

Withdrawal/Redaction Sheet

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DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001. bio	re: Ledonia Kimble [partial] (1 page)	08/08/1995	b(6)

COLLECTION:

Clinton Presidential Records
First Lady's Office
Melanne Verveer
OA/Box Number: 20055

FOLDER TITLE:

Teen Smoking [Folder 3]

2013-0534-S

rc1735

RESTRICTION CODES**Presidential Records Act - [44 U.S.C. 2204(a)]**

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- P3 Release would violate a Federal statute [(a)(3) of the PRA]
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- b(9) Release would disclose geological or geophysical information concerning wells [(b)(9) of the FOIA]

August 8, 1995

*file teen
smoking*

MEMORANDUM FOR HILLARY RODHAM CLINTON

FROM: Brenda Costello
SUBJECT: Briefings for Wednesday, August 9

Safe and Drug Free Schools Event

- Briefing
- Bio of Ledonia Kimball, Director REAP summer program
- Background on students
- Potential questions for HRC to ask students
- Draft of Dr. Brown's remarks
- Safe and Drug Free Schools and Communities State Grants
- Drug Free Schools Project background
- Office of National Drug Control Policy press release, 6/7/95
- "Alcohol and Other Drug Abuse Prevention: The National Structured Evaluation," U.S. Department of Health and Human Services Third Report to Congress
- "Making Prevention Work," Center for Substance Abuse Prevention/Substance Abuse and Mental Health Administration (front pocket)
- "CSAP Statistical Bulletin, 1995" (front pocket)

- "Cigarettes, Alcohol, Marijuana: Gateways to Illicit Drug Use" (back pocket)
- The University of Michigan study - "Drug use rises among American teen-agers" (back pocket)
- "Cigarette -Smoking Youth More Likely to Use Alcohol and Marijuana than Nonsmokers," Center for Substance Abuse Research, University of Maryland
- Tobacco Marketing to Youth - FDA Fact Sheet
- "On My Mind; Save the Drug Czar," Rosenthal, NYT, 8/4/95
- "Connecticut Q&A: Dr. Kathleen R. Merikangas; On Starting Young to Treat Alcoholism," NYT, 6/12/94
- "Cutting Funding...Move to Kill Tobacco Study Riles Researchers," WP, 8/8/95
- "Clinton Calls for Tough--Yet Practical__Program to Combat Teenage Smoking," WP, 8/8/95

Remarks

- Safe and Drug Free Schools

August 8, 1995

SAFE AND DRUG FREE SCHOOLS

DATE:	August 9, 1995
TIME:	3:00 pm
LOCATION:	East Room
FROM:	Brenda Costello

I. PURPOSE

To highlight the accomplishments of the Clinton Administration's drug-free schools program and the importance of such programs with a forum of Baltimore City Public School students and Dr. Lee Brown, Director, Office of National Drug Control Policy.

II. BACKGROUND

Safe and Drug Free Schools and Communities Act

The Safe and Drug Free Schools and Communities program is the only school-based federally funded drug prevention program. Funds for drug education go directly to states for grants to local education agencies, community based groups, and institutions of higher education. Some 94 percent of the nation's school districts receive funding -- more than 15,000 school districts. The program funds drug prevention efforts such as Drug Abuse Resistance Education (DARE) and the Baltimore City Public Schools Recreation Education and Prevention (REAP) program.

The President requested \$500 million for the Safe and Drug Free Schools and Communities program for FY 1996. Last week, the House voted to cut the program's funding by 60 percent, to \$200 million. The Senate has not yet acted on this legislation.

The program's FY 1995 funding was \$482 million, however, Congress passed a rescissions bill which cut 49 percent of that funding, scaling it back to \$246 million. The President vetoed this rescissions bill, which he announced at the Drug-Free School Recognition Ceremony in the Rose Garden on June 7, forcing Congress to rewrite the rescissions package and add \$220 million back into the program. The President signed the final rescissions bill on July 27. (State funding figures attached.)

Baltimore City Public Schools Drug Free Schools Peer Leadership Programs

SHOP

Students Helping Other People (SHOP) is a positive peer leadership program that is designed to support high school students in maintaining drug-free lifestyle. The program provides a 3 1/2-day residential training that equips students with knowledge and skills that will help them plan and conduct drug abuse prevention activities in the school and community. SHOP training teams are made up of a maximum of fifteen students and at least one adult advisor.

REAP

The Recreation Education and Prevention (REAP) program is a drug prevention program of the Baltimore City Public Schools and Parks and Recreation Department, which seeks to assist students in developing constructive use of their leisure time. The program is designed to utilize the skills of trained SHOP members to implement prevention activities in area recreation centers.

The goal of the program is to help young people reach their maximum potential physically, socially, mentally, and academically by engaging them in a variety of activities such as recreation, tutoring and drug abuse prevention education which will provide them with a model for constructive use of their time.

Once trained in the SHOP program, students may apply for paid positions with the REAP program. If selected, students are then assigned to a center where they work after school and/or during the summer. There are six recreation centers participating in the program in Baltimore out of a total of 120 recreation centers.

While REAP is a community-based program, SHOP is a school-based program which provides mentor training during the school year.

Program objectives include:

- Training high school students as peer leaders
- Having students experience the components of the work ethic while gainfully employed
- Training students to provide drug abuse prevention information through a variety of delivery styles, including but not limited to tutoring, skits games, educational/ recreational activities, discussion groups, arts and crafts
- Providing employment opportunities for students in select recreation centers
- Presenting information to help school aged children develop resistance skills and strategies that lead to appropriate choice selections
- Establishing a cadre of student employees who model drug-free life styles

The selection of students in the program is based on the following criteria:

- Students must be committed to a drug-free lifestyle and have been drug-free for the past two years.
- Students should have time and interest in being committed to the SHOP program.
- Students should possess leadership capabilities.
- Students should be capable of socializing with a broad spectrum of their peers.
- Students should come from a variety of cultural and socio-economic backgrounds.
- Students must have the emotional and physical ability to participate in the group process. This does not exclude students with disabilities.
- Students must be in good academic standing

Format

Approximately 75 people are expected to attend, including approximately 60 students from the REAP and DARE (Drug Abuse Resistance Education) Programs and the Boys and Girls Club of America. The students will come mostly from the REAP program, however there will also be children from the DARE program as well as The Boys and Girls Club of America. The peer leaders are 16-17 years old and the younger students who will participate in the skit are 9-12 years old, all from the REAP program. Other participants will include Dr. Brown, the REAP Program Director Ledonia Kimball (bio attached), and DARE program representatives. Other guests include public and private agencies, drug prevention organizations, education organizations.

You will open the program with welcoming remarks and then introduce Dr. Brown. Dr. Brown will give brief remarks (draft remarks attached). He will then introduce the REAP summer program Director, Ledonia Kimball, who will give an overview of the program. Following Ledonia's remarks, she will describe and introduce a skit that the children will perform, a skit typically performed in the REAP program on "Saying No to Drugs".

After the skit, Ledonia will open the floor for discussion with the students by recognizing one of the mentor students, providing you with an opportunity to ask questions (sample questions attached). Following this interactive portion of the program will be testimonials from REAP alumni, on how they benefitted from the program.

Director Brown then introduces the DARE officer, who will talk about the program and introduce the student. The DARE student will discuss why the program is important to him. (DARE is a program of specially trained police officers who go into schools to teach students strategies for resisting the temptations and peer pressure of drug use.)

Director Brown makes brief closing remarks, followed by your closing remarks.

III. PARTICIPANTS

- HRC
- Dr. Lee Brown
- Ledonia Kimball, REAP summer program Director
- Students (see list attached)

IV. SEQUENCE OF EVENTS

- HRC opens and gives remarks and introduces Dr. Brown
- Dr. Brown gives remarks and introduces Ledonia Kimball
- Ledonia Kimball gives remarks
- Ledonia opens discussion and introduces skit
- Students perform skits
- HRC asks students questions
- Director introduces DARE officer
- DARE officer speaks, introduces student
- DARE student speaks
- Director Brown makes closing remarks
- HRC closes program and thanks group
- HRC departs

V. PRESS

Open press.

VI. REMARKS

Prepared by Karen Guss.

Withdrawal/Redaction Marker

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**Biographical information for
Ledonia Kimble, REAP program**

- Currently serving as Staff Associate for the development of curriculum monitoring and implementation for the Baltimore City Public Schools Safe and Drug Free Schools Program
- Has worked for the Baltimore City Public Schools for 31 years
- B.S. degree in Health and Physical Education
- Masters degree in Administration and Supervision
- Born and Raised in (b)(6) [001]
- Resides in Baltimore Maryland

REAP Peer Leaders

Missa Brown Age 17

- Three years in REAP program
- Inspired to do her part to make a difference in the lives of the youth in here neighborhood after witnessing a drug related shooting (victim unknown) at a college home coming event.

Danyell Strickler Age 17

- First summer in REAP program
- Has a younger brother (12) in program
- Had two friends killed in a drug related shooting, one friend (bystander) was paralyzed.

