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The status of drug and alcohol prevention activities in Ohio high schools: Implications for the Ohio High School Athletic Association and the student athlete

DiBiasio, Anthony J., Ph.D.
The Ohio State University, 1987

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To My Wife, Bonnie, and Our Daughter, Amy
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CHAPTER I
INTRODUCTION

Adolescent drug use is a major problem among today's youth. The epidemic nature of the problem is being recognized by community leaders and the general public. For the first time in 18 years, respondents to a national Gallup Poll of public attitudes toward the public schools, identified drug use as the number one problem facing schools today (Gallup, 1986a).

In addition, teenagers in the United States are reported to use drugs at a rate greater than in any other industrialized nation. Compared to Japan, substance abuse problems among adolescents is 10 times greater in this country (United States Department of Education, 1986).

Survey data on adolescent chemical use have revealed two alarming trends. The first showed that teenagers are reporting more frequent chemical use than ever (Miller, Cisin, & Abelson, 1983; Gallup, 1986b). The second trend indicated that, according to student reports, initial drug use is beginning at a younger age (Johnston, O'Malley, & Bachman, 1984, 1986). Johnston et al. (1986) found that the percentage of students who reported using drugs by the sixth grade had tripled over the last decade.
Miller et al. (1983) investigated the use of nonprescription drugs and other substances by persons aged 12 and older. In their findings, 65 percent of the students 12-17 years old reported using alcohol within the last year. Twenty-seven percent of the students in this age range also reported using marijuana over the same time period.

Similar results were found in a comprehensive study of drug use among American high school students. In this study, 63 percent of all students reported using an illicit drug prior to graduation (Johnston et al., 1986). When the survey accounted for students reporting alcohol use, the percentage increased to 93 percent of all students.

Survey data can also be used to demonstrate the epidemic nature of drug use and abuse among Ohio's student population. Buchanan (1984) conducted a statewide survey that shows over three-fourths of Ohio students (grades 7-12) have reported drug and/or alcohol use at least once within the past year. Her research surveyed over 1400 students in 11 separate schools. The data for self-reported lifetime chemical use and current use for Ohio high school seniors closely parallels national figures.

Gender appears to play a significant role in early chemical use. Buchanan found that male students in Ohio reported earlier use than females. For males, 11 percent
claimed to have used drugs before age 10, while this was true of only 2 percent of the females who responded to the survey. This sex difference disappeared when self-reported data for first use occurred after age 15.

The results of the Buchanan study offered a profile of the chemical use experiences for the "typical" high school student in Ohio. This individual reported first using drugs, most likely alcohol, at age 13. As a consequence, he/she had a 50 percent chance of using other chemicals, with a 40 percent chance that one other chemical would be marijuana. If use becomes regular, the individual had a 20 percent chance of requiring treatment for chemical dependency (Buchanan, 1984; Johnston et al., 1984, 1986).

Schools play a major role in the crisis surrounding adolescent drug use. According to the United States Department of Education (1986), 57 percent of the students in a recent study indicated they purchased most of their drugs at school. In addition, 33 percent of the seniors in another study reported smoking marijuana at school, while two-thirds of the seniors admitted amphetamine use during school hours (Bennett, 1986a; DuPont, 1984).

Nevertheless, schools did not cause the abuses of alcohol and other drugs by adolescents. Nor should schools bear the sole responsibility for finding solutions to the
problem. A combined effort that includes the resources of government, business and industry, and education, is required.

The federal government has responded to the problem at both the executive and legislative levels. The President has called for mandatory drug testing for all federal employees. To demonstrate the need for such strong action, the President and the Vice-President submitted to voluntary urinalysis. Each member of the President's Cabinet was expected to follow the example of these two national leaders.

Congressional response was equally swift. Legislation to eradicate this problem was rushed before both the House and Senate. Members of Congress called for mandatory testing as well as the death penalty for drug suppliers. In the end, Congress passed legislation that added $1.7 billion in new fiscal 1987 funding for drug interdiction, eradication, enforcement, education, treatment, and rehabilitation efforts (Rovner, 1986).

The omnibus anti-drug legislation (HR 5484) outlined specific authorizations for the development of drug-free schools. Included in the provisions were funds available for schools to develop and implement drug abuse education programs. Program development in drug education was encouraged for both the general student body and for select
groups of students at risk, including students in extracurricular activities such as interscholastic athletics (Congressional Quarterly, 1986).

Dupont (1984) maintained that schools, by the nature of their high visibility, possess vast opportunities for the development of drug prevention programs. The majority of Americans between the ages of 12 and 20, when most chemical use begins, are in school. In addition, schools represent a standard of instruction that promotes the development of a law-abiding citizenry and the attainment of skills in responsible decision-making (Boyer, 1983).

Given this scope of responsibility, schools have become an important component in the network of resources effectively responding to the problem of adolescent chemical use and abuse. Considerable research is available on school-based drug education programs. It includes attention to such areas as student attitude surveys (Kim, 1981), outcome evaluations of drug education programs (Kinder, et al., 1980; Schaps et al., 1982), educational implications of drug abuse (Hochhuser, 1978), and the identification of effective components of drug abuse prevention programs (Stainback & Rogers, 1983).

Little data, however, exist to describe how schools are attempting to deal with the drug-related issues
experienced by students in special groups. This study is particularly interested in how the student athlete is affected by drug education in the schools.

The use of alcohol and other drugs is widespread among high school students. The effects of substance abuse in the schools have reached beyond the classroom and are now being felt in the locker room (Bellizio, 1985; Dyment, 1987).

High school students participate in a variety of extracurricular activities during these formative years. Interscholastic athletics is one activity that draws thousands of students yearly. In Ohio, for example, the Ohio High School Athletic Association (OHSAA) regulates interscholastic competition in 12 team sport areas for boys and in 11 areas for girls. Last year over 200,000 students participated in high school sports.

With student drug use as prevalent as indicated, many of the young people involved with harmful chemicals must also be student athletes. What efforts have school districts taken to address the issues of drug prevention, education, and intervention with their student population? Two areas are of particular interest. What are the implications of adolescent chemical use for the student athlete and how are the schools responding? This study addressed these two concerns.
Statement of the Problem

The purpose of this investigation was to determine the current status of drug and alcohol prevention activities in Ohio high schools as they relate specifically to the student athlete. A second purpose was to generate recommendations at the state and local levels for a comprehensive drug and alcohol education program for these young participants.

Specifically, four areas of investigation were used to explore the current status of programs in Ohio schools. These themes are; Policy, Staffing, Programs, and Inservice. Under each theme, subsidiary questions were generated to determine the extent of the efforts in each area.

Theme 1: Policy

This theme studied the course of action taken by schools in response to drug/alcohol use by students. The following questions were investigated under Theme 1:

1. What percentage of Ohio high schools are adopting policies that respond to the use and abuse of chemicals by students?

2. What percentage of Ohio school districts are adopting policies that respond to the use and abuse of chemicals by employees?
3. Do Ohio high schools currently have chemical use and dependency policies that specifically affect the student athlete?

4. To what extent have school policies on student use or student athlete use been enforced during the 1984-1985 school year?

**Theme 2: Staffing**

Effective drug education programs have trained staff to meet the special needs of the student population. Theme 2 studied the response by Ohio high schools to add or train staff members in chemical use and dependency program development.

1. What percentage of schools have provided staff members with training in drug/alcohol prevention programs?

2. Do Ohio high schools have a drug/alcohol coordinator position as a member of the certified staff?

**Theme 3: Programs**

Drug education is multidimensional. Recognizing this, Theme 3 endeavored to discover the type of drug education programs that currently exist in Ohio high schools.

1. What percentage of Ohio high schools are offering programs in drug awareness and prevention?

2. What are the specific components of a school-based drug awareness/prevention program?

3. What percentage of school programs provide training for student athletes?
4. What percentage of Ohio high schools use available resources to assist current drug education programs?

5. Is there a need among Ohio high schools to add to existing programs or to develop new drug education programs?

**Theme 4: Inservice**

The sharing and the dissemination of information is essential for effective programs. Theme 4 examined how Ohio high schools increase the awareness of drug/alcohol use and abuse among students and staff.

1. What percentage of Ohio high schools are providing inservice activities in drug/alcohol education?

2. What percentage of Ohio high schools provide teachers and staff training in chemical use and prevention programs?

3. What percentage of Ohio high schools provide interscholastic athletic coaches with training in chemical use and prevention programs?

The frequency of response generated from these questions was one part of the research problem. A second focus was to describe the effect OHSAA regional district, type of school, and OHSAA classification had on the status of drug education programs in Ohio high schools.
Definition of Terms

The following definitions are offered to clarify the meaning of terms used in this study.

Adolescence - in this study the term adolescence is used interchangeably with youth, young people, and student. Developmentally, adolescence is considered the time when childhood ends and youth begins. Erikson (1963 pg. 263) views adolescence as the "psychosocial stage between childhood and adulthood, and between the morality learned by the child, and the ethics to be learned by the adult." According to Erikson's view, the primary task of the teenage years is to construct a sense of personal identity (Elkind, 1984).

Athletics - data received in this study on athletes and athletics refer to those students and teams that participate in Ohio High School Athletic Association (OHSAA) sanctioned, interscholastic activities.

Chemical Use/Abuse - describes the behavior of taking mood-altering drugs for pleasure, performance, or recreation. Substance use/abuse and drug use/abuse are synonymous with chemical use/abuse and are used interchangeably. Use/abuse refers to a continuum of drug-taking experiences, ranging from experimentation (use) to addiction (abuse).
Drug/Alcohol Coordinator - is the title of the staff member with the responsibility to direct the school's drug education program. The position may be either full or part-time, and it includes coordinating services for students, staff, and parents.

Drug Education - refers to the formal or informal process of disseminating information about chemicals to students and communities. Within a school context, drug education is considered either a specific curriculum, infused with other subject matter, or taught as a separate area of instruction.

Employee Assistance Program (EAP's) - a program offered by employers to assist troubled employees, including those with problems relating to chemical use.

Ergogenic Aids - are various types of drugs that are used to delay fatigue, stimulate the nervous system, enhance oxygen delivery to the muscles, and increase muscle strength (Mangi & Jokl, 1981). The most common uses of ergogenic aids by athletes are the use of cocaine to stimulate the central nervous system, and the use of anabolic steroids to increase muscle bulk and strength.

High School - according to Boyer (1983), a high school is an institution that offers an academic, vocational, and general studies program for students. For
this study, high school is defined as any school district chartered by the Ohio State Department of Education containing any combination of grades seven through twelve (Ohio High School Athletic Association, [OHSAA] 1986).

**Intervention** - is any carefully planned meeting or program designed to provide the chemically dependent person with the encouragement to seek help for his/her problem. For individuals, intervention may involve a meeting with those closest to the chemically dependent person to discuss observations and concerns about the dependent person's behavior. Intervention may also be applied to groups through specific policies governing conditions for participation in such groups.

**Illicit Drugs** - refer to those chemicals whose production, use, and sale is prohibited by law. Illicit drugs may also refer to the unauthorized use of prescription drugs.

**Licit Drugs** - are those chemicals permitted by law and controlled by legal authority. Chemicals such as alcohol, prescription drugs and over-the-counter medicines (OTC) are examples of licit drugs.

**Ohio High School Athletic Association** - the Ohio High School Athletic Association (OHSAA) is a non-profit, regulatory organization that supervises and administers interscholastic athletic competition among its member
school districts. Membership in the OHSAA is voluntary and open to any school chartered by the Ohio State Department of Education (OHSAA, 1986).

**Policy** - is the written, school board approved plan of action for a given area of school involvement. In this study, policy refers to specific actions taken by schools, with board approval, regarding chemical use by students and staff.

**Prevention** - refers to the process of establishing programs that will promote and facilitate the necessary conditions for healthy personal-social development. Primary prevention programs address students who have not yet exhibited maladaptive behavior (i.e. drug use). Secondary prevention programs seek to limit moderate maladaptive responses in a targeted group. Tertiary prevention programs seek to reduce the maladaptive behaviors of persons already experiencing severe difficulty (Maher, 1981).

**Programs** - refer to the in-school planned activities designed to carry out the school's drug/alcohol policies. This also includes out of school programs used by schools as a referral source, to assist students with chemical use problems.
Need for the Study

The need for a study of this type was based on three observations of adolescent chemical use and sports in America. First, sports participation holds a special place in American culture, and on the scholastic scene (Talami, 1973; Boyer, 1983). Second, high school athletes were specifically singled out for study because of their unique vulnerability to substance abuse problems. Third, the high visibility associated with interscholastic athletic participation made this an appropriate area of study.

In the first observation, literature supports the view that the world of sports holds a special place in American life (Edwards, 1973; Jessor & Jessor, 1977; Talami, 1973). Nevertheless, many myths surround the value of athletic participation in building character in young adolescents.

Research and educational commentary abound with comments on the positive role of sports in society. From developing a respect for "living life by the rules", to building such qualities as good sportsmanship, loyalty, and cooperation, athletics have become synonymous with clean living (Leavitt & Price, 1958).

The role of organized sports participation in American culture reflects the traditional values of American society. Success in this country has
ideologically been based on the opportunities for free and open competition. The same view has been identified, in principle, as a defining characteristic of the nature of modern American sport (Talami, 1973).

According to Edwards (1973), an American sports creed exists that convinces people of the benefits and virtues of organized sports participation. In his research, Edwards found that people reported the belief that participation in sports builds character, teaches discipline, provides competition, and develops competitiveness.

These views, however, have been weakened by recent events. The use of drugs in sports has contaminated the pristine image of athletics at every participatory level.

The recent death of an All-American basketball player served as a catalyst for investigations into college athletics. Two issues surfaced. One focused on the extent of drug use on the college campus, while the other examined the academic treatment of the college athlete.

A week later the death of a star defensive back in the National Football League shifted the focus of the drug problem to professional athletics. From this perspective, drug use was viewed through a wide-angle lens to encompass all facets of society.
The problems of drug abuse in sports had been simmering for almost a year. The cocaine related deaths of two outstanding athletes might be considered the natural progression of the growing drug problem exposed the previous summer in professional baseball. American sports fans may best remember that summer as the season professional baseball went on trial. A suspected drug supplier for players was tried in a court of law and America's national sport was indicted. Current and former players testified to widespread drug use either personally or by their teammates. It was a sad chapter in the history of a sport rich in tradition and pride.

Repercussions from the baseball drug trials and the drug related deaths of two prominent athletes are being felt throughout collegiate and professional sports. Every level of competition, including interscholastic athletics, stands ready to address the issue of drugs in sports.

Most recently, the National Collegiate Athletic Association (NCAA) instituted drug testing for football teams participating in the 1986 bowl games. Twenty athletes were declared ineligible when they tested positive for anabolic steroids. This approach drew national attention when a two-time All-American linebacker from a nationally ranked team was one of the players to fail the NCAA drug tests (Neff, 1987).
The investigation of drug use in sports has often concentrated on the problems in professional and/or collegiate athletics. As the problems at these levels were exposed the attention shifted to the scholastic scene. The problem at this level affected both students and athletes.

A second observation examined the response of schools in addressing the growing problem of teenage chemical use and dependency. School districts, along with community support, have responded to the problem by implementing school-based drug education programs. Whether the approach was consultative, like Community Intervention (Crowley, 1984,) or curricular, like Decisions About Drinking (Mills, et al., 1978) and Ombudsman (Charlotte Drug Education Center, 1981), the common goal was to stem the rise of adolescent drug use.

The school-based approach focuses primarily on prevention of drug use and education about the effects of drugs. According to one drug-abuse consultant, this is not enough. Along with prevention there has to be an effective intervention strategy (Heitzinger, 1985). Intervention can assume many forms within a school-based program. Schools have developed student assistance programs, core teams, and local community action teams to combat the problem.
There is a wealth of research in the area of drug education and prevention programs for students during school hours (Kinder, et al., 1980). Little data however, are currently available on the relationship between student drug use and participation in extracurricular activities.

The little data available, however, suggest the high visibility of student athletes had often resulted in schools establishing separate drug and alcohol policies for athletes, in excess of the policies for students at large (Quaranta, 1985). Many of these policies for athletes were limited to the selective enforcement of training rules (American Association of Youth Sports, 1983). In most cases, student athletes were required to honor a code of abstinence from chemical use or face immediate removal from the team (Eyden, 1984; Dawson, 1984).

Schools, however, are beginning to discover past practices were either too punitive or too difficult to enforce. A new approach to this problem is needed. State high school athletic associations are taking strong positions against chemical use by adolescent athletes. In Ohio, the OHSAA has issued a position statement on chemical abuse. Adopted by the Chemical Awareness Committee in April of 1985, the statement takes the following position:

The Ohio High School Athletic Association recognizes that a serious problem in the use and abuse of alcohol exists in our nation and
schools. The Ohio High School Athletic Association further recognizes that this same chemical abuse problem is prevalent among student athletes at the same levels as other students. This use and abuse of alcohol and drugs is having a negative effect on behavior, learning and the total development of the user as well as affecting the athletic performance of those participating in athletics. In addition, the use and abuse by the athlete affects skill development, team members, family and other significant individuals in life.

The Ohio High School Athletic Association encourages its member schools to develop a chemical awareness policy and program. The program should focus on prevention (education) and intervention (treatment).

The Ohio High School Athletic Association encourages those in leadership positions in athletics to serve as role models in confronting the chemical abuse problem. This is not limited to but would include the non-use of alcohol prior to and while conducting league meetings, athletic meetings, etc. By such activity, a statement is being reflected regarding alcohol which may influence other people's attitudes and behavior.

The Ohio High School Athletic Association believes that the prevention of chemical abuse begins with the recognition that such a problem exists. The Ohio High School Athletic Association affirms that a problem exists and encourages its members to do likewise. A natural outgrowth of this affirmation will be the development of prevention and intervention programs to combat substance abuse among young people (OHSAA Position Statement, 1985).

Through the efforts of state associations and local school districts, the high school student athlete can become an important component in effective drug education programs.

A third reason to study the implications of a school-based drug education program for the student athlete is due to the special issues surrounding athletes and chemical
use. Athletic participation may result in a greater sense of social isolation for some athletes, thus resulting in weaker coping skills and greater vulnerability to substance abuse ("Drug Abuse in Sports," 1982; Bell & Doege, 1987).

Quaranta (1985) has juxtaposed the benefits of athletic participation with an awareness of the special risks faced by those who compete in athletics. He frames the issues around the wholistic development of the individual. Consequently, the risks faced by athletes may be spiritual, physical, and socio-emotional. In addition, participation in sports creates a special problem related to substance abuse. Sports, at all levels, are linked with the use of alcohol, tobacco, and other drugs, yet at the same time athletic codes restrict it. The mixed message is particularly troublesome to young athletes.

There is also a tendency among coaches and parents to protect athletes from the consequences of their chemical use (Dawson, 1984). Despite the good intentions of concerned adults, this enabling simply permits the athlete to continue his/her chemical use.

Additionally, the need for statewide assessment of drug and alcohol prevention activities lies in the fact that to date, no single study has identified the extent of substance abuse policies and programs in operation in Ohio.
high schools. Further, no survey has sought to study the implications these programs have for the student athlete.

