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Safety First

A Reality-Based Approach to Teens, Drugs, and Drug Education

MARSHA ROSENBAUM

Marsha Rosenbaum begins this chapter by describing the historical and contemporary nature of drug education, most of which has been based solely on the philosophy of abstinence. She reviews the findings from evaluation studies of drug prevention programs such as Drug Abuse Resistance Education (D.A.R.E.) and discusses the problems associated with these programs. Rosenbaum proposes an alternative strategy that focuses on a "safety first" approach to drug education.

Although often championed as a new form of weaponry in the War on Drugs, drug education in the United States was first conceived over a century ago by the Women's Christian Temperance Union (WCTU), a leading organization of the anti-alcohol crusade.[1] Early programs claimed to be based on scientific research. Standard textbooks, however, were filled with misinformation: Alcohol would cause permanent damage to the liver, lungs, kidneys, heart and brain; and marijuana could drive users insane and cause homicidal rages. All drugs were portrayed as equally dangerous and addicting. Only total abstinence could save an individual from inevitable destruction.

Post–World War II drug education portrayed *alcohol* in a way more consistent with the beliefs and practices of most Americans, making distinctions between use and *abuse,* and characterizing the majority of users as moderate.[2] *Marijuana,* however, continued to be described as causing crime and insanity, leaving its users exceedingly vulnerable to heroin addiction.[3] The purpose of these programs was to frighten young people out of using *illegal* drugs, utilizing scare tactics reminiscent of the movie *Reefer Madness,* a 1936 propaganda film now universally regarded as factually incorrect.[4]

By the late 1960s and early 1970s, it was clear that exaggerations of danger had failed to prevent a generation of young people (the Baby Boomers) from experimenting with marijuana and other drugs. In response, there was an effort by some educators to take a different tack. Whereas abstinence continued to be promoted as the wisest choice, the idea was to give students all available information about drugs so they might use their education to make responsible decisions.[5]

In the early 1980s, America's new First Lady instituted "Just Say No" as official policy, with the simple goal of prevention of drug use.[6] Anti-drug budgets climbed and "abstinence-only" school-based programs proliferated, with federal funding

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requiring a firm "zero-tolerance" stance.[7] Materials construed as neutral were prohibited.[8] These new programs were considered sophisticated because they utilized psycho-social innovations. Students were given information about the dangers of drugs as well as techniques for countering "peer pressure." Mrs. Reagan instructed inner city children on how to say "no" to drugs, while "feel good" drug education programs gave them a heavy dose of self-esteem and self-control exercises to fill the alleged void that rendered them "at risk" to the lure of mind-altering drugs.[9]

Today's drug education is *extremely* variable in content as well as quality and price. Classes are sometimes offered as early as kindergarten, and in later grades drug education is often taught in courses such as "family life," or "health education." First, a particular program is adopted by a school and then the school's own teachers or outside "experts" teach the program's curriculum. Some offer video presentations, others stickers, posters, and activity books. Some are designed to stand alone, others to be integrated into health or science curricula. Some hand out T-shirts and certificates when students complete the program; others have graduation ceremonies at which students are encouraged to take a pledge to remain drug-free. All programs provide information about the negative consequences of drug use and teach resistance/refusal skills. The majority teach students that *most* people do not use drugs, that *abstinence* is the societal norm, and that it is acceptable not to use drugs.[10]

Does Drug Education "Work"?

Increased governmental funding for "prevention" in the 1980s resulted in a plethora of "approved" drug-education programs, but it is very difficult to know which, if any, drug education programs really "work." We do know that despite prevention education a majority of students experiment with drugs by the time they reach their senior year of high school. Somewhere there is a "disconnect."