Nicole Sellman Age 16

- First summer in REAP program
- Has a close friend that is battling with drug addiction

REAP Alumni

Mike McCall Age 19

- Junior at Frostburg State College, Maryland
- With REAP 2 years

Jason Morgan Age 19

- Junior at Hampton University, Virginia
- With REAP 2 years

Skdt Participants

Christopher Campbell Age 12

Jhering Wingfield Age 9

Shante Sims Age 10

Darryl Burrell Age 9

Robert Booker Age 9

Jason Parrott Age 11

Danny Smith Age 9

Justin Johnson Age 7

Marvin Parrott Age 9

Patricia Parrott Age 11

Latoria Hicks Age 12

POTENTIAL QUESTIONS

For the 9-12 year olds:

How did the program change your attitudes?
How serious is this problem for kids your age?
Where do you learn the most about drugs?

For the 17 year olds/ Peerleaders:

Why did you go to this program?
If you could tell me one thing as a parent that I need to know for my daughter about the drug issue what would it be?
How can we reach other young people like you?
What else should we do to get the message out to kids and to help them resist drugs?

For Alumni:

How has this program made a difference in your life?

DRAFT**DRAFT**

REMARKS BY DR. LEE P. BROWN
DIRECTOR, OFFICE OF NATIONAL DRUG CONTROL POLICY
WHITE HOUSE SAFE AND DRUG FREE SCHOOLS FORUM ,
AUGUST 9, 1995

I want to recognize the achievement of each child here today, particularly the kids from Baltimore's Recreation, Education and Prevention program. These students are fortunate in that they have had the benefit of learning at an early age the value of a drug free life.

What I want is for all American children to enjoy the same benefits as these youngsters, because the fight against drugs is really a fight for our children and our future.

I learned many years ago that the best way to fight drug abuse is to prevent it before it begins. And that means starting with our smallest citizens so that they will have a head-start in resisting the lure of drugs.

Protecting our children is the reason this Administration is fighting hard to preserve the Safe and Drug Free Schools program. At a time when youth drug use is on the rise, this program serves 39 million children in 94 percent of American school districts.

These young people today will demonstrate in dramatic fashion why Safe and Drug Free schools have been so successful and why drug prevention programs are so needed.

The President had to veto a bill because Congress took back half of the \$482 million for Safe and Drug Free Schools for 1995. President Clinton's action forced Congress to restore nearly full funding.

And now this critical program is under Congressional attack again. Last week, the House approved a 60 percent cut in 1996 funds for the Safe And Drug Free Schools program, a cut of \$300 million from President Clinton's \$500 million request. This is appalling, hypocritical, and downright foolhardy.

While Congress plays politics, we will fight for every investment in our children, especially an investment that ensures that each child has a full stake in this nation's future. The President and I will continue the fight for the Safe and Drug Free schools program--the only school-based federally funded drug prevention program we have.

These young people are role models who can take the anti-drug message to other children in their schools. They are proof that the Safe and Drug Free schools program works. Though these programs can never replace strong parental messages against drug use, they are key in fighting peer pressure and giving our youngsters the strength to grow up drug free.

As you can see on the faces of these children today, learning early about drugs has made a difference for them. And I believe that difference will serve them well far into the future.

Thank you.

SAFE AND DRUG-FREE SCHOOLS AND COMMUNITIES STATE GRANTS

FY 1995 Allocations
FY 1995 ALLOCATIONS

State	Total Allotment (100%)	Allotment To SEA (80%)	Allotment to Governor (20%)
US TOTAL	\$445,908,836	\$356,727,069	\$89,181,767
ALABAMA	7,456,038	6,065,550	1,401,388
ALASKA	2,229,544	1,783,635	445,909
ARIZONA	6,650,532	5,320,426	1,330,106
ARKANSAS	4,480,984	3,584,787	896,197
CALIFORNIA	49,680,531	39,744,425	9,936,106
COLORADO	5,260,947	4,208,758	1,052,189
CONNECTICUT	4,156,030	3,324,824	831,206
DELAWARE	2,229,544	1,783,635	445,909
FLORIDA	19,202,894	15,362,315	3,840,579
GEORGIA	11,199,828	8,959,942	2,239,886
HAWAII	2,229,544	1,783,635	445,909
IDAHO	2,229,544	1,783,635	445,909
ILLINOIS	19,551,262	15,641,010	3,910,252
INDIANA	8,087,117	6,469,694	1,617,423
IOWA	4,015,205	3,212,164	803,041
KANSAS	3,809,629	3,047,703	761,926
KENTUCKY	7,111,028	5,688,822	1,422,206
LOUISIANA	10,026,311	8,021,049	2,005,262
MAINE	2,220,544	1,783,635	445,909
MARYLAND	6,665,737	5,332,590	1,333,147
MASSACHUSETTS	8,323,127	6,658,502	1,664,625
MICHIGAN	17,640,889	14,112,551	3,528,338
MINNESOTA	6,665,919	5,332,735	1,333,184
MISSISSIPPI	6,421,418	5,137,134	1,284,284
MISSOURI	8,156,271	6,525,017	1,631,254
MONTANA	2,229,544	1,783,635	445,909
NEBRASKA	2,417,106	1,933,685	483,421
NEVADA	2,229,544	1,783,635	445,909
NEW HAMPSHIRE	2,229,544	1,783,635	445,909
NEW JERSEY	10,926,289	8,741,031	2,185,258
NEW MEXICO	3,473,092	2,778,474	694,618
NEW YORK	33,744,841	26,995,933	6,748,908
NORTH CAROLINA	9,627,939	7,702,351	1,925,588
NORTH DAKOTA	2,229,544	1,783,635	445,909
OHIO	18,594,922	14,875,938	3,718,984
OKLAHOMA	5,514,018	4,411,214	1,102,804
OREGON	4,562,218	3,649,776	912,444
PENNSYLVANIA	19,008,437	15,206,750	3,801,687
RHODE ISLAND	2,229,544	1,783,635	445,909
SOUTH CAROLINA	5,913,597	4,730,878	1,182,719
SOUTH DAKOTA	2,229,544	1,783,635	445,909
TENNESSEE	8,044,167	6,435,334	1,608,833
TEXAS	35,504,687	28,403,750	7,100,937
UTAH	3,188,294	2,550,635	637,659
VERMONT	2,229,544	1,783,635	445,909
VIRGINIA	8,326,999	6,661,599	1,665,400
WASHINGTON	7,496,125	5,996,900	1,499,225
WEST VIRGINIA	3,538,736	2,830,989	707,747
WISCONSIN	8,208,959	6,565,567	1,643,392
WYOMING	2,229,544	1,783,635	445,909
D.C.	2,229,544	1,783,635	445,909
PUERTO RICO	12,044,196	9,635,357	2,408,839
OUTLYING AREAS:			
TOTAL	4,669,820	3,655,696	913,924
AMERICAN SAMOA	784,483	627,586	156,897
GUAM	1,830,231	1,464,185	366,046
NORTHERN MARIANAS	447,010	357,608	89,402
REPUBLIC OF PALAU	0	0	0
VIRGIN ISLANDS	1,607,896	1,286,317	321,579
INDIAN YOUTH SET-ASIDE	4,569,620	N/A	N/A
NATIVE HAWAIIAN SET-ASIDE	913,924	N/A	N/A
EVALUATION SET-ASIDE	1,000,000	N/A	N/A
TOTAL FUNDING	456,568,656	360,382,765	96,095,891

**DEPARTMENT OF CURRICULUM AND INSTRUCTION
DRUG-FREE SCHOOLS PROJECT**

Background//History: The Drug-Free Schools Project began in 1986 when President Reagan signed into law the Drug-Free Schools and Communities Act, P.L.99-57, October 29, 1986. This act allows Congress to allocate funds to provide drug education to all school age children (K-12). The funds are allocated annually and are administered through the United States Department of Education and awarded to the Governor and the State Department of Education. Each local jurisdiction receives funds according to the student population. Over the past seven years, Baltimore has received eight million dollars to implement drug abuse prevention and intervention programs.

Current Implementation Status:

- A current Student Drug Policy has been developed (Fall, 1993).
- Drug-abuse prevention curricula have been developed and implemented for all grade levels.
- Teachers are trained annually to deliver effective drug abuse prevention instruction.
- Peer leadership prevention support programs are available to students at all learning levels, e.g., Just Say No, Students Helping Others and Understanding Themselves; Students Helping Other People, Recreation, Education, and Prevention Program, and Drug-Free Trails. (More than 10,000 students participate in these programs annually.)
- The Students Assistance Program operates in 21 secondary to assist students in need of help with drug related problems.
- Parents are actively involved in prevention programs at local schools.

Projections:

The focus of the project will change to include more violence prevention, i.e., conflict resolution, peer mediation, and safety activities. Greater numbers of non-public schools will participate in the project. Currently 80% are participating.

Funding:

- The future funding for FY 95-96 will be reduced based on the reduction of Federal budget allocation.
- The recommended allocation has been \$7.55 per student.
- 70% of the total budget will be allocated to schools (FY 1995-96).



EXECUTIVE OFFICE OF THE PRESIDENT

OFFICE OF NATIONAL DRUG CONTROL POLICY

Washington, D.C. 20500

FOR RELEASE:

WEDNESDAY, JUNE 7, 1995

CONTACT: Bob Weiner/A. Revis-Yeoman

(202) 395-6618

DR. LEE BROWN, DIRECTOR, WHITE HOUSE OFFICE OF NATIONAL DRUG
CONTROL POLICY, COMMENTS CONCERNING WHITE HOUSE ROSE GARDEN
RECOGNITION OF SAFE AND DRUG FREE SCHOOLS AND PRESIDENTIAL VETO
OF RESCISSION PACKAGE

Today President Clinton, who has provided great leadership on this issue, hosted a Rose Garden Ceremony recognizing over 100 schools as having exemplary Safe and Drug Free School programs, practices and policies for the 1994-95 school year. Thirty-two states and the District of Columbia were recognized as having schools with the most successful, comprehensive, or noteworthy prevention programs. Student representatives from each school were invited along with federal officials including myself, Education Secretary, Richard Riley, and representatives from the fields of education, crime and drug prevention. President Clinton encourages the youth of our country to be drug-free and will resist any effort to deprive our children of the kinds of programs they need to help them resist the ever present lure of drugs and violence.