Limitations

The population investigated in this study was both large and multifaceted. It consisted of all Ohio high schools and included special services for students and staff provided by each school. A descriptive approach was selected to investigate such a vast and varied population. Survey research is an appropriate choice to accurately assess the characteristics of large populations such as Ohio high schools. Nevertheless, the use of descriptive modes of research has its limitations and weaknesses (Isaac & Michael, 1979)

According to the Principal's Mailing List, used to identify the number of high schools, Ohio has 821 high schools throughout the state. One limitation in assessing such an expansive group was the representativeness of the respondents to the entire population. A first mailing was sent out in the late spring of 1985. A second mailing was forwarded that summer to the school districts not responding to the initial survey.

Second, each survey was sent directly to the high school principal. A number of variables may have affected the completion and return of the survey. The questionnaire
sought data covering the school's drug and alcohol policies and programs. Particular emphasis was given to the impact such policies have on the high school athlete. Many school administrators may not have been able to respond to questions relating to areas outside their immediate area of control. In addition, if the building principal referred the survey to another staff member, he/she may have felt a similar constraint by not having all the information required to respond to the survey.

A third procedural limit was the timing of the mailings. The first mailing occurred in the spring, followed by a second mailing in the summer. Nevertheless, the return rate of the mailed surveys reflects a representative sampling of instruments mailed at the end of a school year with a summer follow-up mailing.

The survey used to measure the current status of drug prevention programs in Ohio schools was a fourth limitation. A review of the literature indicated that an empirically tested survey for use with this population did not exist. As a consequence, the instrument used in this research was specifically designed for this study. Questions were generated from other surveys of drug education programs, as well as from items unique to Ohio high school athletic programs.
Organization of the Remainder of the Study

Chapter I provided a statement of the problem to be investigated, the research questions, and the definition of terms used throughout the study. Additionally, this chapter described the need for the study, and its major limitations.

Chapter II offers a review of relevant literature and studies in the area of drug and alcohol issues affecting young people. Chapter III contains a discussion of the methodology used in this study. A presentation of the findings are offered in Chapter IV, while Chapter V includes the summary, conclusions, and recommendations.
CHAPTER II
REVIEW OF LITERATURE

This chapter provides a literature review for the study under investigation. The areas of review are: Drugs and Youth, Drugs and Athletes, and Responses to Adolescent Drug Use, including the reactions of Communities, Schools and Athletes.

The amount of literature devoted to adolescent drug use is directly proportional to its perception as a national problem. Each year, as the problem escalates, research in the field increases.

Every aspect of youth's involvement with licit and illicit substances has been under investigation. Researchers have studied the effects of drugs on young people (Adler & Loteka, 1973; Johnston et al., 1984; Kandel et al., 1976; Smith, 1981), the use of drugs in sports (Malcom, 1971; Mofenson, Greensher, & Reilly, 1977; Percy, 1980; Rooney, 1984), and the various school-based programs for prevention and intervention (National Institute on Alcohol Abuse and Alcoholism, [NIAAA] 1983; Crowley, 1984; Quaranta, 1987), and yet researchers continue to search for solutions to this problem.
DRUGS AND YOUTH

Adolescence is a paradoxical time of turbulence and ambivalence. This period of development is characterized by exaggerated highs and lows. Developmental psychologists have referred to adolescence as a period of storm and stress (Horrocks, 1969). Erikson (1963) views adolescence as the psychosocial stage between the morality learned by the child and the ethics to be developed by the adult. Typically, as the adolescent moves toward the concurrent goals of parental independence and peer interdependence, he/she invariably experiences problems of adjustment.

In an attempt to cope with adjustment problems, many teenagers have sought relief through the use of alcohol and other drugs. Elkind (1984), in a discussion of teenage stress, maintains that substance abuse is the leading cause of death among teenagers, claiming over ten thousand lives annually. The National Institute on Alcohol Abuse and Alcoholism (NIAAA) claims that in excess of 1.3 million adolescents, between the ages of twelve and seventeen, have serious drinking problems (Elkind, 1984). This is in line with Cummings' (1979) estimate that one of every six teenagers suffers from a severe addiction problem.

One assumption might be to view adolescence, with its inherent struggles, as a major cause of teenage substance
abuse. Smith (1981) suggests that alcohol and drug addiction are due to the teenager's inability to deal effectively with the normal vicissitudes of adolescence. Drug use may serve as a means of escape from the types of stress unique to today's youth. This view has generated a significant amount of research in adolescent chemical dependency.

Many current studies in the field are trying to identify the contributing factors that lead to harmful use (Segal, 1983). This type of research is helpful in building awareness of the personal-social variables of addiction. In addition, it helps provide a framework for understanding the developmental nature of chemical dependency.

The view that chemical dependency has progressive stages of development was enhanced when the American Medical Association accepted the disease model of alcoholism (Jellinek, 1960). According to the disease model, alcoholism develops its own symptomatology. First, alcoholism is a primary disorder. A second characteristic is the progressive nature of the disease. If left untreated, the condition will get worse. Third, the disease is chronic. Alcoholism is not believed to be responsive to medical management. Relapse, for those in treatment, is common. Finally, the disease can be fatal.
The medical model of alcoholism has been expanded to include the whole of substance abuse addictions. Originally intended to describe the disorder in adult populations, the disease model, according to some researchers, has limited application with adolescents. Jessor and Jessor (1975) claim the clinical symptoms of alcoholism are rarely manifested in young people. Physical effects of addiction usually take many years to develop. In adolescents a loss of control may be experienced early, but the risk of serious organic disorders is less likely.

Others differ with the medical model based on the exclusion of personal-social variables in the use of drugs. According to Smith (1981), the disease concept of addiction fails to fully account for the individual's psychological dependence on chemicals.

Cummings (1979) finds two major limitations of the disease concept in explaining adolescent chemical dependency. First, due to the focus on the latter stages of the disease, early signs of problem drinking may go undetected in young people. Second, calling alcoholism and drug addiction a disease implies a degree of helplessness on the part of the addict.

Definitions of chemical dependency among adolescents
have turned toward a psychological and sociological view of the problem. Psychological definitions of addiction hold that the chemical substance of the drug is less important than the user's perception of what the drug can do for him/her (Peele, 1978). For the adolescent, psychological dependence on the drug is much stronger than his or her physiological need (Peele & Brodsky, 1975).

Cultural and environmental factors play an important role in the sociological definition of teenage drug addiction. Attitudes about drinking and the use of alcohol within the family's social structure vary in different ethnic, religious, and cultural groups. Chemical use has become a rite of passage for many young people. Jessor and Jessor (1975) have aptly stated that becoming a drinker is essentially a part of growing up in American society.

Definitions of addiction reflect differing views of the origin and extent of the problem. The process of addiction, however, appears to follow a single, sequential course. From initial use to dependency, the path is similar for adolescents and adults.

Kinney and Leaton (1978) describe a four-step process of change that occurs in chemically dependent persons. Their work is an extension of the developmental model of alcoholism and addiction developed by Johnson (1973).
A stage-directed view of dependency assumes the formation of a relationship between the individual and the drug. Bonding with alcohol and/or other drugs occurs during the experimental stage of chemical use. In this initial phase the individual learns both the psychological and physiological effects of the drug. Typically, the individual discovers that chemicals alter one's mood, producing a sense of euphoria. With repeated use, a person learns the euphoric effects occur each time. For many adolescents, the drug's effects are more reliable than most peer relationships.

Young people appear to learn the lessons of experimental use quite well. Estimates indicate over 93 percent of high school students enter this initial phase of chemical dependency (Gallup, 1986b; Miller et al., 1983).

Many young people remain at the experimental stage throughout adolescence. Others, however, consciously seek the mood swing, thus moving into stage-two use. At this stage the individual anticipates the euphoria produced by the drug and seeks the altered mood. As use increases, the adolescent discovers the concomitant costs involved. Pain associated with use, usually follows a chemically induced experience. Hangovers, feeling physically ill, or feelings of embarassment may be consequences of drinking behavior.
Seeking the mood swing at stage two involves the acceptance of both the physical and emotional cost of continued chemical use. According to studies on adolescent drug use, many students are willing to pay the price for their euphoric feelings. Johnston et al. (1984) suggests roughly 40 to 45 percent of high school students are stage-two users.

The third phase described by Kinney and Leaton (1978) is the harmful dependency stage. A significant change in the pattern of drug use occurs at this stage. Seeking the mood swing exacts a much higher cost for the expected sensations. Pain, experienced after-the-fact in stage two, is now felt before chemical use. To reduce the intensity of waking up in pain, the individual takes the drug to feel better.

In stage three, the individual experiences the progressive nature of chemical use. Beginning in pain, the individual uses to experience euphoria. Initially the mood swing moves in the right direction, achieving the intended purpose. As the mood wears off, however, the person returns to a less comfortable place than where he/she began (Kinney & Leaton, 1978).

Each subsequent episode of chemical use leaves the individual deeper and deeper in the pain area. For an adult this may result in the loss of a job or problems with
the family. An adolescent in pain may experience difficulties in school and disruptive peer relationships.

Once established, this cycle is very dangerous for adolescents. Drug tolerance is increased as well as the student's use of rationalization to support continued use. Independent functioning is now dependent upon the need to use chemicals. Johnston et al. (1984, 1986) estimate that 20 percent of American youth are in this harmful use stage.

By stage four, the chemical dependency phase, the user experiences a primary relationship with drugs. The vicious cycle of use, misuse, and abuse leaves the individual in chronic pain. Starting in pain, the use of drugs no longer produces a sense of euphoria, but rather allows the user to feel normal. Beset with negative feelings, the individual struggles with a loss of values and a sense of hopelessness.

Progression to the chronic stage is characterized by blackouts, distorted thinking, and severely impaired functioning. The chemically dependent person faces the stark option of entering treatment or allowing the disease to progress to its ultimate, fatal solution. According to Johnston et al. (1986), 5 to 10 percent of high school students face this dilemma each year.
Understanding the developmental process of addiction in adolescents is essential in establishing effective programs for youth. This knowledge must also be combined with an understanding of the antecedent variables of drug taking behavior in today's young people.

A quarter century ago, alcohol and drug use among adolescents was considered deviant behavior as well as a sign of a possible pathological condition. More recent studies have also focused on the psychological well-being of the young drug user (Brook, Szandorowsksa, & Whitehead, 1976; Hartment, 1969; Pittel et al., 1971). These findings suggest the determinants of adolescent drug use are multifaceted.

The components affecting teenage drug use vary. Depression, intra-psychic stress, and anti-social behavior have been among the pathological conditions investigated. Hartment (1969) reported 80 percent of the students he studied were considered clinically depressed prior to taking drugs. In another study, Brook et al. (1976) indicated that adolescent amphetamine users had very high levels of psychological distress, highlighted by feelings of inadequacy.

Non-compliant behavior and antisocial characteristics were also reported to be strongly associated with chronic drug use. Sutker, Moan, Goist, and Andallain (1984)
developed Minnesota Multiphasic Personality Inventory (MMPI) profile subtypes for chemically dependent adolescents. The findings identified distinct patterns for adolescent subtypes.

The subtypes were characterized by "significant differences in degree and type of psychopathology but not in antisocial features" (Sutker et al., 1984, pg. 235). The authors concluded that alcohol and illicit drug use are closely linked with psycho-social deviance in adolescent samples.

Other factors affecting chemical use are situational and interpersonal, of which peer and parental relationships are included (Segal, 1983). A number of studies have looked at the family system and its role in explaining adolescent drug use.

Barnes (1977) claims the best predictor of a young person's drinking habits is the pattern established by the parents. A teenage alcoholic is most likely the product of a home where heavy drinking is accepted. At the other extreme, an adolescent who abstains from drinking is more likely to come from a home where alcoholic beverages are not consumed or the use of alcohol is considered moderate.

The type and frequency of chemical use can be influenced by the adolescent's perception of the parenting
style employed in the home. Reilly (1975) identified specific family traits found in drug-abusing adolescents. Characteristics of these families include: establishing inconsistent limits on the child, disagreements over discipline, and poor communication of feelings.

A recent study of high school students, reviewed by Hostetler (1981), confirms the role of parental patterns on drug use and behavior. Students were asked to describe parenting styles in their homes. They were to describe the style as either permissive or controlling, and loving or hostile. Combinations of the bi-polar styles were also accepted. Next, the respondents were asked to disclose the chemicals used during high school. Heaviest drug use was found among the students who viewed their parents as hostile and permissive. Alcohol abuse was most common in families described as hostile and controlling. Overall, the students considered most drug-free came from homes where parents were loving and controlling.

During early adolescence the influence of the family is strong. By middle adolescence, however, peer influence surpasses the authority of the home and school. Adler and Lotecka (1973) found very significant relationships in the patterns of drug use among closest friends. They suggest a correlation between progressive use and limited social interaction. Specifically, as use increases, there is a
strong tendency for a user to associate only with other habitual users. Conversely, non-users appear to maintain relationships with other non-users.

This trend lends credibility to the view that teenage drinking and moderate drug use can be viewed as a function of personal-social variables (Segal, 1980; Huba, 1979). A cycle of peer influence and social pressure was one of the major outcomes discussed in the Johnston et al. (1984) study. In this definitive work, drug use is viewed as the hub around which an adolescent's social interactions revolve.

Johnston et al. (1984) suggested the following socially interactive process. First, a young person with using friends will be more likely to try drugs. Second a young person already using will be very likely to introduce friends to the drug taking experience, and third, an adolescent drug user will be more likely to establish friendships with other users.

In a series of studies, Segal (1980, 1982, 1983) found a peer-social basis for chemical use, especially among older adolescents. Respondents, who were regular users of either alcohol or marijuana, indicated they used to facilitate social involvement or to enhance relationships already established.
Findings in the latest Segal study (1983) claim that unlike older adolescents, younger individuals fail to report alcohol use as a function of sociability. It has been found that young polyabusers use denial as a strategy, denying both the harmful effects of the substances used, as well as the belief that friends contributed to their own decision to use chemicals (Kalami & Steer, 1976).

Whether the antecedents to adolescent chemical use are social, familial, or psychological, the fact remains, this is a problem of epidemic proportions. It transcends age, race, or socio-economic position. In schools the problem affects everyone, including the student athlete. Response to this phenomenon must reflect both an understanding and support of the young people involved.

DRUGS AND ATHLETES

Athletics is an appropriate focus for prevention and intervention strategies. High school athletes, like their counterparts in college and professional sports, report using mood-altering chemicals for recreation and to enhance performance (Bellizio, 1985; Dyment, 1982, 1987; Malcom, 1971; Mofeson et al., 1977). Coaches and school personnel, however, receive little direction in governing drug use among athletes. As a consequence, many high
school administrators and parents tend to deny the existence of a drug problem in interscholastic athletics. Denial of the problem has not been as successful in professional sports. Recent media attention has focused on the drug problems in the National Football League (NFL) and the National Basketball Association (NBA) (Neff & Sullivan, 1986). As a result, a renewed interest in this crisis exists at all levels of athletic participation.

Drug use in sports usually follow two distinct patterns. One involves the use of chemicals as performance boosters. The other, views drug use as a recreational pursuit, influenced by peer-social variables. Both reflect the increased pressure many athletes perceive as conditions of their athletic participation (Dyment, 1987).

Vince Lombardi was fond of saying "winning isn't everything, it's the ONLY thing". This sentiment reflects a win-at-all-cost mentality that makes athletes vulnerable to chemical use (Mangi & Jokl, 1981). Seeking the necessary game plan for victory, athletes are increasingly turning to chemicals for the competitive edge.

Motivation for using ergogenic aids to boost performance may come from coaches, athletic trainers, and fellow athletes (Percy, 1980). These aids include pharmacological substances and nutritional supplements.
Anabolic steroids are the most popular type of chemical assistance used to boost performance. This drug is primarily used to increase muscle bulk and build strength. Many athletes feel if they are bigger and stronger then they will naturally perform better. Research has failed to indicate a positive correlation between steroid use and athletic success (Dyment, 1982; Mofeson, et al. 1977). On the contrary, prolonged use of anabolic steroids produces dangerous side-effects.

Psychomotor stimulants like amphetamines and cocaine are also widely used by athletes. While these chemicals may appear to the athlete to improve performance, their use is likely to have dire, long-term consequences. Percy (1980, pg. 481) illustrates how stimulants mask an athlete's fatigue level allowing him/her to "run the red light." An injury may appear less severe because the drug numbs the pain. If the player continues, the risk of a serious, perhaps career-ending, injury is possible.

Proper nutrition is essential for optimal athletic performance. Nevertheless, many nutrients are being incorrectly advertised and used as sports aids. Common nutritional practices include diet supplements, mega-vitamins, and body fluid replacement. Research, however, has not supported the efficacy of such methods (Haymes, 1980; Horwitz, 1982). Additionally, recent studies have
also discounted past practices like dispensing salt tablets to over-heated athletes. This latter practice is now considered useless and perhaps even dangerous (Mangi & Jokl, 1981).

Ergogenic chemical use is finding its way into high school athletics. According to Murray (1983) and Dyment (1987), young athletes appear to be following the professional's lead in using performance boosters to obtain a competitive edge. The use of recreational drugs among student athletes also follows the national trend.

Bellizio (1985) maintains if drugs were absent from the scholastic scene, athletes would have to be unaffected by changes in society. Statistics, however, do suggest that high school athletes are in the mainstream of today's drug users. Nevertheless, trying to identify the extent of the problem is difficult. Many coaches and parents still assume if young people are involved in sports, they will not use chemicals or alcohol (American Association of Youth Sports, 1983).

Athletic involvement is considered a positive social experience that molds character (Leavitt & Price, 1958). Over a quarter of a century ago the National Education Association (1954) summarized the objectives of athletic participation as enhancing skill development, emotional
growth, and good sportsmanship. According to this view, involvement in sports is beneficial to both the individual and to the republic. The patriotic zeal for athletics has changed little over the years.

Early studies confirm this mythical view of sports. In a survey of self-reported high school drinking behaviors, Hayes and Tevis (cited Rooney, 1984) found that students involved in athletics perceived themselves more often as abstainers and less often as heavy drinkers than the non-athletes.

A study by Jessor and Jessor (1977) on conventional behavior and drug use also supports this notion. Academic achievement, religious involvement, and other conventional behavior appeared to have an inhibiting effect on young people's chemical use. This study did not specifically single out athletes, but a fair assumption can be drawn given sports perception as a conventional activity.

Blum (1970) and Tec (1971) found sports a deterrent to those athletes viewing their participation as very important. In one study, only those athletes who aspired to be "the best", reported they would be less likely to use marijuana (Tec, 1971). The Blum (1970) study concluded that a higher incidence of, and greater experience with chemical use was found in those students who reported sports were of little importance.
Studies of the type just cited foster the mythical view of sports as a synonym for clean living. Current research, however, presents a view diametrically opposed to this prevailing myth (Dawson, 1984; Rooney, 1984). Although limited to local and regional studies, the research is an important component in dealing with chemical use and abuse by the student athlete.

Rooney (1984) has completed the most exhaustive study to date of the effects of sports participation on substance abuse. He surveyed over 4,900 high school seniors in thirty schools throughout six northeastern states. Respondents who reported participation in sports were broken down in the following manner: for males, 40 percent participated in one or more interscholastic sport, 48 percent participated in at least one intramural sport and nearly three-quarters participated in some out of school sport. The corresponding figures for senior girls were 22, 28, and 45 percent, respectively.

The hypotheses that were tested centered on the premise that the greater the number of sports participated in, the lower the rate of (a) illegal substance use, (b) alcohol use, (c) cigarette use, and (d) the number of problems resulting from chemical use. The fifth research question maintained that those students participating in
out of school sports are associated with less chemical use than those in interscholastic and intramural sports.