Of 49 programs reviewed in *Making the Grade: A Guide to School Drug Prevention Programs,*[11] only 10 had been subjected to rigorous evaluations. Of these, a handful of programs developed in university settings have shown favorable results in delaying or reducing some drug use. Yet they tend to be rather expensive, hence less available than those programs that are cheaper to administer, aggressively marketed, and of questionable value.[12]

Some researchers question our ability to determine the effectiveness of drug education programs because the evaluations themselves are too simplistic. They tend to measure student *attitudes* about drugs rather than drug use itself. Unfortunately, attitudes formed about drugs during childhood or early adolescence seem to have little bearing on later decisions, and high school students may rhetorically state reasons for avoiding drugs, yet use them anyway.[13] Furthermore, such evaluations tend to report positive findings, while ignoring or even covering up those that show no effectiveness. In a comprehensive evaluation of several of the most popular programs, D. M. Gorman of Rutgers University's Center of Alcohol Studies argues:

> The evidence presented... from both national surveys and program evaluations, shows that we have yet to develop successful techniques of school-based drug prevention. The claims made on behalf of this aspect of the nation's drug control policy are largely unsupported by empirical data. Evidence is cited selectively to support the use of certain programs, and there is virtually no systematic testing of interventions developed in line with competing theoretical models of adolescent drug use.[14]

Education researcher Joel Brown and his colleagues conclude that flaws in the way programs are evaluated lead us to believe that drug education is effective, although in reality it is an enormous taxpayer drain with precious few positive effects.[15]

Perhaps no program has been evaluated more than D.A.R.E., which has been tested for its impact on drug use, both immediately after the program's completion and several years later. A study tracking D.A.R.E. students over five years found that the program had "no long-term effects... in preventing or reducing adolescent drug use."[16] Another study, funded by the National Institute of Justice,

found that "expectations concerning the effectiveness of any school-based curriculum, including D.A.R.E., in changing adolescent drug use behavior should not be overstated."[17] Based on a ten-year follow-up study conducted when D.A.R.E. graduates were twenty years old, a team of researchers led by Donald Lynam at the University of Kentucky concluded that D.A.R.E. created no lasting changes in the outcomes evaluated, including not only legal and illegal drug use, but self-esteem and peer pressure resistance.[18] Other long-term studies have found little or no difference in drug use between D.A.R.E. graduates and non-graduates.[19]

What do students themselves say? A common complaint about the D.A.R.E. program, according to researchers Wysong, Aniskiewicz, and Wright, was from students who did not believe their opinions were taken into account:

> It's like nobody cares what we think... The D.A.R.E. cops just wanted us to do what they told us and our teachers never talked about D.A.R.E.... It seems like a lot of adults and teachers can't bring themselves down to talk to students... so you don't care what they think either.[20]

As part of a large evaluation study of drug education in California conducted by Dr. Brown and his colleagues, students were asked to tell "in their own voices" how much their drug use had been influenced by the drug education they had received. Only 15% felt drug education had a "large effect" on their choice of whether to use drugs, and 45% said they were "not affected at all."[21] In conversations with students, Brown also obtained their views on the entire drug education experience. Many felt it was insulting to teach so-called "decision-making skills" when it seemed obvious that the only acceptable decision was to decline to use drugs. Brown believes this basic hypocrisy undermines drug education: "When young people recognize that they are being taught to follow directions, rather than to make decisions, they feel betrayed and resentful. As long as federal mandates force this charade, drug education programs and policies will continue to fail."[22]

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Fundamental Problems With Drug Education

The foundations of conventional school-based drug education are fundamentally flawed. Many programs are based on the conviction that any use of illegal drugs is inherently pathological, dangerous behavior, an indication that something is wrong. Some psychologists define drug use as deviant, aberrant behavior caused by a personality problem. Other explanations suggest a "proneness" on the part of some teenagers to problem behavior such as unconventionality (e.g., sagging pants and exposed bra straps) and willingness to take risks (e.g., driving too fast). Sociological explanations link youthful drug use to weak ties to family religion and school, to "peer pressure," and to membership in drug-using groups. Alternative explanations, not based on the idea that experimentation with drugs is pathological, acknowledge the importance of *culture*. The American people and their children are perpetually bombarded with messages that encourage them to imbibe and medicate [themselves with] a variety of substances. We routinely alter our states of consciousness through conventional means such as alcohol, tobacco, caffeine, and prescription drugs. Fifty-one percent of Americans use alcohol regularly and nearly 35% have tried marijuana at some time in their lives.[23] Even in the context of school, today's teenagers have witnessed the Ritalinization of difficult-to-manage students.[24] In today's society, teenage drug use seems to mirror American proclivities.[25] In this context, some psychologists argue, experimentation with mind-altering substances, legal or illegal, might instead be defined as normal, given the nature of our culture.[26]