Drug use among young people is on the rise. It is foolish for Congress to reduce the only federally-funded drug prevention and anti-violence program for nearly 20 million students in over 90 percent of our schools. These programs include conflict mediation, after school activities from debating to sports, peer mediation counseling, teacher training concerning children's drug use and violence, research and advice on personal drug problems and host of others. Under current Drug Free Schools Programs, many schools saw a 25% decrease in tobacco and other drug use.

As the nation's Drug Policy Director, and as a member of the President's Cabinet, I would like to emphasize the importance of the Safe and Drug Free Schools Program currently being threatened by Congress. The new Republican majority in Congress has passed a bill cutting the Safe and Drug Free Schools Program in half from \$482 million to \$236 million. The future of this legislation is still uncertain but President Clinton is vetoing the current version as part of the Rescission Package. It is outrageous that the Republicans have cut in half the most effective education program we have teaching our young people to avoid drugs and violence, at a time when drug abuse among our young is rising. This is like cutting our troops when we are at war.

*Third Report
to Congress on*

**Alcohol and Other
Drug Abuse
Prevention:**

**The National
Structured
Evaluation**

**U.S. Department of Health and Human
Services
Washington, D.C.**

Executive Summary

This report is the third in a series of three that responds to language in Section 3522 of the Anti-Drug Abuse Act of 1988 (P.L. 100-690), mandating that the Secretary of Health and Human Services conduct "a structured evaluation of the different approaches utilized across the Nation to reduce [alcohol and other] drug abuse." Specifically, the report presents the findings and [implications] of a multiyear study that reviewed prevention initiatives conducted during the years 1986 through 1992. This study therefore captures the evolving state of the prevention field during a period of rapid growth and innovation. The Center for Substance Abuse Prevention (CSAP) of the Substance Abuse and Mental Health Services Administration (SAMHSA) was designated by the Secretary as the lead agency for implementation of this National Structured Evaluation (NSE).

Characteristics of Effective Prevention

After identifying and defining seven core approaches to prevention of alcohol and other (AOD) drug abuse, the NSE found that:

- No single approach was rated consistently superior in effectiveness across all types of desired outcome and all populations. Instead, the NSE data suggest a complex pattern of relative strengths and weaknesses, some of which appeared to be specific to individual age groups.
- Although explicit concern about the culture of a population served by prevention cannot overcome problems in implementation of prevention, such concern appeared to enhance the effectiveness of cases of successful interventions targeted to vulnerable individuals.

- Among programs conducted from 1986 through 1992 the prevention approaches that received the highest score on effectiveness concentrated on a few well-chosen types of activities. Some of these seemingly uncomplicated examples of successful prevention were derived from a sophisticated application of current scientific knowledge about the origins and continuation of AOD abuse.

Methodology

The NSE sought information* from any type of effort that sought to prevent alcohol and other drug abuse except programs that were solely treatment oriented and programs that were devoted solely to reduction of tobacco use; a separate review of the latter has been included as an appendix to this report. After collecting documentation from over 2,300 prevention initiatives, the NSE identified 1,642 that were within scope and were described in sufficient detail to permit coding. The NSE's scope encompassed all efforts to prevent AOD abuse, including programs funded by the public and private sectors and programs targeted at individuals of all age groups, at families, and at institutional change. Of these, 309 (18.8%) provided evaluations that documented one or more of the following types of outcome:

- Reduction or delay of AOD problem behavior
- Change in AOD-related knowledge and/or attitudes
- Effects on risk and protective factors that may reduce future AOD abuse

Completion of the analysis required several methodological innovations, including the following:

- Development of a new unit of analysis—the prevention "module"—that consists of the set of prevention activities applied to a given population within a defined period of time;

- Development of tools and procedures to standardize assessment of the methodological rigor of the evaluations conducted among the AOD abuse prevention initiatives;
- Development of tools and procedures to standardize assessment of effectiveness of prevention modules in achieving the desired outcome categories, ranging from very effective to ineffective; and
- Use of cluster analysis, a sophisticated statistical technique, to organize prevention modules into seven prevention approaches, based on recurring patterns of activities used in prevention programming.

Mean effectiveness scores for the seven approaches provided the basis for meeting the congressional mandate of an evaluation of AOD abuse prevention as implemented throughout the United States.

The Seven Approaches to AOD Abuse Prevention

The seven approaches for AOD abuse prevention identified in the NSE can be summarized as follows:

- The **Positive Decisionmaking** approach, usually consisting only of didactic education of AOD-related subjects and development of generic social, decision-making, and mental health skills, was the most frequently adopted approach to individual intervention. Although a few examples of the approach received high ratings for effectiveness, most prevention initiatives adopting the Positive Decisionmaking approach were successful only in changing AOD-related knowledge and attitudes. The examples of the approach applied to young children, generally rated low in effectiveness.
- All examples of the **Safety/Health Skills** approach included safety education activities and most examples also included didactic AOD education and training either in personal skills or specific task-related skills. Although this approach may describe many worksite

prevention efforts, most examples identified for the NSE were conducted in suburban secondary schools. Examples of the approach appeared to hold promise as an effective strategy to prevent AOD problem behaviors among individuals who already are motivated to give priority to health and safety concerns.

- The **Psychosocial Skills** approach consisted of skills development *without* AOD education; the examples studied, often featured increased access to drug-free alternative activities. The NSE findings indicate that examples of the approach were successfully implemented by many different types of agencies using a wide variety of settings,⁸ formats, and personnel. Examples of the Psychosocial Skills approach measuring changes in risk and protective factors among young children and the incidence of AOD use among adolescents received the most consistent high scores for effectiveness. However, examples of the approach generally did not produce major alteration of attitudes and knowledge related to AOD use.
- The **Counseling Intensive** approach is defined by the combination of didactic AOD education with individual counseling and/or family intervention. Most often applied to adolescents and families at high risk for AOD abuse, examples of the approach usually involved fewer than 25 weeks of participation. Seventy percent of the examples of the Counseling Intensive approach addressing risk and protective factors among adolescents were rated effective. However, examples of the approach rarely documented effective results for other age groups or other types of outcomes.
- Examples of the **Case Management** approach included several funded by the Pregnant and Postpartum Women and Infants (PPWI) program that sought to prevent birth complications among the children of pregnant women with a history of substance abuse. The defining combination of activities for this approach included individual counseling, case management, and training in specific task-oriented skills, including parenting skills. Examples of

prevention initiatives adopting the Case Management approach often planned more than 75 weeks of client contact. Like the Counseling Intensive approach, the Case Management approach received its highest ratings for effectiveness in mitigating long-term risk factors for AOD abuse. The PPWI programs were especially successful in positively affecting birth outcomes and early childhood development, with associated savings in health and social costs.

- The **Multidirectional** approach characterized prevention efforts that attempted to provide many disparate activities and services to every client. It may aptly be described as a "scattershot" approach. Often provided to school-aged ethnic minority clients in large city environments, examples of the approach generally did not receive high effectiveness ratings for any type of measured outcome. Overall, they rated lower in effectiveness than prevention efforts that adopted a more limited mix of activities.
- The **Environmental Change** approach attempted to alter the community environment to make it less hospitable to AOD abuse and more conducive to prevention. Examples of activities identified among the many examples of the Environmental Change approach efforts include:
 - development of community linkages in support of prevention, including formulation of Action Plans, needs assessments, interagency agreements, and other tasks found in CSAP's Community Partnership projects;
 - institution of new restrictions on AOD marketing, sales, distribution, and use;
 - increased enforcement of existing AOD restrictions; and
 - training for professionals and other community intermediaries to increase their effectiveness as agents for prevention (e.g.

community policing training for patrolmen, server intervention among bartenders).

The NSE findings did not specify which types of Environmental Change activities were most effective for individual communities, but evaluation results clearly indicate that examples of the approach can produce significant reduction of AOD problem behavior and can positively affect risk and protective factors. CSAP's Community Partnership grant program and the Robert Wood Johnson Fighting Back program are designed to yield additional information on the effectiveness of forming prevention coalitions in reducing AOD abuse.

New Research and Evaluation Priorities

The NSE findings help to define an agenda of further research to determine "what works" in reducing AOD abuse. This agenda includes research on the relationship among the three types of outcome examined in the NSE, on the overall impact of AOD abuse prevention activities and the cost-benefit or cost-effectiveness of specific activities, and on the process for producing systemic change in support of prevention. An additional research task is to determine which risk and protective factors are both potent and capable of being affected by prevention efforts. Finally, given that the NSE provides a snapshot view of prevention from 1986 through 1992, a continuation of the NSE process would be useful to determine whether the knowledge gains since passage of the Anti-Drug Abuse Act of 1988 are reflected in improvements in the practice of AOD abuse prevention during the 1990s.

