 794 sponsored by Donald DiFrancesco would do much to begin the development of a network of care so badly needed in New Jersey.

- 2.A. Key to the establishment of an adequate number of treatment facilities and programs is the enactment of legislation that requires private carriers to ensure coverage for treatment of all substance abuse problems regardless of the substance abused or the age of the abuser.

Currently, New Jersey's private carriers only cover treatment for alcoholism. If coverage were extended to include treatment for all substances abused, a fiscal base adequate to stimulate the creation of treatment facilities could be provided. The lack of a secure financial base has been one of the most significant barriers to the development of an adequate number and type of treatment facilities and programs. There is certainly not enough money in the public coffers to provide such a base and families cannot afford the after tax expenditure of \$1,800 to \$3000 per week for residential treatment. While the cost of day treatment is significantly less, most families cannot afford extended out patient treatment without insurance coverage. And it is extended treatment that is required for drug abusing young people.

- B. Existing Medicaid provisions must be amended so that coverage for treatment of substance abuse problems can be provided at any recognized treatment program whether classified as a hospital or free standing treatment facility. It is unfortunate that the alcohol demonstration projects were terminated. These projects had been extremely successful and we are disturbed that they were terminated and that New Jersey did not request a waiver to continue them.

- C. It is essential that insurance coverage for both alcohol and drug related problems be offered by both the private insurance carriers and Medicaid. We cannot successfully address the treatment of substance abuse if we limit access to appropriate treatment based on ability to pay.

5. Minimum program requirements must be established for the regulation of substance abuse treatment programs for youth. Insurance carriers must not be allowed to shape treatment programs by determining which services will or will not be covered.

Insurance carriers are not treatment specialists. Their expertise does not include the development of appropriate treatment modalities. Treatment modalities should be the province of treatment specialists.

6. Coverage and rate setting for treatment programs for youth should be separate from adult substance abuse coverage and rate setting.

The program and treatment needs of young people are very different than for adults. The same program component criteria for coverage must not be used.

7. New Jersey should develop rules and regulations for licensing substance abuse treatment facilities.

While we recognize that this will be difficult to do, we believe that it is extremely important to monitor and evaluate the operation and quality of such programs. While we recognize that programs run by hospitals are subject to certain controls, free standing programs and facilities may not be subject to systematic evaluation. We believe it is important to develop such regulations for the protection of the patients and their families.

8. The Division of Alcoholism and the Division of Drug Abuse should be merged into one Division with regard to programs and services for children and youth.

Substance abuse in young people and the response to it must be a coordinated effort. Fragmentation of services and divergent philosophies is, at best, inefficient and does not maximize state resources. Additionally, poly-abuse and addiction are now the rule rather than the exception. Separate Divisions are, therefore, no longer appropriate given the nature of the problems.

9. New Jersey should seek the inclusion of substance abuse training in the licensing requirements and require inservice training for those already

licensed for all:

Physicians
Nurses
Paramedics
Social Workers
Mental Health Professionals
Educators
Police
Judiciary
Court In-tak: staff
Probation Officers

10. New Jersey must facilitate the inclusion of substance abuse counsellors in the state's school districts.

Several districts could share the services of one counsellor when communities are too small to justify the hiring of a full time counsellor. Ideally, the numbers of such counsellors per each school district would be determined by a student/counsellor ratio that would ensure adequate access to the counsellor.

11. Appropriate training must be developed to ensure that substance abuse counsellors have adequate training in both alcohol and drug abuse as well as counselling skills. Certification requirements should reflect such training.

Counsellors are now trained in alcohol or substance abuse and "certified" accordingly. Yet when they are working with students and the community they need to deal with both alcohol and drug use and abuse problems. Training must not continue to be provided for alcohol OR substance abuse qualification.

12. The Department of Education must provide a mechanism that facilitates the entry of substance abuse counsellors into the school system.

While it is certainly essential that the Department ensure that these counsellors have the skills necessary to dealing with the problems within their charge, the traditional barriers to their entry into the school system must not be allowed to bar their inclusion. Additionally, it must be recognized that substance abuse expertise cannot be obtained by designated teachers or guidance

counsellors in a few credit hours.

13. The Department of Health and the Department of Education should work together to establish guidelines for the education materials used and distributed in schools. All education materials should be scrutinized for subtle "do drugs" messages as well as reference to "responsible use."

Our youth cannot make a "responsible decision" to use alcohol when non-use is the only legal decision available to them. All education materials must clearly state that it is against the law for anyone underage to drink or for anyone to use drugs not prescribed by a licensed physician. In addition, a mechanism should be established for the continuing evaluation and revision of materials and for distinguishing between reliable and unreliable sources educational materials.

Alcohol and drug education is often sporadic and haphazard. The ultimate goal must be how to make decisions-not about whether to drink or not or use drugs or not-but how to say "NO". Curricula must not contain mixed messages. For example, when students hear don't drink and drive, they often come away with the message that it's O.K. to drink if you are not driving.

14. New Jersey leadership and government-legislature and executive agencies-should endorse the SAFE HOMES program which has already been endorsed by Governor Thomas Kean, Commissioner of Education, Saul Cooperman, the N.J. PTA, New Jersey Education Association, the New Jersey School Boards Association, New Jersey Principals and Supervisors Association.

We believe the intent of the 21 year old drinking age law is in jeopardy. Not because we fear that the legislature or the Governor will reverse their positions. But because New Jersey has, as many other states, fallen prey to a proliferation of insidious programs that have captured the attention of parents, educators, officials and sadly many in the drug and alcohol prevention fields. Often these programs are under the guise of prevention and education. They are neither; they are dangerous .

One of these programs offers rides to inebriated youngsters starting at age 14. We, who are desperate for answers are extremely vulnerable to programs that sound as though they are life saving, when in reality they

are just the opposite. To compound this travesty, they are unwittingly helping kids to break the law. Adults are taking liberties with other people's children by promising confidentiality to prospective intoxicated kids. In other words, the adults who organize and run these programs promise not to tell their parents. A brief description of how these ride programs work will help you to better understand our position.

A town that opts for this ride type program stations two adults and two teenagers at a "base station" located somewhere in town. They receive phone calls between 10:00 p.m. and 2:00 a.m. on Friday and Saturday evenings. Kids who have had too much to drink call the number that has been publicized through the school and other means. The adults then dispatch the two teens, one male and one female-often new drivers themselves-to pick up the intoxicated youngster.

In discussions with those law enforcement officials who concur with our concerns, they explain that, as well trained police officers, even they sometimes have difficulty physically restraining an intoxicated person. Yet those involved in support of these programs are not convinced of the dangers being placed on these teen drivers who transport their peers.

Adults and student drivers are committed to confidentiality. They may not notify the parents of kids they transport. When asked, some of the adults running these programs why they don't notify the parents, their answer is "because the kids won't call us next time." As a parent, how would you feel if it were your youngster who was drinking; your youngster who was being picked up on a regular weekend basis and you had no idea that your child was even into drinking or drug use?

When we try to convince the adults involved in this program that they could be inadvertently covering up for a child who has a serious alcohol or drug problem, their response is, "We are saving lives on the highway; we can't be concerned about all the other aspects of drinking and drug use." We strongly urge that they had better start to think about the other ramifications of teenage drug use and abuse-alcohol included. They had better start thinking about how it affects their entire lives, present and future. According to the New Jersey Department of Health and the Report of the Governor's Committee on Children's Services Planning, 300,000 to 350,000

New Jersey youth ages 12 to 17 use or abuse alcohol and other drugs. 62,000 teenagers are problem drinkers and 54,000 to 62,000 use marijuana daily. Unless these adults realize that intoxicated driving cannot be taken out of the context of the lives of the intoxicated kid, they will continue to help contribute to the problem.

We are concerned that these ride programs may unintentionally encourage more substance abuse. The kids may very well feel that they do not have to limit themselves because they are going to get a hassle free, confidential ride. Additionally, the limited hours of operation can also contribute to the problems of driving while intoxicated. "What does a teenager do when he calls for a ride at 2:10 a.m. and no one is there to pick up the phone to give him his ride home?" No one can answer this because these ride programs operate for eight hours a week out of a possible 188 hours a week. Kids have their stomachs pumped at all hours of the day and night, weekdays and weekends. We are not suggesting that these programs operate for 188 hours each week. We are merely trying to demonstrate that they are poorly conceived and a danger to our kids and the community.

We are caught in a dilemma. On the one hand how can we be against anything which might save young people from injury or death from drug related crashes? On the other hand, how can we support programs which facilitate breaking the law, the very law that was designed to save lives by discouraging under age alcohol use and drug use in general?

Another well meaning but ill conceived program is on that provides for a contract to be signed between parent and child. Under this program, students are encouraged which gives them permission to call their parents any time of the day or night if a friend or if they have been drinking and they need a ride home. The parents agree to pick them up with no questions asked at that time, with the expectation that a discussion will take place at a later date. Our concern is that the kids hear that their parents will leave them alone about drinking and parents hear that they will be able to talk openly with their kids. This is hearing something that is unrealistic at best. Because of the misinterpretation that results, parents and kids are driven further apart rather than closer together. Frankly, the program does not work. The usual scenario is that after the first few discussions, the kids feel "hassled" and stop calling. We are again faced with the dilemma of opposing a program whose intent is laudable.

What we need is a program that has more than good intentions; a program that works. A program that provides young people with a healthy way to socialize and parents with a means of being involved in helping their youngsters socialize without drinking or drug use. SAFE HOMES is just such a program. It is not a difficult program. Parents pledge that any parties held in thier homes will be both alcohol and drug free and that all parties will be chaperoned. This is a proven program which is working well in the communities that have adopted it.

15. New Jersey must enact legislation that would make it illegal to serve or sell alholic berages to underage youth.

Currently, serving alcoholic bereages tounderage youth is prohibited only on public property. S 2224 sponsored by Senator Graves would close the loophole for those drinking on private property and is essential for the full implementa: of the intent of a 21 year old drinking age.

16. New Jersey should adopt legislation similar to a law recently enacted in Maine. Under the Maine statute, drivers under the legal drinking age who register a breathalizer reading of .02 lose thier driving privileges for one year. In addition, Main lawmakers recently approved a statute which permits the administrative revocation of teen-age driving permits in cases where youth register a BAC of .02%.

New Jersey must take every reasonable measure to ensure that the intent of it laws is enforced. Young people must know that drinking underage is a serious problem and that New Jersey means what it says. The lives of these young people as well as the llives of all those on the roads depend on how firmly New Jersey is willing to stand behind the 21 year old drinking age.

17. The County Alcohol Councils should be expanded to include substance abuse in general. Their work should be coordinated with every community within their jurisidciton. These Councils should assist all communities with expertize and resources. Such councils should coordinate their activities with the County Human Service Coalitions in order to prevent duplication of services and inefficient use of public resources. Coordination should strive to achieve parityof program and services between communities. Their charge should be to maximize to use of public resources as translated into program and services.

18. The Department of Education must ensure that school districts develop suspension and exclusion policies that promote the best interest of the students. The need for suspension or exclusion from the general school population should trigger the need for evaluation by the district's substance abuse counselor.

Placing students who are not functioning acceptably in school, unsupervised on the streets so to speak, cannot be viewed as a productive strategy for remediating the students inappropriate behavior. If it is determined that the student has a substance abuse problem, then procedures which ensure that the student receive appropriate treatment must be initiated. While Title 6, Subtitle F, Chapter 29, Subchapter 9 of the New Jersey Administrative Code addresses this, there is no assurance that the districts are complying with this regulation as the Department does not keep records as to suspension rates. While County Superintendents do keep some such records there is no assurance that the policies urged here are being implemented consistently by the districts. Further, as school climate issues are not high on the school monitoring agenda, there is no reason to believe that districts will adopt appropriate procedures or if they do that they will implement them appropriately. In other words, the pragmatics of substance abuse problems in the schools not only requires that districts develop appropriate policies, but that these policies and their implementation be carefully monitored.

In closing, we urge that New Jersey must be careful to fund both treatment and prevention. If we continue to prioritize our funding toward treatment, we will do nothing to reduce the need for those treatment services. We submit to you that this is fiscally and morally irresponsible.

Substance abuse is a terrifying epidemic. There are not easy answers; no magic bullets. We are all scared and angry. We are looking to your government for leadership. We hope that in striving to adopt appropriate response to this issue, that you will reach out to form a partnership with the community you were created to serve so that we may work together to develop the solutions.

In three anti-drug speeches in six days in early August, President Reagan declared a "national mobilization" on narcotics abuse. PTA members are cheering, along with all others who have been working for so long in the fight against substance abuse. It is gratifying, sometimes astounding, to read, watch, and listen to the accounts of what is happening when public officials exert concentrated effort.

Like the alcoholic/addict who suddenly is brought to the realization that everything is lost, the swift consequences of 'crack' use are so devastating, the nation may suddenly have turned a corner and realized that it can no longer tolerate the drug culture.

For 87 years the PTA has been concerned about the effect of drug and alcohol abuse on children and families. Since 1963, delegates to National PTA conventions have passed 17 resolutions calling for action to bring to a halt the advancing problems. Two of the resolutions passed in 1985 were initiated by a New Jersey PTA chairman and submitted to national by vote of the state convention delegates. PARENT PLEDGE PROGRAMS places the responsibility for safe homes on parents and guardians, and ALCOHOL AND DRUG USE BY MINORS admonishes all adults to speak with

ONE VOICE - ONE MESSAGE - NO USE.

Currently, the National PTA supports bills at the federal level that would provide funding for drug abuse education and prevention, but does not support any attempt to tie federal education funding to whether or not a state or local education agency has a drug education program in place. Many federal education dollars are dedicated to special needs students. To jeopardize those programs and to place the U. S. Department of Education in a regulatory or instructional role would likely not have any impact in preventing or reducing drug use.

New Jersey PTA's latest state resolution (November, 1985) recommends that the State Department of Education retire all outdated and inaccurate drug/alcohol curricula material and prepare a resource list of material that gives the NO USE message; and that all members work with local school districts to provide children, at home and in school, with current information that carries a strong prevention component.

The 3rd National PTA "Drug and Alcohol Awareness Week" will again concentrate on problems and solutions March 1 to 7, 1987. Believing that children need to be shown that life without drugs can be exciting, the PTA also encourages children and families to participate in drug-free activities.

Nancy Reagan's prestigious position was the springboard for the success of the CHEMICAL PEOPLE and her continuing, visible efforts to stem the drug problem have now led to the JUST SAY NO campaign for children. A new project urging the formation of clubs for students begins this month. Activities will lead to a JUST SAY NO Walk Against Drugs on May 15, 1987.

All of PTA's efforts, more often scorned than respected, and those of numerous drug prevention and treatment agencies and organizations - local and national, public and private - have not been able to counteract the steady increase in public acceptance of drug use in the United States. For a long period of time our heroes and heroines, in Hollywood, in recording studios, on the TV screen, and on the athletic fields of America, have believed that 'playing' with drugs is smart, modern, and sophisticated. It has been very difficult for us to comprehend that those who deal in drugs are in the trade to make money. In the latest survey, Los Angeles teenagers cited peer pressure as the #1 reason for their drug use. Our children, and adult users alike, must learn early and remember that those who entice and drag others into usage are NOT friends nor are they interested in YOU. They are interested only in partners who share drugs and in the money which an addiction demands of the user. It is a sellers' market. Why would we be surprised that special targets are those with easy money or too much money often seeking attention, diversion, and companionship - sports figures, entertainment personalities, politicians, business people, and affluent teenagers?

Children accept the world literally as it is presented to them. America's young people deserve uninterrupted adult protection from those who rob them of their liberty and their opportunity. They will never understand their position as 'pawns' in this international game. They need adult examples to follow. They need to hear

from everyone in an authoritative position and everyone who loves them that there is no safe recreational use of drugs, and that we speak with

ONE VOICE - ONE MESSAGE - NO USE.

***** 30 *****

Before or after -----

As I was preparing material for this message, I received a packet of mail from National PTA which included a copy of the letter sent August 14 to each of the United States senators by National Vice President for Legislative Activity, Millie Waterman. I have incorporated some of her statements concerning drugs, PTA's involvement, and federal funding.

ACNJ

ASSOCIATION FOR CHILDREN OF NEW JERSEY

17 Academy Street, Suite 709
Newark, New Jersey 07102

September 15, 1986

TO: Senator Catherine A. Costa, Chairwoman
Members, Senate Committee on Children's Services

FROM: Ciro A. Scalera, Executive Director
Cecilia Zalkind, Governmental Relations Coordinator
Susan F. Conti, Staff Associate

RE: TESTIMONY FOR THE PUBLIC HEARING ON ADOLESCENT SUBSTANCE ABUSE

We are here today on behalf of the Association for Children of New Jersey (ACNJ) to present testimony on the issue of substance abuse among adolescents. We thank the committee for the opportunity to present our priorities and concerns in this important area.

ACNJ does not provide direct services nor does it receive any public funding. Rather, our Board of Directors, our staff and, most importantly, our members advocate on many of the significant issues that affect children and families throughout the state. From this diverse and broad base, we identify those priorities with which we become actively involved through legislative and legal advocacy, research, policy analysis, monitoring and outreach. Our range of issues is reflected in the variety of initiatives we have supported in the areas of child care, child welfare, juvenile justice, adolescent pregnancy, health, education and housing, among others.

Before beginning our testimony on programmatic and policy issues specific to substance abuse, we would like to address three related concerns. The first is the concept of prevention, which ACNJ strongly supports in relation to a number of issue areas. True prevention, **primary prevention**, is not the same as early intervention. Prevention addresses the root causes of a given problem or behavior **before** the problem begins to develop. At ACNJ, we believe that adolescent substance abuse, as well as adolescent pregnancy, juvenile delinquency, truancy and other school behavior problems, and teenage suicide are all symptoms of a greater underlying problem. Our youth lack both the skill and confidence to control their lives in this complex and demanding society.

As policy makers, we must approach this situation in much the same way we instruct parents to help their troubled children. Rather than continually focusing on the negative and telling them what they are doing wrong and what they can't do, which can cause a child to begin to believe he or she is bad and cannot do things right, we instruct parents to notice their children's good behavior, praise it and encourage them to continue doing similar things. This approach encourages a child toward more appropriate behavior and at the same time makes the child feel good about him or herself.

This same approach can be followed programmatically. We must balance the present influx of prevention programs (i.e. adolescent pregnancy prevention, substance abuse prevention, crime prevention, etc.) which, in essence, tell our children "Don't do that", with a strong emphasis on programs that encourage and help develop positive behavior. We must provide far more programs that promote **positive youth development**.

These programs present a viable role model while offering an arena for developing positive self-perceptions and life-skills. Young people involved in such programs gain feelings of self-worth, competence, and self-discipline; they learn communication skills, and how to make decisions and set priorities.

Positive youth development programs must be promulgated to address the needs of our youth at the three primary levels of socialization: the family, schools, and the community. Such programs have already been developed. Right here in New Jersey, for example, there are peer-leadership programs offered community-wide through several school systems. One county has piloted a social problem solving skills course in its elementary schools. Another county's Board of Chosen Freeholders has provided a program which teaches parents good communication skills for interpersonal relationships. To supplement these programs we also need more programs that support children and their families in everyday life, like child care, before- and after-school child care, and youth and family oriented recreation programs.

Secondly, we would like to express our frustration over the resistance of the Department of Education to accept and encourage the broad-based use of schools in the effort to provide essential programs and services for our children. Schools are a vital link between troubled children and the professionals that could help them. They are also, a potential resource for providing much needed support services such as school age child care and positive youth development programs.

We have, in numerous areas of the state, strong grassroot efforts which are making headway in individual school systems. The Department of Education, despite the success of many of these programs in meeting the needs of children and families, continues to maintain that it must narrowly focus on its mandate to educate our youngsters. It is time the Department of Education recognized that **troubled children cannot learn**. If the Department of Education wants to fulfill its mission, it must support and encourage the development of programs to aid our children at the point at which children are most accessible - the schools. The Department of Education must be more open to working with others in meeting the needs of our children.

Third, we would like to address our concern over the lack of balance exhibited in the present furor over drug abuse. In addition to failing to question or address the root causes of the present drug epidemic, the various spokes-persons and the media rarely, if ever, note that alcohol is a drug. Because of its legality and social acceptability (for adults) alcohol is the most accessible of all drugs. It is most often the substance that initiates our children to drug usage and abuse. And it is the drug that "costs" our society the most: according to the Research Triangle Institute of North Carolina, in 1983 drug abuse (excluding alcohol) cost the nation's economy \$60 billion; alcohol abuse, that same year, cost \$117 billion. Clearly, we must take care to focus on the entire spectrum of the drug problem in our state and our society.

At ACNJ, we have a number of concerns about the system and programs that are attempting to meet the needs of the vast number of New Jersey's youth with substance abuse problems. This is a very complex problem - one that is not easily addressed in the brief period we have here. For that reason, we have attached to our written testimony the complete text of our recent ACNJ Newsletter entitled **"Substance Abuse in New Jersey: Our Kids are in Trouble"**. In it you will find statistics on the extent of the problem as well as a more detailed examination of the systemic problems and the recommendations we will make here today.

POLICY ISSUES: PLANNING, COORDINATION AND FUNDING ARE ESSENTIAL

Urgent Need for Interdepartmental Effort

Substance abuse by youth impacts upon every system that serves adolescents; each of these systems must become part of the effort if we are to overcome this pervasive problem. A concerted effort must be made by all the State Departments and community agencies that serve youth to work together to meet the need. This was a major recommendation made over a year ago by the Governor's Committee on Children's Services Planning. Furthermore, a very similar recommendation for coordinated planning was made even earlier in the 1982 report by the Governor's Committee, "Linking Policy with Need". Both of these recommendations were strongly supported by ACNJ. We are now reiterating that call for coordination and cooperation; the time has come for implementation. Other states have accomplished similar interdepartmental efforts; New Jersey can too.

Merge The Divisions of Alcoholism and Drug Abuse and Narcotic Control

The first step toward unification must begin in the Department of Health, which separates substances between the Division on Alcoholism (DOA) and the Division on Narcotic and Drug Abuse Control (DNDAC). This separation creates barriers on the funding and programmatic levels that interfere with service delivery. Treatment programs funded by one department or the other have been known to turn away youths in need because they were primarily abusing the "wrong" drug - (poly-abuse is now the norm with adult as well as adolescent abusers).

This separation of the Divisions also creates the need for a substantial degree of duplication of effort, especially at the administrative level. This is clearly an inappropriate use of scarce financial resources.

Regulatory Licensing System Crucial

There are currently no state regulations governing adolescent substance abuse treatment programs (with the exception of health and safety standards for residential programs) There is no mechanism for insuring even minimum standards for program content or staff qualifications. This is a grave omission in a system that is treating such highly troubled and vulnerable children and families, an omission that creates the potential for serious problems.

We must develop a regulatory licensing system for adolescent substance abuse treatment programs that will insure quality programs staffed by qualified professionals. Appropriate treatment of adolescent substance abusers requires personnel with expertise in substance abuse, adolescent development, child abuse and sexual abuse, and family systems therapy. Given this complexity, strict educational and background qualifications should be required for staff. Ratios must be set determining the proportions of staff that must be certified professionals, in training, and aides. Finally, a mechanism must be built in that will require regular ongoing program evaluation.