Another flaw in drug education is its assumption that drug *use* is the same as drug *abuse*. Some programs use the terms interchangeably; others utilize an exaggerated definition of use that in effect defines anything other than one-time

experimentation and any use of illegal drugs as abuse. But teenagers know the difference. Most have observed their parents and other adults who use alcohol, itself a drug, without abusing it. Virtually all studies have found that the vast majority of students who try drugs do *not* become abusers.[27] Programs that blur the distinctions between use and abuse are ineffective because students' own experiences tell them the information presented to them is not believable.[28]

The "gateway" theory, a mainstay in drug education, argues that the use of marijuana leads to the use of "harder" drugs such as cocaine and heroin.[29] There is no evidence, however, that the use of one drug causes the use of another. For example, several researchers, as well as the federal government, have found that the vast majority of marijuana smokers do not progress to the use of more dangerous drugs.[30] Based on the National Institute on Drug Abuse Household Survey, Professor Lynn Zimmer and Dr. John P. Morgan calculated that for every 100 people who have tried marijuana, only one is a current user of cocaine.[31] Teenagers know from their own experience and observation that marijuana use does not inevitably, or even usually, lead to the use of harder drugs. In fact, the majority of teens who try marijuana do not even use marijuana itself on a regular basis.[32] Therefore, when such information is given, students discount both the message and the messenger.

A common belief among many educators, policymakers, and parents is that if teenagers simply understood the *dangers* of drug experimentation they would abstain.[33] In an effort to encourage abstinence, "risk" and "danger" messages are grossly exaggerated, and sometimes even completely false. Although the *Reefer Madness* messages have been replaced by assertions that we now have "scientific evidence" of the dangers of drugs, when studies are critically evaluated, few of the most common assertions (especially about marijuana) hold up.

Marijuana, the drug second only to alcohol in popularity among teens, has been routinely demonized in drug education today. Many "drug education" websites, including that of the Office of National Drug Control Policy "Project kNOw," include misinformation about marijuana's potency, its relationship to cancer, memory, the immune system, personality alteration, addiction, and sexual dysfunction.[34] In their 1997 book. *Marijuana Myths, Marijuana Facts: A Review of the Scientific Evidence,* Professors Zimmer and Morgan examined the scientific evidence relevant to each of these alleged dangers. They found, in essentially every case, that the *claims of marijuana's dangerousness did not hold up.*[35] Over the years, the same conclusions have been reached by numerous official commissions, including the La Guardia Commission in 1944, the National Commission on Marijuana and Drug Abuse in 1972, the National Academy of Sciences in 1982, and, in 1999, the Institute of Medicine.

The consistent mischaracterization of marijuana may be the Achilles' heel of conventional approaches to drug education because these false messages are inconsistent with students' *actual* observations and experience. As a result, teenagers lose confidence in what we, as parents and teachers, tell them. They are thus less likely to turn to us as credible sources of information. As one 17-year-old girl, an 11th-grader in Fort Worth, Texas, put it, "They told my little sister that you'd get addicted to marijuana the first time, and it's not like that. You hear that, and then you do it, and you say, 'Ah, they lied to me.' "[36]

Ultimately the problem with delivering unbelievable messages, particularly about marijuana, is that students define the entire drug education exercise as a joke. But their dismissal of warnings should not be taken lightly. A frightening ramification of imparting misinformation to them is that teenagers, like the heroin addict I interviewed over two decades ago, will ignore our warnings completely and put themselves in real danger. She did not find the negative claims about marijuana credible, discounted the entire message, and tried heroin. Today's increased purity and availability of "hard drugs," coupled with teenagers' refusal to heed warnings they don't trust, have resulted in *increased* risk of fatal overdose such as those we've

witnessed among the children of celebrities and in affluent communities like Plano, Texas.[37]

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Another problem with government-funded drug education programs is that they are mandated simply to *prevent* drug use. After admonitions and instructions to abstain, the lessons end. There is no information on how to reduce risks, avoid problems, or prevent abuse. Abstinence is seen as the sole measure of success and the only acceptable teaching option.