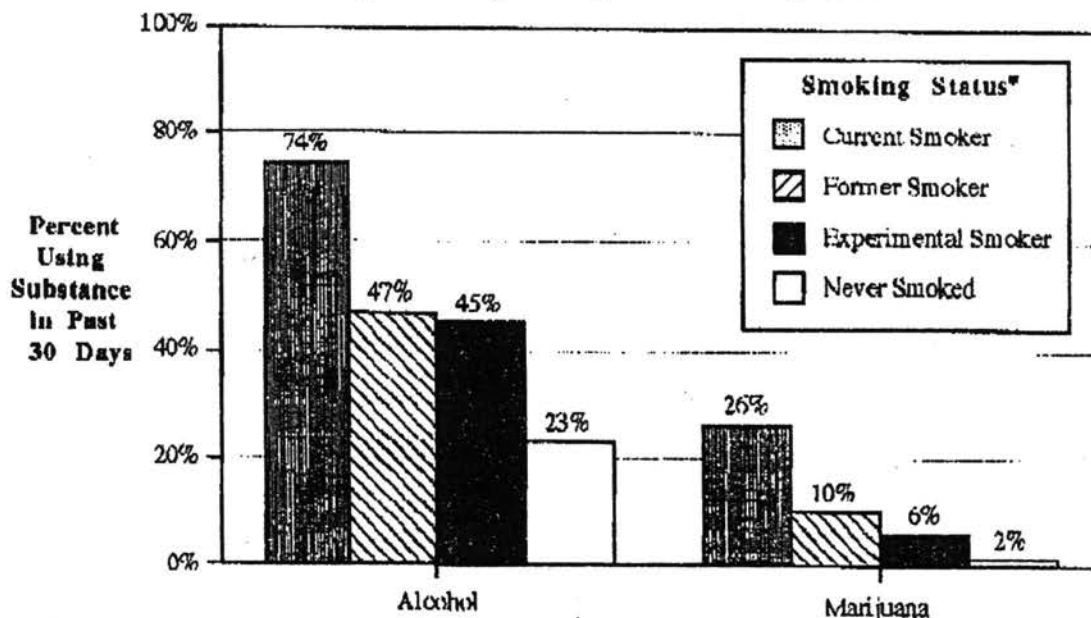
A Weekly FAX from the Center for Substance Abuse Research

University of Maryland at College Park

Cigarette-Smoking Youth More Likely to Use Alcohol and Marijuana Than Nonsmokers

Recently released data from the 1992 National Health Interview Survey of Youth Risk Behavior indicate that there is an association between cigarette smoking and use of alcohol and marijuana among youth 12 to 21 years of age. Current smokers were 3 times more likely to have used alcohol within the past 30 days and 13 times more likely to have used marijuana than youth who had never smoked. These relationships were "stronger at the younger ages, but remained consistent . . . among youth 18-21 years of age" (p. 2).

Percentage of Youth Aged 12 - 21
Who Used Alcohol or Marijuana in the Past 30 Days,
By Smoking Status, United States, 1992†



†Data were collected from in-person interviews of 10,645 youth aged 12 to 21 in the general household population of the United States, conducted from April 1992 through March 1993.

*Current: Youth who had smoked at least one cigarette in the past 30 days.

Former: Youth who had at one time smoked at least one cigarette per day for 30 days, but had not smoked cigarettes in the past month.

Experimental: Youth who had smoked at least one or two puffs of a cigarette, but had never smoked cigarettes every day for 30 days and had not used cigarettes in the past 30 days.

Never: Youth who had never had even one or two puffs of a cigarette.

SOURCE: Adapted by CESAR from data from J.C. Willard and C.A. Schoenborn. "Relationship Between Cigarette Smoking and Other Unhealthy Behaviors Among our Nation's Youth: United States, 1992." Advance Data, Number 263, April 24, 1995. National Center for Health Statistics, Centers for Disease Control and Prevention.

CESAR FAX is supported by a grant from the Governor's Drug and Alcohol Abuse Commission.

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Tobacco Marketing to Youth

"While cigarette companies claim that they do not intend to market to children, their intentions are irrelevant if advertising affects what children know. R.J. Reynolds Tobacco Company is as effective as the Disney Channel in reaching 6 year-old children. Given this fact and the known health consequences of smoking, cigarette advertising may be an important health risk for children."

Fischer, et al., Journal of the American Medical Association, December 11, 1991.

Teenagers respond to tobacco advertising.

- * The Surgeon General has concluded that tobacco advertising and promotion do appear to stimulate cigarette consumption.¹ About 85 percent of adolescent smokers prefer either Marlboro, Newport, or Camel, the three most heavily advertised cigarette brands.²
- * After the Joe Camel campaign was introduced, Camel's market share among underage smokers jumped from 0.5 percent to 32.8 percent in three years.³

Tobacco advertisements are appealing to kids.

- * Tobacco advertising emphasizes themes (sexual attraction, social acceptance, thinness, and independence) which appeal to youth.⁴
- * Six year olds are familiar enough with cigarette advertising that they match the 'Old Joe' Camel character with cigarettes as often as they pair Mickey Mouse with the Disney Channel.⁵ When asked what cigarette brand was most frequently advertised, only 13.7 percent of adults named Camel, compared to 28.5 percent of adolescents (12 to 17 years old). Recognition of the Joe Camel campaign was highest among 12 and 13 year olds.⁶

Children are frequently exposed to tobacco advertising.

- * Cigarette advertising expenditures for promotional items such as hats, t-shirts, and key chains quadrupled, from \$184 million to \$756 million, between 1991 and 1993. These items bear no health warnings and are easily obtained by kids.⁷
- * Thirty percent of kids (12 to 17 years old), both smokers and nonsmokers, own at least one tobacco promotional item.⁸
- * While overall cigarette advertising in magazines has declined sharply, the number of ads per issue in magazines with substantial youth readership has remained constant.⁹

The public supports regulation designed to prevent teenage tobacco use.

- * According to a recent survey, adults overwhelmingly support measures which would prohibit tobacco advertising which appeals to children. Seventy-one percent favor extending regulation of nicotine products, such as patches and gum, to cigarettes; 73 percent believe tobacco ads without pictures and cartoons would make smoking less appealing to kids; 74 percent think cigarette pack coupons for promotional items which appeal to youth should be eliminated.¹⁰ Sixty-one percent of adults believe that the tobacco industry encourages teenagers to smoke.¹¹

1. "Reducing the Health Consequences of Smoking: 25 Years of Progress," A Report of the Surgeon General, Department of Health and Human Services, 1989.
2. "Comparison of Cigarette Brand Preference of Adult and Teenage Smokers," Morbidity and Mortality Weekly Report, Centers for Disease Control, 1992.
3. "RJR Nabisco's Cartoon Camel Promotes Camel Cigarettes to Children," Journal of the American Medical Association, December 11, 1991.
4. "Current Trends in Cigarette Advertising and Marketing," New England Journal of Medicine, Vol. 316, 1987.
5. "Brand Logo Recognition by Children Aged 3 to 6 Years," Journal of the American Medical Association, December 11, 1991.
6. "Does Tobacco Advertising Target Young People to Start Smoking?" Journal of the American Medical Association, December 11, 1991.
7. Federal Trade Commission, "1995 Federal Trade Commission Report to Congress for 1993," 1995.
8. "Teen-age Attitudes and Behaviors Concerning Tobacco," Gallup International Institute, September 1992.
9. "Minority Issues," Tobacco Use: An American Crisis, Washington, DC: American Medical Association, 1993.
10. "Youth Access to Tobacco," Robert Wood Johnson Foundation, February, 1995.
11. New York Times/CBS Poll, May 1994.

Smoking is a Pediatric Disease

"... While the epidemic of disease and death from smoking is played out in adulthood, it begins in childhood. ... [A] person who hasn't started smoking by age 19 is unlikely to ever become a smoker. Nicotine addiction begins when most tobacco users are teenagers, so let's call this what it really is: a pediatric disease."

FDA Commissioner David Kessler, in a speech at the Columbia University School of Law, March 8, 1995.

Most smokers begin smoking during childhood and adolescence.

- * If people do not begin to use tobacco as youngsters, they are highly unlikely to begin smoking as adults. Eighty-nine percent of adult smokers began by age 18; 16 percent began by age 12; 37 percent by age 14, and 62 percent by age 16.¹
- * Three thousand young people become regular smokers every day. Most of the smokers who replace those who quit or die prematurely from smoking-related disease are children or teens.² Almost 1,000 of those 3,000 young smokers will die of tobacco-related disease.³
- * In 1993, 29.9 percent of the nation's high school seniors were current smokers (they had smoked within the past 30 days) and 19 percent smoked daily. Among eighth-grade students, 16.7 percent were current smokers and 8.3 percent smoked daily. Among high school seniors, 10.7 percent were using smokeless tobacco and 3.3 percent were doing so daily.⁴
- * The average teen smoker starts smoking at age 13 and becomes a daily smoker by age 14.5.⁵
- * Almost 75 percent of daily smokers in high school still smoke 7 to 9 years later, even though only 5 percent had thought they would definitely be smoking 5 years later.⁶
- * In 1992, approximately two-thirds of adolescent smokers reported that they wanted to quit smoking, and 70 percent indicated that they would not have started smoking if they could choose again.⁷

Rates of tobacco use are rising among youth.