Balance Insurance Reimbursement

Insurance coverage also differentiates between drugs. While many plans cover alcohol abuse rehabilitation, very few reimburse for drug abuse treatment. Conversely, Medicaid pays for drug treatment and does not pay for alcoholism treatment. Additionally, there are thousands of New Jersey low-income youth with no insurance coverage. These discrepancies in reimbursement must be overcome if we are to seriously impact on the substance abuse problems of our youth.

Insurance regulations have an even greater influence on treatment. Many insurance plans pay only for residential treatment. Others pay a far lower percentage of the costs of after-care and other non-residential treatment approaches than they do for residential treatment. We believe this encourages excessive institutionalization of youth - a problem that has already become a major concern in other states. Finally, insurance companies usually require linkages with accredited hospitals, either medical or psychiatric, which may be unnecessary in terms of the needs of the youngster or the quality of service, yet drives costs up considerably.

We must begin to influence insurance companies to investigate whether it would be more cost effective to reimburse all levels of care equally than to pay the high cost of residential treatment over and over for the same youths.

PROGRAMMATIC ISSUES: A BROAD CONTINUUM OF CARE IS THE ONLY ANSWER

A Severe Shortage of Needed Services

A "conservative" estimate by the New Jersey Department of Health indicates that 1200-1500 New Jersey youth were admitted to residential treatment programs in Pennsylvania, Delaware and New York in 1984. Additionally, substantial numbers of young people were treated for their substance abuse problems in residential programs in Minnesota, Ohio and elsewhere. Clearly, New Jersey has an obligation to provide sufficient quality services to meet the needs of our youth.

A Broad Treatment Spectrum Is Essential

The following services, listed in the order through which a given youngster would travel, represent the treatment continuum for assuring recovery of the greatest number of adolescents. We urge that care be taken to maintain an appropriate balance of services as more programs are brought into New Jersey. The entire continuum is essential if we are to help our youth overcome their substance abuse problems.

Prevention: Research has shown that effective targeted substance abuse prevention programs are intensive and ongoing. They begin in primary school and continue through 12th grade. Support services must be built in, to provide "someone to talk to" for the children of substance abusers as well as other youngsters who are experiencing problems. Additionally, we should be providing training to those who work closely with children, to help them recognize the behavioral clues of a child that needs help.

Early intervention: is contingent upon people who work closely with children being trained to identify children experiencing a problem. Success in this approach to early intervention is contingent upon providing appropriate resources, such as specially trained school counselors, to follow through on the intervention.

Assessment/Evaluation This task requires a high level of skill; both under-and over-reaction by the diagnostician can lead to inappropriate treatment recommendations. Optimally, evaluations should be done by an independent entity to prevent possible vested interests interfering with the diagnosis.

Primary Treatment: As with treatment efforts in all fields, the least invasive effective intervention should be sought for all youth. At present, primary treatment is almost exclusively provided in residential facilities. We recommend that in New Jersey we develop a range of primary care programs, which might also include intensive day-treatment and home-based services.

Transitional Care Services: are a key component essential to the recovery of substance-abusing youth as she/he returns home to community and peers. At present, in New Jersey there are only one or two halfway houses for adolescents and very few outpatient after-care programs. In order to maintain an appropriate balance, we should seek to develop at least one-to-two halfway houses for each residential facility. After-care programs require intensive involvement of both the youth and his/her family members for an extended period of time. We recommend that a wide network of after-care programs be developed at the community level.

Support Groups: are an essential component of the treatment spectrum. Involvement with support groups is begun in the earliest stages of primary treatment and is to be continued well beyond completion of professional treatment. This ongoing support is especially crucial as the young person returns to school, where he or she is certain to be exposed to substances again.

At present AA (Alcoholics Anonymous), which primarily serves and is geared toward adults, is the single most utilized support group. While we recognize and applaud AA's phenomenal success with adults, we feel that our youth need both more guidance and leadership in the self-help process and a broader range of programmatic support. We recommend a special programmatic initiative to develop a broad network of special targeted youth support groups, utilizing the AA model as well as other appropriate models. These programs should include appropriately structured and lead meetings for recovering addicted youth, early intervention peer support groups for those youth that had been abusing substances but were "caught" early, and pre-adolescent (and ongoing) support groups geared toward prevention.

Family Involvement is Crucial To Positive Outcomes

Alcoholism has been identified as a "family disease" for over 15 years - this concept extends itself to other drugs of choice as well. In dealing with an adolescent substance abuser, family treatment is a must. The level of involvement should be intensive and ongoing throughout the youth's treatment. Siblings, who have been identified to be extremely high risk as well as parents, should be involved. We recommend that substance abuse programs be required to include intensive educational, behavioral, and emotional family treatment in their programs. Some allowance should be made, though, to permit treatment of those youth whose parents refuse - after extensive efforts - to participate.

Additionally, adult treatment programs must be required to develop family treatment services: these are practically non-existent now. The children of substance abusers are at high-risk for child abuse, sexual abuse and to become substance abusers themselves. The lack of these services is a serious omission.

SUMMARY

We strongly recommend then the development of far more true prevention programs that stress positive youth development. Concurrently, New Jersey must work toward a well planned, coordinated, quality continuum of care that is financially accessible to all families and youth in need. An interdepartmental planning/quality assurance group made of representatives from all the state departments (including the Department of Education) and community agencies serving children and families must be developed. That group must work toward developing a regulatory licensing system to assure quality and toward increased funding. Only with such a concerted effort can we hope to overcome the ever increasing debilitation of our youth due to substance abuse in our society.

Substance Abuse in New Jersey

Our Kids Are in Trouble

By Susan F. Conti
ACN. Staff Associate

- 300,000 to 350,000 New Jersey young people aged 12-17 abuse alcohol or other drugs.
- About 62,000 of our youth have serious drinking problems.
- 54,000 to 62,000 adolescents smoke marijuana daily.
- 20% to 40% of New Jersey's children live in homes where one or both parents are chemically dependent.

These statistics, released last summer by the Governor's Committee on Children's Services Planning in their *New Jersey's Action Plan for Children* and in ACNJ's *Abandoned Dreams: New Jersey's Children in Crisis*, reveal the alarming extent of substance abuse in the state. Yet these statistics fall far short of describing the devastating impact of substance abuse on both the chemically dependent individual and all of his or her family members.

When parents abuse substances, their children suffer a broad range of severe physical and emotional damage; the pain is often life-long. The children of abusers of alcohol and other drugs are at far greater risk of child abuse and sex abuse. The *New Jersey Action Plan for Children* states that one study of members of Alateen, a self-help group for the children of alcoholics, found that 40% had been the victims of incest.

Women with alcohol problems during pregnancy are at high risk of giving birth to babies suffering from Fetal Alcohol Syndrome and Fetal Alcohol Effects. FAS and FAE can result in a broad range of serious, irreversible physical and/or mental impairments to children. According to a report recently released by the Governor's Council on the Prevention of Mental Retardation, FAS is the third leading congenital disorder associated with mental retardation; as many as 200-1000 infants in New Jersey alone might be born each year suffering the effects of their mother's drinking.

The overwhelming emotional impact of parental substance abuse on children is undoubtedly the most widespread phenomenon. The painful uncertainty and utter helplessness of a child in the face of the erratic behavior of a parent living in a

chemical haze has far-ranging repercussions — on the child's sense of self, as well as his or her relationships with others and society as a whole.

Sadly, due to a combination of factors including the genetic predisposition, learned behavior and, likely, an attempt to numb their own pain, these children are at 50% greater risk than others to become substance abusers themselves.

Whether young people begin using substances because of familial learning, peer pressure, or simply because consuming alcohol (most especially) is socially acceptable/expected adult behavior they wish to emulate, they are at greater risk than adults of becoming chemically dependent. Many in the treatment field ascribe to the "5/15 Theory": while an adult can become addicted in 5 to 15 years of substance abuse, the same results may take only 5 to 15 months for an adolescent, and 5 to 15 weeks for a pre-adolescent.

That chemical dependency develops more rapidly in young people may be related to the susceptibility of physical immaturity. But a large portion of the problem undoubtedly lies in the increased emotional susceptibility of adolescence.

As drug usage increases, favorite activities as well as responsibilities, fall by the wayside. When the young person is sober she/he begins to feel badly — so "gets high" again to numb the negative feelings. As substance abuse continues the cycle intensifies.

It does not take long before the young person's relationship with family members becomes seriously deteriorated, there are discipline and academic problems in school, and important social ties are broken. By this point, the youngster is consumed with guilt, shame, and an overall negative self-image.

Substance abuse interrupts all aspects of adolescent development. Substance abuse can damage the central nervous system: even the earliest changes affect the emotions, judgment, memory and learning ability. In all, adolescent substance abuse interferes with normal physical, emotional, intellectual and social development.

Devastatingly, adolescent substance abuse, like adult abuse, wreaks havoc on the entire family system. Parents are either

unaware of the cause of their child's changed behavior, disbelieving or devastated. Younger siblings are at very high risk of abusing substances themselves. Certainly, everybody hurts.

Most horrendous of all: the four leading causes of death in 15 to 24-year-olds — auto accidents, suicides, homicide and drug overdose — are often related to substance abuse. As stated in *Abandoned Dreams*, at least 30% to 40% of automobile accidents, the leading cause of death among New Jersey adolescents, are drug or alcohol related; and the suicide rate for this age group has tripled in the last thirty years.

PREVENTION & TREATMENT ISSUES

Clearly, New Jersey's youth need our support if we are to stem the ever growing tide of adolescent substance abuse. There has been, of late, a growing effort to better address the problem, but many systemic problems must be overcome if we are to succeed. The fact that there is a shortage of treatment facilities has been recognized for some time, but many other problematic issues have been less evident.

A Severe Shortage of Services

Despite the well documented number of New Jersey youth with serious substance abuse problems, there are few treatment programs in the state geared specifically to adolescents. A "conservative" estimate by the New Jersey Department of Health indicates that 1200-1500 New Jersey youth were admitted to residential treatment programs in Pennsylvania, Delaware and New York in 1984. Additionally, although statistics are not kept, substantial numbers of young people were treated for their substance abuse problems in residential programs in Minnesota and Ohio. Even so, as late as June 1985 there were only three residential treatment programs for adolescents in this state.

Some efforts have been made since that time: the Department of Health has issued several required "Certificates of Need" to permit new facilities to open. If all of the programs that had been slated to open had done so, there may now be as many as seven residential programs in New Jersey with the total capacity to serve approximately 2000 adolescents.

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Kids in Trouble

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adolescents at a time.

A Continuum of Care: The Necessary Range of Services

Much more than residential treatment is necessary, though, if adolescents are to overcome their dependency on chemicals: an entire continuum of services is essential. As one AA (Alcoholics Anonymous) member recently said, "Releasing an adolescent from residential treatment directly back to home and school is the same as sending an adult from treatment to a bar."

The following services, listed in the order through which a given youngster would travel, represent a treatment spectrum for assuring recovery of the greatest number of adolescents.

Prevention Programs are mandated in all schools, yet the extent of these programs varies greatly. Research has shown that effective programs are intensive and ongoing. They begin in primary school and continue through 12th grade. Support services are built in, providing "someone to talk to" for the children of substance abusers as well as youngsters who are experiencing problems. As prevention programs are refined and strengthened, fewer youngsters will need to progress further along the continuum.

Early Intervention is contingent upon people who work closely with children (teachers, school nurses, doctors, police, emergency room staff, etc.) being trained to identify children experiencing a problem. These professionals must be made aware of symptoms of adolescent substance abuse problems, and taught the appropriate steps they must take to intervene. Much of the success of this approach to early intervention is contingent upon providing appropriate resources, such as specially trained school counselors, to follow through on the intervention.

Assessment/Evaluation services are next on the continuum. This task requires a high level of skill: both under- and over-reaction by the diagnostician can lead to inappropriate treatment recommendations. Optimally, evaluations should be done by an independent entity, to prevent possible vested interests interfering with the diagnosis. At present these services are primarily performed by treatment facilities.

Primary Treatment is largely provided in residential facilities, except for those youths with relatively minor use problems. Residential programs range generally from 4 to 6 weeks, while a few extend to 3 months duration. As with treatment efforts in all fields, the least invasive intervention should be sought for all youth. One provider in New Jersey is starting an intensive day-treatment program which may be unique in the country and may be a step in the right direction for some youth. Whatever the level of intervention necessary, primary treatment *must* provide services tailored

specifically to adolescent developmental needs.

Transitional Care Services are a key component essential to the recovery of substance abusing youth. Either halfway houses or after-care services, depending on the level of drug involvement and the home environment, are needed to help the youth maintain sobriety as she/he returns to community and peers.

At present in New Jersey there are only one or two halfway houses for adolescents. There are a couple of programs for adults which accept a few teens — but they do not provide specialized services. There are very few outpatient after-care programs at present despite the fact that these are needed for the greatest number of returning youths.

Support Groups are an essential component to the treatment spectrum. Involvement with support groups is usually begun during the Primary Treatment stage and continues long after the programmatic treatment

their meetings.

Another issue involved here is the appropriateness of AA involvement for those youth whose substance abuse problems were caught early. Should a young person who is truly not addicted to substances be asked to take on a lifelong label of "alcoholic"?

This is not to say that self-help support groups are not needed, in fact, they are essential if we are to help our youth. What is needed are broad networks of appropriately structured and lead youth AA meetings, early intervention peer support groups, and pre-adolescent peer groups geared toward prevention. These must be developed throughout the state.

Other Programmatic Issues

There are other concepts and issues related to the treatment of adolescent substance abuse and the entire continuum of care spectrum.

Family Involvement: Alcoholism has been identified as a "family disease" for over 15 years — this concept extends itself to other drugs of choice as well. There is strong evidence indicating a genetic propensity for developing addictions. Even if this is discounted, anyone who lives with an addicted person is affected by that person's behavior.

In dealing with an adolescent substance abuser, family treatment is a *must*. The level of involvement should be intensive and ongoing throughout the youth's treatment. Siblings (who have been identified to be at extremely high risk), as well as parents, should be involved. At present, although some residential facilities include family treatment in their program descriptions, these services are very limited, usually include only parents, and often are only educational in content — which fails to address either the behavioral or emotional factors.

Additionally, adult treatment programs must be influenced to develop family treatment services: these are practically nonexistent now. Given the high-risk factors for child abuse and for future substance abuse by the children of clients, the lack of these services is a serious omission.

Staff Training and Evaluation are also concerns given the intricacies of effective treatment and the complexity of the problem of adolescent substance abuse. Appropriate treatment requires personnel with expertise in substance abuse, adolescent development, child abuse and sexual abuse, and family systems therapy.

This population is not only suffering the effects of substance abuse, but is also going through a very difficult developmental stage. An additional complication is the fact that a high proportion of the youngsters in treatment are victims of child abuse and sexual abuse. Figures coming out of Minnesota indicate 50% to 80% of youngsters in treatment have been sexually abused. While the magnitude of these statistics may be open to question, no doubt

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SAVE THESE DATES

Helping Kids Face
The Challenge of the '80s
"Sex, Drugs and Rock 'n' Roll"
MARCH 12, 1986

A North Jersey Advocacy Conference
at
Montclair State College
call ACNJ office for more information

■ ■ ■ ■

Networking for Growth:
A Call to Assembly For
Youth Service Professionals
MARCH 24, 1986

at
Mercer County Community College
call 609-586-9446 for more information

■ ■ ■ ■

A Southern Regional
Child Advocacy Conference
Sponsored by ACNJ
MAY 15, 1986

at
Glassboro State College
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process is completed. The single most utilized support group is Alcoholics Anonymous (AA).

The success of self-help and support groups is predicated upon an "identification" factor. Members achieve mastery over their problems because they are involved with groups of people much like themselves who are dealing with similar problems. Questions must be raised about the effectiveness of asking adolescents, who are developmentally at the stage of rebelling against adults and adult authority, to "identify" with a group of adults. This concern is increased when considering the fact that many AA members resent what they perceive as adolescents "intruding" on

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there is a lot of sexual abuse. There is, therefore, a real need for treatment personnel to have a strong background in the special needs of troubled youth.

The need for in-depth family treatment further compounds the demands upon staff's ability. Family therapy requires a very high level of specialized skill. That the parents of adolescent substance abusers are often chemically dependent themselves adds still another demand on an already highly taxed staff.

Given the broad spectrum of knowledge needed by treatment professionals and the high level of skill necessary for successful intervention, it would seem that strict educational and background qualifications should be required. Are there set standards requiring Certified Alcoholism Counselors (CAC) to have additional training specific to troubled adolescents? Are those providing family treatment required to be specially trained in family therapy? What about other staff members: are there set regulations determining the proportions of staff that must be certified professionals, in-training, and aides?

Conversely, in the cases of family service and mental health agencies which also provide services to youth and families with substance abuse problems, are there regulations requiring specific substance abuse training on the part of those providing treatment?

An additional concern is the fact that most adolescent substance abuse treatment facilities are staffed to a large degree by people who are themselves recovering substance abusers. In New Jersey treatment facilities, former substance abusers constitute anywhere from 70% to 100% of the staff. Especially when considering the large number of untrained aides used in these programs, we must ask: what mechanism is used to objectively evaluate whether these staff members are sufficiently recovered from the impact of their former substance abuse experience to be treating our youngsters?

These issues and concerns must be looked into as we seek to expand service provision to adolescents and their families. Staff training requirements and a regular evaluation mechanism should become integral components as the treatment system grows.

A LACK OF PLANNING/ COORDINATION/FUNDING

Successful implementation of the full continuum of care described above is contingent upon many other issues being addressed. Clearly, New Jersey's youth are in desperate need of unified systematic support.

Interdepartmental Effort

Substance abuse by youth impacts upon every system that serves adolescents; each of these systems must become part of the effort to overcome this pervasive problem. A concerted effort must be made by all the State Departments and community agencies that serve youth to work together to meet

the need.

This was the central issue and major recommendation of the Governor's Committee on Children's Services Planning. Their *Action Plan for Children* recommends such an Interdepartmental Committee include representatives of:

- Division of Alcoholism
- Division of Narcotic and Drug Abuse Control
- Department of Education
- Division of Youth and Family Services
- Division of Mental Retardation
- Division of Mental Health and Hospitals
- Department of the Public Advocate
- Department of Corrections
- Department of Community Affairs
- Department of Law and Public Safety
- Department of Labor
- Administrative Office of the Courts
- Youth Services Commissions
- Local agencies
- Experts in treatment and prevention

An additional recommendation: such a committee should include consumer representation, both youth and parent.

Granted, developing such a committee into a working group, given the bureaucratic intricacies involved, may initially be a cumbersome and complex task. But only through a joint effort of *all* the systems that impact on the lives of young people can we hope to overcome the adolescent substance abuse problem. Other states have accomplished similar interdepartmental efforts; New Jersey can too.

Two Divisions

Such a coming together should begin with the Department of Health, which separates substances: there is a Division on Alcoholism (DOA) and the Division on Narcotic and Drug Abuse Control (DNDAC). The reason for the separation of the Divisions may have been appropriate at one time, but is no longer: poly-abuse is the norm. (AA has an expression: "The true alcoholic is a dinosaur.") An adolescent may have a favorite drug, but almost universally abuses a variety — alcohol, marijuana, amphetamines and cocaine. Treatment programs funded by one department or the other have been known to turn away youths in need because they were primarily abusing the "wrong" drug — despite the fact that treatment is substantially the same. (Only heroin addiction requires a substantially distinct treatment approach.)

Unbalanced Insurance Reimbursement

Insurance coverage also differentiates between drugs. While many plans cover alcohol abuse rehabilitation, very few reimburse for drug abuse treatment. Insurance companies use this distinction as an "out" — if a youth's primary drug of choice is one other than alcohol, they can and often do refuse coverage.

Insurance regulations have an even greater influence on treatment — both service delivery and the development of the treatment continuum. Many insurance

plans pay only for residential treatment. Others pay a far lower percentage of the costs of after-care and other non-residential treatment approaches than they do for residential treatment. This encourages excessive institutionalization of youth and likely a major contributor to the lopsided development of services on the treatment continuum. Additionally, insurance companies usually require linkages with a credited hospital, either medical or psychiatric, which may be unnecessary in terms of quality of service, yet drives costs up considerably.

An inevitable result of these unbalanced payment practices is that youths return from residential treatment directly to an environment in which they began drug usage without the necessary follow-up support services. We must begin to influence insurance companies to investigate whether it would be more cost effective to reimburse *all* levels of care equally than to pay for residential treatment over and over for the same youths.

Low-Income Youth

There is also the issue of low-income youth. Contrary to most private insurance, Medicaid pays for drug treatment and not for alcoholism treatment. In addition, always, there are the thousands of New Jersey youths with no insurance coverage. In all, untold numbers of our youths with substance abuse problems have very little chance of receiving treatment.

The most probable outcome for many low-income youths is that their substance abuse problems will become worse and worse until they become involved with the juvenile justice system.

Cost of Treatment

Additionally, there is no systematic monitoring fees charged by treatment providers in the state. The cost of residential treatment ranges from \$125 per day to \$1100 per day, with no appreciable difference in service provided. The most expensive programs are those linked to private psychiatric facilities.

Coordination/Networking

Poor coordination of services in the adolescent substance abuse treatment community goes far beyond the lack of an adequate continuum of care. Networking between services providers is limited to narrow lines of communication. To some extent, providers are not even aware of other programs that exist. This poor communication, needless to say, limits the sharing of knowledge and resources considerably.

As in many fields, there are concrete barriers that must be overcome if true networking is to occur in the adolescent substance abuse field. Providers legitimately believe in the effectiveness of their own treatment approach: they have seen it work to help young people overcome substance abuse problems. Their own strong convictions sometimes lead them to overlook the

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6/14/81

Association for Children of New Jersey
 Academy Street, Suite 709
 Newark, New Jersey 07102

March-April Conference Calendar

Kids in Trouble

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fact that different people respond to different approaches.

We need a variety of methods of treating adolescent substance abuse problems in order to best meet the different sets of needs of all the young people suffering from the affliction. There is much to be gained if we begin to systematically break down the barriers to networking and coordination. The greatest benefit will be to our youth.

What is needed, as the Governor's Committee recommends, is an interdepartmental planning/quality assuring group that includes representatives from all the state departments, community agencies, and consumers. That interdepartmental body must work toward increased funding and standardization of staff training and evaluation requirements. New Jersey must work toward a well-planned, coordinated, quality continuum of care that is financially accessible to all families and youths in need. Only with such an effort can we hope to overcome the ever increasing debilitation of substance abuse in our society.

For a comprehensive, in-depth discussion of many of the issues mentioned in this article, see the Governor's Committee on Children's Services Planning's New Jersey's Action Plan for Children or call their office at (609) 292-1343. Also call Susan Corti of the ACNJ office, at (201) 643-3876.

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|-------------|---|--|
| March 18-21 | Hyatt Regency
Washington, DC | "The National Conference of the Child Welfare League of America: Children '86."
For more info write to CWLA, 440 First St. N.W., Washington, DC 20001 or call (202) 638-2952. |
| March 19-22 | Sheraton
New Orleans, LA | "National Youth Professionals' Institute." A conference for professionals who work with youth. For more info contact Ms. Arrington, Conference Coordinator 1-800-424-9105, (202) 483-0103. |
| March 21-22 | Ramada Inn
East Hanover, NJ | "One Voice, One Message. NO USE!"
First statewide conference on drugs/alcohol and youth. Honorary Chairman, Governor Thomas H. Kean. For more info write to N.J. Federation for Drug Free Communities, Inc., P.O. Box 702, Livingston, NJ 07039. |
| April 1-4 | Wyndham Franklin
Plaza Hotel
Philadelphia, PA | "American Public Welfare Association Northeast Regional Training Conference." The Philadelphia, Pa. theme is Innovative Service Delivery in a Changing Welfare Environment. For more info write to APWA 1986 Conference, P.O. Box 1125, Harrisburg, PA 17108. |
| April 11-13 | Sheraton Centre
New York, NY | "Free to Be Children." Presented by N.Y. State Council for Children. For more info contact Joan Anderson c/o ECEC, 66 Leroy Street, New York, NY 10014. |

New Jersey spends a billion and a half dollars a year on its illegal drug habit. That is not the cost of the drugs purchased by those who choose to break the laws. It's the price New Jersey residents - most of whom are law abiding citizens - pay for law enforcement and incarceration, treatment, health insurance premiums and work-related problems as a result of illegal drug use.