The self-reported data from the 4,900 students indicate that participation in all types of sports has very little effect on the use of mood-altering drugs (Rooney, 1984). The author maintains that his findings provide the lone exception to earlier studies that show athletic participation reduces rates of deviant behavior. Local research in this field seems to support the exception rather than the rule.

The little data available indicates that athletes report using chemicals at much the same rate as their peers. A study by the Minnesota Department of Public Welfare supports this assumption. Over half of the 3,000 students surveyed were identified as athletes. Of those students, one-third reported drinking beer at least once a week, and over half indicated they had tried marijuana ("Drug Abuse in Sports," 1982).

A similar study, reprinted in a pamphlet "Sports, Kids, and Drugs," by the American Association of Youth Sports, Inc. (1983), finds the same patterns. Students reporting regular drug use were found in roughly the same percentages among athletes as nonathletes. With respect to
regular alcohol use, athletes actually reported higher rates of use, 48 to 45 percent, when compared to other students.

On the local level, school districts have carried out in-house surveys to assess the extent of their problem. Anderson High School in Cincinnati conducted a drug information survey of all senior athletes and cheerleaders. The results appear in a drug prevention handbook for athletes. Sixty-eight percent of the seniors surveyed indicated they used alcohol during their sport season, while twenty-seven percent admitted using marijuana in season. In addition, 89 percent of the athletes and cheerleaders reported the existence of parties every weekend involving drinking by student athletes (U.S. Department of Justice, 1985c).

The game has changed since Smith (1971) shared his view of drug use among high school athletes at a convention of the American School Health Association. He proudly declared his Kanawha County school system in West Virginia found only two cases of drug abuse among 3,000 athletes.

According to Smith, a coach's pep talk and team spirit were enough to stimulate peak performance. Today, much of this enthusiasm and excitement is either chemically induced or postponed until the post-game activities.
A review of the previous research suggests that high school athletes are equally as vulnerable to the problems of adolescence as nonathletes. They get involved with drugs for many of the predictable reasons, but also for reasons unique to athletes.

According to Sherman (cited "Drug Abuse in Sports," 1982), athletic participation may create social isolation, resulting in weaker coping skills. In addition, there is a tendency among coaches and parents to protect athletes who have had problems with chemical use. Confronting this problem is complicated when significant adults enable an athlete's drug use.

Enabling occurs at both the institutional and the individual level. Few high schools, state athletic associations, or college conferences have clear policies governing an athlete's drug use. Coaches, trainers and parents of young athletes are also part of the problem. It is incumbent upon all parties involved to recognize and respond to this very serious problem.

RESPONSE TO ADOLESCENT CHEMICAL USE

The war against adolescent drug use has drafted the services of community resources, school districts and athletic organizations. From the Federal Government to the
local student council, drug abuse is the target. Creating a drug-free society for the nation's youth is the primary goal of this joint effort.

A wealth of research and "fugitive materials" exist to describe the combined efforts mentioned above. In an attempt for clarity, a tripartite response to adolescent drug use is viewed using a nine-celled matrix with separate headings for community, school, and athlete's response.

Figure 1 provides a schematic representation of the matrix used to outline the review of literature relevant to the variety of response to adolescent chemical use.

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Figure 1. Matrix of the literature review for Response To Adolescent Chemical Use.
RESPONSE WITHIN THE COMMUNITY

Community/Community Response--Within the community, those agencies and organizations involved in combating drug use among youth include: government and law enforcement; business, industry, and labor; and civic groups. Initially these groups sought to control the problem in the community through tough, punitive measures.

Early attempts to confront the problem were either ineffective or misdirected. Communities first sought legislative action to control the growing chemical use among young people. Paraphernalia laws were passed to restrict the purchase of accessory items frequently involved in drug use. Although this response demonstrates strong community action, the net impact was minimal. This approach did little to alter student attitudes about drugs and much to alienate youth and community groups (Crowley, 1984).

Other forceful, yet ineffective, early responses within the community were programs to apprehend the drug pushers. The Drug Enforcement Agency (DEA) is the model for this type of action. Nationally, with an adult population, this model proved to be more appropriate. By transferring these methods to the local level and targeting youthful offenders, the overall impact was less effective.
Problems in this area center around confronting the source of drugs for young people. Many times the provider is either the parent, older siblings, friends or other relatives (Muldoon, 1982). Local officials are reluctant to become involved in family matters, especially over matters relating to chemical use.

Recently the President's Commission on Organized Crime completed its study. The majority of its time, thirty-two months, was spent investigating drug enforcement programs. One conclusion made by the commission illustrates the frustrations inherent in this battle. The report claims, that law enforcement has been tested to the utmost, but it hasn't succeeded (Brinkley, 1986). As a consequence, the commission recommended shifting the focus from the elusive pusher to cracking down on the consumer.

Community sources have turned to drug testing as an answer. The President's Commission recommends that all Federal agencies should test employees for drugs. In the private sector, one study reports roughly 20 percent of Fortune 500 companies will use drug testing as a condition of employment (Worden, 1986). Business and industry appear to be taking the lead in eliminating drugs in the work place.

In an Ohio city, a community health agency started offering urinalysis tests in an attempt to curb adolescent
drug abuse ("Dayton Agency," 1986). Parents are encouraged to bring their children to the agency if they suspect the child had a problem with drug use. Cost of the test ranges from 10 dollars for a test that detects one drug to 33 dollars for a test that will pick up a wide range of chemicals.

Another community response has gained momentum within the last few years. Federal, state and local legislatures have taken aim at preventing chemical abuse in adolescents and adults. Recently, bills were passed at the federal and state levels to limit the consumption of alcohol by anyone under the age of twenty-one.

During the summer of 1984, the President signed into law a bill that withholds federal highway funds from states that fail to pass laws establishing 21 as the minimum legal drinking age. In December of that year, Massachusetts became the first state in the country to ban "Happy Hours" statewide. Included in this action was the elimination of such promotions as "Ladies Nights," "Spinning Wheel Prices," and "Two For One" gimmicks (Culhane, 1984).

Lawmakers in Washington have also been considering other measures to combat alcohol use and abuse. In 1981, S. 1542 was introduced by eleven senators. The bill would require warning labels on alcoholic beverages containing
more than 24 percent of alcohol by volume (Plymat, 1982). Amendments to the bill also recommended attaching warning labels to beverages containing beer and wine.

In a related move, Senators Pell (D-RI) and Barnes (D-MD) introduced a bill, S. 671, that would establish nationwide, uniform, stringent penalties and standards for drunk driving. The senators maintained this bill would establish minimum standards. States would not be discouraged from enacting more stringent penalties (Pell, 1982).

More recently, Congress is considering proposing federal excise taxes on alcoholic beverages. Taxes on alcohol serve a dual function. First, they may discourage the consumption of alcohol due to increased prices. Secondly, increased revenue generated may help offset suspected budget cuts resulting from passage of the Gramm-Rudman-Hollings plan for deficit reduction ("Congress Looks Again," 1986).

Community resources have also increased their treatment services within the community. Churches and local city halls have opened their doors for Alcoholics Anonymous and AlAnon meetings. Hotlines offering help for cocaine abusers and for parents of youthful offenders are growing rapidly (Morganthau, et al, 1986).

The growth of adolescent treatment centers is perhaps the best indicator of government and business, industry,
and labor working together to serve the community. Five years ago the services available to chemically dependent youths were limited. Most young addicts were sent out of state and the cost of treatment was prohibitive. Today, treatment centers can be found in every major region in the country as well as in most large metropolitan areas (Worden, 1985). Additionally, insurance coverage has helped defray the costs incurred with treating adolescent dependencies.

Community/School Response—Community agencies are actively involved in working with school districts to provide prevention and treatment services to young people and their parents.

Initially, community response within the schools mirrored the punitive actions used by law enforcement agencies. Undercover drug operations in local high schools are examples of such action.

In these operations, undercover police officers would pose as high school students to collect enough information to warrant a "drug bust." Many times the arrests would be made by both undercover and uniformed police. This type of response was often more divisive than constructive. Parents and students were alienated by the media attention and the presence of uniformed police around the school. As
a consequence, students became skeptical of resource people such as teachers, local law enforcement officials, and community leaders (Crowley, 1984).

Programs that punish may have short-term benefits. To be effective over a length of time, an approach must be broad enough to include the resources mentioned above, yet credible enough to attract student support.

Currently, the executive branch of the government is seeking to eradicate drugs from schools by proposing initiatives that would crack down on both the pusher and the drug user. Bennett (1986b) has urged schools to institute random drug testing for students suspected of using drugs, and to expel indefinitely all students involved in selling or using drugs. These programs hope to send a clear and concise message to students about the consequences of chemical use.

Many communities initially tried to appeal to student interests by using famous people to deliver anti-drug messages. The school or community agency would pay top dollar for show business personalities and local sports figures to discuss, in large assemblies, their personal experiences with drug abuse (Scott, 1986). The short-term effects are usually very powerful, however, in the absence of proper follow-up, the problem remains.
Clearly the issue of adolescent chemical use is a complicated one. An adequate response must reflect the complexity of the problem. Failure to do so results in ineffective programs and unenforceable policies. H. L. Mencken aptly describes the dangers of simplicity in his quote, "There is always a simple solution......and it's usually wrong." A broad-based, innovative approach is essential to avoid simplistic solutions (Crowley, 1984).

Effective community action programs are being developed nationwide. Communities have accepted the premise that drug abuse is not just a school problem, but a community problem. This has led to appropriate networking of resources. The National Institute on Drug Abuse (NIDA) (1983a) is encouraging local communities to rediscover their power in solving their own problems through effective prevention strategies.

Forming partnerships, parents, school personnel, city officials, and other concerned citizens can develop positive prevention programs. Such was the case with The Chemical People. Produced by a Public Broadcasting Station in Pittsburgh, The Chemical People is a television outreach project of the National Center for Youth, their Families, and Society (Kaiser, 1983).

Other programs like Mothers Against Drunk Driving (MADD) and Students Against Drunk Driving (SADD) use
community resources and school facilities to help young people. The First Lady, has also emerged as a major spokesperson for community and school partnerships. Her project, "Just Say No", has organized drug-free rallies in schools throughout the country (Reagan, 1986).

The United States Department of Education (1986) has followed up these messages with a plan to create drug-free schools. The Department of Education has developed a framework for discussing the extent of drug use among students and how this epidemic can be stopped. It also recommends strategies for success and describes communities and schools that have succeeded in beating drug abuse in their settings (Bennett, 1986a).

This approach calls for a 12 point plan for achieving schools without drugs. Partnerships must be formed between parents, schools, students and the community. Among the parent responsibilities are to teach children standards of right and wrong, and to be knowledgeable about the signs and symptoms of drug use.

For schools, their responsibilities lie in establishing clear policies and rules regarding chemical use and enforcing those policies fairly and consistently. In addition, schools are recommended to establish a K-12 drug prevention curriculum.
Student responsibilities include learning about the effects of drugs and developing skills to resist the pressures to experiment with mood-altering chemicals. Students are also encouraged to serve as positive peer influences to help other students avoid the use of drugs.

Finally, the plan maintains that communities can assist schools by providing them with the expertise and financial resources of community groups and agencies. Communities can also help by involving law enforcement agencies in the prevention, intervention and enforcement of programs, policies, and laws relating to adolescent drug use and abuse (U.S. Department of Education, 1986).

**Community/Athlete Response**--The drug problem in professional sports has also reached epidemic proportions. Reports of widespread drug use in sports have tainted athletes at every level of participation. Community tolerance for such behavior has reached an all-time low. As a consequence, the community, including business leaders, team owners, and the federal government, have responded.

At the professional level, drug testing is viewed as the only way to remove drugs from the locker rooms and to resurrect the pristine image of athletes. According to one survey, 80 percent of the females and 65 percent of the
males responding agreed that professional athletes should be given tests before games to determine if they have used drugs (Talarigo, 1986).

Each major professional sport approaches the drug problem from a different perspective. The National Basketball Association (NBA) was first to develop a comprehensive drug enforcement policy. The NBA policy was part of a negotiated agreement between the players' representatives and team owners. It is the toughest policy to date in professional sports.

Any player in the NBA who is convicted of, or pleads guilty to, a crime involving heroin or cocaine would be barred from the league for life. The NBA has imposed this penalty on three players within the last eighteen months (Neff & Sullivan, 1986).

The NBA plan also provides for voluntary reporting of drug-related problems. Any player who voluntarily seeks treatment for a drug problem will remain on the team and continue to receive his salary. The team will assume all costs related to the treatment process.

A player voluntarily seeking treatment a second time will be removed from the team and have his pay suspended during the course of rehabilitation. Any drug use thereafter, whether voluntarily reported or not, will result in the player being barred from the league for life.
The NBA plan also provides for reinstatement procedures for players permanently barred from the sport. A player may, after two years, apply to the Commissioner's Office for reinstatement. To return to active duty the player must receive approval from both the league office and the Players' Association.

In the National Football League, the drug program involves education, rehabilitation, and mandatory drug testing in the pre-season. Under the collective bargaining agreement between the NFL and the Players' Association, provisions were made for drug testing. In addition to mandatory pre-season drug tests, a player may be tested during the season, only if the team doctor feels there is probable cause for suspecting a drug problem.

Players are encouraged to volunteer for help through the team physician. Many teams are establishing support groups within the organization. In Cleveland, the Browns were one of the first professional sports teams to institute the support group concept. Their "Inner Circle" program serves as a model for other treatment services available to the professional athlete.

The National Hockey League does not have a uniform drug policy. Each drug-related case is handled differently by the NHL Commissioner. In the past, the Commissioner has
suspended players for an entire season for possession of marijuana or cocaine. Additionally, the league has no set procedures for intervention and treatment of players with drug related problems (Talarigo, 1986).

Professional baseball is the only professional sports organization without a drug program. After the drug trials in Pittsburgh, the owners unilaterally withdrew their agreement on drug enforcement policy. According to the owners, the program was ineffective.

The Commissioner maintains mandatory, random drug testing is the best plan for baseball. Player Association representatives seek a return to the May 1, 1984, policy agreed to by players and management. This policy provides for voluntary disclosure, counseling, and rehabilitation (Thanephon, 1985).

It is clear most professional sport organizations realize the need to move beyond the singular approach of drug testing. Many teams are developing comprehensive programs, combining testing with treatment and prevention strategies. One such program maintains that:

There is a need for a complete player development program in professional sports. We need to start paying attention to the athlete's needs: social, spiritual, legal, housing, educational and financial (Talarigo, 1986, pg.7).
Operating on this belief, a drug treatment program for the Cleveland Browns was established in 1983. The Inner Circle was the first program of its kind for professional athletes. Since that time other professional teams have provided this treatment service for the players.

Korcok (1985) maintains that drug abuse consultants to professional sports are beginning to see measurable relief from the drug use epidemic. One consultant attributes this to three factors. The first factor is the widespread use of urine testing by team physicians. Second, professional organizations have developed educational programs to teach about the hazards of drugs. Third, due to the success of the preceding programs, athletes are recognizing the harmful effects drugs have on performance.

The move to abolish drugs from sports has even reached the high school level. The National Football League has linked with the Drug Enforcement Administration of the U.S. Department of Justice to start a drug prevention program for high school athletes. Co-sponsoring this plan is the National High School Athletic Coaches Association, the International Association of Chiefs of Police, and the National Football League Player's Association.

These community resources work together to provide guidance and direction to high school coaches and athletes. A pamphlet, "For Coaches Only" was printed by the DEA to
offer student-athletes basic information about drug and alcohol abuse (U.S. Department of Justice, 1984a). Since its inception in 1984, the program has organized numerous workshops throughout the country. The DEA estimates that over 10,000 athletes and coaches have been trained to start drug prevention programs in their schools (Mullen, 1984).

The response by members of the community represent one level of response to the growing problem of chemical use in society. The actions previously described have been largely reactive, occurring after the problem had reached epidemic proportions.

A second level of response is both reactive and proactive. The type of action taken by school systems provides for effective intervention as well as provisions for appropriate prevention activities.

RESPONSE WITHIN THE SCHOOL

School/Community Response--School districts have been among the leaders in the fight to create a drug-free climate for young people. To many, education is viewed as the key element in combating adolescent chemical use and abuse. The development of many successful drug education programs has occurred through the effective partnership between schools and communities.
Ohio schools have responded well to the call for community action. Two exemplary programs can be cited. In the Greater Cleveland area, Project C.A.R.E. (Chemical Abuse Reduced by Education), a consortium of over 120 school districts in fifteen contiguous counties, has employed a three-pronged attack to combat adolescent chemical use. The three prongs include Prevention, Intervention, and Law Enforcement (Project Care, 1984).

In this approach, prevention involves expanding awareness of the problem through education. Schools become the main resource for the dissemination of drug education information and in the development of primary prevention programs.

The intervention phase links the efforts of the school with the community. Schools provide the identification and referral services for targeting troubled students. The community provides the necessary facilities for treatment and rehabilitation. Working in partnership, the school and the community intervene to assist students in need.

Support from local law enforcement agencies is the third prong of the program's approach. Communities are enacting laws prohibiting keg parties, while police are enforcing stiffer penalties for drinking and driving. The plan is to hold adolescents accountable through the natural and logical consequences of their chemical use behaviors.
A second model program is in place in the Worthington City School District. The framework for this school-based program also incorporates community involvement. Like Project C.A.R.E., the Worthington program emphasizes education/prevention, intervention/referral, and treatment/follow-up (Quaranta, 1982).

The education/prevention component requires the infusion of drug education into all aspects of the school's curriculum. Emphasis is on the development of decision-making skills, increasing awareness of drug information, and activities to enhance self-esteem and interpersonal relationships.

The intervention/referral area requires a cooperative involvement between the school and various community resources. School-based services, such as individual and group counseling, are combined with system-wide policies for drug use and provisions for referrals to community agencies.

Treatment and subsequent follow-up also demand an effective partnership between the community and school. Agencies providing treatment facilities must maintain an on-going relationship with school personnel. Linkage among these sources is maintained through follow-up procedures.
Support groups are available in the schools for students facing the difficult transition from rehabilitation at the treatment center to recovery in the classroom.

In Los Angeles, Project Drug Abuse Resistance Education (DARE), a cooperative effort between the L.A. Police Department and the L.A. Unified School District, was developed as a primary prevention program (Gates, 1986; "Special Report," 1986). The thrust of the program is to allow young people to develop the necessary skills to resist harmful peer pressure.

Fifth and sixth grade students in the Los Angeles Unified School District were targeted for this program. The curriculum, consisting of seventeen lessons, was authored by health care specialists within the school district. The actual lessons, however, are taught by police officers from the Los Angeles Police Department.

According to Gates (1986), the program has received enthusiastic support from parents and students. Teachers and administrators are equally supportive. An in-house study was undertaken to test teachers' perceptions that Project DARE may actually enhance overall student performance. Student achievement in the first semester (when students were participating in Project DARE) was compared with their academic records the previous year.
The findings show that 50 percent of the students increased their grade point average the semester they were in Project DARE. Additionally, improvements were seen in cooperative behavior and in work habits. These results seem to confirm the teachers' perceptions that students exposed to DARE show academic and behavioral gains.

Programs such as the ones just mentioned meet the special needs of a growing number of students. Schools and communities have responded appropriately to this pressing problem. Nevertheless, this is only half the battle. To effectively deal with adolescent drug use, it is necessary to develop adequate means of prevention through education.