- * The latest research from the "Monitoring the Future Study" conducted by the University of Michigan and sponsored by National Institute of Drug Abuse shows a continued increase from 1991 to 1994 in smoking prevalence among teens of all ages. In 1994, 18.6 percent of eighth-graders said they had smoked in the past month, a 30 percent increase from 1991, when the figure was 14.3 percent. Nine percent of eighth-graders said they smoked daily in 1994. Among tenth-graders, 25.4 percent said they had smoked in the past thirty days in 1994, up 22 percent since 1991, and 31.2 percent of high school seniors reported smoking in the last thirty days, a 12 percent increase since 1991.⁸
- * Adolescent (ages 14-17) smoking initiation rates decreased slightly from 1980-1984, and then increased from 1985-1989, a period in which the rate of young adults and overall prevalence of smoking among adults decreased steadily. This lack of progress in decreasing smoking among youth resulted in more than 600,000 additional teenagers starting to smoke.⁹
- * Between 1970 and 1986, the use of snuff increased 15 times and the use of chewing tobacco 4 times among males aged 17-19 years.¹⁰

1. Data from the National Household Surveys on Drug Abuse, United States, 1991. Office on Smoking and Health, Centers for Disease Control and Prevention.
2. "Trends in Cigarette Smoking in the United States," Journal of the American Medical Association, January 6, 1989.
3. Food and Drug Administration Statement, July 13, 1995.
4. "Monitoring the Future Study," Press Release, the University of Michigan, Ann Arbor, January 31, 1994.
5. Teenage Attitudes and Practices Survey II, 1993, unpublished data. Cited in the Robert Wood Johnson Foundation Survey, "Results of a National Household Survey to Assess Public Attitudes About Policy Alternatives for Limiting Minor's Access to Tobacco Products," December 1994.
6. National Institute on Drug Abuse, National Survey Results on Drug Use from Monitoring the Future Survey, 1975-1992. Cited in "Trends in Tobacco Use Among Youth," Centers for Disease Control and Prevention, March 1994.
7. "Teenage Attitudes and Behavior Concerning Tobacco: Report of the Findings," George H. Gallup International Institute, 1992.
8. "Monitoring the Future Study," University of Michigan, Ann Arbor, cited in Wall Street Journal, July 20, 1995; New York Times, July 20, 1995.
9. "Trends in Smoking Initiation Among Adolescents and Young Adults -- United States, 1980-1989," Morbidity and Mortality Weekly Report, Centers for Disease Control and Prevention, July 21, 1995.
10. "Reducing the Health Consequences of Smoking: 25 Years of Progress. A Report of the Surgeon General, 1989," U.S. Department of Health and Human Services.



"In summary, the evidence is unequivocal — the US public has been duped by the tobacco industry. No right-thinking individual can ignore the evidence. We should all be outraged. . . ."

Editorial signed by all the members of the Board of Trustees of the American Medical Association, Journal of the American Medical Association, July 19, 1995, p. 256.

Smoking Control Advocacy Resource Center (SCARC)
ACTION ALERT

July 24, 1995

Issue: FDA Moves to Regulate Tobacco Products: PM Launches Youth Plan

Summary ✱

Earlier this month, the Food and Drug Administration (FDA) submitted a report to the White House concluding that tobacco is a drug that falls under the agency's jurisdiction, and offered regulatory proposals centered around preventing youth from smoking. The action represents a landmark opportunity to reduce the toll of tobacco.

Although the proposal has not been made public, it is believed to include recommendations for a ban on the sale of cigarettes from unattended vending machines; stricter laws on restricting tobacco sales to minors; measures to curb advertising and promotions appealing to youth; and additional warnings on cigarette packages and ads about nicotine's addictiveness and other hazardous ingredients in tobacco. Although President Clinton has publicly stated that he shares FDA's concern about youth smoking, he has not yet made any statements on possible actions to curb youth smoking.

The proposal is politically sensitive for the President: Republicans are likely to attack new regulations as an example of government over-reaching itself, and tobacco-state legislators have warned Clinton that support for tobacco regulations could cost him political support in the South. If Clinton does support the regulations, the tobacco industry will likely sue FDA, challenging its authority over tobacco, and Congress will likely try to cut off funding for the agency through an appropriations (funding) bill. If such a bill were passed, Clinton could veto it, and it is unclear whether tobacco supporters would have enough votes to override the veto.

In an attempt to preempt the growing momentum for FDA regulation, Philip Morris has announced a voluntary program designed to prevent youth smoking called "Action Against Access." The program is an attempt to gain control of the debate on youth smoking; last March, FDA Commissioner David Kessler labeled smoking a "pediatric disease" and argued for a "comprehensive and meaningful approach" in curbing youth smoking.

The Action Against Access program allows Philip Morris to argue that it is sincere about preventing youth from smoking and is providing an alternative to unnecessary government regulation. The heavily publicized program incorporates some, but not the most significant, of the Institute of Medicine's recommendations to prevent youth access to tobacco. PM's program includes changes in state legislation to

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license retailers who sell tobacco; limits on vending machines; increased minimum age signage; cigarette package labeling; and denying merchandising benefits to merchants fined or convicted of selling cigarettes to minors. (For more information on the Institute of Medicine's report, "Growing Up Tobacco-Free," see SCARC Action Alert, "Institute of Medicine to Release Report on Children and Smoking," August 31, 1994.)

The announcement of PM's program and statements by some tobacco-state lawmakers now supportive of some limited access measures, such as banning vending machines and restricting advertising appealing to youth, indicate that the industry will be all-too-willing to engage in regulatory and legislative tinkering and will offer promises of self-regulation in order to deflect meaningful actions to reduce tobacco's harm. The tobacco industry is most afraid of FDA's designation of nicotine as an addictive drug under its regulatory authority, since the formal legal finding can help change Americans' perspective on tobacco and goes to the heart of the industry's successful, years-long public relations strategy of depicting smoking as a common "lifestyle choice" made by adults. The tobacco industry is lobbying President Clinton and Congress to accept voluntary action or a compromise along the lines of Philip Morris' Action Against Access program, eliminating FDA's authority over tobacco products.

Tobacco industry self-regulation has a long history of producing no real action on tobacco control. For example, in 1964, after Surgeon General Luther Terry issued his report on the health hazards of smoking and federal regulation appeared imminent, the tobacco industry launched a program to prevent kids from smoking. The program was headed by a former New Jersey governor and collapsed as soon as the threat of federal regulation disappeared.

The voluntary advertising code is another example of the weakness and unenforceability of industry self-regulation. Among its provisions, the code mandates that cigarette ads do not feature models that are or appear to be under 25 years of age, do not suggest that smoking is essential to success or sexual attraction, and do not suggest that the healthy and attractive people pictured in its ads are that way due to cigarette smoking. Even if the voluntary code was an effective way to reduce smoking rates, it has been routinely ignored.

Although PM is now pledging to support the enactment of "reasonable" state youth access legislation, the tobacco industry has worked tirelessly at the state level to gut and sabotage meaningful youth access measures. A Louisville Courier-Journal expose of tobacco industry lobbyists at the state level called them "champions of anemic legislation." Last year in Minnesota, for example, the tobacco industry lobby helped defeat a youth access bill which would have imposed stiff penalties on retailers who sold cigarettes to minors. In Kentucky, the tobacco lobby helped pass a weak youth access bill in 1992 which imposed only small fines on retailers (\$10 for the first violation) and placed the responsibility for enforcement in the hands of the Agriculture Department, which has yet to enforce the law.

National data shows support for actions to make tobacco less accessible to children. According to a February, 1995 survey by the Robert Wood Johnson Foundation, 92 percent of Americans believe the nicotine in cigarettes is addictive, and 68 percent believe it is easy for children to purchase cigarettes. Other findings of the survey:

- * 74 percent favor banning all cigarette vending machines.
- * 70 percent favor not allowing coupons on cigarette packs to obtain promotional items that appeal to kids.
- * 78 percent favor keeping tobacco products behind the counter to prevent shoplifting.
- * 73 percent believe tombstone advertising -- limiting advertising to words only, with pictures and cartoons prohibited -- would make smoking less appealing to youth.

- * 71 percent favor extending regulation of nicotine products, such as nicotine patches and gum, to cigarettes.

Philip Morris' promises of self-regulation fall far short of the comprehensive changes needed to protect youth from tobacco. The company's program consists of some cosmetic changes, such as increased signage, and other measures that, even if carried out, will be inadequate to meet the challenge of preventing youth from smoking.

A consensus in the tobacco control community is that a comprehensive approach, whether enacted through regulatory action, legislative action, or a negotiated compromise, should consist of actions in each of the following categories:

Youth Access - A comprehensive set of actions designed to reduce the illegal sale and distribution of tobacco products to minors that contains an effective monitoring and enforcement mechanism and does not preempt more forceful local efforts;

Advertising and Marketing - The goal should be a complete ban on tobacco advertising. An interim step could be the elimination of advertising and marketing techniques used by the tobacco industry to put tobacco products into the hands of children and that appeal to children or contribute to the atmosphere and attitude which make tobacco products desirable to children;

Youth-Oriented Public Education - A well-funded public education campaign targeted at children is essential to provide kids with both the reasons and incentive to refrain from smoking.

Product Control - Almost every product we ingest in the United States is subject to health and safety standards governing how the product is manufactured. The exception is tobacco. The tobacco industry has routinely manipulated the manufacture of its products to control the levels of nicotine and other ingredients and has developed but not used the technology to produce so-called safer cigarettes, even while denying that their products are addictive or cause disease. The FDA should be permitted to develop standards for the different components of tobacco products to better protect consumers.