Despite the high financial toll of illegal drugs, their use is spreading. We know that at this point, almost half of all crimes that are prosecuted are drug related. About one-third of all offenders are under the influence of drugs when they commit a crime. And the number of drug arrests has doubled since 1984.

A recent tri-county round-up of drug peddlers by the Statewide Narcotics Task Force most vividly illustrates the problem. The task force, which I created last March, targeted 222 individuals in Passaic, Mercer and Atlantic Counties for arrest. They all allegedly sold illegal drugs.

Most horrifying is the fact that almost half of the defendants, 104 of them to be exact, had allegedly been selling crack, a highly addictive, purified form of cocaine, in one elementary school yard. With children no older than six or seven just feet away, drug pushers were trading tiny capsules of crack for fees of \$15 or \$20.

Worse, I am told that once we cleared that somewhat organized group of drug peddlars off the school yard, another faction was ready and anxious to move in.

We know that at least some of the sales were to youngsters. I suppose that shouldn't be surprising.

Two previous surveys conducted by the Department of Law and Public Safety, had revealed that the drug problem is particularly acute among our young people.

The 1984 survey showed should that:

- 65 percent of all New Jersey high school students have used drugs.
- 57 percent have used marijuana, 34 percent have used methamphetamine, and 18 percent cocaine.
- 17.5 percent of the students use drugs on a regular basis.

And I suspect that when the report is updated next January, we will find the situation has worsened.

At the same time, the Governor's Committee on Children's Services Planning has estimated that 20 to 40 percent of New Jersey children live with a parent who either abuses drugs or alcohol.

Clearly, unless this problem is brought under control, we can be assured that the next generation will continue to suffer the devastating effects of drug abuse.

At the same time I am painting a very bleak picture, I must also tell you that law enforcement is not and cannot be the answer to the drug crisis.

Yes, as the state's chief law enforcement officer, I am saying that we police, investigators, prosecutors and lawyers cannot look to win this war.

The profits from the sale of illegal drugs are too great. All too many unscrupulous individuals cannot pass up the opportunity to make a quick buck or, probably more accurately, a quick hundred or thousand dollars, depending on the level at which they are dealing drugs. As we have already learned, every time we arrest drug dealers and get them off the streets, others quickly take their places.

Please don't misinterpret what I am saying. Of course, law enforcement plays a very important part in the battle against illegal drugs. In fact, a great deal of the Narcotics Task Force's efforts are focused on reducing the supply of drugs through law enforcement.

We have hired 35 new State Police officers assigned exclusively to the fight against drug trafficking. We've added approximately 20 of the best professional undercover agents, accountants, analysts and prosecuting lawyers to fight this war.

We're investigating organized crime influences in this market and are creating a computerized data bank so we get a better handle on the scope of the problem, as well as its complexity.

But the fact remains that we cannot be operating with tunnel vision. We have learned from experience that a supply-side assault such as I have described should only be considered part of the strategy. In the present escalating environment, we

must recognize the law enforcement efforts can do little more than act as the little Dutch boy holding his finger in the dike, trying to keep the ocean out.

We know this because there has been no appreciable decrease in drug use and trafficking, despite the increased enforcement efforts and harsher sentencing laws.

In addition, the cost of incarcerating drug peddlars is prohibitive. Consider these figures:

- One prison bedspace costs \$75,000 to construct.
- Maintenance of one inmate runs \$20,000 to \$25,000 a year.

In recognition that law enforcement cannot single-handedly clear our streets of drug peddlars, last March I made sure that the Narcotics Task Force was launching a two-pronged attack. Not only would we work to reduce the supply of drugs, we would undertake an aggressive campaign to reduce the demand for drugs.

Only when using drugs becomes as socially unacceptable as it is illegal will we make significant headway in creating a drug-free environment.

This, I believe, is the long-term solution to the drug problem.

It's easy to say we must make use of illegal drugs unacceptable. I recognize that it's not so easy to do.

We all must make a complete, across-the-board commitment to win the war on drugs. That requires every citizen to be a soldier in the war on drugs.

We must coordinate our efforts in state, county and local government. Educators must work with law enforcement. Social services professionals must work with health experts.

Each field has attempted to combat the drug problem, and a great deal of excellent work has already been done by various governmental agencies and private groups. However, because each agency has been working virtually apart from others, results have been fragmented.

Obviously, we must develop a multi-faceted approach.

I believe a cornerstone to our new efforts must be to reduce the demand for drugs among children. We must create a drug-free generation for New Jersey's children.

By building a strong, drug-free foundation for the future, we can provide an environment for children in which they needn't be forced to decide in the fourth or fifth grade whether to accept the pot or hashish offered by one of their peers or an older child or an adult.

Some steps are already being taken to tackle the drug problem on a comprehensive basis. The Commission to Deter Criminal Activity has conducted six months of research into the demand side of drug abuse. It is currently conducting public hearings throughout the state which focus on drugs and children.

At the hearings, experts in the fields of prevention, intervention and treatment of drug abuse are testifying about their programs and their experiences.

Based on their testimony, as well as the commission's previous research, the commission will be issuing a report to the Governor and the Legislature, with recommended strategies to fight the drug problem.

I believe this report can serve as the starting point for the development of a statewide policy on drugs that is responsive, comprehensive and, perhaps most importantly, do-able.

Thank you for your attention. I would be happy to answer any questions.

NEW JERSEY'S
ACTION PLAN
FOR
CHILDREN

RECOMMENDATIONS
OF
THE GOVERNOR'S COMMITTEE
ON
CHILDREN'S SERVICES PLANNING



PREVENTION AND TREATMENT TO STEM THE PROBLEM OF SUBSTANCE ABUSE

Substance abuse is a pervasive problem in New Jersey, and today it probably affects more children and youth than any other single problem. But, a statewide policy has not been established to address the problem and affected children, youth and families do not have access to a continuum of preventive and remedial services.

- HUNDREDS OF THOUSANDS OF YOUNG PEOPLE AFFECTED
- INCREASING PATTERNS OF MULTIPLE AND COMBINED ABUSE
- DEVASTATING EFFECTS AND COSTS OF SUBSTANCE ABUSE
- PARENTAL SUBSTANCE ABUSE
- FETAL ALCOHOL SYNDROME
- CHILDREN GROWING UP IN THE CARE OF SUBSTANCE ABUSERS
- NO CLEAR STATEWIDE POLICY
- INSUFFICIENT PLANNING AND COORDINATION OF SERVICES
- LIMITED PREVENTION EFFORT
- PREVENTION PROGRAMS NEEDED FOR CHILDREN OF ALCOHOLICS
- INSUFFICIENT RESIDENTIAL PROGRAMS
- AFTER-CARE SERVICES NEEDED
- INSUFFICIENT OUT-PATIENT TREATMENT FACILITIES
- MEDICAL INSURANCE ISSUES
- COMPREHENSIVE PLANNING NEEDED



New Jersey Department of Human Services

FOR MORE INFORMATION CONTACT JOHN HIGGINS 609-292-1343

Perceptions of a high school student . . .

DRUGS IN HIGH SCHOOL

I am going to be a Junior in high school and I am a drug addict and an alcoholic. Although it is hard to stay straight anywhere because drugs and alcohol are available almost anywhere, there is an abundance of almost any kind of drugs in almost every high school. Contrary to many peoples' beliefs, most of the drugs consumed in America are consumed by young people under the age of 21. In the high schools I've been in, most of the students used drugs to some degree, some like I did and others not so often.

In this day and age, drugs are considered by many people to be a form of recreation. As I've already said, drugs are very available in high school. Every drug from pot to cocaine can be found in high school. Drugs can be found in the usual places: bathrooms, hallways, empty classrooms, parking lots, etc. In public high schools there is not much supervision, so you can usually get away with using drugs in high school. (Although many people know that drugs are a problem in high school, not many people are willing to do much about it.)

For some people like me, it is extremely hard to go to high school and not have the urge to use. Sure, there are counselors there to help, but there is not much they can do about it. Many of the teachers are not that familiar with the use and abuse of drugs. Drug use and deals sometimes go on right inside classrooms. I know all about drugs in high school, because I've been there before. I used to be one of the head users and dealers of drugs in some of the schools I've been in. There really is not much that can be done about this problem, but what American high schools need is more supervision and more rules to make using drugs harder.

Substance abuse,* a problem which crosses a social and economic lines, may adversely affect more children in New Jersey today than any other single problem. In fact, estimates provided by the New Jersey Department of Health indicate that as many as 350,000 young people aged 12-17 years abuse either drugs or alcohol to varying degrees.²

Further, hundreds of thousands of children risk harm as a result of parental substance abuse. An estimated 20 to 40 percent of New Jersey's children live with a parent who abuses drugs or alcohol, and hundreds of infants are born each year with disabilities resultant from maternal substance abuse.³

Both the causes and results of substance abuse are complex, and the problem cannot be either prevented or alleviated by simple, neat solutions. Moreover, substance abuse affects all areas of human relationships, influencing family life, interpersonal relationships, industry and the professions, and society as a whole. Thus, multi-faceted strategies are necessary to prevent as well as alleviate the harm to children from substance abuse.

YOUNG PEOPLE AND SUBSTANCE ABUSE

HUNDREDS OF THOUSANDS AFFECTED

Over the past two decades, the incidence of substance use and abuse among young people has surged with the onset of use "most likely to occur during early adolescence."⁴ Children from all backgrounds and communities are affected, and, according to 1981 Department of Education report, "the practice spreading from colleges and high schools to the junior high, middle schools, and even grade schools."⁵

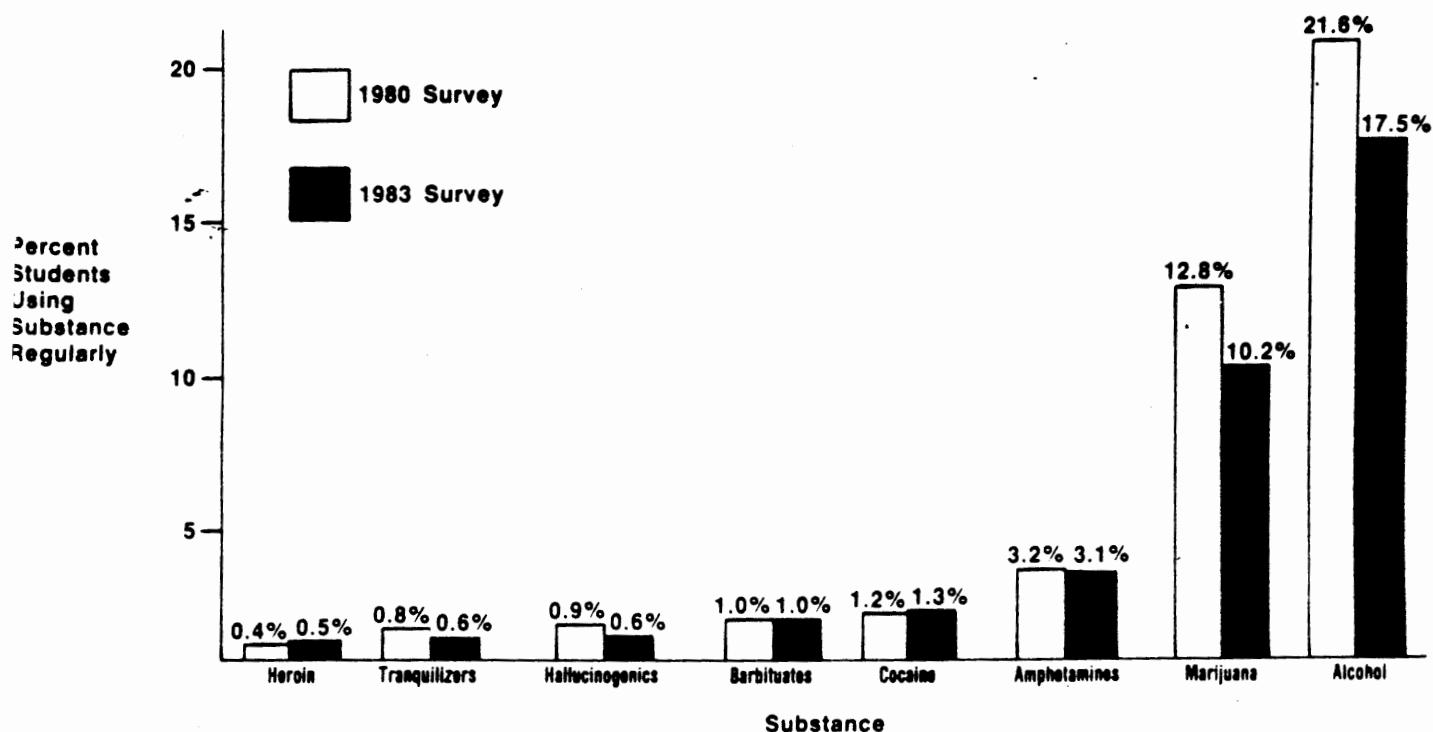
National data reported by the U.S. House Select Committee on Children, Youth and Families show that 8 percent of all teenagers have a serious drinking problem, and an estimated 7-8 percent use marijuana daily.⁶ If these figures hold true for New Jersey's youth in the 12-17 year old age group, over 62,000 New Jersey teenagers are problem drinkers and another 54,000 to 62,000 are using marijuana everyday. And as the House Committee found, other drugs such as cocaine and amphetamines are used weekly by as many as 5 percent of the teenage population.⁷

While no one knows the full extent and nature of substance abuse among New Jersey's young people, two recent surveys of high school students conducted by the New Jersey Attorney General show that the vast majority have had some involvement with illegal substances. Over 91 percent of the high school students surveyed in 1980 reported using alcohol at some point in their lives, and 67 percent reported using an illicit drug. Another 43 percent reported using a substance other than alcohol or marijuana.⁸ A second

*Substance abuse is defined here as the use of any chemical which alters mood, brain function or perceptual ability taken in a manner differing from generally approved social or medical practices. Substances abused include alcohol, marijuana, tranquilizers, hallucinogenics, amphetamine, cocaine, opiates, phencyclidine (PCP), and inhalants such as solvents, aerosols, and glue.¹

Graph 5.1

30 DAY PREVALENCE OF REGULAR USE* FOR EIGHT SUBSTANCES
SURVEY 1980 AND 1983



*Regular use defined as use on ten or more occasions in the last 30 days.

From: Wayne S. Fisher, *Drug and Alcohol Use Among New Jersey High School Students 1984* (Trenton, NJ: New Jersey Department of Law and Public Safety, Division of Criminal Justice, 1984).

1983 study found almost identical patterns of drug and alcohol exposure.⁹

Further, substantial numbers of the students reported **regular use** of alcohol and/or drugs. For example, as illustrated in Graph 5.1, nearly 18 percent reported use of alcohol on 10 or more occasions within the last 30 days and over 10 percent reported this pattern of marijuana use.¹⁰

And, there are strong indications that drug and alcohol use is common in New Jersey schools. Over one quarter of the students surveyed reported using drugs at least once during school hours, while over 16 percent reported using alcohol at least once during school hours.¹¹

ALCOHOL THE MOST PREVALENTLY USED DRUG

Alcohol, the drug most readily available to young people, is the substance most widely used and abused by youth today.¹² Further, studies show that problem drinking commonly precedes use of drugs such as hallucinogens, cocaine, heroin and amphetamines.¹³

Binge drinking—uncontrolled drinking sprees—is also becoming popular among young people. For example, a recent national survey conducted by the National Institute on Alcohol Abuse and Alcoholism found that 54 percent of the teenagers viewed binge drinking as acceptable. Further, 41 percent of the teenagers

who drink reported that they "binge," a practice which increases the likelihood of drunk driving, unwanted pregnancy and anti-social behavior.¹⁴

INCREASING PATTERNS OF MULTIPLE AND COMBINED ABUSE

While alcohol is the favored drug among teenagers, the incidence of multiple and combined use of two or more different substances is increasing. For example, a 1983 study of New Jersey students found that:

- Over 36 percent reported the combined use of either alcohol and drugs other than marijuana, or marijuana and other drugs.
- 12 percent reported the combined use of alcohol, marijuana and other drugs at least once.
- Nearly 11 percent reported the combined use of two illicit drugs other than marijuana.¹⁵

Also, there is increasing evidence of dual and multiple addictions. In fact, one residential center which treats about 400 New Jersey youth a year, reported that most have a double addiction to alcohol and another drug.¹⁶

EARLIER ONSET OF USE

The available data also suggests that New Jersey's children are becoming involved with alcohol and drugs

at younger ages, sometimes well before they reach high school. For example, more than 34 percent of the students surveyed in 1983 reported that their first use of alcohol occurred before the 7th grade, and nearly 65 percent reported first use before the 9th grade.¹⁷

Further, more than 25 percent of the students reported first use of marijuana and other illicit drugs before the 9th grade.¹⁸ Moreover, statistics gathered by a New Jersey drug treatment program showed that 67 percent of their young clients first used an addictive substance between the ages of 6-13 years.¹⁹

THE DEVELOPMENT OF SUBSTANCE ABUSE—MULTIPLE FACTORS RESPONSIBLE

Numerous theories exist regarding the causes of substance abuse. Factors such as genetics, parental and peer influences, psychological make-up and sociological influences have been commonly cited.²⁰ But, no single factor has been shown to cause substance abuse and it appears that a mix of factors usually comes into play.

The available research does suggest that both parents and peers play strong roles in influencing the substance use habits of young people. For example, studies have found that children tend to model the drinking habits of their parents. One 1978 study reported that the overwhelming majority of children whose parents drink ultimately drank, while the children of abstainers usually were abstainers too.²¹

Studies have also shown that the children of alcoholic parents, particularly an alcoholic father, are more likely to show deviant drinking behavior.²² A number of studies report too that the children of alcoholics are more at risk of becoming alcoholics.²³

Three disturbances in family functioning have also been found to be associated with adolescent problem drinking:

- parental deviance, including heavier drinking
- parental disinterest and lack of involvement
- lack of positive parent-child interaction, affection and nurturance²⁴

The influence of peers can be a critical factor in a young person's decision of whether or not to use alcohol or drugs. Studies show that prior association with users of a particular substance is the greatest predictor of the individual using that substance.²⁵ However, a 1980 study found that peer influences are short-lived in comparison with parental influences.²⁶

While there is no reliable composite picture of the child who is at risk of substance abuse, studies have identified a number of characteristics which are common among young people who abuse drugs and/or alcohol. They include:

- Perceived distance in the family—findings from studies conducted in schools, treatment centers and correctional institutions all show that the substance abuser saw the family as not being close knit.
- Low self-esteem, with drugs used to avoid feelings of "unsatisfying personal states."

- Low achievement motivation, coupled with an inability to set realistic, attainable goals.
- Tendency to disregard rules, accompanied by hate for authority figures and a preference for high flexibility.
- Higher need for sensation, manifested by a quest for high levels of excitement (more common among youth who abuse alcohol).
- Lesser involvement with religious institutions and events.²⁷

Current research has identified four distinct developmental sequences in adolescent involvement with drugs. These stages include the use of:

- 1) Beer and/or wine.
- 2) Hard liquor and/or cigarettes.
- 3) Marijuana.
- 4) Other illicit drugs.²⁸

One stage—e.g. use of beer—does not necessarily lead to further involvement with a higher stage substance. However, studies have found that many young people who abuse illicit drugs began with a pattern of problem drinking.²⁹

Further, drugs that are more prevalent or available in the community tend to be used more frequently, in greater quantities and over longer periods of time. And, increases in the prevalence of the use of a drug have been found to be related to a decrease in the age of onset of use.³¹ Clearly, the availability of a drug enhances the likelihood of its abuse.

EARLY ONSET OF USE INCREASES THE LIKELIHOOD OF SUBSTANCE ABUSE

The available research also shows significant reasons to be concerned about early use of chemical substances. For example, starting to drink at an early age and drinking abusively before sound coping mechanisms have been developed increases the likelihood of losing control over drinking habits and developing alcoholism.³² And, the earlier the onset of use of a drug, the greater the incidence of use of other drugs.³³

DEVASTATING EFFECTS AND COSTS OF SUBSTANCE ABUSE

Substance abuse bears particularly devastating effects for adolescents because it can interfere with normal development.



Princeton Packet, Andrea Kane, Photograph

mal physical, emotional, intellectual and social development. Further, physical and emotional damage from substance abuse is believed to occur more quickly in teenagers than in adults.³⁴

In addition to impairing the nervous system, substance abuse stalls the maturation process in adolescents by impeding the youth's ability to move through the normal developmental tasks of the adolescent period. Rather than learning mature coping skills to deal with stress and anxiety, adolescents who heavily abuse chemical substances become accustomed to using drugs to avoid the stress altogether.³⁵ Also this avoidance adds to their inability to deal with the world around them, creating more stress and anxiety. Further, youth who use stimulants or hallucinogens for two to three years can suffer long-term changes in motivation and the ability to experience pleasure through conventional activities.³⁶

Substance abuse is particularly risky for adolescents because their physical, psychological and experiential immaturity increases their vulnerability to addiction. In fact, substance abuse may become part of a vicious cycle for youth: the abuse impairs skill development and, because they do not have the coping skills and personality strengths that come with maturity, they are more likely to remain fixed in abusive patterns.³⁷

Substance abuse also adversely affects the educational process. The adolescent who is using or dealing drugs often disrupts the school environment to the detriment of other students, and requires administrative intervention which strains the resources of the school. Further, because substance abuse impairs the student's ability to learn, (s)he may leave school without the basic skills for self-support.³⁸

Numerous studies have found, too, that substance abuse is associated with higher drop-out rates, absenteeism and criminal activity.³⁹ In fact, New Jersey Department of Corrections (DOC) officials report that the vast majority of the youth committed to DOC for delinquent acts are substance abusers, and most abuse more than one drug.⁴⁰

In addition to impairing the physical and emotional development of adolescents, substance abuse when carried into adulthood bears heavy costs for the individual and for society as measured in terms of health care problems and costs, crime rates, accidents and lost productivity. For example, data show that:

- Youth aged 18-20 accounted for 32 percent of all alcohol-impaired driver deaths in New Jersey auto accidents for 1980.⁴¹
- Nationally, alcoholism is the fourth leading cause of death.⁴²
- The rate of accidents for substance abusers is four times higher than the rate for non-users.⁴³
- At least 40 percent of the nation's industrial fatalities and 47 percent of the industrial injuries can be attributed to alcohol abuse.⁴⁴
- 20 to 50 percent of general hospital beds are occupied by patients with alcohol or drug related problems.⁴⁵
- Nationally, substance abuse costs \$70 billion a year in health care costs, days lost from work and lost productivity.⁴⁶

- About 50 percent of the 12,000 state prison inmates surveyed in a nationwide 1979 study had been drinking just prior to the commission of the crime. Over 30 percent had been drinking heavily and nearly 33 percent were under the influence of an illegal substance at the time of the crime.⁴⁷

EARLY INTERVENTION REDIRECTS YOUTH

The devastating and costly effects of substance abuse are not inevitable. As one leading New Jersey expert describes her program:

"The program assumes that all adolescents wish to meet high expectations but sometimes use methods, such as excess substance use, that actually diminish their ability to meet them. Experience has shown that active monitoring and coordinated efforts on the part of program staff, parents, and school personnel can help adolescents reduce behaviors that are defeating their purposes and improve their abilities to reach their goals."⁴⁸

PARENTAL SUBSTANCE ABUSE

Parental substance abuse also affects hundreds of thousands of New Jersey's children, and many of these children suffer serious long-term physical and emotional damage. For example, maternal alcohol abuse has been identified as responsible for the third leading known congenital disorder associated with mental retardation.⁴⁹

FETAL ALCOHOL SYNDROME AND EFFECTS

In New Jersey, an estimated 135,000 women of child-bearing age (15-45 years) have an alcohol abuse problem.⁵⁰ Children born to women who have abused alcohol during pregnancy are at high risk of Fetal Alcohol Syndrome (FAS) or Fetal Alcohol Effects (FAE), both of which can seriously impair physical and mental development. The recent, limited conservative estimates indicate that nearly 600 infants are born in New Jersey each year with either FAS or FAE symptoms, and the incidence may be as much as 10 times more.⁵¹

A completely preventable problem, FAS can result in devastating impairments such as facial abnormalities, post-natal growth deficiencies, damage to the nervous system, and abnormalities in the skeletal, cardiac and urogenital systems.⁵² Children afflicted with FAE also suffer defects, although they are less pronounced and often less apparent.