While the abstinence-only mandate is well-meaning, it is misguided. According to the government's own General Accounting Office, the expectation that teenagers, at a time in their lives when they are most amenable to risk-taking, will be inoculated from experimentation with consciousness alteration is unrealistic at best.[38,39] In fact, more than *half* of all American teenagers have tried marijuana by the time they graduate from high school, and four out of five have used alcohol.[40] The insistence on complete abstinence has meant the inevitable failure of programs that make this their primary goal.[41]

The abstinence-only mandate leaves teachers and parents with *nothing* to say to the 50% of students who say "maybe" or "sometimes" or "yes," the very teens we most need to reach. As seasoned drug education researchers Gilbert Botvin and Ken Resnicow note:

> As mandated by federal guidelines, most current substance-use prevention programs emphasize "zero tolerance" and abstinence. Although controversial, programs that include messages of responsible use, however, may be more credible, and ultimately more effective.... The primary goal of substance abuse prevention programs should, it could be argued, be the reduction of heavy use and abuse rather than limiting experimentation among individuals unlikely to become frequent users.[42]

Increasing numbers of educators are becoming frustrated by the abstinence-only mandate of federally funded drug education. While attending a local summit on teens and drugs, a county-funded drug educator pulled me aside and whispered that he would like to give his students (whom he knew smoked marijuana) information that might help them minimize its dangers (e.g., not to smoke and drive). But for him to admit that they might use it at all would violate the abstinence-only school policy dictated by federal funding regulations. He believed his hands were tied, and he could not really educate his students at all. This man was only one of dozens who have expressed such frustrations to me.

Safety First: A Reality-Based Alternative

A *safety-first* strategy for drug education requires *reality-based* assumptions about drug use and drug education. Whether we like it or not, many teenagers will experiment with drugs. Some will use drugs more regularly. At the same time we stress abstinence, we should also provide a fallback strategy for risk reduction, providing students with information and resources so they do the least possible harm to themselves and those around them.

We must approach alcohol and other drugs as we approach other potentially dangerous substances and activities. For instance, instead of banning automobiles, which kill far more teenagers than drugs do, we enforce traffic laws, prohibit driving while intoxicated, and insist that drivers wear seat belts. Reality-based alcohol education provides a model, with Students Against Drunk Driving (SADD), "Alive at 25," as well as many "designated driver" programs adopting a risk-reduction approach. Such "responsible use" messages are being introduced in alcohol education as an alternative to zero-tolerance.[43]

The first assumption of *safety-first* drug education is that *teenagers can make responsible decisions* if given honest, science-based drug education. Few young people are interested in destroying their lives or their health. Many already know the pitfalls, having experimented with drugs before, during,

and after receiving drug education, and/or having seen [the] consequences [of drug use] in their own families and communities.

The majority of teenagers do make wise decisions about drug use. According to the 1998 Household Survey, 90% of 12–17-year-olds *refrained* from regular use.[44] In fact, studies conducted to discover the reasons why students quit using marijuana found they were motivated by health reasons and negative drug effects, *which they themselves experienced.* Thus, any form of drug education should respect and build upon teenagers abilities to reason and to learn from their own experiences.[45]

A second assumption of a *safety-first* drug education program is that *total abstinence may not be a realistic alternative for all teenagers.* Drugs have always been, and are likely to remain, a part of American culture. To proclaim a "drug-free America by the year 2008" or some other arbitrary date is pure wishful thinking. Teenagers know this, and most parents and teachers know that they know it. Instead, a realistic perspective emphasizes safety and a reduction in drug problems rather than abstinence as the key measure of success of any program.

At the same time we stress abstinence, we should also provide a fallback strategy for risk reduction.

A third assumption of *safety-first* drug education is that the *use of mind-altering substances does not necessarily constitute abuse.* The majority of drug use (with the possible exception of nicotine, which is the most addictive of all substances) does not lead to addiction or abuse. Instead, 80–90 percent of users *control* their use of psychoactive substances.[46] According to Professor Erich Goode, author of the best-selling text *Drugs in American Society:* "The truth is, as measured by harm to the user, most illicit drug users, like most drinkers of alcohol, use their drug or drugs of choice wisely non-abusively in moderation; with most, use does not escalate to abuse or compulsive use."[47]

Students who, despite our strong admonitions to abstain, use marijuana, need to understand that there is a huge difference between use and abuse, between occasional and daily use. If they persist, students need to know that they can and *must* control their use by using moderation and limiting use. It is *never* appropriate to use marijuana at school, at work, while participating in sports, or while driving. As the late Harvard psychiatrist Dr. Norman Zinberg stressed, users must recognize the complex interaction between the drug they are ingesting, their own mind-set, and the setting in which they use substances, which combine to form the context of drug use.[48] As with sexual activity and alcohol use, teenagers need to understand the importance of context in order to make wise decisions, control their use, and stay safe and healthy.