**School/School Response**--As the problem of adolescent chemical use intensified, communities stepped up the pressure on school boards to respond. In 1973, the Drug Abuse Council of Washington D.C. conducted a nationwide study of State Departments of Education. At that time, only eighteen of the thirty-nine states that responded had a uniform drug education policy for public schools ("Drug Abuse Policies," 1984). In recent years the situation has improved.

Hochhauser (1978) noticed the deleterious effects drug use could have on learning. He suggests that the declining Scholastic Aptitude Test (SAT) scores from 1970
through 1975 may coincide with the rising drug use during the same period. Other educators have also recognized the need to address this problem and have proposed ways to thwart the effects of drug use on the educational process.

One type of response undertaken by many school districts is the development of school-based substance abuse programs. Quaranta (1982) has outlined six elements of an effective school program in his staff development program, "Inservice-Staff Development Approach to Substance Abuse Programs in the Schools."

The first component of a school-based program is a written, Board of Education policy on drug and alcohol use. In this current study, roughly 80 percent of the schools surveyed reported their district had a board adopted policy on chemical use or dependency for students.

Establishment of such a policy sets a tone and implies a commitment to the problem as well as a desire to work toward an effective response. The scope of the policy is also important. To be effective the policy must cover procedures for dealing with students and staff involved with illegal aspects of chemicals in school, on the grounds, at school functions, and in similar circumstances (Project CARE, 1984).

In addition, the written policy must set guidelines for intervention, referral, re-entry, and follow-up, as well as
discipline (Worthington Board of Education Policy, 9-38 Drugs and Alcohol Policy, 1983). School systems have also used the Board of Education Policy as a springboard for other action.

The second part of a school substance abuse program includes an education/prevention component. Two ways to incorporate the education/prevention aspects of a program are discussed below.

Preventive drug education is one approach. Students need accurate and timely information regarding the effects of drugs (Hochhauser, 1978). Curriculum infusion of drug-specific information can accomplish this goal. The curriculum is most effective if it is viewed as a kindergarten through senior year experience. Secondly, drug education must be available to school personnel. Through course work or training workshops, teachers, counselors, and administrators can become more aware of the relationship between drugs and adolescent behavior.

A plethora of drug education programs have appeared on the scene in the last decade. Research has taken a critical look at the outcomes of these programs (Kinder, et al., 1980; Schaps et al., 1981; Stainbeck & Rogers, 1983; and Weisheit, 1983). Viewed on a specific outcome basis, the results of the studies are not encouraging. Both
Kinder et al. (1980) and Schaps et al. (1982) concluded that most drug education programs have little effect in changing adolescent attitudes and behaviors regarding chemical use. The Kinder et al. (1980) review tacitly reinforced Stuart's (1974) belief that increased information actually leads to increased use.

According to Kinder et al. (1980) one reason for such poor outcome data is the serious methodological flaws in the studies reviewed. Most of the programs in the review seemed to be based on the idea of presenting factual knowledge alone. This approach was not viewed as a valid method for producing attitudinal and behavioral change. On the contrary, these types of drug education programs were implicated in contributing to adolescent chemical use.

Success in drug education may depend on the perception of the evaluator. Many programs have failed the statistical test carried out by outcome research. According to Kim (1981), the fault may not be with the program but with instruments used to measure outcome data. Stainbeck and Rogers (1983) claim many outcome studies are only concerned with behavior change as a function of increased information. They maintain other variables in drug education need to be addressed. In their study they found fear appeals are successful in strengthening a student's decision not to use chemicals.
Weisheit (1983) gives perhaps the best defense for continuing drug education programs despite their apparent ineffectiveness. He suggests that evaluators, by limiting the focus to adolescent behavior, have ignored the larger social and political context which gave rise to these programs (pg. 75).

Support for these programs continues because educators, as well as parents and community leaders, feel something must be done about this problem.

Drug education has developed a wider focus in the last five years. Programs are being implemented in elementary schools as well as in junior and senior high schools. District policies regarding chemical use are being reinforced with curricular infusion of drug education programs. Primary prevention programs like Casper (Mills, et al., 1983) and Children Are People (Lerner & Naiditch, 1977) for school-aged students, and Quest, Skills for Living (Kirschenbaum and Glaser, 1978) for adolescents are being taught in many school districts.

These programs share a common methodology. Each curricular-based approach utilizes components that build decision-making skills, offer general coping skills, and enhance self-esteem. According to Mooney et al. (1979) and Black (1982), these are the program qualities that have maximum impact on today's student.
It is through these prevention activities that the third component of a substance abuse program is activated. Procedures for early identification and early intervention are important aspects of a school program. One measure of success of a prevention program is the degree to which it turns up alcohol and drug problems (NIAAA, 1983).

Early identification is possible through specific support services for children at risk. Schools have organized concerned persons groups for children of alcoholics to meet the special needs of these students. Teachers may also receive inservice training to enhance sensitivity to the roles children adopt in a chemically dependent family. This type of early identification and intervention is most appropriate in the early school years (Wegscheider, 1981).

At the junior and senior high school level more specific procedures must be established for this component. Staff inservice is also important here. Teachers need specific training to recognize students who need help and to learn how to get them the necessary assistance (Crowley, 1984). Procedures are established that outline the steps in the identification, intervention, and referral process.

Referral and treatment make up the fourth component of a school-based program. Tied closely to this part of the
program is the follow-up component. Teachers may refer students to the school's counseling department or the coordinator of the substance abuse program. Services at this level are either provided within the school setting or referred to community treatment centers.

Students in violation of the school's policy, or those individuals who self-refer may participate in group support services. Insight and support groups are the two types of treatment offered to students within the school. The Community Intervention model describes the insight group as a time-limited, structured series of discussions, presentations, and confrontations regarding the participants' chemical use (Crowley, 1984). The time limit on an insight group is usually eight weekly sessions of one hour in length, for a total of eight hours. After the group terminates, students can be referred for assessment to community treatment centers.

Adolescent treatment centers offer in-patient care for chemically dependent individuals. The nature and length of treatment depends upon the particular center.

Upon release a student re-enters the school setting. Support groups are offered as a means of re-introducing the student to the stresses of the school environment. After-care is an important part of the individual's
treatment plan. Assistance is provided as the student follows through with his/her scholastic and personal-social activities (Muldoon, 1983).

The final aspect of a school's substance abuse program concerns those services provided employees. Adopting an approach used in business and government, some schools now offer employee assistance programs (O'Connell, 1985). In addition, drug and alcohol policies approved by school boards also impact on the staff as well as the students. Support services are also available to classified and certified personnel.

State Departments of Education are beginning to mandate the inclusion of guidelines on drugs, alcohol, and tobacco in the minimum standards for schools. In Ohio, The Department of Education calls for the implementation of a program on the harmful effects of drugs, alcohol, and tobacco in a school's written guidance plan ("A K-12 Written," 1983).

Within the last year a reemphasis on drug education has emerged. Programs and policies are being developed that affect both the curricular and extracurricular life of the student. These attempts have reached beyond the classroom. One approach emphasizes athletics and the role of the coach in preventing chemical abuse in the student
athlete. A second response involves the development of code of conduct policies for athletic eligibility.

**School/Athlete Response**--In the past, myths about athletes blinded parents and school officials from recognizing the problem of drugs in sports (Dawson, 1984; Rooney, 1984). Today, few people deny that drug use and abuse among high school athletes is a serious problem. The difficulty lies in the methods used to respond to the problem.

According to Trethric (cited "Waging War on Drugs," 1985), of the Drug Enforcement Administration, the popularity of sports in this country allows athletics to be a natural vehicle to stimulate interest in the problem of adolescent drug use. Schools are responding to the problem by combining education, prevention, and intervention components as a means of inhibiting chemical use among athletes ("Young Athletes," 1985).

College and university athletic programs are also cracking down on the use of chemicals among amateur athletes. Ninety-six NCAA schools have adopted a policy using urinalysis testing to detect the use of illegal substances and performance enhancing drugs. This approach has become a matter of policy in NCAA sanctioned championship events in all sports (Worden, 1986).
According to a recent survey on drug education and testing by the NCAA Drug Education Committee, there is considerable variance in drug related programs and policies in college athletic departments (National Collegiate Athletic Association, [NCAA] 1984). Of the 510 schools that responded, only 17 percent reported a drug/alcohol education program currently in operation. Even fewer schools, 11 percent, reported a program in operation for coaches and other staff.

Policies of NCAA schools regarding drug testing, and the treatment of student athletes with chemical dependency problems were also investigated by the survey. Thirty percent of the colleges and universities responding, reported a plan for treating and rehabilitating athletes with a drug problem.

Nevertheless, only 10 percent of the schools reported using drug tests to identify the extent to which student athletes are using and abusing drugs and alcohol. In those athletic departments where drug testing was in operation, 73 percent of the programs reported were mandatory, while 68 percent report having a specific written policy outlining the procedures for testing.

The NCAA study found that schools reporting drug testing plans differed in their response to athletes who tested positive for chemicals. Over half (57%) of the
schools reported placing the athlete in a drug education program or referring him/her to counseling. According to the survey, the next most utilized response was to do nothing. This occurred in 19 percent of the schools. Other actions taken included: time-limited suspension (13%), removal from the team (4%), removal from school (4%), a talk with the coach (4%), and extra sprints or calisthenics (2%).

Using the developments within the NCAA as a model, high schools have teamed with community and government agencies to provide training in chemical awareness to parents and coaches. The development of school-based programs and policies affecting student athletes was a result of the combined efforts of athletic associations and school districts at the national, state and local levels.

In Minnesota, the Hazelton Foundation developed a Sports Education Program available to schools throughout the country. Hazelton-Cork provides training, workshops, and presentations for athletes, coaches, and directors of activities/athletics (Griffin, 1985). This project has been endorsed by the National Federation of State High School Associations.

The National Federation has also teamed up with the Drug Enforcement Administration and the National Football
League to provide two-day prevention workshops for student athletes and coaches. Their publications, "For Coaches Only" and "Team Up For Prevention," provide guidelines for establishing a school based prevention program (U.S. Department of Justice, 1984a, 1984c).

In the January issue of the National Federation News, the Chemical Health Resource Center reports that over 12,000 student athletes, parents, athletic directors, and coaches have received training in the first nine months of this nationwide program. The success of the program was based on attracting school leaders to play an active role in promoting drug-free messages throughout the school.

Objectives of the National Federation's Student Leadership Program include:

1. The development of peer leadership skills.
2. Support for students, coaches, advisors, and staff, experiencing personal problems.
3. Encouragement of a healthy life-style which includes safe and appropriate decisions about the non-use of mood-altering chemicals.
4. Development of trust between student-athletes/leaders, coaches, athletic directors, activity advisors, and parents.
5. The development of special programs to meet local needs and special interests ("Workshops Benefit," 1986, pg. 17).

These national education/prevention programs appear to share a common theme. They focus on the role of the coach
in a drug education program for athletes. Coaches can have a powerful and positive impact on young people. Eyden (1984), however, maintains coaches must first become effective "team players" by receiving training, and learning new skills in identifying and confronting drug problems. Secondly, they must enforce the school-based drug policy along with the district's requirements for athletic eligibility.

National education/prevention programs are important and necessary. Nevertheless, standing alone, they fall short of resolving the problem of chemical use among high school athletes. Based on the federal initiative, state high school athletic associations and local school districts have responded with policies and programs that stress intervention and treatment.

The Minnesota State High School League (MSHSL) developed a model policy for athletic eligibility that covers the use of mood-altering chemicals by student athletes. Penalties and recommendations are set forth in Article VI, Section Four of the MSHSL Policy. These procedures cover all Category I activities, which includes interscholastic athletics is included (MSHSL, personal communication, September 7, 1985).

Interventions, for students violating the stated policy include specific punishments and recommendations
for education and treatment of the problem. Suspensions from participation are progressively more severe for repeated violations. Students, however, are always provided the chance for reinstatement through the participation in school sponsored, support services or by seeking treatment.

A similar policy is being recommended to the Massachusetts Interscholastic Athletic Association (MIAA) by a Blue Ribbon Committee On Chemical Awareness. Like the Minnesota Plan, this proposal combines penalties for chemical use with opportunities for rehabilitation.

The MIAA policy suggests a two-step process for student violations. After confirmation of the first violation, the student athlete will lose eligibility for the next two interscholastic events or for two weeks of the season, whichever is greater. After a second or subsequent violation, the student shall miss twelve events or twelve weeks of the season. Under the proposed policy, a student may be reinstated on the athletic team after six weeks if he/she volunteers for treatment in an approved chemical dependency treatment center (W. Sargent, personal communication, September 9, 1985).

Under both the Minnesota and the Massachusetts policies, the penalties for drug use violations are
cumulative. The procedures cover a student athlete's entire athletic career at any level of interscholastic competition.

In Wisconsin, Article XXVII of the Wisconsin Interscholastic Athletic Association (WIAA) Handbook mandates, under its rules for athletic eligibility, that a school have a code of conduct for its athletes. The WIAA state policy does establish minimum standards for in-season violations of Article XXVII. A suspension of no less than one game or meet will be levied against any athlete using or possessing alcohol, tobacco, and/or any controlled substance. School districts are expected and encouraged to establish standards for all other provisions of their athletic codes of conduct policy (D. E. Herrmann, personal communication, September 5, 1985).

A less uniform approach was taken by the Pennsylvania Interscholastic Athletic Association (PIAA). Although the PIAA's Board of Control passed a resolution on "The Use of Mood-altering Chemicals by Secondary Student-Athletes," the resolution does not establish a statewide policy governing chemical use by athletes (R. T. Werner, personal communication, September 6, 1985).

It does however, reaffirm the PIAA's commitment to involve coaches, school personnel, and students in confronting the problem. The resolution also encourages
each member school district to provide drug/alcohol education programs for students involved in interscholastic athletics.

The position of the Pennsylvania Interscholastic Athletic Association is similar to most state high school associations. In the absence of a uniform, statewide policy, the state associations suggest that each school district establish its own eligibility rules or codes of conduct for athletes.

Of the thirty-three state high school athletic associations that responded to an informal survey of state policies governing chemical use in athletics, only Minnesota had a statewide policy in place. Most responses indicated their state was considering a written policy similar to the Minnesota model.

An interesting response was received from the Iowa High School Athletic Association (IHSAA). The IHSAA had recently declared that individual schools in Iowa establish their own rules and regulations regarding athletes and substance abuse. At one time Iowa had a statewide code of conduct policy regarding chemical use. That rule was struck down by the Iowa Supreme Court, thus requiring each school to adopt its own policy (B. Saggau, personal communication, September 7, 1985).
The legality of statewide substance abuse policies like the Minnesota model may have to stand the test of time. Nevertheless, the problem remains and schools must continue to respond. Throughout the country, states have responded by providing programs that promote chemical health in the student athlete.

According to a summary of chemical health programs appearing in the National Federation News ("Chemical Health," 1985), many states had actively responded to the chemical health challenge. The Connecticut Interscholastic Athletic Conference co-sponsored a series of one-day student leadership workshops with Hazelton-Cork and the McDonald's Corporation.

The Michigan High School Athletic Association (MHSAA) also held chemical awareness workshops for coaches and athletic directors, as well as principals and other school personnel. Future planning includes three coaches' workshops per year for the next three years in Michigan. In addition to coaches' workshops, the MHSAA proposes offering programs on "training trainers" and other school support personnel.

In New Hampshire the State Athletic Association and the Department of Education combined to present a coaches' workshop in the fall of 1985. Other programs are being planned.
The Indiana High School Athletic Association (IHSAA) has already conducted five chemical health workshops in the past year. Two representatives from each member school district attended the workshops. The IHSAA designated that one participant must be an administrative representative while the other could include a coach, counselor, school board member, or activity advisor.

In June of 1985 Hazelton-Cork and the National Federation conducted a state-wide meeting in Iowa on substance abuse. Over 200 school administrators and athletic directors attended the workshop. As an outgrowth of that meeting, the Iowa High School Athletic Directors Association, the Iowa High School Athletic Association, and the Iowa Girls' High School Athletic Union, co-sponsored four regional substance abuse workshops around the state. The workshops were presented by Hazelton-Cork with coordination and support from the National Federation.

Ohio also held chemical awareness workshops throughout the state. Approximately 200 coaches, team captains and student leaders were in attendance at the three programs sponsored by the Ohio High School Athletic Association.

In addition to the programs offered at the state level, individual school districts are responding to the problem by establishing codes of conduct rules for student
activities, including athletics (Bartos, 1985). Ohio schools are taking advantage of Substitute House Bill No. 421 which allows local school districts to provide procedural standards for students participating in extracurricular activities.

In Bay Village, Ohio, the Bay Board of Education passed a student activities code for the middle school and the high school. The policy covers all hours of the school year including vacations, and violations that occur off school grounds. According to the school's superintendent, the activity code is an attempt to standardize the procedures for dealing with chemical abuse in all school related organizations and activities (Bartos, 1985).

The Rocky River School District has also adopted a student activity code. All Rocky River students who participate in athletics and/or non-credit student activities (grades 7-12) are affected by the code.

Other Ohio school districts have limited the training rules to students involved in athletics. In the Kenston Schools, athletes are held accountable under the student discipline code adopted by the Board of Education. If, however, a violation involves the use of tobacco or other mood-altering chemicals, a separate discipline code has been developed and is enforced.
This policy, similar to the one in Bay Village, covers all student actions including those off school grounds and at non-school functions. In addition to prohibiting the use of chemicals, the Kenston policy also forbids acts of insubordination and hazing (F. Barr, personal communication, August, 1986).

Athletes in the Parma City School District must sign a contract regarding chemical use in order to participate in interscholastic athletics. The Worthington City Schools also require athletes to have a signed, training rules card on file in the athletic office as a prerequisite for participation. Both school policies supplement the rules and regulations established by the school's discipline code (R. Tarnowski, personal communication, August, 1986).

Common characteristics of the student activity codes and the athletic training rules described above are the procedures used to enforce the regulations. Similar to the Minnesota State High School League Policy, violations of these codes result in a combination of time-limited suspensions and recommendations for rehabilitation.

School systems, as well as state and national athletic associations, have responded to the problem of adolescent chemical abuse using a similar approach. All stress a need to offer educational programs as one means of prevention. In addition, all three sources of support recognize the
need for appropriate intervention. As a result, punitive policies of the past have given way to procedures that combine behavioral consequences with opportunities for rehabilitation and growth.

ATHLETE RESPONSE

Athlete/Community Response--Individual athletes at the professional, college and scholastic levels are joining the fight against adolescent chemical use. College and professional athletes are spreading their anti-drug message through the use of public service announcements (PSA's) over radio, television, and in the printed media.

Many players work with community agencies to sponsor PSA's directed at the young athlete. The United Way has been a leader in using the professional and collegiate athlete in public service announcements. Sixty-second spots appear regularly during televised games, showing how the players and community respond to the drug epidemic among young people.

The Sports Drug Awareness Program of the Drug Enforcement Administration has teamed up with nationally recognized sports stars and The National Association of Broadcasters (NAB) to produce public service announcements against drug use. According to a DEA news release, the "Team UP" series will use baseball, hockey, and basketball
celebrities in association with the Sports Drug Awareness Program to continue the battle against chemical use by young people (Mullen, 1984).