In addition to serious physical defects, many of these children experience developmental delays and require programs which offer extra stimulation. Further, while the more severe cases of FAS can be readily recognized, less severe cases are often overlooked and go untreated, contributing to the child's having learning and social difficulties in school.⁵³

The costs for treatment and remediation of FAS and FAE are enormous. One recent study found that the costs of lifetime care for infants born with alcohol-

related defects in a single year in New York will be at least \$155 million.⁵⁴

DRUG-RELATED EFFECTS

Maternal use and abuse of other substances such as prescription drugs, tranquilizers, heroin and methadone have also been found to damage fetal development and cause delivery complications damaging to the infant.⁵⁵ The reported effects include: central nervous system defects and other physical abnormalities such as cleft lip and palate; increased infant mortality; and withdrawal symptoms in the infants.⁵⁶

Additionally, there is evidence to suggest that infants born to methadone users are at higher risk of Sudden Infant Death.⁵⁷ The full extent and nature of drug-related damage to infants is, however, unknown because there has not been a systematic method for collecting data on the incidence.

EFFECTS ON CHILDREN GROWING UP IN THE CARE OF A SUBSTANCE ABUSER

Children who grow up in the care of a parent who abuses drugs or alcohol are at risk of a host of problems damaging to their physical and emotional development. For example, recent studies show that these children are at higher risk of child abuse.

In fact, a major national study on the problem found that 38 percent of child-abusing parents had histories of drinking problems, and other studies indicate that up to 65 percent of child abuse cases are alcohol-related.⁵⁸ Child abuse related to alcohol and drug abuse includes severe physical abuse as well as emotional harm and sexual abuse. One Alateen study, for example, found that 40 percent of the children had been victims of incest.⁵⁹

Further, children in the care of substance abusers manifest a host of other symptoms such as: problems with school work; a greater incidence of emotional disturbance in social and familial relationships; and a higher incidence of depression.⁶⁰ Also, numerous studies have found a higher rate of substance abuse among these children as well as higher rates of suicide.⁶¹

Experts who work with the children of substance abusers report that many experience intense, prolonged stress resultant from the behavior of the substance abuser as well as from disruptions in the overall family situation.⁶² Generally, the children are affected in four different areas of their life: self-concept, peer relationships, home life and school life. Additionally, these children are often beset by heavy responsibilities at home, parental inconsistencies, and heavy burdens of guilt for the family situation.⁶³

While there has begun to be widespread recognition of the risks to children of substance abusers, the needs of these children often are not identified because neither the non-abusing adults in the family nor other interested adults such as teachers realize the affect of the family situation upon the child. Further, these children often stand alone because they are afraid no one will believe them or are ashamed of their home situations.⁶⁴

Some children are reached by Alateen, a self-help

support group for family members of alcoholics and drug addicts. But, since there usually is a long delay between recognizing substance abuse as a family problem and obtaining remedial action for other family members,⁶⁵ children usually do not come to Alateen until long after the family began to be affected by the substance abusing member. Thus, many children live in destructive family situations for extended periods of time without support to cope with the problems at home.

ADDRESSING THE PROBLEM: ADMINISTRATIVE ISSUES

In response to the growing recognition that substance abuse is a serious problem in New Jersey, a variety of prevention and treatment efforts have been developed with federal, state and local funds. However, comprehensive planning has not been developed to assure that a continuum of services are in place to meet the increasing need, and there are significant gaps in preventive as well as treatment services.

NO CLEAR STATEWIDE POLICY

Planning and coordination of services to address the complex problem of substance abuse is impeded by the fact that there is no clear statewide policy to guide the efforts of state and local agencies.⁶⁶ This absence of a statewide policy is especially critical in light of the fact that there are a multiplicity of state and local agencies responsible for services for children and families affected by substance abuse.

For example, at the state level at least six different departments have some role in addressing the problem:

- **Department of Corrections (DOC)**—responsible for providing custody and aftercare services for young people adjudicated delinquent, most of whom evidence substance abuse problems
- **Department of Education (D. of Ed.)**—responsible for developing guidelines for preventive education programs in the public schools
- **Department of Health (DH)**—through its Division of Narcotic and Drug Abuse Control and Division of Alcoholism, responsible for developing and funding preventive and treatment services
- **Department of Human Services (DHS)**—through its Division of Youth and Family Services and Division of Mental Health and Hospitals, responsible for providing counseling and residential services for children and families affected by substance abuse problems (provides direct services as well as funding for contracted services)
- **Department of Higher Education (DHE)**—responsible for setting standards for training and certification of professionals such as physicians, nurses, psychologists and teachers who may deal with substance abusers.
- **Department of Law and Public Safety**—responsible for law enforcement efforts and educational programs for highway safety.

Additionally, the courts, particularly through the new Family Part of the Superior Court, must routinely deal with familial problems and juvenile delinquency cases where either the parent or the child has a substance abuse problem. In fact, the recently established county Crisis Intervention Units, linked to the Family Part of the court, must handle crisis situations which may arise as a direct result of substance abuse.

At the local level, there are also a broad mix of public and private agencies that serve children and families who are affected by substance abuse problems. The local public schools represent the largest single group of "agencies" which have consistent contact with children and families.

Other involved local agencies may include:

- Mental health clinics.
- County welfare departments.
- Hospitals and other health care providers.
- Local law enforcement agencies.

The absence of a uniform state policy has fostered considerable inconsistency in how the problem of substance abuse is addressed. For example, some communities and schools view it as a problem to be "treated," while others see it primarily as a matter for law enforcement agencies. Consequently, there are wide variations in the type and extent of services provided for young people at risk.⁶⁷

Even recently enacted state laws reflect an inconsistent approach to the issue. To illustrate: Chapter 85 enacted in 1970 requires that preventive education be required in the public schools.⁶⁸ However, this law was followed by P.L. 1981, Chapter 59 which allows school administrators to suspend or expel students who abuse substances, and it does not require the schools to try other less drastic measures before excluding a youth from school.⁶⁹ Some schools have instituted programs to keep these youth in school, while others have exercised their discretion to simply punish them by suspension or expulsion.⁷⁰

INSUFFICIENT PLANNING AND COORDINATION OF SERVICES

There have been a number of successful joint projects among the different agencies which address substance abuse and, as well, increasing efforts to develop linkages among the many state and local agencies. However, joint planning has not taken place on an annual basis to set a common strategy and to unify resources in a coordinated approach.

Additionally, planning efforts are to some extent impeded by the fact that reliable data on the prevalence of substance abuse, the characteristics of the youth at risk, and treatment needs are not readily available. The estimates and surveys done to date do not by themselves quantitatively indicate the number and types of services needed. This overall lack of data is an obstacle to efficient resource allocation and programming for services.

Administrative barriers may also complicate the planning process. Within the Department of Health itself, for example, two separate administrative units exist, one to address drug abuse and one to address

alcoholism. While there is some merging of activities on behalf of children and youth, each unit carries out separate prevention and treatment efforts. Further, the two units have not developed a common prevention strategy to address youth. There is also some concern that the separation of functions by type of chemical substance may impede the development of a continuum of services for youth who have dual and multiple addictions.

NEW PLANNING EFFORTS

There are several planning processes underway that can improve the overall quality and quantity of preventive and treatment services for substance abuse. For example, through the state Youth Services Commission representatives of different agencies have been brought together in a Health Care Coordinating Committee which has been focusing on substance abuse.

Further, in 1984 the Department of Human Services established a state Human Services Advisory Council with companion councils in all 21 counties. These county councils, charged with the task of making funding allocation recommendations for the Social Services Block Grant funds, can be instrumental in assessing local service needs and increasing the resources for substance abuse programs. Both the state and county councils can, as well, promote improved coordination of social service agencies with those agencies whose primary task is dealing with young people and families affected by substance abuse.

Additionally, improved planning may be spurred by the Citizen Advisory Committees which, under the new Juvenile Code, are required to identify youth needs and develop a plan for provision of services for youth in each county. Recently, a joint request was made by Chief Justice Robert N. Wilentz, Department of Human Services Commissioner George Albanese and Attorney General Irwin Kimmelman that these Citizen Advisory Committees be designated as county Youth Services Commissions linked to the state YSC. These county-level YSCs could be effective in involving both service providers and citizens in assessing and meeting the need for substance abuse programs.



International Youth Organization

Since the new Alcohol Tax legislation, P.L. 1983, Chapter 531, also requires that Citizen Advisory Committees be formed at the county level to assess needs and prepare a county plan for services, it is anticipated that a new emphasis will be placed on the development of alcohol abuse programs at the local level. Under the legislation, youth needs are singled out for priority attention.⁷¹

There exist, as well, in at least 12 counties Councils on Alcoholism which play a role in the planning of prevention and treatment programs. Some of these councils have been successful already in developing resources for programs serving youth.

While all of these individual planning efforts are quite promising, significant steps have not yet been taken to assure that the different entities will coordinate their activities. Some coordination will be necessary to avoid duplication of effort and a consistent approach in addressing the problems of children and families affected by substance abuse.

PREVENTIVE NEEDS

While treatment programs are needed for both young people and adults who abuse alcohol and/or drugs, they do not substantially reduce the overall incidence of substance abuse. And, if broad-based prevention efforts are not implemented, society will continue to pay a high price for the lost productivity and dependency of those youth whose functioning is impaired by the effects of either their own or their parents' abuse of alcohol and/or drugs.

Many different state and local agencies have recognized the need for preventive programs and some very comprehensive programs have been developed. But, priority for funding has not been placed on preventive services and often promising models have not been implemented because funds were not available.

PREVENTION PROGRAMS ARE COST EFFECTIVE

While it is often difficult to ascertain the actual cost-benefits of prevention programming, a 1984 study of programs in four New Jersey communities strongly suggests that such programs do yield benefits that outweigh costs. The study, which looked at the cost-benefits of four different prevention programs, found that the target communities experienced measurable benefits in terms of reduced vandalism in the community, the provision of volunteer services by community members, and increased school attendance rates.⁷² In addition, an educational-intervention program run in the State of Florida has also indicated a favorable cost/benefit effect.⁷³

LIMITED PREVENTION EFFORT FOR YOUNG SUBSTANCE ABUSERS

Primary responsibility for prevention programs for young substance abusers has rested with the Division of Narcotic and Drug Abuse Control (DNDAC) and the Division of Alcoholism (DA), each of which has a separ-



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ate prevention effort. The 1984 prevention budget for DNDAC totaled \$1.2 million in federal funds. In 1985 the prevention budget (excluding methadone maintenance programs) will decrease by 9 percent to \$1.1 million. Of this fund, \$576,923 has been clearly earmarked for projects serving youth such as \$200,000 to local agencies for general prevention projects; \$283,000 to 19 drug treatment centers to serve 566 youth; and \$93,923 for the Statewide Community Organization Project.⁷⁴

Until recently, DA was provided with only minimal funding for prevention efforts. For example, in 1984 DA's budget included only \$105,000 for prevention efforts administered through 14 Councils on Alcoholism, and an additional \$26,725 for preventive activities such as training courses on youth issues, conferences and training seminars.⁷⁵

DA will receive an additional \$766,000 in 1985 for educational programs under the provisions of P.L. 1983, Chapter 531. However, even with this new funding, the total funds available to both DNDAC and DA are far from adequate to develop sufficient preventive programs to reach the young people at risk in New Jersey today. And, funding has not been allocated to implement a full range of comprehensive programs that can effectively provide early intervention services for youth in the beginning stages of substance abuse. According to one New Jersey treatment expert:

Hundreds of thousands of New Jersey parents are worried about the potential link between their adolescent's substance abuse and other problems, and do not see anything they can do about it. In addition, there are thousands of human ser-

vices workers—probation officers, juvenile conference board members, guidance counselors, psychologists, psychiatrists and family therapists—who see young people making poor decisions regarding substance abuse and do not know what to do about it.⁷⁶

FOUR POINT PREVENTION STRATEGY: POSITIVE YOUTH DEVELOPMENT

Generally, there are four different levels of strategies that can be used for prevention of substance abuse among young people. The first level focuses on positive youth development, using programs and activities to reduce dysfunction and alienation in young people, thereby decreasing their vulnerability to substance abuse. This approach emphasizes building strengths through programs such as those which: involve youth in community services; develop youth leadership skills; provide recreational opportunities; and develop vocational skills. A compilation of research and programs for the promotion of positive youth development was drafted in 1983 at Rutgers University.⁷⁷

In New Jersey, the Statewide Community Organization Project (SCOP) has been instrumental in helping communities develop more than 36 model youth development projects. SCOP, housed in the Department of Health, attempts to reduce the prevalence of substance abuse by involving communities in identifying and addressing the needs of young people. Through the SCOP method, teams of community members are trained to plan and implement youth development projects.

An Interagency Youth Development Consortium also has been organized in New Jersey to involve different agencies and community groups in developing prevention efforts. The Consortium, in cooperation with the Association for Children of New Jersey, recently published a resource guide listing programs which communities could utilize for prevention efforts.⁷⁸

EDUCATION

Prevention education is a second approach through which the schools, media and other educational vehicles can be utilized to teach young people about the risks inherent in substance abuse. Generally designed to enable young people to make responsible decisions about the use of alcohol and drugs, preventive education programs also focus on teaching young people alternative coping mechanisms to handle stressful life situations.

Since 1970, public schools have been required by law to provide preventive education. Further, D. of Ed. established a Drug and Alcohol Task Force in 1979 which developed recommendations for prevention and treatment strategies to address student substance abuse. The Task Force's recommendations included suggestions for guidelines for public schools, requirements for teacher training and prevention curricula.⁷⁹

However, many of the Task Force's recommendations have not been funded fully or implemented. As a follow-up report prepared by D. of Ed's Alcohol and Drug Education Committee stated in 1981:

The Committee notes with dismay the State's lack of continuous funding for drug and alcohol programs that affect school age children. The practice of intermittent funding has been demonstrated to be clearly ineffective, and it is, therefore, the Committee's consensus that a permanent funding commitment by the state is absolutely essential. The Committee is greatly concerned that in recent years the amount of money provided for prevention programs for school age children by the State of New Jersey has not kept pace with the severity of the problem. In fact, the monies appropriated have been negligible. (emphasis ours)⁸⁰

Further, although the D. of Ed. and Division of Alcoholism cooperatively developed curricula guidelines and models for use by the local public schools, many school districts have not implemented the necessary preventive education programs. It has been reported that the quality of the available programs varies greatly, and, some schools have no preventive education at all.⁸¹ The local variations in curricula used for preventive education are of concern in that studies have shown that inadequate preventive education programs may actually lead to an increase in the incidence of substance abuse.⁸² One-shot preventive education approaches have also been found to be counter-productive.⁸³

In 1985, substantial funding will be made available for preventive education activities and this may result in expanding current prevention efforts. Through the Alcohol Education, Rehabilitation and Enforcement Fund established under the new Alcohol Tax law, \$766,000 is being earmarked for preventive education. Mandated plans include utilizing these funds for in-service training for teachers, school-based intervention programs for students, and employee assistance.⁸⁴

EDUCATE ADULTS

While they have not yet been significantly developed in New Jersey, education programs for parents and other adults who have regular contact with children are also an important component of a comprehensive prevention strategy. Through preventive education, adults can be taught how to identify and deal with children who either are at risk of substance abuse or involved with substance abuse.

EARLY IDENTIFICATION AND INTERVENTION

The fourth general prevention measure is to identify young people when they first begin abusing substances and intervene before the problem has become a set pattern. Prevention programs in this category focus on reaching the youth while the problem is still relatively easy to correct, and they generally include services such as: counseling; peer group interactions; and joint counseling with the youth and his/her parents.

Comprehensive preventive programs have not been widely implemented in New Jersey. However, some school districts have established programs which may serve as models for other communities. For example,

the Manchester school district in Ocean County began a program four years ago in cooperation with the National Council on Alcoholism of Ocean County (NCA).

The Manchester program includes: education and training for teachers; student education; student assistance using counseling, support groups, and referrals for treatment; and employee assistance. The student assistance component was initially run by trained staff who were not from the schools, and now school faculty members have been trained by NCA to move into these roles. Plans are now underway to make available similar services in 86 schools in Ocean County with funding from the Alcohol Tax.⁸⁵ Union Township also has initiated a program with services such as those provided by the Manchester school district.⁸⁶ The River Dell Regional High School District has moved one step further and has combined an adolescent suicide prevention program with its comprehensive prevention program.⁸⁷

PREVENTION PROGRAMS NEEDED FOR CHILDREN OF ALCOHOLICS

Preventive services are needed as well to stem the harm to the hundreds of thousands of children at risk because of parental or even sibling substance abuse. For example, much can be done through public education to raise awareness of how parental substance abuse can contribute to family dysfunction and result in grave emotional and physical damage to children.

Further, parents and other adults who deal with children can be made aware of the need for preventive services to counteract the impact of a very troubled home situation. Currently, the needs of these children often go unrecognized because adults do not realize that the child is being damaged. Some harm to these children could be mitigated if adults were taught to identify the trouble signs and offer assistance in a non-threatening, non-stigmatizing manner.⁸⁸

To date, little emphasis has been placed on developing services for this group of children. Effective approaches, which can be provided through schools and community agencies, include peer support groups such as the Alateen model and counseling.

One relatively new program which might serve as a model, is that provided for children of alcoholics and substance abusers by the Center for Industrial Resources Chemical Dependency Unit of the Community Mental Health Center of Rutgers Medical School. Using a multi-faceted approach, this program is being offered as a comprehensive package for Middlesex and Hunterdon Counties. Components include: training in the identification and referrals of children of alcoholics for school personnel; training for mental health professionals in working with this population; and treatment offered directly to children of alcoholics by the Center's staff. Treatment is based on the concept that alcoholism is a family problem and services are offered for children as well as parents who are living with substance abusing or recovering family members. Group programs are conducted with specific ages, (ages 5-9, 10-12, 13-17, and parents) focusing on the unique requirements of each group, as well as family therapy where necessary.⁸⁹

PREVENTION OF FETAL ALCOHOL SYNDROME

Preventive efforts are necessary too in order to reduce the incidence of Fetal Alcohol Syndrome (FAS) and Fetal Alcohol Effects (FAE). In New Jersey substantial work on identifying prevention needs has been done by a Task Force on Fetal Alcohol Syndrome established by the Division of Alcoholism (DA). The Task Force has found that two basic approaches are required to prevent FAS/FAE:

- 1) Education of all citizens about fetal alcohol risk
- 2) Identification, intervention and treatment of alcohol abusing women by trained professionals preferably before pregnancy.⁹⁰

DA has prepared a plan which calls for a multi-faceted approach to preventing FAS, using a network of all those who have an interest in or provide services for women and their families. According to DA, public education is a key prevention method since "research has shown that women want information on all risk factors during pregnancy and are willing to modify the behaviors." The comprehensive prevention strategy developed by DA would also include training of health care professionals to recognize women at risk, and to identify and treat infants born with FAS/FAE.⁹¹ Through DA, technical assistance can be provided for the establishment of a statewide prevention effort.

GENERAL PREVENTION: TRAINING PROFESSIONALS

Professionals in fields such as health care, education, social services and law enforcement are in key positions to either initiate or provide primary as well as secondary prevention services. However, in order to do so, they must be trained to identify the problem of substance abuse and they must know basic interventions. But often substance abuse issues are either overlooked completely in professional training programs or given very minimal coverage.

For example, although physicians have a great deal of contact with substance abusers, since they often experience medical problems, many physicians do not receive adequate training on the topic. In fact, a 1977 study of 117 medical schools found that almost half of the schools did not provide instruction on substance abuse issues for their residents.⁹² This lack of training may well contribute to a failure to diagnose the problem and provide appropriate, early intervention.

As one expert noted, "failure to treat seems to be determined more by a failure to diagnose."⁹³ And despite the fact that alcoholism is the fourth leading cause of death in the United States, "the prevalence of alcoholism as seen in general office practice is usually estimated as exceedingly low,"⁹⁴ which points to a failure to identify the problem.

Failure to properly diagnose is very dangerous in light of the fact that physicians may prescribe medications that are alcohol interactive or which may interact harmfully with another illicit substance the patient has been taking. For example, valium has been one of the most widely prescribed drugs in the world, and ca

ct with alcohol. Once given to alcoholics, these
are frequently taken in conjunction with al-

relatively low emphasis placed on training of
cians is perhaps most evidenced by the fact that
ledge of substance abuse issues is not required
censing. In fact, the national board examinations
nistered to physicians do not have any questions
ther alcohol or drug abuse.⁹⁵

st as physicians should be able to identify
stance abuse, so should other professionals who
k with children and families such as school nurses,
hologists, social workers and juvenile officers.
le awareness of the need for such training is in-
asing, it still is generally given only slight emphasis
professional curricula.⁹⁷

ew Jersey, however, does show a progressive
nce in the area of training of professionals. One
national study, for example, cited Rutgers Univer-
which offers a doctorate in psychology with a
cial concentration on alcoholism.⁹⁸ Further, Rutgers
also pioneered an innovative Center for Alcohol
udies which provides comprehensive training pro-
ams for professionals from many different fields in
identification and treatment of substance abuse.

TREATMENT ISSUES

Treatment for youth must be geared not only to the
asic issues of substance abuse but must also address
e unique needs of adolescents. Generally, residential
eatment services include these program elements:

- Counseling, both on the individual and group levels, in order to deal with any deeply set pathologies, foster interaction with others, and develop more effective coping strategies for day to day living.
- Education to provide the adolescent with the necessary skills to earn a living.
- Recreation to provide constructive outlets for energy.
- Development of a non-substance abusing peer group—This is essential if continued abstinence is to be maintained, particularly since the adolescent's group of friends in the community usually was involved in fostering the drug use. Peer support and a social network of other non-users is also necessary to aid in the resolution of day to day problems.
- Intervention for problems in the family, to address those familial problems related to the youth's substance abuse. Studies have shown that treatment programs which include intervention with the family show a lower rate of client recidivism.⁹⁹

However, despite the need for programs tailored to the specific needs of adolescents, few treatment services exist for youths who are substance abusers or heavily addicted. Further, a full continuum of services ranging from community based out-patient programs to residential care is not available nor are there a range of programs for youths with dual and multiple addictions.