Some "How To's" of Safety-First Drug Education

Communication is key in *safety-first* drug education. We must keep the channels of communication open, find ways to keep the conversation going, and listen, listen, listen. If we become indignant and punitive, teenagers will stop talking to us. It's that simple.

Safety-first drug education should be *age-specific* and begin in middle school, when teens are actually confronted with drugs. Courses should run continuously through high school, when most experimentation occurs, utilizing both student engagement and participation (which conventional drug education acknowledges as crucial) and reality- and science-based educational materials.

Almost any discussion of drugs captures the attention of students. Teenagers often know more than we (want to) think about drugs through experience, family and the media. We must include them, incorporating their observations and experience in any drug education curriculum if we want it to be credible.[49,50] There must be *no negative repercussions* for their input and honesty.

Safety-first drug education affords us the opportunity to engage students in the broad study of how drugs affect the body and mind. Quality drug education may provide an introduction to physiology, including the psychopharmacology of

drugs (how they work), as well as their health and psychological risks (and benefits). An exceptional text is Dr. Andrew Weil and Winifred Rosen's *From Chocolate to Morphine: Everything You Need to Know About Mind-Altering Drugs,*[51] which describes nearly every drug available to teenagers in a comprehensive but objective way. Finally, students should learn about the social context of drugs in America. Drug education courses provide an opportunity to teach history, sociology, anthropology, and political science.

Students must also understand the *legal* consequences of drug use in America. Because teens are underage, *all* drugs are illegal for them. With increasing methods of detection such as school drug testing and escalating "zero tolerance" efforts, drug education must acknowledge *illegality* as a risk factor in and of itself, extending well beyond the physical effects of drug use. There are real, lasting consequences of using drugs and being caught, including expulsion from school, denial of college loans, a criminal record, and lasting stigma.

The goals of realistic drug education, as noted, focus on safety. With such an education, students will more deeply understand the concrete risks inherent in the use of drugs. But if we are to capture and retain students' confidence, we must separate the real from the *imagined* dangers of substance use. Just as drugs can be dangerous, they can also provide users with psychological and medical benefits, which explains why use has persisted around the world since civilization began. Reality-based drug education will equip students with information they trust, the basis for making responsible decisions.

As the demand for reality-based drug education, grows, programs are being developed in the United States and abroad. A listing of such programs can be found at the website of the Lindesmith Center: *www.lindesmith.org.*

Summary

Drug education has existed in America for over a century. It has utilized a variety of methods, from scare tactics to resistance techniques, in the effort to prevent young people from using drugs. Nonetheless, teenagers continue to experiment with a variety of substances. Despite the expansion of drug prevention programs, it is very difficult to know which, if any "work" better than others. The assumptions that shape conventional programs render them problematic: that drug experimentation constitutes deviance; that drug *use* is the same as drug *abuse;* that marijuana constitutes the "gateway" to "harder" substances; that exaggeration of risks will deter experimentation.

Reality-based drug education will equip students with information they trust, the basis for making responsible decisions.

The main reasons many students fail to take programs seriously and continue to experiment with drugs is that they have learned for themselves that America is hardly "drug-free"; there are vast differences between experimentation, abuse, and addiction; and the use of one drug does not inevitably lead to the use of others.

While youth *abstinence* is what we'd all prefer, this unrealistic goal means programs lack *risk-reduction* education for those 50% who do not "just say no." We need a fallback strategy of *safety first* in order to prevent drug *abuse* and drug *problems* among teenagers.

Educational efforts should acknowledge teens' ability to make reasoned decisions. Programs should differentiate between use and abuse, and stress the importance of moderation and context. Curricula should be age-specific, stress student participation and provide science-based, objective educational materials. In simple terms, it is our responsibility as parents and teachers to engage students and provide them with credible information so they can make responsible decisions, avoid drug abuse, and stay safe.

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