The first PSA featured the Commissioner of the NFL and the President of the NFL Players Association. Their message, along with a 30 minute program on substance abuse, was sent out in September, 1985 on TELEJOURNAL, NAB's monthly satellite feed ("Sports Drug Awareness," 1985).

In Ohio, the Cleveland Indians and Project CARE collaborated on a PSA aired during most of the Indians seventy televised games. The sixty-second spots encouraged young people to seek help from support people such as school counselors and Project CARE coordinators. The PSA concludes with the team members reminding young people that it's "OK to say NO to drugs" (R. DiBiasio, personal communication, August, 1985).

The Commissioner of professional baseball claims these messages serve a dual purpose. They use recognized sports figures to promote anti-drug attitudes, while also serving to restore the tarnished image of professional sports (Thanepohn, 1985).

**Athlete/School Response**—Due to the paucity of research in this field and because athletes are just beginning to mobilize their efforts, the final two areas
are limited in the extent of their response. It has only been within the last year that athletes have actively provided formal services to school districts and interscholastic associations as well as their colleagues.

In the state of Washington, members of the Seattle Seahawks, Mariners, and Supersonics have teamed with the Washington Interscholastic Athletic Association (WIAA) to increase chemical awareness among young people. Their poster "Score Touchdowns, Homeruns, and Slamdunks - Without Drugs" is sent to each WIAA member school district throughout the state (J. R. Truant, personal communication, October 2, 1985).

As a part of a new policy, the WIAA, in collaboration with the state's professional teams, will sponsor radio and television productions to increase chemical awareness. The goal of the public service announcements is to use athletes to promote the idea of a healthy, drug-free lifestyle to young student athletes.

A former All-Pro football player is also involved in working with school districts to change student attitudes about drug and alcohol. His consulting firm, Triumph Life Center in Minneapolis-St. Paul, uses athletes to spread the message to young people and their parents that athletics and chemicals don't mix (Eller, 1986).
In California, Pros For Kids, uses credible male and female athletes in a dedicated effort to reduce drug abuse among young people ("Pros Help Tackle," 1986). Established in 1982 by two former San Francisco 49ers, Pros For Kids takes prevention programs directly to schools and communities. The organization is also involved with treatment as well as education and prevention. Pros For Kids provides outpatient counseling services for adolescents and adults through their Balance Center.

Athletes/Athlete Response—Athletes helping athletes and athletes helping other students was the thrust behind the DEA's Sports Drug Awareness Program. The goal of the program was to prevent drug abuse among school-age youth by utilizing the power, interest, and impact of organized sports (U.S. Department of Justice, 1984a). This program placed special emphasis on the role of the coach and the student athlete, particularly the team captain.

These key individuals in the schools will disseminate drug abuse prevention information to the other student athletes. Ultimately the Sports Drug Awareness Program endeavors to reach the 5.5 million high school athletes in this country. The appeal of sports and the use of athletes at every level of competition has become a popular approach in the war against adolescent chemical use.
SUMMARY

Chapter II has reviewed the research and relevant literature regarding drugs and youth, drugs in athletics and the response to adolescent chemical use. A number of conclusions can be drawn from this review.

While most researchers agree that adolescent chemical use has reached epidemic proportions, there is great diversity of opinion regarding the antecedents to this problem. Two opposing views of adolescent addiction have emerged.

One view supports the notion that alcoholism and drug addiction is a progressive disease with specific stages of addiction (Jellinek, 1973; Kinney & Leaton, 1978). The other view supports the notion that personal-social variables are at the heart of adolescent substance abuse. Among these variables are cultural and environmental factors (Jessor & Jessor, 1975), family influences (Reilly, 1975; Hostetler, 1981), and peer influences (Adler & Lotecka, 1973, Johnston et al., 1984; Segal, 1980).

A second conclusion drawn from the literature review is that chemical use and abuse is a special problem for specific groups like athletes. The myth that athletes are immune to chemical dependency problems is being challenged
by studies like Rooney's (1984) that conclude that sports participation has little effect on the use of mood-altering chemicals by adolescents.

Other studies indicate that athletes may even be more vulnerable to the chemical use. At both the professional and interscholastic levels, drugs are viewed as potential performance boosters capable of providing the competitive edge (Percy, 1980; Dyment, 1987). In addition, athletic participation may actually contribute to an individual's sense of social isolation and weakened coping skills, thus increasing the tendency toward chemical use.

Third, the literature demonstrates that within the past five years communities, schools, and athletes, have been vigilant in their response to the problem of adolescent substance abuse.

Community response has often resulted in legislative action to provide funding and support for drug interdiction, enforcement, education, and treatment. In addition, communities have linked resources with schools and athletic organizations to develop positive prevention programs for young people (Crowley, 1984; Talarigo, 1986).

School districts across the country have actively assumed responsibility for the development of effective prevention and intervention programs in drug education. In partnership with community leaders, schools have developed
model programs that stress prevention, early identification, and treatment (Quaranta, 1982). A significant part of these programs is the training of staff, students, and parents in adolescent chemical use and dependency.

Schools have also responded to the problem by revising or creating uniform chemical use policies for all students. These policies establish guidelines and consequences regarding the possession, use, and/or sale of controlled substances at school. Many schools have taken this response one step further. Programs and policies have been established for special student groups like athletes and individuals involved in other extracurricular activities.

This latter approach is particularly true for the student athlete. Schools are moving in the direction of creating activity codes of conduct for athletes that also stress education, prevention, and appropriate intervention. Schools are beginning to recognize that any response to adolescent chemical use must be flexible enough to address the special issues of specific student groups.

Athletic organizations have also responded to the problems of drugs in sports. At the professional and collegiate level, athletes are producing public service announcements that encourage youths to make drug-free
decisions. In addition, associations that represent professional athletes are involved with management in negotiating appropriate drug prevention and intervention programs. Finally, at the scholastic level, young athletes have teamed up with nationally recognized sports figures to produce training programs on drug awareness.

The information in this review provides a background for the research questions addressed in this study. Chapter III presents the methodology employed to respond to the research questions.
CHAPTER III
RESEARCH METHODOLOGY

This chapter provides information regarding the population, procedures, and instruments used in this study. In addition, procedures used to analyze the data are presented.

The purpose of the investigation was to determine the current status of drug and alcohol prevention activities in Ohio high schools as they relate specifically to student athletes. A second objective of the study was to generate recommendations at the state and local level for a comprehensive drug and alcohol prevention program. Four themes, Policy, Staffing, Programs, and Inservice, were used to classify the research questions to determine the frequency with which these variables exist in Ohio high schools.

This study utilized a descriptive research design that collected data through an extensive mail survey. Survey data yielded classification of high schools by a number of different variables. These include:

- Board adopted chemical dependency policy for students
- Board adopted chemical dependency policy for employees
An employee assistance program

A K-12 Written Guidance Program

A drug and alcohol coordinator position

Short term programs to develop drug and alcohol awareness for: students
athletes
staff
parents
community

Extensive inservice training programs on chemical dependency for: students
staff
parents
community

Locally conducted surveys on chemical use and dependency to assess student knowledge, attitudes, and use

Specific aspects of a school based chemical use and dependency program that includes the following:
identification and referral system for students
ongoing relationship with community agencies
in-school support group for students
preventive education programs in grades K-12
a budget for a district-wide drug education
core teams or building teams
parent support groups
school sponsored AA, NA, and Alanon meetings

Training on adolescent chemical use and dependency for: staff
coaches
student athletes

Drug/alcohol policy violations by student athletes

Resources used by school districts for chemical use or dependency related services.

Once the survey data were analyzed to yield the classifications above, they were crosstabulated by variables identified in the research problem statement, to
answer the research questions of the study. The three variables included the OHSAA Regional District of the school, the Type of School, and the OHSAA Classification for the high school.

This study was conducted with the help of the Ohio High School Athletic Association. The OHSAA is a voluntary, unincorporated, non-profit association of public and private high schools and junior high schools. This association regulates, supervises, and administers interscholastic competition among its member schools (OHSAA, 1986).

The Ohio High School Athletic Association was founded in the late 1800's as a result of discussions held by the Western Ohio Superintendent's Roundtable. In the spring of 1908, the first state high school championship was sanctioned by the OHSAA. By that time the OHSAA had expanded to its current level of six regional districts statewide. From its humble beginnings of one state championship in 1908, the OHSAA presently sanctions state championships in 12 sports for boys and in 9 sports for girls (Dafler, 1985).

The OHSAA is also a member of the National Federation of State High School Athletic Associations. The National Federation consists of the 50 individual state high school
athletic and/or activities associations. The OHSAA Handbook (1986, pg. 139) describes the federation's purpose as "coordinating the efforts of the member associations toward the ultimate objectives of interscholastic activities."

Each state organization follows certain basic beliefs outlined by the National Federation. One such belief holds that:

> Participation in interscholastic activities is a privilege to be granted to those students who meet the minimum standards of eligibility adopted cooperatively by the schools through their state associations, and those additional standards established by each school for its own students (OHSAA Handbook, 1986; pg. 139).

This tenet directly relates to the central purpose of this investigation. Local school districts are beginning to develop standards of eligibility that directly address the issue of chemical use by student athletes.

**RESEARCH SETTING**

The research setting for this study was the 821 high schools in the state of Ohio. The setting includes those drug education programs and policies available in any particular high school, and the faculty, staff, and student population therein.
Student athletes participate in interscholastic sports as a privilege of maintaining proper eligibility standards established by the Ohio High School Athletic Association and the local school district. This study investigated student athletes to ascertain the impact school-based drug prevention programs had on athletic eligibility and participation.

In 1984-85, the OHSAA sponsored state championships in 12 boys' sports and 9 girls' sports. Overall, the OHSAA sponsors 12 interscholastic sports for boys and 11 for girls.

Table 1 showed the level of participation in Ohio High School Athletic Association sanctioned team sports for boys and girls. This table represented the total student athlete population at the time of the study.

Figures under the teams heading represented the number of high schools participating in that particular sport, while the figures under the student headings described the number of boys and girls participating in their respective team sports. At the time the study was undertaken over 240,000 students on over 10,000 teams participated in OHSAA sanctioned athletic competition. The data presented is representative of the 821 high schools in the state of Ohio.
<table>
<thead>
<tr>
<th>Sport</th>
<th>Boys Teams</th>
<th>Boys Students</th>
<th>Girls Teams</th>
<th>Girls Students</th>
</tr>
</thead>
<tbody>
<tr>
<td>Baseball</td>
<td>766</td>
<td>21,516</td>
<td>796</td>
<td>16,794</td>
</tr>
<tr>
<td>Basketball</td>
<td>791</td>
<td>18,772</td>
<td>796</td>
<td>16,794</td>
</tr>
<tr>
<td>Cross Country</td>
<td>645</td>
<td>9,545</td>
<td>544</td>
<td>4,539</td>
</tr>
<tr>
<td>Field Hockey</td>
<td>28</td>
<td>814</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Football</td>
<td>718</td>
<td>36,727</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Golf</td>
<td>620</td>
<td>7,605</td>
<td>20</td>
<td>174</td>
</tr>
<tr>
<td>Gymnastics</td>
<td>37</td>
<td>266</td>
<td>128</td>
<td>1,691</td>
</tr>
<tr>
<td>Ice Hockey</td>
<td>38</td>
<td>804</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Soccer</td>
<td>275</td>
<td>9,163</td>
<td>115</td>
<td>3,038</td>
</tr>
<tr>
<td>Softball</td>
<td></td>
<td></td>
<td>556</td>
<td>13,421</td>
</tr>
<tr>
<td>Swimming</td>
<td>213</td>
<td>2,841</td>
<td>234</td>
<td>2,993</td>
</tr>
<tr>
<td>Tennis</td>
<td>442</td>
<td>6,833</td>
<td>346</td>
<td>4,483</td>
</tr>
<tr>
<td>Track and Field</td>
<td>751</td>
<td>25,879</td>
<td>753</td>
<td>20,790</td>
</tr>
<tr>
<td>Volleyball</td>
<td>756</td>
<td>17,152</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Wrestling</td>
<td>577</td>
<td>17,994</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Totals</strong></td>
<td><strong>5,873</strong></td>
<td><strong>157,945</strong></td>
<td><strong>4,276</strong></td>
<td><strong>85,889</strong></td>
</tr>
</tbody>
</table>
Within the setting of Ohio high schools, the OHSAA has divided member schools into six regional districts. The figures in Table 2 represented the number of high schools in each region and the statewide percentage for schools within the OHSAA's six regions. Figures also represented the number of schools in each region from which a survey was returned, and their respective regional percentage.

TABLE 2
Regional Comparison of Ohio High Schools vs. School Response Returned by High School Personnel

<table>
<thead>
<tr>
<th>Region</th>
<th>Total Schools</th>
<th>% of Total</th>
<th>School Response</th>
<th>% of Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>Central</td>
<td>95</td>
<td>12</td>
<td>65</td>
<td>12</td>
</tr>
<tr>
<td>East</td>
<td>59</td>
<td>7</td>
<td>39</td>
<td>7</td>
</tr>
<tr>
<td>Northeast</td>
<td>252</td>
<td>31</td>
<td>167</td>
<td>30</td>
</tr>
<tr>
<td>Northwest</td>
<td>170</td>
<td>21</td>
<td>130</td>
<td>22</td>
</tr>
<tr>
<td>Southeast</td>
<td>76</td>
<td>9</td>
<td>53</td>
<td>9</td>
</tr>
<tr>
<td>Southwest</td>
<td>169</td>
<td>21</td>
<td>109</td>
<td>20</td>
</tr>
<tr>
<td>Totals</td>
<td>821</td>
<td>100</td>
<td>563</td>
<td>100</td>
</tr>
</tbody>
</table>
To be representative, the percentage of respondents from each region must closely approximate the total percentage. For example, in the Central district, the 95 high schools in that district represented 11.6 percent of all Ohio high schools. The 65 Central district high schools that responded to the survey made up 11.5 percent of the schools responding. The results summarized in this table indicated that the percentage of response for those schools returning a survey was representative of the high schools throughout Ohio in the six OHSAA regions.

The demographic representativeness of the schools within the research setting, was further demonstrated by comparing the type of schools within the state and their respective rates of response to the survey. Table 3 divided the 821 Ohio high schools into five types of school districts; City Schools, Exempted Village Schools, Local Schools within a county system, Diocesan Schools, and other Private Schools. The total sample size of 819 excludes the two state supported schools, the Ohio School for the Blind, and the Ohio School for the Deaf.

Each type of school was compared to the percentage of schools from which a survey was returned for that type of district. The results of the comparison are summarized in Table 3.
TABLE 3

Response Rate of High School by Type of School Districts: Total Schools vs. Respondents
N = 819

<table>
<thead>
<tr>
<th>Type of School</th>
<th>Total Schools</th>
<th>% of Total</th>
<th>School Response</th>
<th>% of Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>City Schools</td>
<td>279</td>
<td>34</td>
<td>202</td>
<td>36</td>
</tr>
<tr>
<td>Exempted Village</td>
<td>48</td>
<td>6</td>
<td>31</td>
<td>6</td>
</tr>
<tr>
<td>Local School District</td>
<td>388</td>
<td>47</td>
<td>275</td>
<td>49</td>
</tr>
<tr>
<td>Diocesan Districts</td>
<td>83</td>
<td>10</td>
<td>47</td>
<td>8</td>
</tr>
<tr>
<td>Other Non-Public</td>
<td>21</td>
<td>3</td>
<td>8</td>
<td>1</td>
</tr>
<tr>
<td>Totals</td>
<td>819</td>
<td>100</td>
<td>563</td>
<td>100</td>
</tr>
</tbody>
</table>
PROCEDURE

In the spring of 1985, with the assistance of the Ohio High School Athletic Association, the Chemical Use and Dependency Survey was mailed, first class, to the principals in all of Ohio's 821 high schools. Using the principals' mailing list, each high school principal was mailed a copy of the instrument. Instructions indicated the survey was to be completed by the staff member most knowledgeable about the school's drug and alcohol education programs.

Returns reveal that a wide variety of school personnel participated in responding to the survey. Of the surveys that had the respondents position recorded, 60 percent were completed by high school principals, and 23 percent were returned from athletic directors. The remaining range of staff members responding included: drug/alcohol coordinators (5%), other administrators (4%), school counselors (3%), other staff (3%), and athletic coaches (2%).

Table 4 summarized the frequency of response of school personnel who completed the Chemical Use and Dependency Survey, and also indicated their position in the district.
<table>
<thead>
<tr>
<th>School Position</th>
<th>Frequency</th>
<th>Percentage</th>
<th>Cumulative Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Principal</td>
<td>295</td>
<td>60</td>
<td>60</td>
</tr>
<tr>
<td>Athletic Director</td>
<td>114</td>
<td>23</td>
<td>83</td>
</tr>
<tr>
<td>Drug/Alcohol Coordinator</td>
<td>25</td>
<td>5</td>
<td>88</td>
</tr>
<tr>
<td>Other Administrator</td>
<td>20</td>
<td>4</td>
<td>92</td>
</tr>
<tr>
<td>School Counselor</td>
<td>16</td>
<td>3</td>
<td>95</td>
</tr>
<tr>
<td>Other (Teacher, Nurse)</td>
<td>14</td>
<td>3</td>
<td>98</td>
</tr>
<tr>
<td>Athletic Coach</td>
<td>13</td>
<td>2</td>
<td>100</td>
</tr>
<tr>
<td>TOTALS</td>
<td>497</td>
<td>100</td>
<td>100</td>
</tr>
</tbody>
</table>
After the initial mailing, 552 surveys were returned for a return rate of 67 percent. A follow-up letter was sent to those high schools from which no survey was returned, and/or the form was received but did not identify the school, principal, or athletic director. An additional 11 surveys were returned in the second mailing for a final return rate of 68.6 percent.

The surveys were tabulated using Fortran coding sheets to establish an initial frequency and percentage analysis. Each high school on the principals' mailing list was assigned a three-digit code for scoring purposes. The codes range from 001 for Ada High School to 821 for Zane Trace High School.

In addition to coding each survey for its individual responses, all 821 schools were coded for demographic data. The demographic data included the OHSAA regional district of each school, the school's county, boys and girls OHSAA classification for team sports, OHSAA sanctioned team sports offered at each school, and the type of individual school district.

Three limitations existed within this mailing procedure. First, the surveys were all mailed directly to the high school principal and not to the drug/alcohol coordinator in those schools with such a position. This
may have prevented staff members working directly with the school's drug and alcohol program from contributing their expertise regarding the school's drug and alcohol programs and policies.

Second, the mailing did not account for any position changes in building level administration. Since each survey was personally addressed to the principal whose name appeared on the mailing list, any personnel changes at that level may have affected the return rate.

The third limitation concerns the problems of large AAA high schools responding on a school-wide or district-wide basis. In many cases the school districts with more than one single high school had programs that varied from school to school. Therefore, attempts to generalize information may have been confusing for personnel in the larger schools.

INSTRUMENTATION

This study was undertaken with the awareness that Ohio high schools currently have in operation many outstanding programs in drug/alcohol education. Nevertheless, it was equally clear that little information was available to assess the extent and impact these programs have statewide. An instrument was needed to provide data on the existing programs, resources, and needs for each school district.
The Chemical Use and Dependency Survey was developed by the author, and Dr. Joseph J. Quaranta of The Ohio State University, in consultation with the Chemical Awareness Committee of the Ohio High School Athletic Association. The design of the survey was to address the concerns mentioned above, and to determine the implications these high school programs have for the student athlete. The survey construction followed a review process involving both a literature review and a critique by a panel of experts.