INSUFFICIENT RESIDENTIAL PROGRAMS

Although there are an estimated 36,000 teenage alcoholics in New Jersey,¹⁰⁰ there are only three facilities with a total of 111 beds providing residential treatment for adolescent alcohol abuse—New Hope, Beacon Hall and Monmouth Chemical Dependency Center. Other facilities which primarily serve adults will accept adolescents, but their programs are not tailored to the unique needs of youth. In 1983, a total of 487 youth were admitted to hospitals or residential treatment centers for alcohol abuse.

Residential treatment resources are even scarcer for those youth whose primary problem is drug abuse. No state operated facilities exist for treatment, although state supported facilities for adults will accept some adolescents. There are a few private hospitals with special programs for adolescents, but these facilities are quite expensive and often the fees are not covered by private medical insurance. Limited data on admissions to public and private New Jersey facilities indicate that about 158 youth under the age of 18 were treated in residential drug treatment centers.¹⁰¹

RELIANCE ON OUT-OF-STATE FACILITIES

In the absence of sufficient programs in New Jersey, many youths are sent to out-of-state facilities. In 1983 alone, at least 414 youths were treated out-of-state, and almost all of these youths were sent to facilities in Pennsylvania.¹⁰² Data prepared by the Pennsylvania Department of Health show that 27 percent of these youth had been referred by New Jersey legal authorities. Similar statistics were reported in 1981.¹⁰³ Nearly half of these youth had a primary problem of alcoholism; the remainder were abusing drugs such as marijuana, amphetamines, cocaine, PCP and sedatives. Over 75 percent of these youth were abusing both drugs and alcohol.¹⁰⁴

Due to "gaps" in the data collection process it is difficult to ascertain the number of adolescents treated in states other than Pennsylvania. Many youth are sent to treatment facilities in states which do not report the number of New Jersey clients treated¹⁰⁵ (e.g. Hazelden in Minnesota). And the lack of sufficient treatment often makes treatment inaccessible or extremely expensive. Further, the lack of sufficient out-patient treatment programs at the community level may necessitate the use of residential treatment.¹⁰⁶ It is therefore safe to assume that some children who require treatment are not receiving it due to the costs involved or are not receiving treatment which is least intrusive in their lives.

DIMINISHED RECOVERY POTENTIAL

Use of out-of-state residential treatment centers may lead to service gaps which greatly diminish the potential for successful, long-term recovery. First of all, placement in a distant facility makes it difficult to work with the family of the youth, and most experts believe this is an important part of the treatment process.¹⁰⁷

Additionally, when the youth is placed a long distance from home, (s)he may be denied the contact and support the family would be able to offer. Further, young patients leaving out-of-state facilities may not

have access to suitable after-care services when they leave the treatment center.

After-care is almost always required for the substance abuser to maintain the treatment gains made while in a residential facility; in fact, treatment without appropriate after-care has a low probability of success.¹⁰⁸ As one expert noted, "Prevention of relapse is a lifelong struggle and can only become . . . successful when strong post-hospital care services are available."¹⁰⁹ Further, numerous professionals report that those abusers who do not have access to after-care services are far more likely to require additional admissions to residential care.¹¹⁰

AFTER-CARE SERVICES NEEDED

However, New Jersey has a paucity of after-care services for youth returning from residential treatment, and many of these youths simply do not receive the necessary services. Further, there are no half-way houses or transitional living facilities specifically for young people who cannot return to their families or original living situations when they leave residential care. Thus, many youths return to the community without the kind of support or living environment they require to assure their continued recovery.

Since some of these young people come from very troubled family situations, they may be eligible for post-release services from the Division of Youth and Family Services (DYFS) which could include the provision of out-of-home placement. It is possible that their after-care needs could be met through the joint provision of services through the Division of Alcoholism and DYFS.

OUTPATIENT TREATMENT

Outpatient treatment consists of a variety of services offered through an agency established in the community such as an independent clinic or as an ancillary service of a residential treatment facility. There are basically two types of services offered, treatment of the client and/or referral for more extensive residential treatment.

Evaluation of the "needs" of the client determines the type of treatment offered. Clients who are physically addicted, having serious psychological or medical problems and without the support of their family are referred to inpatient residential treatment. Outpatient care is offered as an "aftercare" program in some instances.¹¹¹

Outpatient drug-free treatment is appropriate for clients who display a pattern of abuse consisting of a frequency of use of 2 to 3 times weekly and of a duration of less than 18 months. In addition, clients should have a limited history of anti-social behavior and the support of the nuclear family, while still being enrolled in school or employed.¹¹²

In cases of clients who are more dysfunctional, outpatient day-care services are appropriate. Clients have a more extensive history of abuse, (a frequency of use up to 4 times weekly and for a period not to exceed 24 months). Their history of anti-social behavior should be brief (up to 3 years) and some family support should be available. In addition, the client's involvement with

school or employment may be minimal.¹¹³

The role of the family is very important in outpatient treatment because the family provides the basic environment of the client. Cooperation of school personnel is also important in helping the client recover. Many of the outpatient agencies stress these roles and work with both families and teachers.¹¹⁴

INSUFFICIENT OUTPATIENT TREATMENT FACILITIES

Just as there is a shortage of residential treatment facilities and no transitional living facilities for youth there is a shortage of outpatient treatment facilities for youth. One leading New Jersey drug treatment expert stated, "Federal cuts have fostered the closing of approximately ten nonprofit agencies in New Jersey. These cutbacks were the rationale for eliminating 5 percent of the treatment available to dysfunctioning marijuana clients . . . In addition, we know that cost inpatient hospitalization is inappropriate for the vast majority of drug users."¹¹⁵

In 1983, limited data reports that 394 youth under the age of 18 utilized outpatient services for alcohol abuse in New Jersey facilities.¹¹⁶ And, approximately 47 utilized outpatient drug treatment services in New Jersey facilities.¹¹⁷

MEDICAL INSURANCE COVERAGE FOR SUBSTANCE ABUSE TREATMENT—INCONSISTENT

Conflicting public policies regarding both public and private medical insurance coverage for treatment of substance abuse are indicative of the confusion and lack of consistency in dealing with drug and alcohol abuse. Although alcoholism was accepted as a "disease" by the American Medical Association in 1956, it was not until 1977 that private medical coverage became mandatory in New Jersey.¹¹⁸ However, Medical coverage has not been provided and it has only been through select demonstration projects that alcoholism treatment is available to Medicaid clients in New Jersey.¹¹⁹

Recent passage of P.L. 1984, Chapter 86 has expanded Medicaid coverage for drug abusers under the age of 21 who are Medicaid eligible. Although legislation has been introduced to mandate private insurance coverage for drug abuse treatment, current coverage is not mandated.

Therefore, drug abuse treatment is only available for Medicaid eligible youth, while for the most part alcoholism treatment is only available for privately insured youth.

NEW PROGRAM DEVELOPMENT FOR ADOLESCENTS—COMPREHENSIVE PLANNING NEEDED

While it is clear that specific additional services are needed for adolescents in New Jersey, comprehensive planning has not taken place to determine where and how these programs should be provided. Nor has

determination been made as to how extensive a role the state should take in developing and providing the services.

Many experts agree that, while fiscal support from the state is necessary to assure the provision of adequate services, the state's role should be that of a catalyst for the planning and provision of services by local agencies rather than a direct service provider. As the Director of one of the nation's foremost chemical dependency treatment centers for youth stated:

"Ideally the State should not focus on being the actual provider of services. Rather, it should assess the number and types of services available, and through evaluation, determine the service needs areas. Special funds could then be made available for the implementation of needed programs and services, either through direct reimbursement, County funding or through special grants. The State should also be involved in program licensing, prevention services, and possibly continuing education."²⁰

However, the current planning system used for program development is not structured to catalyze local, public and private agencies to develop and operate specific needed services for the state's young people. Nor are current planning efforts sufficiently comprehensive to assure that existing resources are efficiently utilized and that maximum cooperation is obtained from the local public and private agencies for the development as well as operation of needed services.

The provision of major new funding for services could, at first glance, appear to be the obvious solution to the urgent need for additional treatment programs. However, unless funding is preceded by appropriate planning, it is unlikely that the new funds allocated will be effectively applied to bring services to the young people who are most in need of them.

RECOMMENDED ACTIONS

I. STATEWIDE POLICY FOR BROAD-BASED PREVENTION AND TREATMENT

The Governor should initiate a statewide policy for the development of a broad-based, coordinated effort to prevent substance abuse and to assist and treat children youth and families affected by substance abuse. Prevention and early intervention programs should be given equal priority with treatment services in the development of policy and programs.

II. STATEWIDE MECHANISM FOR COORDINATED PLANNING AND IMPLEMENTATION OF SERVICES

A. An on-going statewide mechanism should be established to coordinate the work of the different state departments and community agencies in planning and implementing prevention, early intervention and treatment services for children and youth affected by their own or parental substance abuse. This mechanism should:

1. Include in its membership:

- The directors of the Divisions of Alcoholism and Narcotic and Drug Abuse Control of the Department of Health.
- Representatives of the Department of Education units responsible for prevention and early intervention programs in the schools.
- Representatives of the Divisions of Youth and Family Services, Mental Retardation, and Mental Health and Hospitals of the Department of Human Services.
- Representatives of these other state government units: the Departments of the Public Advocate, Corrections, Community Affairs, Law and Public Safety and Labor, and the Administrative Office of the Courts.
- A representative of the state Youth Services Commission.
- Representatives of community groups and local agencies who work with children and families affected by substance abuse, and experts in the fields of prevention and treatment.

2. **Maintain close linkages with county level planning groups** which specifically address the problem of substance abuse such as the county Councils on Alcoholism, and maintain linkages with other state and county level planning groups which address youth needs.

3. **Function as a special committee** of the new Governor's Commission for Children and Youth with responsibility to prepare recommendations to the Commission on at least an annual basis for state action to improve services for the prevention, early intervention and treatment of substance abuse.

III. STATEWIDE PREVENTION AND EARLY INTERVENTION EFFORTS

A. STATEWIDE PLAN

Through the special committee of the Governor's Commission on Children and Youth, a statewide plan for prevention and early intervention efforts should be developed and modified as needed on an annual basis. This plan should include efforts addressing substance abuse among young people as well as efforts to ameliorate the problems resultant from parental substance abuse, including Fetal Alcohol Syndrome. The plan should also incorporate the additional recommendations for action reported here.

B. ESTABLISHMENT OF A NEW PREVENTION OFFICE

The Department of Health should combine the preventive efforts of the Division of Narcotic and Drug Abuse Control, which are non-meth-

adone maintenance oriented, with the preventive efforts of the Division of Alcoholism. This new office, the Office of Alcohol and Drug Dependency Prevention should:

1. Be a central resource for all state, local, and voluntary agencies which deal with children and their families, functioning as a Clearinghouse and Data Bank.
2. Have as its initial and primary focus, the population under 21 years of age.
3. Develop and implement strategies to focus on the family as a unit.
4. Have written agreements with all state departments and divisions that deal with children, youth and families as well as special contracts with each county.
5. Have designated liaisons with each major state department and county to meet regularly, coordinate, evaluate and provide assistance in preventive efforts.
6. Report to the special Committee of the Governor's Commission for Children and Youth on a regular basis, cooperating with the Committee's statewide prevention efforts.

IV. SCHOOL-BASED EFFORTS

A. UNIFORM GUIDELINES

The Department of Education should ensure that the local school districts adopt and utilize uniform guidelines to provide prevention and early intervention services for:

1. Substance abuse among students.
2. Services for children and youth at risk because of parental or sibling substance abuse.
3. Staff problems related to substance abuse.

B. PREVENTIVE EDUCATION, STUDENT ASSISTANCE AND EMPLOYEE ASSISTANCE

The Department of Education should also ensure that local school districts:

1. Educate students grades K-12 on substance abuse, including the effects of parental substance abuse, through implementation of approved curricula which meets already existing state mandates.
2. Provide student assistance services and constructive intervention in accordance with the intent of P.L. 1983, Chapter 531, for students who manifest substance abuse related problems affecting performance in the school setting. The local school districts should be required to utilize less drastic alternatives before excluding a youth from school. The program, which should also address the needs of children affected by parental substance abuse, should include:
 - Staff training and development.
 - Educational awareness.

- Procedures for a system of referrals youth for intervention and treatment services.
- Development of support groups for youths who are recovering substance abusers.
- Development of support groups for children and youth who live with substance abuser.
- Programs utilizing peer leadership to educate and assist other students.

3. Incorporate Substance Abuse Counselors into the school system to implement curricula, provide counseling services and develop as well as implement programs. These counselors should be certified by the New Jersey Alcoholism Certification Board and meet appropriate requirements developed by the Department of Education.

4. Provide an Employee Assistance Program for school personnel affected by substance abuse. At minimum, the program should include a mechanism for the referral of staff to treatment services. Teacher representative groups should be encouraged to participate in the development of the program.

C. EVALUATION

The Department of Education shall develop and implement criteria for the evaluation of the quality of these programs to ensure parity of services, regardless of the district in which a student resides.

D. PROGRAM ASSISTANCE

The Department of Education shall offer to Districts program assistance in conjunction with the Department of Health in the development of the programs outlined here for both students and employees when:

1. A District's substance abuse program is deemed inadequate by the Department of Education.
2. A District requests aid.

V. TRAINING OF PROFESSIONALS

A. School personnel: Training for school administrators and teachers should include education for the identification of substance abusers and the identification of children at risk because of substance abuse within the family situation. Mandatory training should be included in the curriculum for teacher certification. In-service training should be required for those personnel who have already been certified.

B. Health Care and Mental Health Professionals: Training in the identification, treatment and effects of substance abuse should be made mandatory for the certification and licensing of health care and mental health professionals.

Professionals licensed to practice in New Jersey should be required to demonstrate competency before licensing. Such professionals should include but not be limited to:

- Physicians.
- Psychiatrists.
- Clinical Psychologists.
- Counseling Psychologists.
- School Psychologists.
- Social Workers.
- School Nurses.
- Pharmacists.
- Registered and Practical Nurses.
- Other professionals in the practice of psychotherapy.

VI. PUBLIC EDUCATION

The Departments of Education, Health and Human Services should be directed to develop a public education program involving local schools, community agencies, community groups and the media in:

- A. **Training parents to recognize patterns of substance abuse** in young people, and educating them on intervention.
- B. **Informing the public of the incidence and effects of parental substance abuse** on children in their care, and early intervention strategies to protect vulnerable children.
- C. **Informing the public of the risk and effects of Fetal Alcohol Syndrome and Fetal Alcohol Effects.**

VII. TREATMENT

A. CONTINUUM OF SERVICES

The special Committee on substance abuse should develop a plan for the development of a continuum of treatment services for youth who are substance abusers. The continuum should be designed to tailor services to the individual needs of the youth and to provide services in the least intrusive and least restrictive manner necessary. The continuum should include programs for youth who are abusing more than one substance and should consist of but not be limited to these types of services:

- Out-patient treatment.
- Out-patient care services
- Residential care.
- After-care.
- Transitional living facilities.
- Host homes for youth who cannot return from treatment to their own homes.

B. FUNDING

The state should provide a minimum of \$10 million for the development of this new continuum of services. According to the Department of Health, \$10 million would support the development of sufficient services to reach 3,500 youth over a 30 month period.

C. STUDY EFFECTIVENESS OF HAVING SEPARATE UNITS

The Office of Management and Budget and the Department of Health should be directed by the Governor to conduct individual studies of the effectiveness of the current separation of the Division of Alcoholism and the Division of Narcotic and Drug Abuse Control. These studies should focus on efficient utilization of fiscal resources by each Division, maximization of the state's ability to develop an appropriate continuum of services for youth who are multi-abusers and efficient utilization of funds in order to implement such services.

D. MEDICAL INSURANCE AND MEDICAID COVERAGE

Medical Insurance and Medicaid Coverage for Both Drug Treatment Services and Services for Alcohol Abuse-Related Problems: Private insurance providers should be mandated by law to provide coverage for drug treatment services and Medicaid coverage should be provided for drug treatment services regardless of the age of the client. Further, Medicaid should expand its coverage to include treatment services for alcohol abuse related problems for all those who are Medicaid eligible.

VIII. STATEWIDE PLAN TO ADDRESS FETAL ALCOHOL SYNDROME

The Department of Health should implement a statewide plan for the early identification and treatment of children at risk of Fetal Alcohol Syndrome (FAS) or Fetal Alcohol Effects (FAE). That plan should include:

- A. Educating physicians to identify and intervene with pregnant women who are abusing alcohol.
- B. Standard criteria for medical evaluation of infants and children suspected of suffering from FAS or FAE.
- C. Steps for smooth coordination of medical, developmental, psychosocial, educational and alcoholism treatment services for affected children and parents.
- D. Development of a directory of appropriate resources and services for prevention and treatment of FAS/FAE.
- E. Mainenance of a data collection system as part of the Special Child Registry to gather data on the incidence of birth defects resultant from maternal alcohol or drug use and abuse.

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To provide a picture of the types of activities and programs needed to address the problem of substance abuse, following is a chart which summarizes the key elements of a comprehensive prevention, identification, early intervention and treatment strategy.

Attachment 5.1

PREVENTION, IDENTIFICATION, EARLY INTERVENTION AND TREATMENT FOR THE EFFECTS OF SUBSTANCE ABUSE UPON CHILDREN AND YOUTH

I. PREVENTION

INFANCY

Education about alcohol and drug effects on the unborn for women and treatment for substance abuse for pregnant women.

Identification of the use of drugs/alcohol by the mother or parents.

Data collection from birth certificates or death certificates of infants.

CHILDHOOD

Education of all children and parents about alcohol and drug abuse.

Positive youth development programming, i.e., problem solving, coping strategies, dealing with emotions.

Development of trusting relationships with appropriate adults outside the immediate family structure as well as normal relationships with other children.

ADOLESCENCE

Includes items listed under Childhood.

Support for a chemical-free lifestyle.

Education for appropriate alcohol/prescription drug usage.

Student Assistance Programs to help divert the development of a problem.

YOUNG ADULTHOOD

Community Programs.

Information through the media.

Student Assistance Program for college students.

Employee Assistance Program.

II. IDENTIFICATION

INFANCY

Infant withdrawal from alcohol or other drugs.

Fetal Alcohol Syndrome or Effects.

Drug induced birth defects

Sudden Infant Death Syndrome

CHILDHOOD

Identification of children:

- from dysfunctional homes of alcoholics or drug addicts
- who are victims of physical or sexual abuse.
- with emotional problems;
- having low self-esteem.
- with low achievement motivation;
- with a tendency to disregard rules;
- perceiving a distance within their families
- who are sensation seekers.
- who exhibit self-destructive behavior.
- who began the use of alcohol, cigarettes or other drugs at an early age

ADOLESCENCE

Includes items listed under Childhood.

Excessive absenteeism from school

Involvement with the Juvenile Justice System

Suspended/Expelled

Drop-outs

Teenage Pregnancy

YOUNG ADULTHOOD

Regular use of drugs or problem and binge drinking

Multiple and combined use of alcohol and/or drugs

Motor vehicle offenses, accidents, driving while intoxicated

Excessive absenteeism from school/work

Financial difficulties

Inability to maintain employment

Involvement with the Criminal Justice System

III. EARLY INTERVENTION AND TREATMENT

INFANCY

Treatment for the following conditions if present

- withdrawal from alcohol or drugs to prevent seizures
- cleft lip or palate
- feeding difficulties
- hypothermia and hypoglycemia.
- cardiac abnormalities.
- pulmonary difficulties

CHILDHOOD

Early intervention and treatment for the following conditions if present

- developmental delay and learning disabilities.
- remediation or alleviation of handicaps.
- physical and psychological difficulties resultant from physical, emotional or sexual abuse.
- family problems—e.g. often the non-drinking parent prevents the child from obtaining help

ADOLESCENCE

Treatment Modalities

Out-patient Treatment

- 1 Referral for appropriate treatment after the child or youth has been identified and is still relatively unharmed
- 2 Treatment of the family in conjunction with the youth.
- 3 Support for non-using behavior through the use of peer groups in school and the community

ADULTHOOD

Residential Treatment

Detoxification Program

Medically supervised detoxification from the substance abused

Rehabilitation Program

Specifically designed for youth who abuse or are addicted to mood altering substances. Program should teach a functional lifestyle free from substances. Duration—2 to 6 months followed by an aftercare program.

Transitional Living Facility

Facility and program for youth who are in need of longer term programs in order to learn substance free lifestyle or who cannot return home

Host Homes, Group Homes, Teaching Parents Homes

Extended care in a supportive environment for youth who cannot return home and need stable living arrangement

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NOTES

1. This definition of abuse was obtained from: Marc A. Schuckit, M.D., *Drug and Alcohol Abuse: A Clinical Guide to Diagnosis and Treatment* (New York: Plenum Medical Book Co., 1979). The substances are those identified in Wayne S. Fisher and Anne C. Paskow, *Drug and Alcohol Abuse Among New Jersey High School Students; Report of the Attorney General's Task Force on Juvenile Drug and Alcohol Use in New Jersey* (Trenton, NJ: 1981).
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9. Wayne S. Fisher, *Drug and Alcohol Use Among New Jersey High School Students 1984* (Trenton, NJ: New Jersey Department of Law and Public Safety, Division of Criminal Justice, 1984).
10. *Ibid.*
11. *Ibid.*
12. *Ibid.*
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14. "Kids and Booze," *The Princeton Packet*, 11 May 1983. This was a supplement written by Yury Tarnavsky, reporter for *The Princeton Packet*.
15. Fisher, *Drug and Alcohol Abuse Among New Jersey High School Students 1984*.
16. "Kids and Booze," *The Princeton Packet*, 11 May 1983.
17. Fisher, *Drug and Alcohol Abuse Among New Jersey High School Students 1984*.
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**NEW JERSEY ASSOCIATION FOR THE
PREVENTION & TREATMENT OF SUBSTANCE ABUSE**
486 LAWRIE STREET • PERTH AMBOY, NEW JERSEY 08861

TESTIMONY PRESENTED TO
THE
SENATE COMMITTEE ON CHILDRENS SERVICES
SEPTEMBER 24, 1986

Drug Abuse Prevention and Treatment Providers View on the Problem of
Substance Abuse among Adolescents.

I represent a network of 45 agencies across the state that provide the complete continuum of substance abuse services. We are specialized professionals in this field and address the adolescent in our delivery system to the maximum degree possible given the circumstances with funding and jurisdiction in New Jersey.

In an attempt to be brief, I will outline for you the problems as we see them in providing the adequate level of quality services to the substance abuse affected adolescent and then offer some recommendations for your consideration.

1. Adolescent substance abuse must be addressed as a primary problem and not a symptom of an emotional or social problem. When recognized as such, the treatment will be appropriate and timely.
2. That the professionals who are positioned to see the troubled adolescent early on in their substance abuse experimentation, be credentialed in drug and alcohol as well as adolescent development so that proper assessment, referral to treatment and aftercare can be planned.
3. Treatment for adolescents must be adequately funded; Private Insurance and Medicaid coverage must be mandated for full complement of services; a fund for the indigent or neglected adolescent must be made available and reimburse treatment in a non-discriminatory way.