Objectives

1. To generate support for FDA regulation of tobacco products to protect children from becoming addicted to tobacco.
2. To expose "Action Against Access" as a public relations endeavor, not a meaningful attempt to reduce youth smoking.

Useful Quotes

"Smoking begins as a pediatric disease. Each day, 3,000 children become regular smokers and almost 1,000 of them will eventually die from diseases related to smoking. The focus of our attention is to find ways to discourage children from starting in the first place."

Food and Drug Administration statement, July 13, 1995.

"My concern is apparently what the FDA's concern is, and that is the impact of cigarette smoking, particularly on our young people, and the fact that cigarette smoking seems to be going up among our young people, and certainly among certain groups of them. And I think we ought to do more about that than is being done. And I'm willing to do that."

President Clinton, New York Times, July 14, 1995, p. A18.

"The concept -- pediatric disease -- qualifies as an epiphany, given the acknowledged authority of society over a minor. He/she has to go to school, has to wait until a certain age before being allowed to drive, to vote, to drink beer. It yields no substantial libertarian ground to add to the list enforcement mechanisms designed to dissuade the 15-year-old from taking up aching experiences (those who give up smoking), and at the other end premature and painful death."

William F. Buckley Jr., in a syndicated column printed in The (South Carolina) Post and Courier, March 16, 1995.

"Research by the FDA and by the Institute of Medicine of the National Academy of Sciences found that it is easier to prevent children from starting to smoke than it is to get addicted smokers to quit. Experts say no other addiction is so tenacious. . . . Smoking is an addiction that is almost exclusively acquired between ages 12 and 19; of those who try to take up smoking after that age, only a very small percentage become addicted. But during those formative years, 91 percent of all smokers become hooked for life. If fewer teenagers smoke in each successive generation, hundreds of thousands of deaths per year could be prevented."

Philip J. Hilts, New York Times, July 16, 1995, Section 4, p. 3.

"We know that no proposal we could make, no matter how far-reaching, will satisfy those whose agenda it is to regulate cigarettes in a manner that would severely restrict, if not prohibit, the sale of cigarettes to adults. . . . We believe Action Against Access represents a rational, effective approach to the key issue -- how to prevent minors from smoking -- and we believe that reasonable people will agree with us."

James Morgan, CEO of Philip Morris USA, Philip Morris Press Release, June 27, 1995.

"While [the Action Against Access program] has the appearance of a positive step, if the tobacco industry is truly interested in keeping cigarettes out of the hands of minors, they would stop spending millions in states like Minnesota to defeat efforts to strengthen laws banning tobacco sales to kids."

Hubert H. Humphrey III, Minnesota Attorney General, Wall Street Journal, June 28, 1995, p. A3.

"By pretending to care about our nation's youth, their future customers, Philip Morris has once more demonstrated its ability to say one thing while doing another."

Reps. James Hansen (R-UT) and Martin Meehan (D-MA), "Dear Colleague" letter, June 30, 1995.

"Let's see. Philip Morris wants to sell cigarettes -- that's its business. And most smokers start when they are teen-agers. Yet last week the company said it would go all out to keep minors from smoking. . . . What this means (choose one): a) Philip Morris, in a stunning about-face, actually wants fewer people to smoke, or b) 'They are scared,' as an American Heart Association spokesman said, and want to undercut efforts to regulate tobacco as a drug and head off state efforts to clamp down on sales to minors."

New York Times, July 2, 1995, Section 3, p. 2.

Framing Suggestions

Philip Morris is not a credible source on preventing youth from smoking.

After 30 years of denying the risks of smoking and opposing tobacco control measures, is Philip Morris a credible source of youth access measures? Action Against Access is a cynical public relations ploy, an attempt to substitute one company's unenforceable self-regulation for comprehensive and meaningful youth-centered tobacco policy. Philip Morris' sincerity should be measured by its actions over the years sabotaging youth access measures, not by its anti-youth smoking rhetoric.

Action Against Access is not a comprehensive proposal.

Action Against Access is a limited proposal from one company; it does not guarantee how other companies will behave regarding youth smoking. PM referenced the Institute of Medicine's (IOM) recommendations on restricting youth access to cigarettes, but ignored the IOM's recommendations for curbing advertising and marketing that appeals to young people. The program makes no mention of

the proven health hazards and addictiveness of smoking, merely repeating the ineffective message that smoking is an adult choice.

FDA's proposed regulations will protect kids.

Reducing tobacco use by children is the key to reducing the death toll from tobacco: 89 percent of adult smokers began by age 18. Although tobacco use among adults has declined over the last decade, recent studies indicate that the rates among youth are rising.

The FDA protects consumers from injury from all other consumable products by overseeing how they are manufactured, distributed, labeled, and marketed. It is time that we subject tobacco to these same requirements.

Suggested Actions

1. Write or call the White House to urge President Clinton to support FDA's authority to regulate tobacco as a drug and FDA regulations to protect children. The address is: 1600 Pennsylvania Avenue NW, Washington, DC 20500. The phone number is (202) 456-1111.
2. Contact local media outlets to explain the importance of strong federal regulations to protect children from tobacco. Use the enclosed fact sheets. Make the point that Philip Morris' Action Against Access program is a public relations move to fend off federal regulation.
3. Write or call your Member of Congress, urging him or her to support FDA's authority to regulate tobacco as a drug and FDA regulations designed to protect children.
4. Write to former senator Warren Rudman, urging him to resign as Action Against Access' independent auditor if Philip Morris refuses to incorporate all of the IOM's recommendations. His address is: Paul, Rifkind, Wharton & Garrison, 1615 L St., NW, Suite 1300, Washington, DC 20036.
5. **A broad show of support for FDA's proposal is critical. Organize your coalitions and networks to speak out in favor of it. Please feel free to share this Action Alert with your colleagues and members.**

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August 4, 1995, Friday, Late Edition - Final

SECTION: Section A; Page 27; Column 6; Editorial Desk

LENGTH: 717 words

HEADLINE: On My Mind;
Save The Drug Czar

BYLINE: By A. M. ROSENTHAL

BODY:

Four or five times a week I get letters saying yes, I agree that crime and drug abuse are twin enemies of American society, but what can one person do to make a difference?

Here is one thing that is urgent -- I mean today, as soon as you finish this column. Pick up the phone, call both your senators in Washington. Push beyond receptionists and then say you do not want the office of the drug policy coordinator -- known as the drug czar -- wiped out.

That's right -- suddenly a termination campaign has popped up. It would hurt the whole drug war, and accomplish exactly nothing except to stick a finger in President Clinton's eye; high price for sport.

Senators and aides on both sides of the issue think public opinion could make the difference if voters react fast. The vote could come anytime.

The office of the drug czar was created in President Reagan's time with bipartisan backing. It was the center of a detailed public and Congressional debate before it was approved. Now, with no real debate at all, some senators led by Richard C. Shelby, Republican of Alabama, are moving to eliminate the budget for the coordinator and staff. "Terminate" is Senator Shelby's word, precisely right.

Opponents of termination ask for public help. The termination drive has received little attention so far and its supporters would just as soon keep it that way until the deed is done.

The Shelby measure has been written into a bill approved in committee and now before the Senate, tucked into a \$22 billion appropriations bill.

As a supporter of the drug coordinator-czar concept but often a critic of the way it has been handled by the Bush and Clinton White Houses -- fine talk, mingy support -- I think it makes no common sense to wipe it out. Neither do leaders of anti-drug groups I have talked with -- police chiefs to therapists.

The Federal Government spends \$14 billion a year fighting drugs in the three essential areas. The money goes to enforcement -- police, special agents, courts. It goes to interdiction -- fighting smuggling and cartels. And it goes to therapy for addicts. That is long and expensive but shows real signs of success, particularly in prisons -- and gives hope and energy to the whole anti-narcotics struggle.

About 50 agencies and departments are involved in anti-drug work. Until now, the complaint against the drug czars was that they did not have enough power to force cabinet secretaries and department heads to work together. The complaint was valid and the remedy plain: Give them more. Instead, the termination measure would just end current coordination and planning. It would substitute a big fat nothing.

All the Shelby legislation does is to take dead aim at the drug coordinator and his office. Total savings for coordination termination would come to \$10 million -- in a \$14 billion government anti-drug budget. High-tech therapy research and anti-cartel programs directly under the coordinator, Lee Brown, costing about \$130 million, would be moved to the Treasury and Justice departments, whose chiefs say they should stay where they are.

Senator Shelby says Mr. Clinton himself is at fault, for cutting back the drug czar's staff drastically after he became President, which he did, and by not pushing the drug war hard enough. Mr. Clinton's leadership has sometimes seemed to us anti-drug types as ranging from absent to lackadaisical. But for Congress to hobble the war by wiping out its coordinator seems a strange way of inspiring the President or the country.

Senator Shelby says that Mr. Brown, by emphasizing treatment and prevention, has sent a message that "doing drugs is not a crime." That is a false accusation against this former New York City Police Commissioner -- and undocumented. Mr. Brown has risked and received the venom of the pro-drug lobby by denouncing not just hard drugs but marijuana, that favorite wedge of the drug legalizers.