Four surveys were found that addressed school involvement with drug and alcohol issues. At the college and university level the NCAA Drug Education Committee conducted a survey of 793 member universities (NCAA, 1984). The survey focused on the programs and policies in athletic departments and their implications for the college athlete.

Another resource used in the construction of the Chemical Use and Dependency Survey was the Hazelton Foundation in Center City, Minnesota. The Hazelton Foundation has developed a survey/checklist to assist individual school districts in a review of their programs in chemical awareness education. The survey, "A Checklist For Assessing School Chemical Health Policy,
Procedures and Prevention Efforts" is also used to implement policy procedures and program decisions (Hazelton Cork, 1984).

The format of the Hazelton survey utilized a thematic approach to assist a school district's review of their current drug education program. The instrument was organized into four themes; administrative concerns, staff training issues, prevention activities, and treatment questions.

Other resources used in developing the instrument for this study were surveys conducted by Project CARE in Ohio, and by the Kansas State High School Activities Association (KSHSAA). The Project CARE Status Survey looked at the progress of school-based programs in the Northeastern Ohio area. Particular emphasis was placed on the community resources used by schools and on the extent staff members were trained in chemical dependency education (F. Barr, personal communication, September, 1986).

The Drug And Alcohol Issues Survey used by the Kansas State High School Athletic Association was a statewide assessment of drug and alcohol abuse programs in member schools. The survey focused on five areas. One survey item focused on the clarification of consequences for violating rules related to the use of drugs and alcohol, as stated in the school's policy. A second item
assessed the existence of board adopted codes of conduct for the general student population. The third item focused on special policies for students who participate in extracurricular activities.

The fourth question investigated the extent staff members and coaches have been trained in alcohol and drug abuse education/prevention. The fifth area asked respondents to indicate if athletes and their parents are required to attend a pre-season meeting, conducted by coaches, for the purpose of clarifying policies including those related to drug and alcohol use/abuse. A follow-up question asked respondents to indicate if they favored the KSHSAA providing services for member schools in the area of drug and alcohol use/abuse (C. Casselman, personal communication, September 3, 1985).

The intent and the scope of the Kansas survey was very similar to the objectives of this study. Questions on the Chemical Use and Dependency Survey appeared to measure the same areas of drug and alcohol issues as the surveys mentioned above. This provided one measure of the validity of the instrument used in this study. Persons responding to this instrument were able to accept the items posed as a valid measure of their schools' chemical dependency programs and policies.
Once the items for the Chemical Use and Dependency survey were identified, the instrument was submitted to a panel of experts for consideration and to establish a measure of its content validity. The committee reviewing the instrument included high school administrators, college professors, specialists in the field of drug and alcohol education, and community leaders involved in the prevention and intervention/treatment aspects of chemical dependency.

This panel was asked to determine the validity of the survey items in assessing the extent drug and alcohol prevention programs, policies, and staff development activities are in place in Ohio high schools. The members of the panel reported the survey items were representative of the content areas being measured in Ohio high schools. Their judgement of the representativeness of the items insures, to a reasonable degree, the content validity of the survey.

Once the questions of the validity of the instrument were satisfied, the survey was submitted to the Ohio High School Association's Committee on Chemical Dependency. The committee reviewed the survey as a second test of its content. They also found the items to be representative of the areas being measured. With confirmation of the
survey's ability to measure what it purports to measure, it was mailed to the 821 high schools principals in Ohio.

DATA ANALYSIS

Both descriptive and inferential statistics were computed in this study. First, the data were checked for accuracy and computerized. Second, frequency tables were computed for each variable and re-checked for accuracy, and corrected as necessary. Third, frequency tables were again computed for every variable using the corrected data. Fourth, chi-square analyses were computed for all contingency tables suggested by the research questions. The chi-square analysis tested the independence of the samples in the analysis at the .05 level of significance (Isaac & Michael, 1979).

When expected frequencies were less than 5, Yates correction for continuity was used to prevent the chi-square test from being overestimated and thus leading to erroneous conclusions (Downie & Heath, 1974). Similarly, Yates corrected test was applied for all 2 X 2 contingency tables with greater than 21 cases. When there were fewer than 21 cases in 2 X 2 tables, Fisher exact test was applied.
SUMMARY

Chapter III described the methodology employed in conducting this research. The findings of the study are presented in Chapter IV. Chapter V will discuss the summary, conclusions, and recommendations of the study.
Chapter IV presents the results of the statistical analysis of the self-reported data accumulated in this study. The primary focus of the investigation was to describe the current status of drug and alcohol prevention activities in Ohio high schools as they relate to the student athlete. A second objective was to generate recommendations for a comprehensive drug and alcohol program at the state and local levels.

The specific research questions in the study were divided into four areas of investigation. Each question focused on a particular area of school administration. The four themes explored were: Policy, Staffing, Programs, and Inservice.

An initial step in the data analysis was the presentation of frequency tables that provided a distribution of the survey responses. This presented an overview of the status of drug education services in Ohio high schools, as perceived by school personnel.

Second, a chi-square analysis was run for each survey item under the four themes investigated. Chi-square was used with the frequency distributions as a test of
statistical significance to insure that the differences in the data were not caused by chance. The survey items were crosstabulated by Ohio High School Athletic Association region (R), type of school district (T), and Ohio High School Athletic Association classification (C) for team sports.

The regional data were based on the OHSAA's division of the state into six interscholastic regions, the Central, East, Northeast, Northwest, Southeast, and Southwest Districts. This is in accordance with Article 5, Section 8 of the OHSAA Constitution (OHSAA Handbook, 1986).

Ohio high schools were also classified by the type of school district. Using the Ohio Educational Directory as a guide, this study categorized the 821 high schools as either City schools, Exempted Village schools, Local schools within a county system, Diocesan schools, and other Private schools.

In addition, the OHSAA has three levels of classification for team sports. Teams are classified according to the number of boys (for boys sports) and the number of girls enrolled in the school's high school. Schools with the smallest enrollment are Class A schools, moderate sized high schools are Class AA and large schools are Class AAA. According to Bylaw 2, Section 1, Item 2 (2-
1-2), one third, or as near to one third of the member schools will be assigned to each classification (OHSAA Handbook, 1986).

A fourth type of classification was used for this study. Schools with boys team sports and girls team sports classified in different categories, and those districts with enrollments of all boys or all girls, were identified as schools with mixed classifications.

The remainder of this chapter will provide the data necessary for answering the subsidiary questions under the four themes. Each theme will be discussed by first presenting the frequency distribution for each item, and second discussing the results of the chi-square analysis.

**Theme 1: Policy**

Board of Education policies refer to a written and approved course of action enforced by the school district. In this section of the questionnaire, the survey items dealt with board action concerning the use and abuse of chemicals by staff, students, and athletes. The respondents answered these, and the remaining questions by indicating "YES", "NO", or "DON'T KNOW" for each item. The frequency and percentage distributions for the survey items under Theme 1, Policy are presented in Table 5.
Table 5  
Distribution of Frequency and Percentages for Theme 1, Policy Questions for the Chemical Use And Dependency Survey

<table>
<thead>
<tr>
<th>Survey Item</th>
<th>YES</th>
<th>NO</th>
<th>DK</th>
<th>%</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Does the school district provide the following:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Board adopted chemical use or dependency policy for students.</td>
<td>445</td>
<td>101</td>
<td>9</td>
<td>80</td>
<td>18</td>
</tr>
<tr>
<td>2. Board adopted chemical use or dependency policy for employees.</td>
<td>128</td>
<td>375</td>
<td>48</td>
<td>23</td>
<td>68</td>
</tr>
<tr>
<td>3. School has an employee assistance program.</td>
<td>50</td>
<td>458</td>
<td>46</td>
<td>9</td>
<td>83</td>
</tr>
<tr>
<td>Drug/alcohol policy violations: During the 1984-1985 school year were student athletes in your district:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>20a. Suspended from athletic participation? If yes, how many?</td>
<td>229</td>
<td>257</td>
<td>55</td>
<td>42</td>
<td>47</td>
</tr>
<tr>
<td>20b. Referred for assessment? If yes, how many?</td>
<td>156</td>
<td>315</td>
<td>60</td>
<td>29</td>
<td>59</td>
</tr>
<tr>
<td>20c. Referred for counseling? If yes, how many?</td>
<td>176</td>
<td>302</td>
<td>62</td>
<td>33</td>
<td>66</td>
</tr>
<tr>
<td>20d. Entered an in/out patient treatment program? If yes, how many?</td>
<td>95</td>
<td>375</td>
<td>67</td>
<td>18</td>
<td>70</td>
</tr>
</tbody>
</table>
Survey Item 1--The data reported by school officials indicated that board adopted chemical use or dependency policies were more likely to be established for the entire student body, then for specific groups such as employees and athletes. With regard to the existence of a policy for students, 80 percent of the school officials responding indicated that their school had such a policy.

Survey Items 2 & 3--In comparison, only 23 percent of Ohio high schools reported a chemical use and dependency policy for staff members. Further, the response from school personnel indicated that less than one out of every ten (9%) high schools in the state had an employee assistance program in place.

The data also provided information on the extent school board policies have affected student athletes during the 1984-85 school year. This study identified four ways schools responded to drug and alcohol policy violations by high school athletes. Student violations resulted in schools suspending athletes from participation, referring them for assessment and/or counseling, and in some cases, having students enter in- or out-patient treatment programs.

Survey Items 20a, 20b, 20c, & 20d--In 42 percent of the schools, officials reported students were suspended
from athletic participation for violating the chemical use policy. A third (33%) of the respondents indicated that schools referred students for counseling due to drug/alcohol policy violations. In 29 percent of the high schools, student athletes were referred for assessment. Nearly one respondent in five (18%), indicated that their school district had student athletes who required treatment for chemical dependency.

A review of the nominal data indicated that while schools were more likely to report suspending athletes for drug/alcohol violations, more students (698) were referred for counseling than were suspended (676).

Significant Differences: Policy

School board policies that impact on the students and staff were the first to be crosstabulated. Based on the self-reported data from school officials, regional differences were found only among those schools reporting board adopted policies for students. The degree of significance for this item was found at the p< .02 level, based on a chi-square value of 21.01 with 10 degrees of freedom.

Each survey item was crosstabulated by the OHSAA region, type of school, and OHSAA classification. A summary of the differences is presented in Table 6.
<table>
<thead>
<tr>
<th>Survey Item</th>
<th>X2</th>
<th>df</th>
<th>p &lt; .05</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Board adopted chemical use and dependency policy for students.</td>
<td>21.01</td>
<td>10</td>
<td>.02</td>
</tr>
<tr>
<td>R =</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Board adopted chemical use and dependency policy for employees.</td>
<td>18.64</td>
<td>8</td>
<td>.01</td>
</tr>
<tr>
<td>R =</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. School provides an Employee Assistance Program.</td>
<td>37.63</td>
<td>8</td>
<td>.00</td>
</tr>
<tr>
<td>R =</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>20a. Athletes suspended for drug/alcohol policy violations.</td>
<td>27.03</td>
<td>8</td>
<td>.007</td>
</tr>
<tr>
<td>R =</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>20b. Athletes referred for assessment for policy violations.</td>
<td>22.63</td>
<td>10</td>
<td>.01</td>
</tr>
<tr>
<td>R =</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>20c. Athletes referred for counseling for policy violations.</td>
<td>19.97</td>
<td>10</td>
<td>.02</td>
</tr>
<tr>
<td>R =</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>20d. Athletes entered an in/out patient treatment program for drug/alcohol policy violations.</td>
<td>19.33</td>
<td>10</td>
<td>.03</td>
</tr>
<tr>
<td>R =</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Level of Significance for OHSAA Regional District (R), Type of High School (T), and OHSAA Classification (C)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Differences by OHSAA Region--As noted earlier, board adopted chemical use and dependency policies for students were reported in eight out of ten Ohio high schools. Response rates for the schools with student policies ranged from 89 percent of the districts in the Central region to a low of 68 percent for schools in the East. Regions falling between these two points were the Northeast, Southwest, Northwest, and the Southeast. The percentage of schools in these regions reporting student policies were; 86, 82, 75, and 69 percent, respectively.

Schools in the Central, Northeast, and Southwest regions exceeded the state average for this item. These regions contained the following three largest metropolitan areas in the state: Columbus, Cleveland, and Cincinnati. Based on the self-reported data from school personnel, the districts surrounding these areas appeared most likely to adopt board policies regarding student chemical use.

Regional differences were found among Ohio high schools for those districts referring students for assessment, counseling, and treatment. No significant differences by region were observed for those schools suspending students from athletic participation.

The chi-square value of 22.63 with 10 degrees of freedom ($p < .01$) indicated that school referrals for
student chemical use assessment were statistically significant by OHSAA region. Referrals for assessment were reported in 37 percent of the schools in the Southwest, 36 percent of Central Ohio schools, and in 32 percent of the districts in the Northeast. School systems in the Southeast, Northwest and East regions reported response rates below the mean for the state. Specifically, in the Southeast, 28 percent of the schools report referring students for assessment. This was followed by 21 percent of the schools in the Northwest and 14 percent in the East.

Regional differences were also found among districts that referred students for counseling due to violations of the school drug policy. The level of significance for this item was $p < .02$, based on a chi-square value of 19.97 with 10 degrees of freedom.

Counseling referrals for student athletes were reported much more frequently in schools in the Northeast and Central region of the state. The rate of response for the six regions ranged from 40 percent of the schools in the Northeast to a low of 22 percent in the East. Within the range, schools in the Central and Southeast region exceeded or equaled the state average with rates of 38 and 33 percent, respectively. Schools in the Southwest (31%) and the Northwest (26%) reported response rates that fell below the mean.
Staff in Ohio high schools also reported referring student athletes to treatment centers for drug and alcohol policy violations. According to the chi-square value with 10 degrees of freedom of 19.33 (p < .03) for this item, region and schools that have had students enter an in/out patient treatment center are statistically significant.

Based on data reported from school personnel, schools in the Northeast and Central regions were more likely to refer students to treatment for chemical dependency problems. Twenty-two percent of the schools in both regions reported referring student athletes for in-patient or out-patient treatment. Following close behind was the Southwest region, where 21 percent of the schools reported treatment referrals for student athletes. The regions falling below the state average were the Southwest (16%), Northwest (12%), and the East (6%).

Schools employed a variety of consequences when enforcing their drug policies for students. Students were either suspended or referred for assessment, counseling, and/or treatment. The self-reported data suggested region influenced the extent to which schools choose to enforce that policy. The greatest percentage of schools referring students for assistance were reported in the Northeast, Central, and Southwest region of Ohio.
Districts in these regions were significantly more likely to have had students referred than those schools in the more rural regions of the Northwest, Southeast, and East.

**Differences by Type of School**--Chemical use policies for employees were reported much less frequently than comparable policies for students. Nevertheless, the type of school was found to significantly affect both the implementation of board adopted chemical use policies for employees and the existence of employee assistance programs in Ohio high schools. Differences among schools with employee policies were found at the p< .01 level of significance. The differences among those schools with EAP's were significant at the p< .00 level. The resulting chi-square values with 8 degrees of freedom were 18.64 and 37.63, respectively.

Of the schools reporting board adopted chemical use policies for employees, Private schools led the way with a 33 percent response rate. The percentage of other schools with this type of policy were; City schools, 31 percent; Diocesan schools, 28 percent; Local schools, 18 percent; and Exempted Village schools, 10 percent.

Significant differences among the type of schools are more clearly illustrated by comparing City schools with Local districts. City schools accounted for 36 percent of
all schools responding. Forty-nine percent of the schools studied were classified as Local districts within a county system. When schools with policies for employees were accounted for, the representation of these schools was reversed. Forty-eight percent of the respondents reporting employee policies were from City schools. Conversely, Local schools represented slightly more than one-third (38%) of the districts reporting such a policy.

A similar pattern was found among the 9 percent of Ohio high schools that reported providing an employee assistance program. The range of response flowed in the same direction. Private School officials reported 29 percent of their districts with EAP's. This was followed by City schools, Diocesan schools, and Exempted Village and Local schools, with response rates of 16, 7, and 4 percent, respectively.

Once again, City and Local schools represented the extreme differences found among the various types of schools. For this item, City and Local districts represented 36 and 49 percent of the sample surveyed, respectively. Nevertheless, City districts represented 64 percent of all the schools with employee assistance programs. Comparatively, Local schools accounted for 22 percent of the districts reporting EAP's.
According to the reports from school officials, City school systems clearly led in providing chemical use policies and services for employees. They were followed by Private and Diocesan schools. Local schools, on the other hand, were not as likely to provide these services to employees.

The type of school was also found to affect the enforcement of a district's drug and alcohol policy. Significant differences were observed for student suspension, referral for assessment, referral for counseling, and for entering an adolescent treatment center.

Schools that reported suspending students from athletic participation were significantly different by type of school. The differences found for this item were significant at the p< .007 level, based on a chi-square value of 27.03 with 8 degrees of freedom.

Sixty-six percent of Exempted Village schools reported suspending students for drug policy violations. Suspensions from athletic participation were also reported in 48 percent of City schools, 38 percent of Local schools, 33 percent of Diocesan schools, and 13 percent of Private schools.

Differences noted earlier between Local and City schools were maintained for this item. City schools
accounted for 36 percent of all schools surveyed, but they represented 41 percent of all schools that reported suspending student athletes. Local schools, conversely, made up 49 percent of the schools in the study, while accounting for 44 percent of the schools enforcing the chemical use policies by suspending students.

School districts that referred students for assessment were also affected by type of school. The resulting chi-square value of 34.71 (p< .00) indicated statistical significance between type of school and a school's use of student referrals for substance abuse assessment.

Differences were greatest between Diocesan and City schools, and Local school districts. Three types of school systems reported response rates greater than the statewide percentage. They were: Diocesan, 40 percent; City, 38 percent; and Private schools, 37 percent. Reports from Exempted Village and Local school districts fell significantly below the state average of 29 percent, with response rates of 25 and 21 percent, respectively.

City and Local schools maintained the significant differences mentioned above. City districts represented 47 percent of the schools reporting student referrals for assessments, even though they accounted for just over one-third (36%) of the total sample. Conversely, Local schools
made up 49 percent of the sample, but just 36 percent of the schools that reported referring student athletes for assessment. According to the data reported by school officials, as a percentage of the total sample surveyed, Local schools tended to be under-represented and City districts over-represented for the type of school that referred students for assessment.

The same pattern was observed for the relationship between type of school and schools referring student athletes for counseling. The chi-square value of 30.93 ($p < .00$) indicates that referring students for counseling is statistically significant with the type of school.

As a percentage of schools referring students for counseling, Local districts, once again represented the low end of the range. Twenty-six percent of the Local districts reported referring students for counseling, compared to 40 percent of the Diocesan and City schools. Both Exempted Village and Private schools reported 38 percent of their districts have used this type of policy enforcement.

The data for schools that have had students enter treatment programs provided a slightly different pattern. Twenty-seven percent of Diocesan schools and 25 percent of Private schools reported having student athletes enter treatment, as a consequence of drug policy violations.
City schools followed with a response rate of 22 percent. Each of these types of schools exceeded the average of 18 percent for all state high schools. Local and Exempted Village schools completed the range with 14 and 11 percent, respectively.