The three points attempt to summarize a very complex problem. The issues of adolescent substance abuse have been with us for many years; they are now in epidemic proportions and cannot be solved easily or overnight.

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Testimony
September 24, 1986
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I urge you to support the Insurance legislation already sponsored by Senator Carmen Orechio. Medicaid legislation by Assemblyman Van Wagner and the Student Assistance legislation by Assemblywoman Maureen Ogden.

As a policy, I would urge you to support the lead government agency as the Department of Health, who has the experience in this area and require the cooperation of the Departments of Education and Human Services and Corrections as appropriate.

Thank you for your time and consideration.

Respectfully submitted,



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73 Green Street
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CKC:cm

REPORT TO THE SENATE CHILDRENS SERVICES COMMITTEE HEARING
TRENTON, NEW JERSEY

SEPTEMBER 23, 1986

By: Carolyn Hadge
Coordinator, Alcohol Substance Abuse Program
Toms River School District
Toms River, New Jersey

I appreciate the opportunity to present to this committee. I would like to express the needs of adolescents, particularly those affected by substance abuse. I shall do this by giving the background of my professional experience working in the New Jersey Public Schools; by relating to the data from this experience; by analyzing the areas of concern.

As a professional, I am certified as a New Jersey Alcoholism Counselor, a New Jersey Department of Education social worker with a masters in counseling, a bachelors in psychology and an associates in Alcohol Studies.

I coordinated the first New Jersey student assistance program originated in Ocean County through the National Council on Alcoholism in 1979.

During August of 1983, Toms River Schools, the fifth largest school district in the state, with a student body of 16,000 plus, was the first school district to hire an alcohol/drug professional to coordinate a comprehensive primary and secondary prevention program. Albert J. Dietrich, Superintendent, initiated A.S.A.P. (Alcohol Substance Abuse Program) which is now in it's fourth year. As coordinator of A.S.A.P., I bring to you an overview of our findings.

1. Students Affected By Substance Abuse: A.S.A.P. has been able to intervene with a yearly increasing number of affected students. One measure of success is indicated by the fact that over 50% of those students precipitated into inpatient and outpatient counseling programs completed the school year; all were at risk of failure. Yet, through the New Jersey Attorney General's Survey on New Jersey High School Students and through a pre-test for this survey, which was run in one of our high schools, we know that 10% of our New Jersey high school students are in serious trouble. Through A.S.A.P., 3% of our high school students have been identified. In order to facilitate further positive school performance and in order to identify more students, we realize that the following issues need to be addressed:

- A. Substance abusing students who participate in outside treatment programs need consistent and continuing aftercare and support. The key is not with one to one counseling but with the building of bridges - networking - within school resources, family systems and community resources IF they exist. Without these, long term positive behavior change is rarely accomplished. Networking utilizing support groups, follow-up day treatment including family counseling, is crucial for these students "success".

In relation to this:

- B. Alcoholics Anonymous, as a community support group, provides a philosophy that allows young people to "identify" and "grow". This philosophy, however, needs to be perpetuated and expanded in order for students to change. Adolescents are NOT adults. Adult support groups do not necessarily address the developmental skills that the adolescent lacks. Providing a structure that allows adolescents space to develop and build these skills, which are unique to adolescents, is a job that needs the cooperation of both the education field and the treatment field.
- C. Choice of Chemical: Alcohol is by far the leading drug choice for adolescent recreational use. We cannot allow ourselves to be distracted by the current rush of cocaine use via "crack". When we look at our numbers from our own survey of spring 1985, we find that regular use of a substance (10 or more times in the past month) of those students using showed 13.7% used alcohol, 7.8% used marijuana, 2.6% used cocaine. Of these same students, alcohol was cited as the predominant first drug of use and that use was prior to the ninth grade. From our own inside identified overt abusers, our urine testing has surfaced, in the past three months some cocaine use. This leads us to the knowledge that the combining of these mood altering substances is prevalent. The identified overt abusers inevitably list alcohol as the consistently paired drug of abuse. Therefore, we cannot allow our prevention and intervention effort to concentrate on only illegal drugs.

- D. High risk students come into focus through evident behavior patterns: disruptive school behavior, poor attendance, class cutting, change in attitude, peer relationships, suicide threats, child abuse and court problems. Yet, often hidden is the child from the alcoholic or chemically dependent home who does not exhibit these clusters of characteristics but who is a prime target for substance abuse. The depth of alcoholism as a family problem needs exposure. Understanding of this problem is not sufficient; resources for dealing with it must be developed.

This leads us to our second area of discussion:

2. Primary Prevention Efforts: These, we have found, are also intervention efforts. Through the use of (1) the Here's Looking at You curriculum, (2) teacher/staff inservice and (3) peer education, we are not only building an "aware" community but we are also precipitating early identification.

T.E.A.M., our peer education program, utilizes all three strategies. Aimed at the elementary grades, we are seeing problems surface at this level. Again we need to build the bridges - develop the resources - to address these problems. Elementary school counselors are a beginning, however, the community needs to back up the school resources.

As a fringe benefit of T.E.A.M. we found that positive behavior on the part of the T.E.A.M. trained high school students was reinforced. By bonding these high school students a "ripple" effect has taken place. These students are motivating other students. We have adopted this same approach with our developing athletic program. Furthermore, high school students are role models for elementary students; athletes are role models for their peers. The ability to "just say no" is strengthened. This emphasizes the need to recognize prevention as an integral part of intervention and as the vehicle to promote a healthy school community. Support for prevention efforts is imperative; we look to leaders of your calibre for this support.

TESTIMONY OF BRUCE STOUT, ASSISTANT DIRECTOR OF THE JUVENILE
DELINQUENCY DISPOSITION COMMISSION, BEFORE THE SENATE COMMITTEE
ON CHILDREN'S SERVICES

SEPTEMBER 23, 1985

PUBLIC HEARING: THE PROBLEM OF SUBSTANCE ABUSE AMONG ADOLESCENTS

Thank you for the opportunity to speak with you today. My name is Bruce Stout and I am the Assistant Director of the Juvenile Delinquency Disposition Commission. As you know, the Commission was established by the Legislature as a research and analysis group responsible for monitoring juvenile justice system functioning, particularly the implementation of the 1983 Code of Juvenile Justice. I would like to share with you some of the things we have learned about substance abuse and juveniles in New Jersey's Family Courts.

Juveniles who are brought before the court on drug and alcohol charges (illegal consumption, possession, use or distribution) are only a subset of all court involved juveniles with substance abuse problems. Many juveniles commit drug and alcohol offenses which go undetected and others become involved in different forms of delinquency as a consequence of personal and family problems, including substance abuse. Additionally, the number of drug and alcohol offenses in court may rise or fall as a result of changes in law enforcement activity rather than from real changes in incidence. Despite these problems, the number of drug and alcohol charges brought to court does provide a crude measure of the magnitude of the substance abuse problem among court involved juveniles.

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During the period July, 1985 through April, 1986 11.6%, or more than one out of every ten charges brought against juveniles before the Family Courts was a drug or alcohol offense. This is the second most frequent category of offenses juveniles commit. Trends are not encouraging. When data for the first seven months of 1986 is compared to data for the comparable period in 1985 there has been an 11% increase in drug possession charges and a 28% increase in drug distribution charges during the current year. Clearly this is a problem of some magnitude.

Yet as I have said, other court involved juveniles besides those who have committed drug and alcohol offenses have substance abuse problems. We surveyed the records of juveniles in correctional institutions, correctional residential facilities and Division of Youth and Family Service residential facilities, the primary out-of-home placements available to Family Court judges. We found that about one-quarter of the juveniles in both correctional settings and a third of the juveniles in DYFS residential programs had parents who were abusing drugs or alcohol. About one-half of the juveniles themselves from both types of correctional settings and a quarter from DYFS residential programs had drug abuse problems. Individual levels of alcohol abuse were lower; 36% of the juveniles in correctional institutions, 28% in correctional residential programs and 20% of the juveniles in DYFS residential programs had alcohol abuse problems. Because this information was extracted from official records I suspect it underrepresents the true incidences.

As frightening as these statistics are, what is even more frightening is the gap which existed between these incidences of substance abuse and the level of treatment services these juveniles had received. Fewer than 16% of the juveniles from any of these three settings had ever had any drug counseling or therapy and fewer than 10% had ever had any alcohol counseling or therapy before their most recent sentencing. These juveniles weren't strangers to the juvenile justice system. The DYFS juveniles, who were newest to the system, averaged nearly two prior adjudications of delinquency. Committed juveniles averaged over five prior adjudications.

The reasons underlying the ineffectiveness of our social service, educational, and justice system responses to the problem are almost as complex as the causes of substance abuse. Many treatment programs rely on third party payments for services. Many juveniles included in the court system don't have insurance to cover such payments. School officials are hampered in their efforts because the highest risk youngsters are often not in school.

The court system does not have a comprehensive system for diagnosing and evaluating the needs of all juveniles who come before it. Substance abuse training would enhance the ability of court actors to preform these functions. While lack of resources to make effective programs available to all Family Court judges is a problem, there are also obstacles in place which impede the

court's ability to optimally utilize existing services. As a service user dependent on a system of independent service providers, the court relies on agencies which can often unilaterally define who they will and will not serve. Substance abusing delinquents, who typically present a multiplicity of problems in addition to substance abuse and delinquency, can be the most difficult to work with, and are often excluded from existing programs.

The Commission has recommended that mechanisms be established which would improve the court's diagnostic capability and more closely align the courts with the service provider systems on which they depend. One approach to this would be the formation of multi-disciplinary review teams in each court who would be responsible for gathering diagnostic information; making sentencing recommendations, procuring services, and monitoring case progress and outcomes. These types of solutions would improve the ability of the courts to address this serious problem. Coupled with improvements in education, prevention and treatment, I believe we can enhance the effectiveness of our response to the problem of substance abuse.

Thank you.

TESTIMONY OF ROBERT F. STUCKEY M.D. M.Sc.

BEFORE THE

NEW JERSEY SENATE

CHILDREN SERVICES COMMITTEE

September 23, 1986

MY TRAINING AND EXPERIENCE

I am a Certified Psychiatrist with a Public Health degree. My medical and psychiatric training were done at Columbia University in New York. I have lived and practiced in this state for twenty six years. I am the senior developer of twenty eight addiction and psychiatric centers, nationally and internationally.

For two years, I chaired the New Jersey committee of Youth, Alcohol and Drugs for the Health Department. For three years I chaired the Governors committee on Alcoholism. For two years I chaired the national committee on addiction for the National Association of Psychiatric Hospitals; and for four years, I was the national chairman of the treatment committee for the Trustees of Alcoholics Anonymous.

Since 1969, I have been the senior developer of eight New Jersey addiction programs and the senior clinician for more than ten

thousand addicted residents of this state. It is my guess that I have treated more adolescent addicts than any professional in New Jersey today.

This number of treated addicts was made possible primarily by the support of New Jersey Blue Cross and at the suggestion of Reilly Regan, Richard Russo and former Health Commissioner Richard Goldstein, whom you all know.

Seventeen years ago, I was designing and establishing the alcohol and drug addiction program known as "New Hope." This was accomplished by removing patients from Marlboro state hospital. I was told then that the patients there were psychiatric, not addicts. I noted however, that many of the adolescents there had been excellent students and had originated in stable families; In the therapy these juveniles had received, however, the addiction had unfortunately been seen as only secondary or symptomatic. The incorrect treatment for these adolescents, as it turned out, destroyed not only the childhood of the addict, but much of the joy of life for the entire family.

THE NATURE OF ADDICTION AND RECOVERY

Addiction is a biological disorder with no biological solution. but NOTE WELL, IT IS EASIER TO OBTAIN RECOVERY from addiction and

alcoholism than it is to stop smoking. There is one catch. As recovery is initially an almost total lifestyle change today, the lifestyle change need to be that of the entire family. We have found few exceptions to this in the success stories of adolescent addicts.

The overwhelming majority of relapses of the adolescent addicts, in our programs, are related to the refusal of one or both parents to refrain from their own drinking. Recovery is a specific lifestyle of drawing daily enthusiasm and strength from the recovered persons that have gone before. It is the adopting of sober extended family to establish all priorities related to sobriety. This cannot be done if family members are breaking every rule of that clan or subculture.

Almost all sustained recoveries are related to ongoing attendance of the adolescent addict at Alcoholics Anonymous or Narcotics Anonymous. This attendance occurs oftentimes because the parents accept the nature of addiction and commit themselves to the child's program long before the child can or will.

Addiction is an acquired drive. It is recorded in the region of the brain where programs of instinctual behavior are written. It is permanent and does not respond to insight or intellect any more than one can overcome their own appetites passions or thirst through intellect and will.

Everyone knows that you cannot give a former smoker the advice to smoke two or three "cigs" a day; Why this insane urge to teach the alcohol and drug addict the intellectual strength to drink moderately. We think it more to avoid the "groupy" approach to life or to avoid the culture of abstinence than to avoid abstinence itself.

ALCOHOL VERSES DRUGS

Alcohol is the primary drug of relapse for adolescents no matter their primary drug of choice. In the real world there is no separation of alcohol and drugs. That is a reality that must now be addressed both in the State government and in the recovery subculture.

The adolescent drug addicts are yesterdays and today's alcoholics. Eighty percent, plus of the children addicted to marijuana and cocaine or crack have a family history which is positive for alcoholism.

Most addicts over 35 choose alcohol and most under 35 choose drugs. About twenty five percent of adult patients choose cocaine, and approximately sixty percent of adolescents choose cocaine or marijuana as their drug of choice. Drugs are routinely available on the high school grounds and have been for

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fifteen years. In the sixties, the youth went to Staten Island for "hooze." In the late sixties they shifted to marijuana and hallucinogen available on the school grounds.

With cocaine coming to the foreground, these same children are getting help sooner, - before the alcohol destroys their character and brain; They are getting help before marijuana removes their motivation.

DENIAL

The addiction of youth begins with such drama, that it truly require skill to avoid calling it by its specific name. Note a typical case; The child's grades drop suddenly and precipitously, the child refused to let parents know their whereabouts or who their friends are. They youth remain "holed up" in their room, avoiding all family functions and meals. But rather than label a child, the parents and school have a round robin of mutual but fruitless blame.

By 1975, most substance using youth were finding that the drugs could be better concealed than alcohol and thus drugs were preferable at school. The majority of these users did not begin as "bad" kids, but came from homes and schools where the terms drug addiction and alcoholism were much too stigmatizing to be directly confronted in dinner conversation. Other labels were

used. Many of the parents spent a fortune on private schools and expensive psychiatric programs but with every effort to teach the adolescent addict moderation and self control, rather than accepting a primary diagnosis of addiction.

The State of New Jersey Education Department, to this day, has no official diagnosis for alcoholism or addiction.

This State Agency has lumped these epidemic disorders with all chronic illness. The child guidance specialists have, through the years seen addiction as a symptom of a personality disorder or learning disability, not a primary biological disorder.

The following dramatic story is not meant to offend. It is simply true. One of our adolescent patients in a state hospital in 1973, came from a particularly affluent family. The family asked us to consult with the child in the state institution. The story is one of success for the boy is now a young and successful physician in Union county. But in those days the school had given up on him as hopelessly incorrigible.

And now to the point. Within three months after my consultation, the school superintendent called me and told that he, the principal and the child's primary teacher all had drinking problems. The school system had mixed feelings about addictive disorders; the above staff were dismissed eventually even though two of them had exemplary recoveries. They made the mistake of

honesty with the school board.

Last summer, I was in Atlantic city and noted the New Jersey School board was meeting there. The program showed a session on chemical dependency. I went to the session to observe, but low not one school board member attended. Not one. The other workshops were filled but no one came to the space allotted for discussions on addiction in the schools.

WHY ARE ADOLESCENT ADDICTS SENT OUT OF STATE?

The best answer to this question is in the last paragraph of this section, however for those interested, we will provide the full and logical explanation. During the last four years, I have sent over six hundred adolescents out of state. This was after four futile years of attempting to establish a hospital center for adolescent addiction or a residential center for addiction. My reasons for this decision are listed below. Presumably other providers have followed the same reasoning.

For approximately twenty years, adolescents have received primary direct, confrontive treatment apart from adults in the state of Minnesota. I was alerted to the difference of philosophy in 1978, when I addressed two thousand recovered adolescent addicts in Bloomington Minnesota. Minnesota kept a simple philosophy regarding adolescent addiction. By the end of the sixties, it

was recognized in the school systems as independent of psychological problems. Minnesota has never distinguished drugs from alcohol in their programs. They coined the term "Chemical Dependency."

Minnesota has not been afflicted by the endless reliance on non-directive or "talking" therapy in their quest for a solution to these troubled youth. They have proceeded to provide specific programs of a social nature to youth as well as to senior citizens.

The Minnesota programs do not have paralysis of analysis. They separate chemically dependent persons into peer groups and utilize intense confrontation of the parents as well as the kids as to their personal reliance on alcohol or habit forming medications. It was difficult to establish an island of pure confrontation and honesty on this subject within families of the metropolitan New York area in 1980.

The non-directive approaches were still the gods. Parents would bolt if confronted about their drinking. Direct confrontation was and still is distasteful to the residents of the Eastern Seaboard.

Thus the lack of singleness of mind about the nature of addiction and the nature of treatment by the residence of the East has

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manifested itself in the provision of conflicting philosophies, for example, mixing adolescent addicts with adult addicts or with mentally ill adolescents in psychiatric settings.

Illit, Pennsylvania, Louisiana and recently New York have moved ahead on provisions of adolescent services for alcoholic and drug addicted youngsters. Most of these out of state programs are direct shuttles of personnel and program procedures from the original adolescent programs from Minnesota.

We in this state retain the myths that the insight therapies will solve problems and there has not been the demand for special programs. This is the condition of society, not the condition of the health officials.

A second reason for the lack of adolescent services is the fact that a credentialed professional can make a much higher salary by working in a Psychiatric unit than he can in a purely addiction oriented institution. Therefore the more credentialed persons seek work outside the pure alcohol and drug treatment tracks of health care. Addiction centers have lost many of the most experienced and trained therapist to the more expensive psychiatric hospitals.

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There is a third and unrelated reason that beds are unavailable for adolescent addicts in New Jersey. The delay in licensing and the delay in a single insurance for all addictive disorders including gambling is a function of the uneven way the legislature has divided the States's work between Commissioners. For example, in most states, more health insurance matters are given to the Insurance Commissioner, thus lightening the work of the Health department.

A fourth reason for the lack of New Jersey licensed beds for adolescent addicts, is the mission of the health department itself, to cut the number of acute bed. There was a similar mission of health department throughout the nation. This however has only served to spur the growth of Psychiatric hospitals to unprecedented heights.

The rate of adolescent admissions to psychiatric hospitals rose 450% between 1980 and 1984. And so in New Jersey, the lack of licensing of adolescent facilities came from a combination of a commitment by the state, to keep these adolescents out of hospitals; at the same time, the states licensing bureau was years behind it's own goals for hospital licensing. It is unlikely that time is near for the bureau to move on to residential and day programs with such backloging of hospital work to do.

the fifth reason for lack of fine facilities for this fifteen year old "crisis" is a prevalent prejudice within this state, and perhaps all states, that a child whose teachers and parents are seeking "private health care" should nonetheless send their kids only to public and/or non profit centers. Capitalistic society is trusted for adults, but mistrusted in the provision of health and social services for youth. You tell me the basis? This prejudice is a real hindrance to progress in addiction services for youngsters.

Within the last 24 months, I have personally been asked by three health corporations to join a venture in the development of addiction services for youth. Each wished to build a residential center for youngsters in the state of New Jersey. They then learned, that in New Jersey, the return on their investment was so low that they moved on to other states.

This last reason, which I will label the "anti capitalistic prejudice," is strong in this state, particularly toward healthcare services. This is, in my opinion, the true reason we do not have beds for adolescent addicts in this state.

In sum, we lack beds primarily because it is not profitable for anyone to invest in this health service. The investor's money provides a much better investment by remaining in the bank. Some of us did not feel it was moral to wait on state officials to

solve our problem. The chances of recovery seemed best then through Minnesota treatment. That is not true today. Note the section below on The Third Option.

WHY SHOULD WE HAVE MANDATORY INSURANCE FOR DRUG ADDICTS?

The first reason is to allow providers to tell the truth. Fifty percent of the kids getting treated under the alcoholism insurance are primarily drug addicts. In the early seventies, I had to treat several hundred alcoholics under the diagnosis of depression. Doctors will take care of patients by other diagnosis if the coverage is not available for the correct diagnosis. Insurance is being used on most of addict's medical needs, except it is mislabeled in the reporting systems.

And there lies the problem for they are now getting treated primarily for symptoms. The direct assault upon the lifestyle and peer group are not changed and relapses are documented at as high as 63% within the same months.

And there is a far more important reason to provide the mandatory insurance than the one above. This is the need to immediately begin treating addiction as a primary disorder and not treat it only symptomatically. Much of today's treatment under the wrong diagnosis is by a medical person who yet treats the symptoms for

Lack of knowledge or facilities to treat the addiction itself.

Mandatory insurance will save health dollars to the state and to the insurance companies under certain conditions. It will be quite costly under others. If one tracks any addict and his family he will find that as in alcohol the family use at least 400% of their fair share of health benefits under such labels as digestive diseases, headache, chronic backache, flu, colitis and on and on.

If case management of any population for beneficiaries is provided to all beneficiaries who exceed \$1800.00 a year in claims, or some similar filter applied, it will be found that the relapsing disorders are in fact individuals refusing treatment for addiction or unable to afford treatment for addiction.

THE PROGRAM OF THE DECADE AHEAD.

But there is a new program that has swept Minnesota for the past couple of years. It is certainly to be the program of the decade ahead. We have newer knowledge now about the causes of relapse. We know that a family centered "day" and "evening" program is superior to inpatient programs for over eighty percent of adults and over sixty percent of adolescents. The addicts become involved not so much in counseling but in joining of the

recovery plan on a family unit basis.

Yes, we need several hundred public and private beds immediately, but those beds will be worthless if they do not provide recovery. Many of those numbers of addicts on the waiting list have had previous treatment. I am reminded of the time my wife caught a game fish off Mexico. It has previously been caught and labelled by another fisherman in the Southern Hemisphere. A close look will show that many of the thousands treated in New Jersey, have been caught before. What is more needed than beds is higher budgets for the beds that are available and higher standards, derived from mandatory outcome studies.

But there is a better way for most kids today than placement in institutions. Please note there is something new in 1986. Commissioner Goldstein inaugurated it last October. He referred to it as the third option. It is neither inpatient or outpatient. It is not residential, but is conducted in the community. The family unit is the key to preventing relapse. Let's not hear now about the kids without families. The overwhelming majority of kids have parents who will turn heaven and earth if they can be convinced of a method to help their kid. We find outcome in adolescent more related to this family treatment than to the initial good response of the adolescent. We know that many youth need 90 hospital days, or perhaps they

and only ten days to clean out the physiological machine and get control of the youth's attention.

Recovery is sustained and relapse prevented when an addict becomes bonded to the recovering community. The relapses are rare, if full treatment is conducted within the context of multiple family units. This is best done in community day programs. Parents must take vacations from work to attend. And parents must stop drinking for six months. Alas many parents opt to put the kid in the hospital.