Senator Joseph Biden, Delaware Democrat, shaped the 1988 drug czar legislation and now fights to save it. Senator Robert Dole is thinking it over. Maybe he is also thinking, given his own possible future, that sometimes Presidential eye-gouging just gets to be too expensive a sport for the country. You could give him a ring, too, to encourage such good thinking.

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June 12, 1994, Sunday, Late Edition - Final

SECTION: Section 14CN; Page 3; Column 1; Connecticut Weekly Desk

LENGTH: 1558 words

HEADLINE: Connecticut Q&A: Dr. Kathleen R. Merikangas;
On Starting Young to Treat Alcoholism

BYLINE: By ALIX BOYLE

BODY:

ALCOHOLISM is the largest preventable public-health problem in the United States today, says Dr. Kathleen R. Merikangas, director of the Genetic Epidemiology Research Unit at Yale University. Although treatment is successful for some people, Dr. Merikangas says that pinpointing children susceptible to the disease and treating them is vital to preventing it in the next generation.

Dr. Merikangas, an associate professor of psychiatry and epidemiology who has studied the causes of alcoholism for 15 years, spoke about her research in an interview at her New Haven office. Here are some excerpts from the conversation.

Q. How do you identify people susceptible to drug and alcohol abuse?

A. One of the major predictors of alcoholism is early smoking. Approximately 80 percent of the people with alcoholism are also smokers, and there is a dramatically strong link between those two substances. And the fact that they use tobacco first may have very important implications for trying to understand the link between these two substances.

One of the second signs is that children of alcoholics and people who eventually develop alcoholism tend to report that they can drink more alcohol without having the negative effects. They say they can hold more liquor at parties and they have less impairment, or they perceive they have less impairment. They feel less drunk than somebody who does not have high risk for alcoholism or who doesn't develop it.

Q. What makes people susceptible to drug and alcohol abuse?

A. That's a question that has numerous studies around the country trying to

gain understanding. The reason to focus on susceptibility is because we have not been very successful in developing treatment programs for adults for drug and alcohol abuse. We've decided that we need to go backward and try to understand people who are high risk and people who are vulnerable, so that perhaps we can prevent the development of alcoholism. And I think this is particularly true for drug abuse.

So the focus of our group and others around the country is to examine the children of parents with alcoholism and/or drug abuse to gain understanding of what these risk factors may be. A study in Denmark recently followed children to age 30 and found that the major predictors in very early life, this would be around the age of 6 or under, are increased impulsivity, low frustration tolerance and some indicators of impaired cognition -- difficulty making decisions. It seems particularly pronounced when the person is under stress. The response to stress seems to be impaired in some way.

Q. It's almost as if people with these characteristics are drinking to be normal, to tolerate stress.

A. Yes, that's our hypothesis. None of this is going to apply to all alcoholism, and I think this is the difficulty. Alcoholism is obviously made up of many different subtypes with different causes. If we can even identify a proportion of alcoholics and drug abusers who develop because of specific pathways, then we will have accomplished a great task.

Q. What is alcoholism?

A. Alcoholism is divided into alcohol abuse and dependence.

With abuse, the people have some kind of consequences in their social, occupational or educational roles, or they have difficulty with the law. The alcohol causes problems. As you can imagine, that's highly variable, because if somebody gets arrested for drunken driving, then he's identified as having problems with alcohol. But for this definition of abuse, you can even have problems within your own family and still be identified as an alcoholic. It's very common. One in every five males, for example, meets the criteria for alcohol abuse at some point in his life.

With dependence, the people become preoccupied with the use of alcohol, they can no longer use the substance with control. In common lay terms, this would be an addiction.

Q. At what age do you begin talking about alcoholism with children?

A. I would probably begin in the late grade school -- fifth, sixth, seventh grade. It depends on your social and peer network. In some areas in the inner

city, the children are exposed at a much earlier age than they are in the suburbs. But we think that exposure in the suburbs is dramatically underreported. It does cross the socioeconomic boundaries. It's just much more hidden in the suburbs and the upper classes. In the highest echelons of society, we see a lot of alcoholism and drug abuse.

Q. Once you identify children who are susceptible, how should they be treated?

A. You may try to get them engaged in Al-Anon and group forms of treatment where they can get support for deciding to be abstinent before they even begin. That's easier said than done. But when children see the scourge of alcoholism, when they see the devastation in the family, there are a lot who say, "I'll never touch alcohol," because this has been so painful to grow up this way.

I think it's very important to educate kids about the dangers of smoking and alcohol and drugs. The child who is not at risk may benefit from this kind of educational approach, particularly if you apply it early enough. The children who are really at risk, who may have family disruption, they may go home and the parents are neglectful, often the mother is an alcoholic. These are the parents who are not coming to the school, they're not helping the child to develop self-esteem, they're not driving the child to activities.

You want to get the kids before puberty. You want them to feel success at something, so they can develop some self-esteem. You need to find a sport or an activity that really helps them to have some success on their own, because if a child has self-esteem, that's the beginning of this whole resistance. The advice for prevention is to target the children who are really at increased risk. These are the ones that the programs don't touch at all.

We need to work with the family, we need really intensive intervention. The best thing we can do is help the parents. If mom's depressed, if dad's alcoholic, one of the best things we can do is get the family into Al-Anon or Alateen, to treat the underlying psychiatric disorder in the parents and to work with the family to minimize the dysfunctional patterns.

Q. Is alcoholism more prevalent now than 20 years ago?

A. No. In fact, the rates of alcohol use are going down. Over the last decade, we found a decrease in the per capita consumption of alcohol in the United States. We find that people are drinking less hard liquor, and more people are using beer and wine. Teen-agers tend to use more beer and wine and don't understand that this can have as much alcohol content as the stiff drink.

Q. What is the economic impact of alcoholism?

A. For alcohol abuse, it was \$10.5 billion per year, direct costs, in 1990.

It's not only the direct impact on the employment sector, the occupational sector where people are working and there's a lack of productivity or lost productivity. But there's also the cost of the medical illness that alcohol causes, particularly when it's combined with smoking.

There are estimates that vary; 25 to 30 percent all the way up to 60 percent of all hospital beds are occupied by people with the complications of alcoholism. So the expenses are not only to the employers, but also to the health-care sector. A large proportion of automobile accidents are the result of alcohol. It's a tremendous cost.

People are focusing more on drug abuse than alcohol abuse now, because they see it as a more serious problem because of the criminality associated with it. So a lot of the programs that have been instituted are to teach the children about drugs without taking seriously the alcohol, which is also a drug and probably has more serious complications over a lifetime. I think it's the nation's No. 1 preventable public health problem.

I got my master's working with alcoholics doing psychodynamic therapy, and I realized this wasn't the way to go. I saw their families, and I realized this is a disease and people really can't help themselves. They promise you that they're not going to drink anymore, and they do mean it. It's not that these people have these moral flaws. This is a disease which affects their thinking and begins to take over their lives and that of their families.

I wanted to understand what the causes of this were. The policies, which are strictly aimed at treatment, are not going to really help the next generation. We find that they're at equal or increased risk. The majority of families across the world are affected by one of these major problems: alcoholism, depression, anxiety, drug abuse. The children are not alone, and it's very important we work together to try to help people. Even if we can't prevent alcoholism in the parent, prevent the devastating consequences it's going to have on the next generation.

Q. Some psychologists say that only about one third of substance abusers will remain abstinent following treatment. What's your feeling about that?

A. I think it's probably true. The statistics are grim. Our efforts must be placed at prevention, and it's even more so for drug abuse, because the statistics are even worse when we look at heroin, crack, and these kinds of substances, which are much more powerfully addicting.

GRAPHIC: Photo: Dr. Kathleen R. Merikangas heads a research unit at Yale. (Janet Durrans for The New York Times)

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Cutting Funding

WASHINGTON POST
AUGUST 8, 1995
P. A7

Move to Kill Tobacco Study Riles Researchers

By Rick Weiss

Washington Post Staff Writer

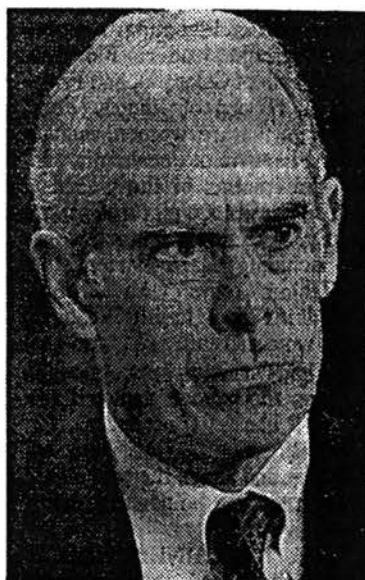
Amid criticism that Congress has been too involved in deciding how the National Institutes of Health should spend its research dollars, the House emphasized last week that next year's \$12 billion appropriation should be parceled out on the basis of scientific value. But legislators couldn't resist making one notable exception.

The House Appropriations Committee instructed the National Cancer Institute (NCI) to stop funding an ongoing study of how lawmakers may be influenced by contributions from the tobacco industry.

The directive has riled researchers and public health officials, who see it as a political intrusion into the traditionally independent scientific grant-making process. The study in question, which received top scores from an internal NCI review committee last year and is now starting the second of three years of funding, focuses on industry practices and government policies that affect an individual's decision to smoke. Preliminary results from the study, highly critical of the tobacco industry, have already been published in some of the world's top medical and public health journals.