**Differences by OHSAA Classification**—Schools that reported board policies for students and employees, and those reporting provisions for EAP's, were found to be significantly affected by school size. The chi-square values for each item were; 15.50 ($p < .01$) for student policies, 21.67 ($p < .001$) for employee policies, and 33.35 ($p < .00$) for those districts with employee assistance programs.

Throughout Ohio, 80 percent of the high school officials reported having a board policy regarding student chemical use and dependency. In AAA schools, 88 percent of the respondents reported this policy. Of the schools with mixed classifications, 81 percent reported student policies. In AA and single A schools, however, the percentages fell below the state figure, with reported rates of 78 and 74 percent, respectively.

Respondents in twenty-three percent of Ohio high schools reported having a board adopted chemical use policy for employees. Once again, AAA schools and those in the
mixed classification reported a greater percentage of their districts having employee policies than schools with smaller class enrollments.

For AAA districts, employee policies were reported in 33 percent of the schools. Twenty-eight percent of mixed classified schools also reported this type of policy. In single A schools 19 percent of staff members indicated their schools have adopted employee policies. This was true in only 16 percent of the schools classified AA.

The same pattern was found for schools with employee assistance programs. Once again, AAA and mixed classification schools reported the highest percentage of districts with EAP's. These two classifications significantly exceeded the statewide percentage of 9 percent with reported response rates of 16 and 14 percent, respectively. Employee assistance programs were reported in only 6 percent of the AA schools and in 4 percent of the single A districts.

The Ohio High School Athletic Association has organized the classification system so that AAA, AA, and A schools would be equally represented throughout the state. According to the results reported by school officials, the representative balance among the three classifications was not maintained.
For these three policy items, AA schools accounted for 32 percent of the total respondents, followed by AAA with 31 percent, and single A with 27 percent. Nevertheless, among all schools with board adopted policies for employees, AA and A schools each accounted for just 23 percent of the total. Triple A school systems, however, represented nearly twice that percentage. They made up 44 percent of all the schools that reported employee policies. In addition, AAA districts accounted for 54 percent of all schools with employee assistance programs.

Based on the response from staff members, schools that reported drug and alcohol policies for students and employees were found significantly more often in districts with larger enrollments. Triple A high schools and districts in the mixed classification category consistently reported percentages that exceeded the state average for schools with student policies, employee policies, and EAP's.

School enforcement of chemical use and dependency policies for student athletes is also affected by class size. In each of the four referral areas, significant differences were reported among schools classified A, AA, and AAA. The pattern that emerged indicated that larger school systems enforced policy violations more often than the smaller districts. The chi-square value of 41.46
(p < .00) for suspension, 58.31 (p < .00) for assessment, 49.99 (p < .00) for counseling, and 14.81 (p < .00), all indicated statistical significance by OHSAA classification.

Staff reports indicated that student athletes in AAA and AA schools were suspended more frequently for drug policy violations than their peers in single A and mixed classification districts. Forty-eight and 47 percent of AAA and AA schools reported suspending students in their athletic program. The response reported for single A and mixed schools were 34 and 35 percent, respectively. The average for all state high schools was 42 percent.

Referring students for assessment was also reported more often among AAA schools. In 39 percent of the AAA schools, athletes violating the drug and alcohol policy were referred for chemical dependency assessment. Triple A schools were twice as likely to take this step as single A districts. Only 19 percent of all Class A schools reported referring student athletes for assessment. Mixed classification districts and AA schools reported response rates of 33 and 29 percent, respectively.

In addition, AAA schools represented 40 percent of all schools that reported referring students for assessment, even though they accounted for 30 percent of the total sample. As a comparison, single A schools made up 27
percent of the high schools in the study, but accounted for just 17 percent of the ones that reported having referred student athletes for assessment.

The larger school districts also reported using counseling referrals more frequently than smaller school districts. Thirty-eight percent of the AAA schools and 35 percent of the AA systems reported enforcing their school's drug policy by referring students for counseling. In mixed classification schools, 33 percent of the high schools reported counseling referrals. For single A schools, close to one-fourth (24%) of the school districts reported referring student athletes for counseling for drug and alcohol policy violations.

The policy enforcement indicative of the most serious substance abuse problem resulted in the referral of student athletes to a treatment center. Staff in 18 percent of Ohio high schools reported making referrals of this type. Once again, AAA and AA schools were the type of districts most likely to report having referred students for treatment. Twenty percent of all AAA schools and 19 percent of the AA schools reported referring student athletes to in-patient or out-patient treatment. This was reported in 13 percent of single A schools.

According to the data reported by school officials, Ohio high schools have attempted to respond to the current
epidemic of adolescent substance abuse. Written drug and alcohol use policies for students and staff are in place in many schools. In addition, the data reported indicate that OHSAA region, type of school, and OHSAA classification significantly influenced the extent to which these policies have been utilized in Ohio schools.

School board policies for students and staff, and enforcement of the policies for student athletes were reported more frequently in schools located in the large metropolitan regions of the state. These schools could be further described as City schools, classified AAA by the Ohio High School Athletic Association.

Theme 2: Staffing

Staffing questions focused on the staff development approaches used by Ohio high schools to combat adolescent chemical use. These approaches included the hiring drug/alcohol coordinators and the staff development training of teachers and coaches. The frequency data for the staffing questions are presented in Table 7.

Survey Item 5--In Ohio, 182 high schools, one-third (32%) of those responding, reported a drug/alcohol coordinator position in their school. For most schools
TABLE 7
Distribution of Frequency and Percentages for Theme 2, Staffing Questions for the Chemical Use and Dependency Survey

<table>
<thead>
<tr>
<th>Survey Item</th>
<th>YES</th>
<th>NO</th>
<th>DK</th>
<th>%</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>5. Does the School have a Drug/Alcohol Coordinator Position?</td>
<td>182</td>
<td>373</td>
<td>6</td>
<td>32</td>
<td>66</td>
</tr>
<tr>
<td>Full Time Coordinator</td>
<td>55</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Part Time Coordinator</td>
<td>147</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>17. Have staff received training on adolescent chemical use and dependency?</td>
<td>391</td>
<td>142</td>
<td>25</td>
<td>70</td>
<td>25</td>
</tr>
<tr>
<td>If yes, how many attended:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3 - 5 day sessions</td>
<td>2104</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1-2 day sessions</td>
<td>1803</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>less than one day</td>
<td>2146</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>18. Have coaches been trained in adolescent chemical use and dependency?</td>
<td>254</td>
<td>254</td>
<td>52</td>
<td>45</td>
<td>45</td>
</tr>
<tr>
<td>If yes, how many attended:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3-5 day sessions?</td>
<td>296</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1-2 day sessions?</td>
<td>602</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Less than one day?</td>
<td>321</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
this is a part-time position. Of the 202 drug/alcohol coordinators identified, 72 percent (147) were reported as part-time personnel.

**Survey Item 17**--The data from school personnel indicated that many school districts have provided staff training in adolescent chemical use and dependency. Seventy percent of the respondents reported their districts offered training activities for staff members. Training workshops included: 3-5 day sessions, 1-2 day sessions, and sessions lasting less than one day. In Ohio, 6,053 school officials were reported to have received training in adolescent chemical use.

**Survey Item 18**--Of the school districts responding, 45 percent also reported providing special chemical dependency training for coaches. The data reported indicated that throughout the state, 1,219 high school coaches have received training.

**Significant Differences: Staffing**

According to the self-reported data, staff development approaches were influenced by a school's regional location, type of school, and school size. Table 8 presents the summary data for Theme 2, Staffing questions.
Table 8

Summary Table for the 3 Survey Items Which Indicate Significant Differences for Theme 2, Staffing by Chi-Square, Degrees of Freedom, and Level of Significance for OHSAA Regional District (R) Type of High School (T), and OHSAA Classification (C)

<table>
<thead>
<tr>
<th>Survey Item</th>
<th>X2</th>
<th>df</th>
<th>p&lt; .05</th>
</tr>
</thead>
<tbody>
<tr>
<td>5. A drug/alcohol coordinator position at the high school.</td>
<td>R = 55.45</td>
<td>10</td>
<td>.02</td>
</tr>
<tr>
<td>17. Staff members have received training on adolescent chemical use or dependency.</td>
<td>R = 57.31</td>
<td>10</td>
<td>.00</td>
</tr>
<tr>
<td>18. Coaches have received training on adolescent chemical use or dependency.</td>
<td>R = 65.11</td>
<td>10</td>
<td>.00</td>
</tr>
</tbody>
</table>

Differences by OHSAA Region--In Ohio, 32 percent of the high schools reported a drug/alcohol coordinator in their district. The chi-square value of 55.45 (p< .02) indicated that this variable is statistically significant by OHSAA region. According to the regional data, these positions were heavily concentrated in three regions of the state.
The percentage of schools that reported having drug/alcohol coordinators ranged from 48 percent in the Northeast area of the state to 8 percent in the East region. The remainder of the regional representation reported was: 36 percent Southwest, 35 percent Central, 23 percent Northeast, and 14 percent Southeast.

The heaviest concentration of schools with drug/alcohol coordinators was reported in the Northeast. This region accounted for 30 percent of the total respondents, yet 44 percent of the schools in the Northeast reported having drug/alcohol coordinators. Conversely, the Eastern region accounted for 7 percent of the schools in the total sample, but only 2 percent of the schools reporting coordinators.

Once again, the data reported from school officials indicated that the regions with larger urban-suburban districts were more likely to have drug coordinators as a part of the high school staff. The four regions with the largest urban centers accounted for 95 percent of the schools reporting coordinators. A breakdown of the regions shows schools in the Northeast with 44 percent, the Southwest 21 percent, the Northwest 17 percent, and the Central region with 13 percent.

Another component of the staffing theme involved the extent to which schools are training staff members in the
area of chemical use and dependency. Staff training for adolescent chemical dependency showed significant differences according to the school's regional location. The chi-square value of 57.31 (p< .00) indicated this statistical significance between the schools that train staff and its OHSAA region.

School districts in the Northeast represented the top of the range, reporting that 36 percent of the schools have provided training for staff members. Schools in the Eastern districts, on the other hand, represented the bottom end, accounting for only 4 percent of the schools that offered staff training.

According to the data reported by school personnel, districts in the Northeast have taken the lead in training staff members in the area of adolescent chemical use and abuse. Of the 164 schools in this region responding to this survey item, 141 or 86 percent reported providing training for school personnel.

Regional differences were also reported among those schools providing chemical dependency training for interscholastic coaches. Statistical significance was indicated by the chi-square values of 65.11 (p< .00) for region. The larger urban school districts were more likely to offer training in adolescent chemical dependency
to high school coaches. Once again, schools in the Northeastern region top the state in the percentage of school districts providing training services for coaches. In the Northeast region, 66 percent of the schools reported having training in adolescent chemical use or dependency.

At the opposite end, schools in the Southeast region reported only 16 percent of the school districts provided training for coaches. Regions within the range of schools that reported providing coaches with training activities included; the Southwest, 51 percent; the Central, 43 percent; the Northwest, 32 percent; and the Southeast with 25 percent.

Differences by Type of School--The type of school was also significantly related to whether or not a district was likely to employ a drug/alcohol coordinator. The chi-square value with 8 degrees of freedom 64.05 (p< .00) indicated that a drug coordinator position in high schools was statistically significant by type of school.

Within the different type of schools, City districts reported having the highest percentage of high schools employing either full or part-time coordinators. Specifically, 48 percent of the City schools reported having coordinators in their districts. Local districts represented the low end of the range with a response rate of 19 percent. The middle portion of the range was filled
by Diocesan schools, 47 percent; Exempted Village schools, 29 percent; and other Private schools, 25 percent.

A significant result in this analysis indicated that the two largest groups, Local districts (274 schools) and City schools (201) represented opposite ends on the range of response. Local school systems accounted for 48 percent of the total school population. Nevertheless, they represented only 29 percent of the high schools with drug/alcohol coordinators. Conversely, City schools made up 36 percent of the total respondents, but they comprised over half (53%) of the districts with coordinators.

These reported findings suggest that City schools and, to a lesser extent, Parochial and Private schools, were much more likely to employ drug/alcohol coordinators than Local schools within a county system. Schools with the most comprehensive drug education programs continue to be found in City school systems.

Type of school was also significantly related to the extent to which schools train staff members. The chi-square value of 24.66 (p < .001) indicates statistical significance by type of school.

Seventy percent of the high schools in Ohio reported providing staff training on adolescent chemical use or dependency. According to school type, the districts that
reported staff training most frequently were Diocesan and City schools, with response rates of 83 and 79 percent respectively. The three other types of schools studied, reported percentages that fell below the state average. Specifically, 65 percent of Exempted Village, 63 percent of Private, and 62 percent of Local Schools reported training staff members.

The data reported suggested that each type of school was actively providing staff development in the area of adolescent chemical dependency. Regardless of the type of school, districts tended to provide staff training in the same percentages as their total representation. Diocesan and City schools in slightly higher proportions, and the other types in slightly lower proportions.

The differences reported by the respondents (p< .00) indicated that City schools provided significantly more training for coaches than other types of school. Of the 200 City districts responding to this item, 120 (60%) reported that coaches have received training. Local districts represented the low end of the range with 34 percent of the districts reporting this type staff development activity.

The differences between City and Local schools were even greater when the percentage of "YES" respondents were
compared to the total number of schools responding. Close
to half (49%) of the schools responding were Local
districts, yet they accounted for just over a third (36%)
of the schools that reported coaches had received training
on adolescent chemical use and dependency. Conversely,
City schools accounted for almost half (47%) of the
districts that reported training coaches, while comprising
just over one-third (36%) of the total schools surveyed.

Exempted Village and Diocesan schools reported 48 and
49 percent of their districts provide coaches with training
in chemical use and dependency. Even though these types of
schools made up a small percentage of the total, their
relative frequency of response indicated a willingness to
provide staff members with information to combat adolescent
drug use and abuse.

**Differences by OHSAA Classification**—Sharp differences
were also found when drug/alcohol coordinators were viewed
as a function of school size. Schools reporting
coordinators increased in proportion to their OHSAA
classification. The resulting chi-square value of 98.84
(p< .00) indicates that the employment of drug coordinators
and school size is statistically significant.

For single A schools, 10 percent of the 155 schools
indicated they employed drug/alcohol coordinators. The
percentages reported for AA and AAA schools were 25 and 54
percent, respectively. Schools in the mixed classification category reported 51 percent of these districts have hired drug/alcohol coordinators. According to the self-reported data, the frequency of response for AAA schools was five times as great as Class A and twice the rate for Class AA schools.

This pattern was maintained even when schools with coordinators were viewed as a percentage of the total respondents. Class A schools made up 28 percent of the sample and 9 percent of the schools reporting drug/alcohol coordinators. Schools with mixed representation accounted for 9 percent of the total, and 15 percent of those schools reporting coordinators. Double A districts represented 32 percent of the schools surveyed and one-fourth (25%) of those with coordinators. Finally, AAA schools made up 31 percent of the total sample, but they accounted for 51 percent of the schools that reported having drug/alcohol coordinators on staff.

Differences among those schools providing staff training were also found for districts with different OHSAA classification. This is confirmed by the resulting chi-square value of 31.80 (p< .00) for this item.

While all schools were actively involved in staff development, the data indicates that larger districts were
more likely to report training for staff personnel in adolescent chemical dependency. Within the classifications, 84 percent of the AAA schools reported they provided this type of training. In comparison, 63 percent of AA and 59 percent of Class A schools report similar training activities for staff.

Compared to total representation, AAA schools and those districts with mixed classifications reported more frequent involvement in staff training. Triple A schools made up 31 percent of the schools responding and 37 percent of the schools reporting staff training. Similarly, mixed schools accounted for 9 percent of the sample, and 11 percent of the respondents reporting training programs. For single A schools the figures were reversed. These districts made up 28 percent of the total sample, but they accounted for only 23 percent of the districts reporting staff training.

A significant relationship (p< .00) was also found between school size and those districts providing training for coaches. As noted above, larger AAA schools reported more specialized training in chemical awareness for coaches in their districts. Twice as many AAA schools reported coaches had received training compared to single A school districts. Among those districts that reported
coaches had been trained on adolescent chemical dependency, 43 percent were AAA, 27 percent were AA, and 21 percent were single A.

Triple A schools also topped the range of response within the various classifications. Sixty-three percent of AAA schools reported training for coaches, compared to 42 percent for schools with mixed classifications, 38 percent for AA and 34 percent for single A school districts.

According to the data reported by school officials, staff training in adolescent chemical use and dependency occurred most often in AAA schools. This was particularly evident when the training activities were designed for a specific population like high school coaches.

Sixty-three percent of the 174 AAA schools responding have had coaches receive training. This is almost twice the percentage of Class A (34%) and AA (38%) schools that provide comparable training for coaches. According to this survey item, school size was significantly related to the staff development opportunities for interscholastic coaches in Ohio high schools.

Theme 3: Programs

The third theme investigated in this study was the extent to which drug education programs were in operation within Ohio high schools. In this study, programs referred
to any planned activity, implemented by school districts in response to adolescent chemical use and dependency problems.

School-based drug programs were viewed as both developmental; emphasizing prevention, and educational; focused on increasing student awareness and knowledge. Programs also included intervention and referral strategies that provide ongoing support services to students in need. In addition, comprehensive substance abuse education programs provided direct and indirect treatment/follow-up services to students and staff.

A summary of the frequency distribution results, for items under Theme 3 Programs, is presented in Table 9. This table addressed the extent to which Ohio high schools were involved in drug education programming, and the type of activities used to carry out such programs.