CONCLUSIONS:

Since the beginning of recorded history, alcoholism and drug addiction have required the services of physicians, law enforcement programs, social services and yet refused to come under control in any situation other than the covenant political and religious communities of the world. Without the extended family and the clan in the American culture, there is little hope of preventing high levels of addictive disease, except in the developing of a strong minority group or extended family of recovering persons and families. That is what I have attempted to do with the last seventeen years of my life.

No single treatment will provide the covenant of the Jewish or Greek community throughout the centuries, but even these cultures

cannot lay claim to controlling addiction with the new world of "I'll do it my way" and "go for it". The philosophy of our culture is "get all you can today," and hardly anyone will submit their strong emotional drives to group control in the society of today, and likely the culture for decades to come.

Therefore, there needs to be a central committee such as the Senate's committee on youth services that keeps alive a single commitment to the specific biological entity of addiction. Addiction may be on the verge of responding to pharmacological therapy, but until that day comes we need a place in this State where common sense reigns and the addicts are treated with what ever works.

Follow up studies are not hard to do, despite the protest; and these outcome studies should be mandatory in the institutions of today. Effective programs are all around but the factual evidence is missing. These outcome studies should be sponsored by all the health, correction, human services and insurance institutions. The fact that the committee has so few facts to describe what techniques or factors produce recoveries is, in my opinion, the most limiting factor for this committee to overcome. More is not always better. We must know what that "more" is accomplishing.

There must be a permanent committee including the agencies mentioned and it must operate only on data: a) cost data, b) recovery data and c) medical facts.

As stated earlier we find addiction easier to reverse than smoking tobacco.

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Manchester Township High School
101 South Colonial Drive
Lakewood, New Jersey 08733

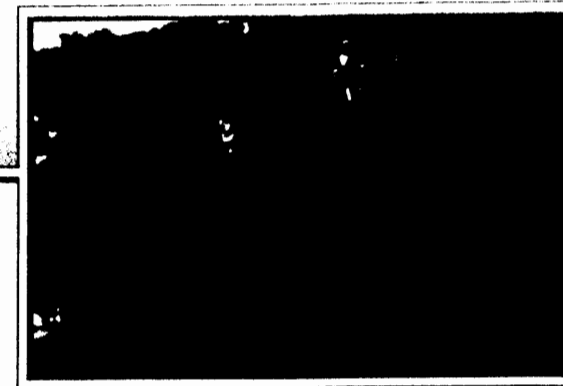
- I Association of Student Assistance Professionals of New Jersey
 - A. Description
 - B. Membership
 - C. Credentialing

- II Impact of Adolescent Drug and Alcohol Abuse
 - A. School
 - B. Peer Relationships
 - C. Family
 - D. Community

- III Statement of Need
 - A. Policy
 - B. Curriculum
 - C. In-service training
 - D. Counselors/coordinators

- IV Support of Legislation
 - A. Prevention
 - B. Intervention
 - C. Community based referrals
 - 1. outpatient
 - 2. residential
 - 3. aftercare

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TREATMENT AT DISCOVERY is viewed as a voluntary decision to change the behaviors and lifestyles associated with substance abuse as well as to confront the attitudes and feelings which foster drug dependence.

Discovery has been operational as a residential substance abuse treatment program since 1970, when it was first opened as the Marlboro Narcotic Project. It continued as Discovery House, a state operated program, for fourteen years. Recently incorporated, Discovery, Inc., has evolved from a therapeutic community project to a multi-modality

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Whereas, the structured, productive environment of a therapeutic community remains intact, a blending of professional expertise ensures the treatment is individually developed. The treatment plan is based on the recommendation of a team which includes a staff psychiatrist, masters level therapists, social workers and certified substance abuse counselors. All medical services are delivered or supervised by a Medical Director and a registered nurse.

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Individual Counseling — One-on-one counseling, clinical diagnosis, individualized treatment plan, psychotherapy, family therapy.

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Fees — As a result of the relationship between Discovery, Inc. and the N.J. Department of Health, fees for residential services are nominal.

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Therapy sessions may be held either on- or off-site by specific arrangement. Monitored urine

testing for a broad range of substances is also provided.

Clinical services are delivered by experienced masters level counselors.

The following services are available through the outpatient treatment program:

- Psychiatric evaluation • Urine monitoring
- Substance abuse evaluation
- Educational, vocational and medical treatment

- Development of individualized treatment and aftercare plans
- Clinical sessions inclusive of individual, group, family, and couples therapy
- Referrals to other treatment programs and support groups

Fees — are determined on a sliding scale. No individual will be refused treatment due to inability to pay.

PREVENTION AND COMMUNITY SERVICES: Due to the increasing number of people in need of treatment as a result of substance abuse, Discovery has developed a comprehensive Prevention and Community Assistance Program. The Prevention and Community Services component offers

schools, parents, communities and business groups assistance in meeting the needs of adolescents.

Training is provided in the following areas, all of which are necessary to prevent the onset and/or effects of substance abuse:

- Responsible Decision Making

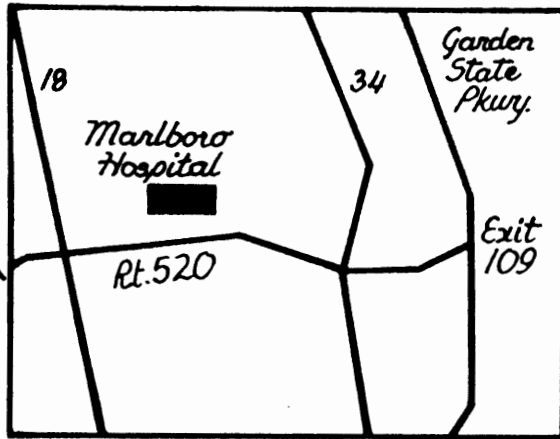
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- Communication Skills

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Peter Scales, Ph.D.

EMPOWERING YOUTH FOR THE FUTURE: The Responsibilities of Helping Professionals

Despite 1985's being proclaimed "International Youth Year," there seems to be less interest in youth than the older folks these days, perhaps with good reason: for the first time in our history, there are more Americans over 65 than there are teenagers. (1) By 2000, the median age of the population will be about 37, versus 31 today. (2) For the last few years, many communities have put schoolrooms to other uses as the population barely replaces itself, and more attention than ever is being focused on the problems at the later end of the life cycle, as we debate the future of Social Security and how we are going to keep medical costs of an aging population both down and financed with equity.

But youth remains the future. And thanks to the baby boomlet now under way, their numbers will again start increasing in the 1990s. (3) In order to help today's young people, and those on the horizon, to get the most out of their lives and avoid becoming a mental health casualty, we must face a bottom-line issue. We are still not empowering young people to find their own solutions and exert control over their destinies. Much of the debate about educational reform, for instance, is about the length of school days and the further manipulation of teacher certification and salaries. Most of the discussion has avoided the central problem. In our society, now and increasingly, the ability of youths to make good choices about their lives will be the single most important insurance we can provide for their mental health and our social well-being.

Even now, we learn daily of choices which people must make in their everyday lives that sometimes boggle the imagination, everything from the right-to-life to the right-to-die movements. Last year, we

even watched as Australian authorities tried to determine the legal rights of frozen embryos after their parents or parents-to-be, depending on your perspective, were killed in a plane crash. (4) How young people handle their choices related to friends, family life, schooling, sexuality, alcohol, driving and other daily matters affects their likelihood of coming into young adulthood with a solid base of possibilities and strengths. How they understand and take positions on nuclear weapons, human rights in South Africa, censorship, hunger in America, bilingualism and the space program will affect our future as a society. Our stake in their learning the facts of living is substantial.

John Naisbitt wrote in the popular book *Megatrends* that we have become an information society rather than an industrial one, and that we have moved from either/or choices, institutional helping of people and representative democracy to multiple options for choice, self-help movements and participatory democracy. (5) In that description lies the agenda of responsibilities for helping persons: we should be helping young people be comfortable with data of all kinds, know how to make choices and be critical consumers of products and relationships, how to help themselves and how to make a positive impact on the lives of others through activism.

That orientation should be, but is not always or even usually, the focus of our education. What we tell people to be on



Peter Scales

the one hand is not what we prepare them to be on the other. Perhaps that is one reason why National Institute of Mental Health researchers are estimating that about 20% of adults (43 million) and 12% of children (over 6 million) need help for mental and emotional problems. (6) Given that we estimate 28 million adults and 15 million children are living in alcoholic homes, however, even those alarming NIMH figures seem low. (7) Here is some of what I think we can do to reduce those figures.

PROMOTE POSITIVES MORE THAN PREVENT NEGATIVES

A good deal of our helping orientation has been compensatory, remedial or driven by a desire to avoid negatively-valued outcomes of behavior. Prevention of sexual abuse is the latest example of this type of perspective, joining other issues such as preventing teenage pregnancy, preventing alcohol and drug abuse, and others. Instead, it seems to me we would have more chance of improving people's quality of life by focusing on the generic issues that

"In our society, now and increasingly, the ability of youths to make good choices about their lives will be the single most important insurance we can provide for their mental health and our social well-being."

underlie all these social problems, that is, by assuming that in many cases they have relatively common etiologies. The health promotion movement provides a good example. Just as we have encouraged good eating and exercise habits, we should focus on teaching people how to identify options, to set priorities and express them, to take someone else's point-of-view, to teach something to others, to have and share opinions, to tell a good risk from a bad one, and to seek help within and outside the family. Such an approach may have a more profound impact, over time, than many single-focus "prevention" programs. (8)

ENCOURAGE AND CULTIVATE CRITICAL THINKING

I believe that we must reassert a key goal of education, that is, to enable people to think clearly. John Stuart Mill wrote in his classic "On Liberty" that the purpose of liberty is to allow "human nature to expand in innumerable and conflicting directions." (9) So much of our education, however, especially pre-college, is based on giving the correct answer. I read the other day that the three greatest human fears seem to be of public speaking, of heights and of insects. To that, I would add, only slightly behind the insects, the fear many people have of other people's ability to think. Maurice Bigelow, one of the pioneers of sexuality education in the early part of this century, was for all his foresight inevitably a product of his time. He was of the opinion that thinking about masturbation was even worse than doing it, because thinking can be done without detection or limit! (10) Today, the very people who complain the loudest about the apparent decline in abstract reasoning among young people, as measured by the National Assessment of Educational Progress, are among those who explicitly advise young people not to have opinions, discuss social issues or think about the future. (11) High school and even some college newspapers continue to be censored in surprising proportions, as even a casual reading of the Student Press Law Center Reports will illustrate. (12)

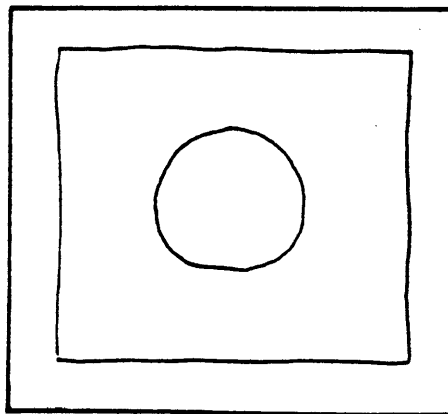
Even well-intentioned critics of secondary education today suggest reforms that do not, for all the appropriate rhetoric, do much to reorient the nature of education to-

"A good deal of our helping orientation has been compensatory, remedial or driven by a desire to avoid negatively-valued outcomes of behavior."

ward critical thinking. (13) In my view, we should be cultivating the abilities to question, exercise judgment, make fine distinctions, and see several points of view. I would like to see us guided by what the poet Sir Thomas Pope Blount said several hundred years ago, that some people will never learn anything, because they understand everything too soon. (14) We should always be ready to understand more.

SHIFT PARADIGMS AND CHALLENGE ASSUMPTIONS

The difference in approach between trying to prevent problems versus trying to promote positive values and skills is an example of a paradigm shift, a fundamental reordering of the models we use to solve the puzzles or problems we face. As we cultivate critical thinking abilities, we will also be laying the groundwork for what may be drastic shifts in our thinking. I recently used as an example the time when my youngest son, unaware he was being observed, carefully slathered peanut butter thickly on a sandwich, brought it slowly to his mouth and took a bite right out of the middle. The editor of a journal to which I submitted an article containing that illustration wrote back that this was hard to believe, and drew a little diagram to make sure he understood. Here it is: He did understand, and this was the most endearing exchange I've ever had with an editor!



It took a paradigm shift to get us to stop blood-letting as a medical intervention or to accept gradually over the centuries that we were not only not the center of the solar system but not even close to the center of our galaxy. We could have used some critical thinking and paradigm shifting in other fields as well. Because we did not challenge our assumptions, for example, we allowed the completely fabricated IQ "data" of Cyril Burt to indicate spurious racial differences in inherited intelligence. (15)

Let me give a few more mundane, but still important, examples. We frequently say that "raising self-esteem" is an important aspect of improving people's quality of life. Yet some research suggests that for some people, who already have a high degree of self-esteem, trying to raise it may unintentionally heighten their sense of being invulnerable to problems, and therefore make it less likely that they will protect themselves from risk. (16) As another example, we often believe that trained experts are better instructors than those less schooled in a given area. Yet, looking at sexuality education, one recent study of California students found that students of teachers who were more factually knowledgeable about the subject actually learned less than students whose teachers knew a little less but were more confident about what they knew. (17)

We see another example in family therapy, where therapists are in an extremely powerful position relative to their clients. One study has compared family therapists' views on family strength with what family members not in therapy think about it. The results were that the two groups disagreed widely, with therapists feeling that adaptability is the most important contributor to family well-being, but families feeling that a sense of family unity and pride are most important. (18) Yet, how often do family members' views get incorporated into our treatment plans and evaluations? Differences in values are especially

important in clinical fields, where I suspect there are still adherents to the view that the more one disagrees with the therapist's analysis of the situation, the more this proves how sick one really is.

As a final example of an assumption that needs to be challenged is accompanied by a reminder that most of us need to be regularly cautioned about our ethnocentrism. A recent study of 146 Ohio mothers and their adjustment to single parenthood indicates that those who had a more African view of the world (more spiritual, communal, and interpersonal) rather than a European one (more achievement-oriented, materialistic, and individualized) had higher self-esteem, less depression and anxiety, and were generally more satisfied with being mothers.(19) In the same way, a typically Anglo view of adolescents' needs for developing independence can often conflict with the higher value many Hispanics place on interdependence.

BE REALISTIC ABOUT BEHAVIORAL IMPACT

It is difficult to understand why those of us who work with human frailty and limits should think that our programs can quickly overcome either or both of these and make magnificent impact overnight. Many of us get trapped into evaluating our approaches by the yardstick of very fast and significant change. The reality is usually more complicated. Bernard Bloom and his University of Colorado colleagues followed 134 men and women through divorce and its aftermath for four years, and did an especially detailed study of their progress. Although an experimental intervention program did show some positive results in areas such as increased personal growth (compared with a control group), the program also failed to increase significantly happiness, relief from conflict and a number of other issues. For all participants, some problems simply got worse partway into the program(20). A similar type of finding is reported in some studies of treatment approaches for aggressive, abused children: after a helping intervention their behavior often gets worse before it gets better.

Basic limits are present, too, as well as unusual paths of impact. For example, studies of abusing parents suggest that, re-

gardless of treatment method, if the parent and child are in the same home again, 20-30% of the abusers will repeat the abuse(21). Finally, our results with trying to change behavior in various subfields of health education are mixed at best(22). We need to apply a bit of Heisenberg's Uncertainty Principle from physics here: the more you know about an atomic particle's location, the less you know about its direction and vice versa. There is a mystery and undetectable quality in the human spirit that ought to warn us against any straight-line thinking.

ADMIT AN INTEREST IN SOCIAL CHANGE

I recall coming close to not receiving my Ph.D. when, at my dissertation defense, I managed to say that social scientists, while needing to collect their data objectively, also had a responsibility to interpret the data and advocate for social change on that basis. I learned quickly to save such utterances for my post-doctoral days. Some assumptions do die hard, among them that scholars should let the data speak for them-



selves. We cannot simply let the data speak for themselves when dealing with views such as those expressed by some recent education critics who suggest that it is all right to help people adjust to social change, but not to promote change. These are the same people, by the way, who wrote that sexual activity among young people was at least partly responsible for lower SAT scores over the years(23). My response to them was to ask if they would now be equally willing to give sexual activity the credit for the recent rise we've seen in SAT scores(24)! I've not heard back.

PROMOTE A VISION OF A JUST SOCIETY

Advocating for our visions of a just society is such an important part of what all of us can do, yet to do so takes the courage to tell the truth to those in power and to reject

the old notion that scholars must sit on the sidelines pretending to be neither involved nor invested in the construction of social realities and social policies. Beyond our own areas of specialty, those with interdisciplinary training in the human sciences are in unique positions to contribute to the dialogue about many issues, such as our nationwide need for good child care, the continuing inequality of women's wages even as more become sole breadwinners, the question of asbestos in our schools, what to do about harmful chemicals in our food chain, interest rates that affect housing patterns and hence family relations across several generations, the millions of illiterate people in our information society, the need to improve our polio immunization rates among urban, minority children of whom only half have been immunized(25), and many other questions. Some of these may seem tangential to our daily work and stretching the limits of our expertise, but our contribution to the understanding of these problems and to the solutions is part of the payoff of having broad, interdisciplinary and humanistic training.

As we look to the future, these are some of the challenges to which we should respond effectively. We should not be afraid to examine critically our goals, our curricula and our basic approaches to getting things done and to redesign them. By the year 2000, the college-age population will again be expanding, and will do so for the remainder of the first decade of the new century(3). Inevitably, those 21st century young adults are going to be compared with today's college men and women. When the comparison is made, I hope we will see a reversal of at least two of today's statistics, perhaps brought about in part by a steady habit of challenging our assumptions.

Only 13% of high school seniors, many of whom will enter college and all of whom will be entering a more adult phase of their lives, feel that working to correct social and economic inequalities is a very important goal today; 26% thought so in the early 1970s(26). I'd like to see that reversed again. In addition, one out of three of today's high school seniors feels that nuclear annihilation will be the fate of

humankind within their lifetimes(26).

Recently, the Association of American Colleges called the bachelor's degree "meaningless."(27) Regardless of whether we agree with this assessment or not, we might ask how meaningful that degree would be if our values, teaching, research and advocacy over the next 20 years could help promote a society that was viewed as more just, equal, tolerant and at peace than ours today is perceived to be? I can't think of a greater fulfillment of the mission to improve the quality of our lives.

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Adapted from a presentation to the faculty and students of the School of Family Studies and Consumer Sciences, San Diego State University, May 16, 1985
Scales is executive director of Family Connection, Inc., an Anchorage, Alaska, counseling center for children and youths -17 years old and their families

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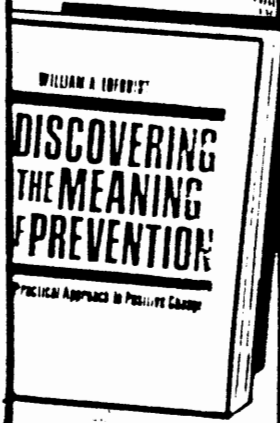
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MAKING SENSE OF PREVENTION: A Conceptual Framework

"Prevention" has probably been the least understood term in the field of human services. It is often viewed as nebulous, unclear, unmeasurable, a nice idea but . . . etc. Yet the prevention concept seems to be clear in at least one field: public health.

Public health has taught us that if we wish to be free of diseases such as polio or smallpox, we must be immunized against them. To decrease the likelihood of malaria epidemics in parts of the world, we can drain swamps to breed fewer mosquitoes. To minimize the risk of lung cancer and heart disease, we can choose not to smoke. It is commonly accepted that behaving in such ways will be likely to prevent the onset of these diseases, or at least to minimize the risk of contracting them. The statement, "an ounce of prevention is worth a pound of cure" has become a truism. We know we will never solve the problem of diseases by treating only the casualties after the fact.

It would seem logical for the same concept to be readily applied to human service-related behavior problems, but, for some reason, preventing problems like juvenile delinquency, drug abuse, or child abuse seems more difficult. Why? Do not the same principles hold?

Perhaps it is a limited understanding of the causes of these socially destructive behaviors. Perhaps it is a lack of understanding of practical solutions to prevent such problems.

It is helpful to think of prevention in terms of desired outcomes. The Vermont Statutes define "primary prevention" as "efforts to decrease the likelihood of juvenile delinquency, truancy, substance abuse, child abuse, and other socially destructive behaviors before intervention by authorities." "Secondary prevention"

can best be thought of as intervention at the earliest sign of such behaviors or efforts directed at "high risk" populations. "Tertiary prevention" can best be considered "treatment." There may be some overlap, but the issue hardly seems worth debating. Ultimately, the end result of "prevention" is to reduce behaviors which are troubling for people.

Our challenge becomes how to successfully translate this concept into practical reality. The first step is to examine what research has to offer, and when individual studies are examined, although the terms used in describing the various causes vary widely from field to field, the very same factors appear to be at work contributing to a variety of socially disruptive behaviors. (1,2,3,4,5,6,7) It also is clear that there is no single cause of any problem behaviors. Rather, a multitude of factors contribute.

SYNTHESIS OF CONTRIBUTING FACTORS

Research conducted on various causal theories of delinquency and other forms of socially disruptive behavior focused first on demographic or epidemiological or physical conditions. Such studies make it readily apparent that in this society we are continually bombarded by an abundance of stimuli over which we appear to have little control. Although the terms used by various research fields to describe such stimuli vary widely, it becomes clear through analysis that, in general, we experience these stimuli in four ways:

1. through our culture in the form of expectations;
2. through our social structure as perceived opportunity or lack thereof;



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3. through our social environment and stressors;
4. through organic factors which become problems.

CULTURE — BEHAVIORAL EXPECTATIONS

Our culture maintains certain values, beliefs, and norms passed down to us from generation to generation. Much of what our culture transmits to us can be considered standards of behavior or expectations for what is considered proper. Many of these behavioral standards are communicated to us through the media. Television, for example, communicates that it is okay to be violent, that consuming alcohol is the proper activity for almost any occasion, that it is advisable to self-medicate problems away and not endure a moment's discomfort. These are but a few examples of the types of values and beliefs about our behavior which are communicated to us and modeled for us.

To complicate matters, our culture also communicates norms for accepted behavior which are in conflict. For example, it is all right for parents to hit their kids, but unacceptable to cross over the magical, undefined line called abuse. It is all right to drink, but not too much. It is all right to consume some drugs, but not others.

To add to the confusion, different sub

culture and neighborhoods in which people reside hold different sets of expectations. Together they act upon us as learned ways of behaving that define the boundaries, if in a blurred way, of what is considered acceptable and unacceptable, appropriate and inappropriate.

SOCIAL STRUCTURE — LACK OF OPPORTUNITY

The society in which we live places value on achieving certain of life's success goals, such as monetary rewards. This can affect us in a variety of ways. If we perceive that we lack the opportunity of the means of fulfilling certain desired personal goals or needs, and if the value placed upon them by society is very high, we may seek to fulfill those goals and needs in ways that are unacceptable to society. Advertisers of alcohol and cigarettes exploit this desire for success by attempting to substitute for the success goal itself the use of certain drugs, equating such use with sex, money, status, etc. Furthermore, a perceived discrepancy between where one is and where one wants to be can "strain" an individual and thus affect behavior.

SOCIAL STRUCTURE AND ENVIRONMENT — STRESS

Many of the stimuli in our environment do not affect us in healthy ways. These stimuli produce stress which in turn produces frustration which produces more stress, and so on. When we feel stress it is very difficult to experience a sense of well-being. Too much stress will often produce a breakdown in healthy functioning which can manifest itself in a wide variety of ways.