"For the U.S. Congress to politicize the decision as to what specific research is or is not funded, thereby circumventing the NIH's peer review system which has been used so successfully for so many decades, is reprehensible," said George D. Lundberg, editor of the *Journal of the American Medical Association*, which has published many of the grant's results. "In my view, the public health of millions of Americans is far more important than the political health of a few tobacco-state congressmen."

The demand to cut funding for the \$600,000 project came from the office of Rep. John Edward Porter (R-Ill.), chairman of the Labor, Health and Human Services, and Education subcommittee, and is included in a report to the NCI approved by the House Appropriations Committee. The report does not have the force of law and the NCI has made no official response. But congressional and scientific sources said the committee's word-



REP. JOHN EDWARD PORTER

... his office issued the directive

ing is so specific as to be impossible for the NCI to ignore.

NCI officials said they could not recall any other instance of Congress specifically cutting off approved funds for an individual NIH-funded investigation. Some expressed concern that the directive might presage new efforts to block scientific or social research embarrassing to elected officials or contrary to the interests of the lobbyists who contribute to their campaigns.

"It is unusual for Congress to take this much interest in a particular grant," said Marc Manley, chief of the NCI's public health applications research branch, which funded the grant as part of the branch's larger mission to help prevent cancer. "The quality of the work has been sound scientifically."

Manley said the challenge comes at a particularly sensitive time. A new director of the NCI was just appointed last week by President Clinton, and the president is now considering controversial changes in the way tobacco is regulated.

In a statement released yesterday, Porter said: "Clearly, smoking contributes greatly to the incidence of cancer and other diseases. That is why it is so important, for example, to study why people smoke and how to discourage them from doing so. In this case, however, the study that has been funded focuses on the political process and those who lobby legislatures on to-

bacco policy. This is not clinical or behavioral research and should not have been funded through the NCI."

The committee's report, which circulated around NCI last week, reads in part: "The committee was disturbed to learn that NCI has funded a research grant studying tobacco industry campaign contributions to State legislators and voting records by those individuals on tobacco control initiatives. While the Committee is not rendering judgment on the merits of the grant proposal, it feels strongly that such research projects do not properly fall within the boundaries of the NCI portfolio, especially when nearly three-quarters of approved research projects go unfunded."

"Accordingly, the Committee does not provide any further funding for this research grant within the NCI appropriation."

Among the most visible reports financed by the grant was a study published in *JAMA* last year showing that state lawmakers who receive money from tobacco interests are as much as 42 times more likely to vote with the industry than are others, and a series of articles published in *JAMA* two weeks ago analyzing the contents of internal research documents obtained from the tobacco company Brown & Williamson.

"The reason the scientific community and the public has confidence in the NIH and other government science agencies is their independence of judgment of what is the best science," said Stanton A. Glantz, the University of California at San Francisco researcher who won the grant and led the studies. "This is a direct intervention in this process."

Glantz said the research is medically relevant because cigarette smoke is the cause of at least 80 percent of the nation's lung cancers, a disease that is almost always fatal and so is best fought by prevention. "In biomedical terms you can think of the tobacco industry as a disease vector like a malarial mosquito," he said. "If you want to beat malaria, you have to understand the malaria mosquitoes that spread malaria. And if you want to prevent lung cancer, you have to study the tobacco industry to see how it spreads smoking."

Clinton Calls For Tough—Yet Practical—Program to Combat Teenage Smoking

By Ann Devroy
Washington Post Staff Writer

President Clinton said yesterday he wants a "tough and mandatory" program to discourage smoking among young people but not one the tobacco industry can delay for years with legal challenges.

The statement, made in an interview with National Public Radio, reflects the competing practical and political imperatives at play as Clinton and his aides struggle to produce a new anti-smoking initiative.

White House officials caution that Clinton has not made a decision on whether the Food and Drug Administration should regulate nicotine as a drug and propose new rules to discourage teenage smoking as part of such a regulation.

Clinton—who has had weeks of discussion with his aides and with congressional Demo-

crats who favor or oppose regulating tobacco—is seeking a route to regulation that is stronger than voluntary steps by the industry, his aides said.

Officials had said the president could make a decision in time for a speech tomorrow in North Carolina, the heart of tobacco country, but last night they cautioned that a series of complex legal issues would likely delay a decision until later.

Asked about the issue, Clinton said in the NPR interview, "I think we need a tough and mandatory-type program. But I don't want to see us in a position where we act like we're going to do something, but we wind up in years and years and years of costly litigation while kids continue to be bombarded with advertisements plainly designed to get them to smoke."

Clinton outlined some of the areas that could be attacked to discourage teenage

smoking. He cited advertisements that encourage adolescents to smoke as well as promotional activities that do the same. He also criticized the unattended sale of cigarettes in

*"I don't want to see us
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— President Clinton

vending machines, which makes enforcement of the ban against underage smoking impossible. He cited the lack of a "real, comprehensive national law" against the sale of

cigarettes to minors.

The tobacco industry, a significant southern political force, sharply opposes regulation by the FDA and has said it would fight such a move in court, where it has carried out long, costly legal battles on virtually every point of challenge.

Rep. Ron Wyden (D-Ore.) made the case to the White House last week that reaching agreement with the tobacco industry on preferred steps, with the industry signing binding commitments with the threat of FDA regulation as a next step, might be better than seeking regulation first.

Officials said Sen. Wendell H. Ford (D-Ky.) and North Carolina Gov. James B. Hunt Jr. (D) both have had extensive conversations with White House officials this week about devising an approach to reduce teenage smoking without the FDA's directly regulating the industry.

"There are an infinite number of permutations on how to do that," one senior official said, with all of them aimed at the central goal of not giving FDA jurisdiction over tobacco. The FDA would regulate the tobacco industry if the government concludes that cigarettes are used to administer doses of nicotine, an addictive substance.

More than 100 medical, religious and children's groups have urged Clinton to authorize the FDA to regulate nicotine, as have several Democratic members of Congress from states that do not produce tobacco.

In urging FDA regulation last week, the American Medical Association compared the tobacco industry to Colombia's Medellin drug cartel.

The White House has said Clinton is considering no regulations affecting adult smoking.

REMARKS OF HILLARY RODHAM CLINTON
SAFE AND DRUG FREE SCHOOLS EVENT
AUGUST 9, 1995

It is a pleasure to welcome you all to the White House.
[Acknowledgements: Dr. Lee Brown, Director, White House Office of National Drug Control Policy; Madeleine Kunin, Deputy Secretary of Education; representatives from education and drug abuse prevention groups; students]

This is an exciting time to be a young person in America. As we approach the 21st century, we are coming into more contact with the rest of the world. Technology is advancing by leaps and bounds. The world is changing very quickly. These changes present us with many opportunities, and with many challenges. If we are to successfully meet these challenges and become the nation we want to be, we do not have a single person to waste.

Drug use is one of the greatest threats to our nation's young people -- and therefore, to our nation's future. Like thousands of other parents of teenaged children, I am very aware -- and very worried -- about the pressures on young people to use drugs.

The Safe and Drug Free Schools program is an important part of the President's strategy to fight drug abuse. The Drug Free Schools program reaches students in over 90% of our schools by giving communities across America the funding and the tools to combat our nation's drug problem at its root.

And the program is flexible so that it can accommodate the needs and resources of different communities. As many of you know, the Recreation, Education and Prevention program [REAP] encourages students to serve as mentors for other students. By contrast, Drug Abuse Resistance Education [DARE] brings specially trained police officers into the schools to serve as role models and teach young people the skills they need to resist drug use.

Whatever the format, Safe and Drug Free Schools programs are an effective way for adults to support the thousands of courageous young people who are not giving into peer pressure and who are not involved with drugs. In fact, I'd like to take this opportunity to salute all of you here today who are doing your part by turning your back on drugs.

Despite the importance to our nation's future of the fight against substance abuse, there are some in Congress who tried to slash 1995 funding for the Safe and Drug Free Schools program and who now want to cut 23 million students from the program in 1996. With drug use among America's young people the serious problem it is today, cutting our only federally-funded drug prevention program would be foolish. All of you here today are good reasons why we must continue to support Safe and Drug Free Schools and

why the President and I feel so strongly about this program.

The Drug Free Schools program makes sense. For example, it fights tobacco use as well as other substance abuse. This is important because smoking is harmful in and of itself: it significantly increases the risk of cancer, heart disease, and respiratory ailments. And a national study recently released by the Center on Addiction and Substance Abuse at Columbia University demonstrates that there is a strong statistical correlation between using tobacco and using illicit drugs. For example, the study found that 90% of the children and adults who use marijuana smoked cigarettes or drank alcohol first, and that adults who smoked as children are three times more likely to use cocaine regularly than are adults who never smoked as children. The President believes that our government has a responsibility to protect our nation's youth and to help parents keep tobacco products away from their children.

It is important to remember that no federal initiative -- no matter how effective -- can take the place of parents sitting down with their children and telling them about the dangers of tobacco and drug use and teaching them the difference between right and wrong. I commend the thousands of parents across the country who are committed to keeping their children drug-free. And I want to encourage those of you who will be parents some day to stay involved and to set good examples for your children tomorrow just as you are doing for your peers today.

In a few minutes, we will have the opportunity to hear firsthand from participants in REAP and DARE about how they are making their communities safer places to learn and grow. But first, it is my pleasure to introduce Dr. Lee Brown, the Director of the White House Office of National Drug Control Policy.

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