The stress we feel can come from numerous sources; some of it comes directly from the environmental conditions in which we find ourselves. For example, stress can be experienced through living in overcrowded conditions or through its opposite, social isolation. Stress can be increased by living in substandard housing, by having limited financial resources, by experiencing certain traumatic events. An inadequate diet or lack of sleep can place increased stress on one's

body and thus on one's ability to function adequately(8).

Another powerful stressor on one's life can be one's own family. The extent to which a family is in conflict, the extent to which a family displays confusing adult-child roles (disorganization), or the extent to which a member of the family is chemically dependent(9) or experiences some other powerful dysfunctional behavior, will determine the extent to which a family produces its own stress. These behaviors, which imply acceptable ways of acting, are also modeled and learned by children and younger siblings.

Stress can be experienced in a variety of ways, but no matter what the cause, stress affects healthy functioning, which in turn affects behavior.

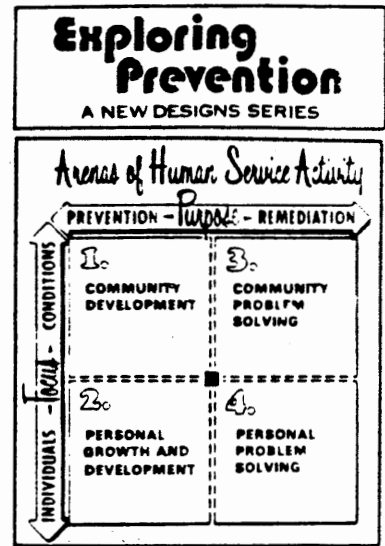
ORGANIC PROBLEMS

It is also possible to interact with the environment in ways which not only produce stress but harm our being. Organic problems like brain damage can be caused by the fetal alcohol syndrome, ingesting lead-based paint, automobile accidents, traumatic head injury, chemicals in the environment, etc.(10). It has even been postulated that certain genetic factors which increase one's predisposition to alcoholism can be inherited. Obviously these factors can influence behavior.

SOCIAL INSTITUTIONS — THE FILTERING MECHANISMS

Early research failed to answer an extremely important question. Why is it that everyone subjected to these outside forces does not react in the same way? People can grow up side-by-side in apparently similar environmental conditions, and some will display various types of problem behaviors while others will not. Some other dynamic must therefore be involved in absorbing environmental forces and filtering them, translating them into individual behaviors. By the late 1970s, a new set of research was materializing which attempted to extract what made the difference(1,7).

From the time we are born we almost never exist in complete isolation; we al-



most always live within some type of social context: our immediate environmental forces and our individual behavior. We first enter some type of family environment; second, the school; third, our peer group; and fourth, the rest of the community in which we live and work. These social institutions determine the context through which we receive outside stimuli. They have a powerful influence on our lives, they filter outside forces that we absorb, and ultimately they affect how we react to those forces.

THE DEVELOPMENT OF HEALTHY SELF-PERCEPTIONS AND LIFE SKILLS

Many different types of socially destructive behaviors have been researched, and although this research is incomplete and somewhat disorganized, the conclusions about what causes and what has the best chance of working to prevent each of these problems are remarkably consistent.

...after years of seeing teenage pregnancy as one issue, delinquency as another, and dropping out and underachievement as another issue, we have found that the chronic forms of all these problems reflect the very same set of issues. People who are chronically dependent on alcohol and drugs in their lives are very much the same as those who are chronically dependent on crime, delinquency, van-

dalism. And they are very much like those who are chronically dependent on the educational system (they express it by underachievement, absenteeism, disciplinary referrals), and they are very much like the chronically dependent family member or the chronically dependent unemployable person.

That we have not seen this relationship earlier is in part a result of the "special interest" approach we take in solving problems. Each approach to the problem has been highly specific and designed to solve a specific problem (such as drug abuse) without analyzing a type of behavior. The behavior we see is dependency—the inability to manage the freedom and resources available to us in our socio-economic system. Until we approach the problem of dependency as a type of behavior, it is not possible to solve the range of specific problems which are actually different manifestations of the larger problem of dependency(7).

Although the terms used in different sets of research vary considerably, they describe quite similar phenomena (see Figure 1). To ensure healthy functioning and reduce the likelihood of problem behaviors, research concludes that certain self-perceptions and skills must be present. These are:

1. **A feeling of self-worth, competence, capability; identifying with viable role models in one's life;**
2. **Belief that one is an important contributing part of or has a stake in things greater than oneself; a sense of belonging;**
3. **A feeling of power or control over one's life; belief in the ability to affect things in one's life;**
4. **Self-discipline – the ability to set aside what one feels like doing to accomplish what needs to be done;**
5. **Communication, including the skills of cooperating, empathizing, sharing, negotiating, and listening;**
6. **Responsibility – understanding cause and effect, limits and consequences, privileges and responsibilities;**

7. **Judgement – moral and ethical reasoning, understanding and applying concepts as safe-dangerous, fair-unfair, etc. to the decisions one makes(7).**

As young people grow and develop, they acquire these self-perceptions and skills through the immediate, institutional environments in which they live and grow. It is within this context that they gain the means for healthy functioning.

THE INFLUENCE OF FAMILY

In their early years the most powerful influence on children's lives is the family. Families either create healthy perceptions in their children or they unintentionally damage them. Families either build skills for acceptable behavior or promote unacceptable behavior. If the family builds a strong foundation, providing the young person with the tools needed to survive and be successful in a difficult world, he or she will have the best chance of growing up displaying socially acceptable and non-troubled behavior. In contrast, if the family, through the environment it creates and the way it responds to problem behaviors, destroys a young person's feelings of worth, capability, belonging, sense of power, etc., then the young person will have the greatest chance of displaying some problem behavior. We have no sure way of knowing through which specific behavior pattern the problem will manifest itself (although this technology is in the early stages of development(11)), but chances are that at least one of the many inner or outer-directed problem behaviors will emerge.

THE INFLUENCE OF SCHOOL

If the child does not gain the needed self-perceptions and skills through the family, all is not lost, for in the early-middle elementary school years, school often takes over as the most powerful in-



fluence in a child's life. It is quite possible for the school to structure its environment or "climate" to respond to student behavior problems in ways that help the child gain what was not developed in the family. Because the child returns to the home environment every day, it can be difficult at this level to have as powerful an impact; however, research indicates that the school can have a very powerful influence in this way(1). In fact this research shows that it is most often easier to alter the school environment than the family, and it is likely to be less costly.

Unfortunately, because of the way most schools in this country are structured, children are often unintentionally affected in counter-productive ways.

THE INFLUENCE OF PEERS

In early adolescence peers often take over as the most powerful influence in a young person's life. In fact, association with delinquent and drug-using peers was found to be the greatest contributing factor to delinquency and drug abuse(2). However this same research showed that if a solid foundation was built within the family and school then the influence of such peers was minimized. In short, if children have not assimilated a set of healthy self-perceptions and skills by the time they become affected by strong peer influence, the young person will often attempt to gain a sense of worth, belonging, and power from these peers. This can happen in constructive ways but, more often than not, the peer influence is likely to be in socially unacceptable directions.

THE INFLUENCE OF COMMUNITY

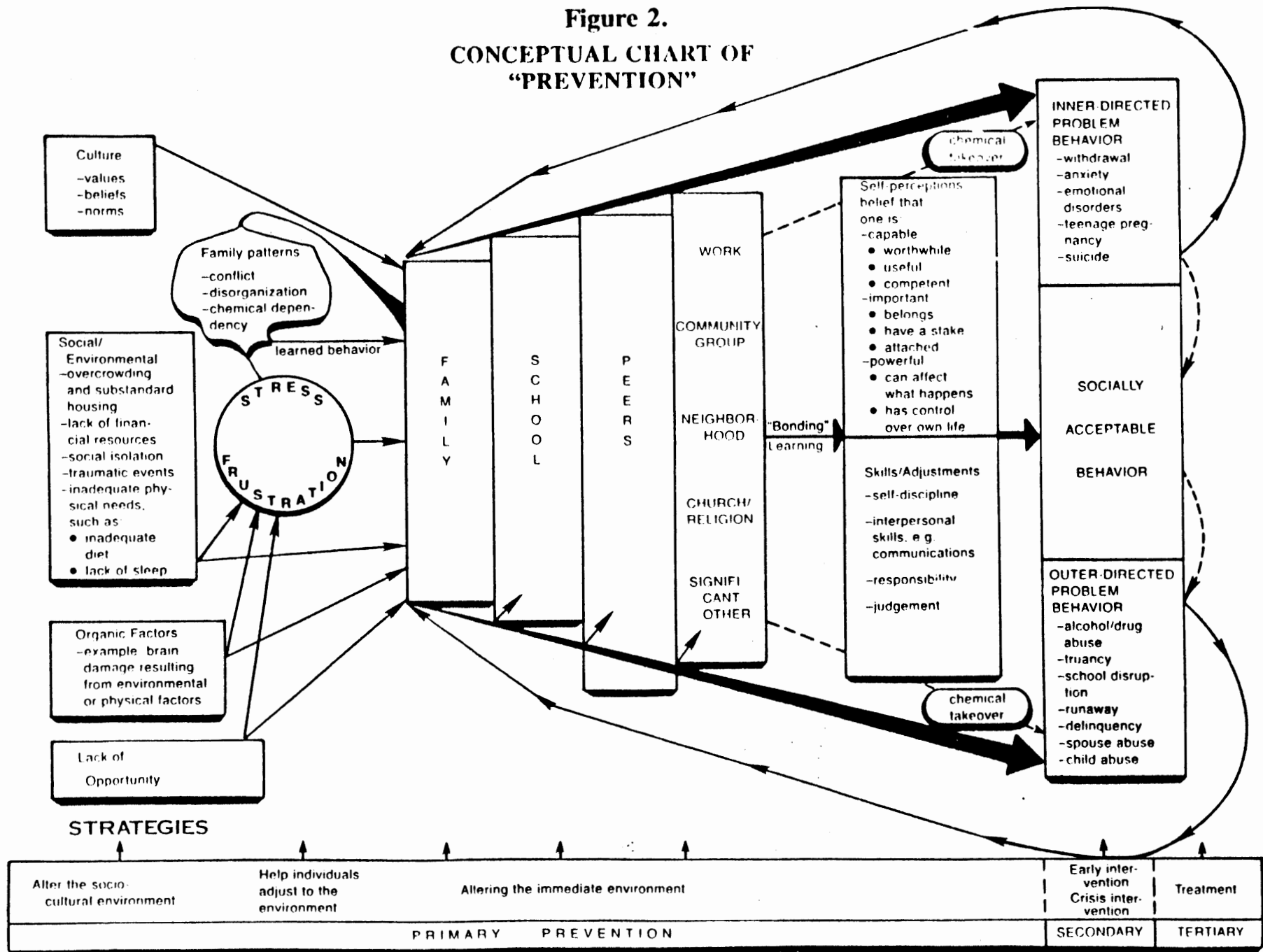
Some elements in the community can have a constructive influence on young people to turn them around if they have not gained what they need from family or school. Meaningful work or community service(1), participation in a meaningful community group, neighborhood pride, strong religious beliefs, or attachment to some person who significantly influences the young person, can make up for earlier deficits. At this stage, however, picking up the pieces is quite difficult.

Figure 1.

	Delinquency Research	Child Abuse Research	Substance Abuse Research	"Developing Capable Young People Research"
SELF-PERCEPTIONS	-Self-worth -Usefulness -Competence	-Self-esteem	-Self-concept	-Capable of finding one's way-in life
	-Belonging -Having a Stake -Commitment Attachment Involvement Belief	-Having support	-Change the perception that use is normative, expected, respected -Peer acceptance -Peer expectations	-Important contributing part of something greater than self meaning, purpose, significance, relevance
	-Power or Control over one's life		-Non-dependency	-Can affect what happens to self
LIFE SKILLS*	"behaviors must be modeled or learned and rewarded"	-Skill Building "parenting" skills -Basic Living skills Communication Interpersonal relations Interaction patterns Problem-solving Conflict resolution Assertiveness	-Affective Education Communication Decision-making** Resisting peer pressure Saying "No" to drugs assertiveness Values clarification	-Self discipline Interpersonal skills Responsibility Judgement
		Accurate Information***	Awareness***	

* skills take practice and reinforcement
 ** must be specific to problem
 *** the only purposes of information/awareness are to assist people who already have a problem to identify it and seek help and/or to aid in making decisions which reflect good judgement.

Figure 2.
CONCEPTUAL CHART OF
"PREVENTION"



HOW IT ALL FITS TOGETHER

To make sense of all this, a chart is helpful (see Figure 2).

This model can be adapted to allow for an expansion of George Albee's (10) prevention formula: (see below).

The extent to which a person experiences some type of dysfunctional behavior, whether manifested internally or externally, depends upon how strongly that person experiences negative socio-cultural-environmental stimuli, and, conversely, how strongly she or he experiences healthy perceptions and skills which are developed in his or her immediate environment. In addition, logically, one needs to have enough correct information about an issue (awareness) to make responsible decisions concerning it. And it certainly helps if one is supported in the process. In short, the more we experience stresses and strains, negative models, and organic problems, the greater the likelihood that we will develop some form of problem behavior. Likewise, the more we acquire healthy self perceptions and skills from our immediate environments, coupled with the information and supports we need, the greater the likelihood of our displaying generally socially acceptable behavior.

In at least one circumstance, this process of developing socially acceptable or non-problem behaviors can be diverted. Drug experimentation and resultant use can for some individual body chemistries reach a point where a physical and/or psychological dependency begins to occur. The person is overtaken by that chemical. This can happen even though from all appearances the individual appears to be progressing nicely through the process of healthy perceptual and skill development. This may be the result of a

genetic predisposition. It is less likely to occur if a solid foundation has been built in family or school, but chemicals can have a powerful enough effect over some people to divert into problem behavior what would normally be socially acceptable.

STRATEGIES TO PREVENT SOCIALLY DISRUPTIVE OR PROBLEM BEHAVIORS

Given this schema it becomes apparent that no matter what the specific socially destructive behavior we target, similar factors affect the development of that problem. Social-institutional environments contribute, often unintentionally, to many different types of problem behaviors. This is true for delinquency, substance abuse, truancy, school behavior problems, running away, child abuse, sexual abuse, domestic violence, as well as emotional problems like withdrawal, anxiety, suicide, or problems like underachievement, chronic unemployment, teenage pregnancy, and many more. The same factors contribute to each of these problems; only the behaviors emerge differently, depending on the individuals involved. The implications for human services work are staggering. The different disciplines must begin to work together to prevent these problems.

"Prevention" practitioners are faced with a choice. At what point should impact be attempted?

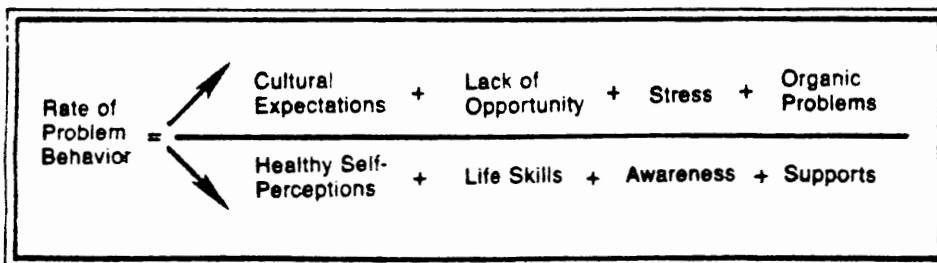
On the "primary prevention" level, one could choose to attack the source of the stimuli: the outside forces which model inappropriate behavior, which produce stress, which promote lack of opportunity, which minimize the risks in the physical environment, etc. In this set of strategies would be found media cam-

paigns or neutralizing the effects of the media. In this set of strategies would be found organizing to eliminate social injustices, restructuring the country's economic system, and other "radical" approaches (6,10). Focusing on this set of strategies, while important, is quite difficult because it requires changes in the very fabric of the society and the culture in which we live.

One could choose to focus on the stress produced by outside forces, to help the stress become less overwhelming and more easily handled, e.g. stress management and stress reduction techniques (12). These methods usually target the individual or a group of individuals, and even though these techniques can be quite useful to a wide variety of people, it is also true that little, if anything, actually changes about the conditions which caused and will continue to cause the stress in the first place. The individual is simply helped to adjust or cope.

One could choose to focus on changing the conditions of the local institutions through which young people are largely influenced. These would be strategies which assist the family and/or school to create an environment conducive to building healthy self-perceptions and needed life skills. This would include promoting awareness of the specific problems about which young people are concerned, with responsible decision-making skills geared directly to those specific behavior problems (4). The technology is now available to implement such efforts successfully and the research indicates that this is where we can expect to have the most impact (1,7,13).

All these are "primary prevention" strategies. It is also possible to focus on "secondary prevention" strategies, i.e. intervention at the earliest signs of a problem to "cool down" crises or try to prevent further problems in so-called "high risk" groups. Treatment or "tertiary prevention" occurs when the behaviors have become serious problems. Intervention and treatment are individual and group strategies which are essential. It is also true, however, that intervention and



treatment or rehabilitation do little if anything to change the conditions which initially caused the problem (the exception being some types of family therapy), conditions to which the client usually returns. Once "treated" the individual is again faced with the same difficult situation. Those who have gained those missing self-perceptions and skills from the rehabilitation process, have a fairly good chance of recovering from the problem. Those who have not, once they return to the old environment, often emerge again to manifest the same or a different problem, because the conditions have not changed and they must continue to struggle against the forces of their environment.

Treatment and rehabilitation are also more costly.

As we examine the pattern and interview the people in the rehabilitation process, we make an interesting discovery. To speak of rehabilitation is misleading. To rehabilitate someone involves restoring them or returning them to a former state of excellence. Yet these people have never been capable, productive or independent. Because of this we discover that these people who need so-called rehabilitation, in reality need primary habilitation.

Habilitation is the process by which people develop the primary skills for living. Discovering this fact suddenly put our priorities elsewhere. Rather than funding more and more rehabilitation programs, more effort and resources began to be funneled toward preventive or development projects. The family has traditionally provided experiences which greatly aid a young person in preparing for life. The recent incursion of technology and urbanization into our culture has altered the family's ability to provide these experiences... To conduct an enlightened examination of this situation, we must decide what young people need to become fully functioning, capable adults... seven basic skills and attitudes which are necessary for young people to possess if

they are to be successful people(7).

A TEN POINT PLAN FOR COMMUNITY PREVENTION

At a minimum, if a community – any group or government – is truly serious about solving the socially disruptive problems which face us, an effective community prevention strategy must include within it the following 10 facets:

1. **School environment or school "climate" improvement** to ensure the development of healthy self-perceptions in students. Such efforts should include at least an examination of school practices in accordance with the school philosophy and mission statement and a community-wide revision of the philosophy if necessary; clear and consistent rules perceived as fair by students; consistent enforcement of those rules but with emphasis on demonstrated caring for and building success of all students; student involvement in the governance of the school (not just the student council); increased parent involvement; effective teaching strategies (for example, cooperative learning, mastery learning); and curriculum relevant to life outside the school.

2. **Parent skills and supports** to alter conditions in the home environment to ensure development in children of the cited healthy self-perceptions and skills. Such efforts should be made available to community families on a systematic, rather than "hit or miss" basis and should emphasize the development of the child's perceptions of capability, importance, and power, instead of merely skills like communication, which many "parenting" courses largely consist of. Highly recommended is the course *Developing Capable Young People* by Glenn and Warner(7).

3. **Constructive peer influence** programs, and schools. Highly recommended are the very effective "Teenage Institutes" which bring influential students from different high schools together for an intensive, often emotional week of alcohol and drug education and helps turn negative peer pressure into

constructive peer influence, as well as often generating much prevention-related activity back at the school and community levels.* Peer-to-peer counseling and peer education programs could be considered as well.

4. **A comprehensive, sequential, K-12 health education curriculum** within schools, including information on alcohol and other drug abuse, child abuse, sexual abuse and sexual issues, eating disorders, and other problems children and teenagers may be exposed to. The curriculum must also include the development of decision-making skills directly related to those specific issues. In addition the curriculum should include information which neutralizes the effects of the advertising media on children.

5. **Support groups for highly susceptible populations such as children of alcoholics, victims of child and sexual abuse, eating disorders.** One caution: it is important to be extremely careful that these groups are not mandatory, that confidentiality is assured, and that no one is "negatively labeled" in the process.

6. **Respite day care coupled with parent supports** and skills for families at risk of child abuse.

7. **Emergency crisis services** such as runaway shelters and other ways of getting fast, emergency help to adolescents in need.

8. **Early childhood education programs** emphasizing developmental readiness for school.

9. **Pre- and post-birth care**, which could include programs such as pre-natal information and care, pride in parenthood, neo-natal perception inventories, paraprofessionals to talk to couples about their first parenthood experience and to help parents learn to care for the child, mother-child bonding techniques, nutritional and developmental information, ect.

10. **Constructive alternatives** for young people. This strategy has unfortun-

*Note: for further information contact Green Mountain Prevention Projects, 109 S. Winooski Ave. #201, Burlington, VT 05401.

nately often been used as the sole community strategy in attempting to prevent problem behaviors and, by itself, it usually will not work. "Alternatives" are opportunities that aid young people to develop the perceptions and decision-making skills necessary to take advantage of them. Alternatives selected must be conducted from beginning to end with the young peoples' full participation and leadership in the process, for if they do not perceive that they "own the project," they will not readily participate. Alternatives which make the most difference are those which include meaningful work programs and meaningful community service perceived as such by both the young people and the community. Programs such as school-sponsored day care programs come to mind, where students are trained in day care operations, child development, and program management while providing a no-cost or low-cost service to the community.

These are but some of the creative community "prevention" approaches which can be employed to solve the behavior-related problems our communities face. The technology is now available to accomplish all of them. This 10-point approach to solving community behavior problems, if followed systematically and provided with enough resources, may be able to put a dent in the problem. To ensure making the greatest difference in the least amount of time, it is advisable to begin with the activities toward the top of the list. If any of the first five are missing, it is unlikely the community will begin to experience a real reduction in problem behaviors, and that is what "prevention" is supposed to be all about.

OUR CHALLENGE

In summary, to intervene by means of treatment or tougher laws or increased severity of punishment solely after symptoms have manifested themselves is to ignore the evidence of what has the best chance of reducing social problems. It is clear from the research that the chronic forms of all these problems are rooted in the same conditions. To direct energy largely toward attacking symptoms is like pushing one's finger into

"If we are faced with only limited resources and energies, the research clearly suggests that we should focus on changing the environmental conditions of our major social institutions, families and schools, to develop healthy self-perceptions and skills in young people."

a tightly held balloon full of air: the bubble will show up someplace else.

Ideally we should focus on all strategies in the prevention continuum. They are all important and necessary to achieve the best results. If we are faced with only limited resources and energies, the research clearly suggests that we should focus on changing the environmental conditions of our major social institutions, families and schools, to develop healthy self-perceptions and skills in young people. Viable primary prevention strategies are our greatest opportunity to improve the behavior patterns about which we are all concerned. The result should be fewer behavior problems and less need for intervention and treatment.

But we must have the resources to conduct these programs on a massive enough scale to truly make a difference in each community in each state. If we do not, we will continue to be plagued and overburdened by these problems, the fallout from which costs us billions of dollars each year. It is far too costly to society to continue to rely mainly on alternatives to prevention to respond to the socially destructive and problem behaviors which face us.

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