Survey Item 4--A majority of Ohio high schools reportedly have used their K-12 written guidance plan to provide a developmental framework for drug/alcohol education and prevention activities for their districts. This plan, with provisions regarding chemical use and dependency instruction, was reported in 58 percent of the high schools responding to this survey.
TABLE 9

Distribution of Frequency and Percentages for Theme 3, Program Questions for the Chemical Use and Dependency Survey

<table>
<thead>
<tr>
<th>Survey Item</th>
<th>YES</th>
<th>NO</th>
<th>DK</th>
<th>%</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Does the School District Provide the Following?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. A K-12 Written Guidance program regarding chemical use or dependency?</td>
<td>318</td>
<td>190</td>
<td>36</td>
<td>58</td>
<td>35</td>
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<tr>
<td>6. Does the School District Provide Short Term Programs To Develop Drug and Alcohol Awareness for:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>a. Students?</td>
<td>503</td>
<td>57</td>
<td>3</td>
<td>89</td>
<td>10</td>
</tr>
<tr>
<td>b. Athletes?</td>
<td>304</td>
<td>228</td>
<td>5</td>
<td>57</td>
<td>42</td>
</tr>
<tr>
<td>c. Staff?</td>
<td>308</td>
<td>232</td>
<td>7</td>
<td>56</td>
<td>43</td>
</tr>
<tr>
<td>d. Parents?</td>
<td>278</td>
<td>255</td>
<td>9</td>
<td>51</td>
<td>47</td>
</tr>
<tr>
<td>e. Community?</td>
<td>244</td>
<td>284</td>
<td>9</td>
<td>45</td>
<td>53</td>
</tr>
<tr>
<td>8. Has the School District Conducted Local Surveys On Chemical Use and Dependency To Assess:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>a. Student Knowledge?</td>
<td>292</td>
<td>243</td>
<td>23</td>
<td>52</td>
<td>43</td>
</tr>
<tr>
<td>b. Student Attitudes?</td>
<td>298</td>
<td>233</td>
<td>23</td>
<td>54</td>
<td>42</td>
</tr>
<tr>
<td>c. Student Use?</td>
<td>298</td>
<td>234</td>
<td>22</td>
<td>54</td>
<td>42</td>
</tr>
</tbody>
</table>

Does the School District Provide the Following:
Table 9 (continued)

<table>
<thead>
<tr>
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<th>NO</th>
<th>DK</th>
<th>%</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>9. Identification and referral system?</td>
<td>476</td>
<td>78</td>
<td>7</td>
<td>84</td>
<td>14</td>
</tr>
<tr>
<td>10. An ongoing relationship with community agencies?</td>
<td>510</td>
<td>40</td>
<td>12</td>
<td>91</td>
<td>7</td>
</tr>
<tr>
<td>11. In-school support groups for students?</td>
<td>307</td>
<td>249</td>
<td>5</td>
<td>55</td>
<td>44</td>
</tr>
<tr>
<td>12. Preventive education programs in grades K-12?</td>
<td>292</td>
<td>234</td>
<td>30</td>
<td>52</td>
<td>42</td>
</tr>
<tr>
<td>13. A budget for a district wide drug program?</td>
<td>123</td>
<td>399</td>
<td>34</td>
<td>22</td>
<td>72</td>
</tr>
<tr>
<td>14. Core teams as a part of the school drug program?</td>
<td>232</td>
<td>314</td>
<td>14</td>
<td>41</td>
<td>56</td>
</tr>
<tr>
<td>15. Parent support groups?</td>
<td>168</td>
<td>371</td>
<td>22</td>
<td>30</td>
<td>66</td>
</tr>
<tr>
<td>16. Does your school district host meetings for AA, NA, and/or Alanon?</td>
<td>68</td>
<td>463</td>
<td>27</td>
<td>13</td>
<td>83</td>
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</tbody>
</table>

Indicate resources/services used in school's drug program:

<table>
<thead>
<tr>
<th>Indicate resources/services used in school's drug program:</th>
<th></th>
<th></th>
<th></th>
<th>%</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>22. Other school districts?</td>
<td>133</td>
<td>235</td>
<td>53</td>
<td>32</td>
<td></td>
</tr>
<tr>
<td>23. Publicly funded drug and alcohol agencies?</td>
<td>366</td>
<td>67</td>
<td>46</td>
<td>76</td>
<td></td>
</tr>
<tr>
<td>24. Private treatment or training/education centers?</td>
<td>265</td>
<td>130</td>
<td>53</td>
<td>59</td>
<td></td>
</tr>
<tr>
<td>25. Individuals with expertise in chemical use or dependency?</td>
<td>257</td>
<td>128</td>
<td>50</td>
<td>59</td>
<td></td>
</tr>
</tbody>
</table>
Survey Item 6a--The self-reported data indicated that school districts are providing programs aimed at increasing student awareness with respect to drugs and alcohol. By far, most schools reported directing their short-term chemical awareness programs to student populations. In this study, 89 percent of the schools responding provided this type of student programming.

Survey Items 6b, 6c, 6d, 6e--It was reported, however, that schools were reaching beyond the classroom to provide awareness programs for other groups. Programs for student athletes were reported in 57 percent of the schools, while staff programs were identified in 56 percent of the schools. Many schools also reported providing programs designed to increase the awareness of parents (51%) and the community (45%)

Survey Item 12--Developmental approaches to drug education programs were also reported in other sections of the school curriculum, outside the areas of guidance and counseling, and health education. Staff members reported that drug prevention activities of this type, were implemented in 52 percent of Ohio schools.

Survey Items 8a, 8b, 8c--Many Ohio high schools have tried to address the drug and alcohol epidemic in their districts through local student surveys on chemical use and
dependency. Throughout the state, over half of the high schools responding indicated they have conducted surveys to assess student knowledge, attitude, and use. Survey assessment of student attitudes and student use were reported in 54 percent of the schools. Local surveys to assess student knowledge of chemical use and dependency were reported in 52 percent of Ohio high schools.

Survey Items 9 & 10--Effective drug education programs need to embody more than information through education. They require procedures for identification, intervention and treatment. In Ohio high schools, 84 percent of the schools reported having an identification system for referring troubled students. Intervention activities appear to be heavily linked with community resources. The majority of schools, 91 percent, reported maintaining an ongoing relationship with community counseling agencies for chemical use/abuse referrals.

Survey Items 11, 12, & 13--The data reported by school officials indicated that schools were less likely to provide follow-up support group activities within the school. Two components of drug education programs found in schools, support groups for students and preventive education in grades K-12, were reported in 55 and 52 percent of the schools, respectively. In addition, only 22 percent reported any special funding for drug education,
indicating that a limited number of Ohio Schools were interested in providing separate budgets for the drug and alcohol program.

Survey Items 14 & 15--Based on the data from staff reports, less than half (41%) use core teams as part of their programs. Parent support groups were reported less frequently than student groups, with only 30 percent of the schools providing this service.

Survey Item 16--Respondents reported that few school districts offered support to recovering students by sponsoring Alcoholics Anonymous or Alanon meetings in the high school. This opportunity was reported in only 12 percent of the schools responding.

Survey Items 21, 22, 23, 24, & 25--Another important facet of drug education addressed was the type of resources used by schools in their program development. When schools sought drug specific information to assist in the development of their programs, the respondents indicated they utilized various sources of information. Both private and public resources were used. Use of publicly funded agencies like Regional Councils on Alcoholism and other county and local services were reported by 76 percent of the schools. Fifty-nine percent of the schools reported using private treatment centers such as St. Luke's Hospital
in Cleveland, and Talbot Hall in Columbus. Resources also included private training programs such as Community Intervention and the Hazelton Foundation.

Additional services reported by school officials were from individuals with expertise in the field. This source of information was used in 59 percent of the schools responding. Among other reported resources used were colleagues from other school districts (32%) and college and university personnel (23%).

**Significant Differences: Programs**

A K-12 written guidance plan that included program recommendations regarding chemical use and dependency was reported in 58 percent of Ohio high schools. Nevertheless, no significant differences were found among schools that utilized a K-12 guidance plan. The distribution of those districts were unaffected by region, type of school and classification.

No significant differences were found among the Ohio high schools that provided short-term programs on drug and alcohol awareness for students. Eighty-nine percent of the districts responding reported providing these programs for students regardless of region, type, and size of the school district. Significant differences, however, were found
among schools that reported short-term awareness programs for athletes, staff, parents, and the community.

A chi-square analysis was completed on the 19 survey items for Theme 3. Levels of significance were obtained to clarify that differences found among OHSAA regional district, type of high school, and OHSAA classification, were not due to chance. A summary of the results of the test of statistical significance was presented in Table 10.

**Differences by OHSAA Classification, Survey Item 6b**—Drug and alcohol awareness programs for athletes were reported in 57 percent of the schools. Region and type of school were not significantly related to the existence of such programs. School size, however, did indicate a difference at the p< .003 level of significance. The direction of the reported differences indicated that AAA schools were the most likely to report having awareness programs for student athletes. In AAA schools, 64 percent of the respondents reported the existence of such programs. In the smaller AA and A districts, programs for athletes were reported in 53 and 51 percent of the schools, respectively. Of the 50 schools responding with mixed classifications, 60 percent reported providing programs for athletes.
Table 10
Summary Table for the 19 Survey Items Which Indicate Significant Differences for Theme 3, Programs, by Chi-Square, Degrees of Freedom, and Level of Significance for OHSAA Regional District (R), Type of High School (T) and OHSAA Classification (C)

<table>
<thead>
<tr>
<th>Survey Item</th>
<th>X2</th>
<th>df</th>
<th>p&lt; .05</th>
</tr>
</thead>
<tbody>
<tr>
<td>6b. Short-term programs to develop drug and alcohol awareness for athletes.</td>
<td>R =</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>T =</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>C =</td>
<td>6</td>
<td>.0034</td>
</tr>
<tr>
<td>6c. Short-term programs to develop drug and alcohol awareness for staff.</td>
<td>R =</td>
<td>10</td>
<td>.02</td>
</tr>
<tr>
<td></td>
<td>T =</td>
<td>8</td>
<td>.00</td>
</tr>
<tr>
<td></td>
<td>C =</td>
<td>6</td>
<td>.0005</td>
</tr>
<tr>
<td>6d. Short-term programs to develop drug and alcohol awareness for parents.</td>
<td>R =</td>
<td>10</td>
<td>.00</td>
</tr>
<tr>
<td></td>
<td>T =</td>
<td>8</td>
<td>.00</td>
</tr>
<tr>
<td></td>
<td>C =</td>
<td>6</td>
<td>.00</td>
</tr>
<tr>
<td>6e. Short-term programs to develop drug and alcohol awareness for the community.</td>
<td>R =</td>
<td>10</td>
<td>.00</td>
</tr>
<tr>
<td></td>
<td>T =</td>
<td>8</td>
<td>.00</td>
</tr>
<tr>
<td></td>
<td>C =</td>
<td>6</td>
<td>.00</td>
</tr>
<tr>
<td>8a. Completed local surveys on chemical use and dependency to assess student knowledge.</td>
<td>R =</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>T =</td>
<td>8</td>
<td>.0014</td>
</tr>
<tr>
<td></td>
<td>C =</td>
<td>6</td>
<td>.0229</td>
</tr>
<tr>
<td>8b. Completed local surveys on chemical use and dependency to assess student attitudes.</td>
<td>R =</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>T =</td>
<td>8</td>
<td>.0015</td>
</tr>
<tr>
<td></td>
<td>C =</td>
<td>6</td>
<td>.0090</td>
</tr>
<tr>
<td>Survey Item</td>
<td>X2</td>
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<td>p&lt; .05</td>
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<tr>
<td>------------------------------------------------------------------------------</td>
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</tr>
<tr>
<td>8c. Completed local surveys on chemical use and dependency to assess student use.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>R =</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>T = 25.58</td>
<td>8</td>
<td></td>
<td>.0012</td>
</tr>
<tr>
<td>C = 19.51</td>
<td>6</td>
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<td>.0034</td>
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<tr>
<td>9. Identification and referral system for students with problems.</td>
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<td>R = 27.26</td>
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<td>T = 26.40</td>
<td>8</td>
<td></td>
<td>.0009</td>
</tr>
<tr>
<td>C = 51.18</td>
<td>6</td>
<td></td>
<td>.00</td>
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<tr>
<td>10. Ongoing relationship with community agencies for counseling.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>R =</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>T = 19.98</td>
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<td></td>
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<td>C = 14.15</td>
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<td>.0280</td>
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<tr>
<td>11. In-school support groups for students.</td>
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<tr>
<td>R = 40.44</td>
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<tr>
<td>T = 47.63</td>
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<tr>
<td>C = 77.49</td>
<td>6</td>
<td></td>
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<tr>
<td>12. Preventive education programs at grades K-12, other than health.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>R =</td>
<td></td>
<td></td>
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<tr>
<td>T = 23.54</td>
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<td>C = 15.88</td>
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<tr>
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<td></td>
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<td>T = 31.37</td>
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<tr>
<td>C = 74.38</td>
<td>6</td>
<td></td>
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<tr>
<td>14. Core teams or building teams as a part of the chemical use or dependency program.</td>
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<tr>
<td>R = 109.83</td>
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<td></td>
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<tr>
<td>T = 48.19</td>
<td>8</td>
<td></td>
<td>.00</td>
</tr>
<tr>
<td>C = 74.80</td>
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<td></td>
<td>.00</td>
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<tr>
<td>15. Parent support groups.</td>
<td></td>
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</tr>
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<td>R = 36.87</td>
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<td></td>
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<td>T = 39.90</td>
<td>8</td>
<td></td>
<td>.00</td>
</tr>
<tr>
<td>C = 46.45</td>
<td>6</td>
<td></td>
<td>.00</td>
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<tr>
<td>16. The school hosts meetings for AA, NA, and/or Alanon.</td>
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<td></td>
<td></td>
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<tr>
<td>R =</td>
<td></td>
<td></td>
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<tr>
<td>T = 38.76</td>
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<td></td>
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<tr>
<td>C = 32.70</td>
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Table 10 (continued)

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<th>X²</th>
<th>df</th>
<th>p &lt; .05</th>
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<tbody>
<tr>
<td>Indicate the resources used by your school district for chemical use and dependency related services.</td>
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<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>T = 15.66</td>
<td>6</td>
<td>.015</td>
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<tr>
<td>22. Other School Districts.</td>
<td>R = 44.04</td>
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<tr>
<td></td>
<td>T = 20.98</td>
<td>6</td>
<td>.0018</td>
</tr>
<tr>
<td>24. Private drug/alcohol treatment centers or training/education programs.</td>
<td>R = 53.62</td>
<td>10</td>
<td>.00</td>
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<tr>
<td></td>
<td>T = 31.99</td>
<td>8</td>
<td>.0001</td>
</tr>
<tr>
<td></td>
<td>C = 48.92</td>
<td>6</td>
<td>.00</td>
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<tr>
<td>25. Individuals with expertise in drug education.</td>
<td>R =</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>T = 20.73</td>
<td>8</td>
<td>.0079</td>
</tr>
<tr>
<td></td>
<td>C =</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Differences by OHSAA Region, Survey Items 6c, 6d, 6e--

Short-term programs for school staff, parents, and members of the community were also reported by school personnel. Significant differences were found in the self-reported data indicating that these programs were affected by a school's regional location, type of district, and OHSAA classification.

The location of a high school appears to significantly affect the percentage of schools providing short-term programs. Regional differences were found at the p < .02 level of significance for programs developed for staff members, and the p < .00 level for parent and community programs.

Across the state, 56 percent of the schools responding reported the development of drug awareness programs for staff members. The distribution of the districts by OHSAA region significantly affected the percentage of Ohio high schools that provided short term programs.

The range of response for schools that reporting staff programs reached a high of 66 percent in the Northeast region, and a low of 37 percent in the Southeast. Regions like the Southwest and Central, with large urban/suburban centers, reported responses slightly above
the statewide figure. In both areas, 59 percent of the schools indicated providing programs for staff members.

School districts in three regions reported figures below the statewide average. Fifty-two percent of the schools in the Northwest offered short-term programs for staff members, while districts in the East and the Southeast reported programs in 42 and 37 percent of the schools respectively.

Significant regional differences were also reported for schools that offered short-term drug awareness programs for parents. The range of response and the nature of the differences were identical to those found for staff programs.

In the Northeast, 68 percent of the schools reported drug programs for parents, whereas only one-fourth (25%) of the schools in the Southeast reported having these same programs. Within this range, only schools in the Southwest region (51%) reported figures that either matched or exceeded the statewide average of 51 percent.

Based on the reports from school staff, the regions with large urban/suburban centers were more likely to provide parent programs, than schools in the rural regions. In the remaining regions throughout the state, the percentage of staff reporting these services fell below the state average. In the Central and Northwest regions, 49
and 48 percent of the schools indicated offering parent programs, compared to 33 percent in the Eastern region.

Short-term awareness programs for the community were also affected by regional district. Overall, fewer staff members reported their schools offered these programs to community members. Throughout the state, less than half (45%) of the school personnel reported this type of service in their school district.

The percentage of schools statewide that provided programs for the community was significantly influenced by the response of the schools in the Northeast region. This is the only region that exceeded the overall percentage for Ohio high schools. In the Northeast, 64 percent of the schools responding provided community programs. Schools in this region represented less than one-third (29%) of all schools, yet they accounted for 41 percent of the schools offering community drug awareness programs.

Patterns similar to those found for staff and parental programs also emerged for those schools providing services to the community. Regions in the Southwest (44%), Northwest (44%), and Central (36%) Ohio were more likely to provide school based drug programs for the community. In contrast, staff in the Southeast reported 27 percent of their schools provided this service. In the East, less
than one school in five (18%) reported offering short-term programs to develop drug awareness in the community.

As reported earlier, drug and alcohol awareness programs for students and athletes are provided in schools across the state, regardless of regional district. The data, however, suggest that region did have a significant influence on the type of drug education program schools offered for staff, parents, and the community.

In all three program areas, the nature of the reported differences were similar. School districts in urban and/or suburban areas were significantly more likely to report programs for staff members, parents and, the community. Staff members in rural regions reported fewer school districts that developed and offered short-term awareness programs on drug and alcohol education.

Differences by Type of School, Survey Items 6c, 6d, 6e--Type of school also appeared significantly related to the differences reported among the various drug programs offered in Ohio high schools. A consistent pattern emerged suggesting that Diocesan, Private and City school districts were significantly more likely to provide a broad range of drug education programs than Exempted Village and Local school systems.

Differences in the data may be more clearly understood when comparing City and Local schools. These two types of
schools accounted for 85 percent of the schools surveyed, with Local schools representing nearly half (49%) of all schools in the study. Nevertheless, City schools consistently represented a larger percentage of the schools that provided drug education programs. Local districts, by comparison, consistently reported a smaller percentage of schools with comprehensive programs.

Schools with short-term programs for staff members effectively illustrated this pattern. Within the responses by school types, 87 percent of the Diocesan and 75 percent of the Private schools reported programs for staff members. City schools were close behind with 67 percent of the schools reporting staff programs. The figures reported for Exempted Village and Local districts were 45 and 44 percent, respectively. Across the state 56 percent of the schools reported short-term awareness programs for the staff.

The nature of the differences were more precise when comparing City and Local districts. City schools made up 37 percent of the total sample and 44 percent of the schools reporting staff programs. Conversely, Local districts represented 49 percent of the total schools, but just 38 percent of the schools with short-term programs.
The same pattern emerged when type of school was crosstabulated with school-based drug awareness programs for parents. Diocesan and Private schools represented the upper end of the range, with respective response rates for schools with parent programs of 76 and 75 percent. Local schools were at the low end of the range with a response rate of 37 percent. City schools with a rate of 66 percent, and Exempted Villages with 38 percent, represented the remaining values within the range. Statewide, 51 percent of the schools reported programs for parents.

When City schools were compared with Local districts the pattern was similar. While Local districts represented 49 percent of the schools responding to this item, they accounted for 37 percent of the schools that reported offering parent programs. Conversely, 36 percent of the schools responding were City districts, yet they accounted for 46 percent of the schools with drug awareness programs for parents.

According to the data, the type of school was also significantly related to whether high schools across the state provided drug awareness programs for the community. School-based programs that extended to the community were most frequently reported in City districts (61%). In Diocesan and Private schools, 50 percent of the respondents reported providing community programs. Exempted Village
and Local districts, respectively, reported 38 and 34 percent of the schools offered programs to members of the community.

As with region, a clear pattern of response emerged for type of school. Based on the reports from school officials, City schools offered the most comprehensive range of drug awareness programs. Diocesan and Private schools were also active in providing direct services to students, staff and parents. Local Schools, however, presented an interesting study. The raw totals of Local schools with broad based drug education programs were impressive. Nevertheless, when viewed as a percentage of response, the data indicated that fewer than half of the state's Local school districts provided drug awareness programs for school staff, parents, and the community.

Differences by OHSAA Classification, Survey Items 6c, 6d, 6e—School size, as measured by OHSAA classification, was also a factor in the type of drug awareness programs offered in Ohio high schools. Schools with the largest enrollments, classified AAA by the OHSAA, reported offering a wider range of programs than Class AA or Class A school systems. Schools in the mixed classification category also reported providing more short-term programs than either AA or A schools.
Drug awareness programs for staff members were reported in 56 percent of Ohio high schools. The data reported suggest that this figure was significantly affected by the response rates from AAA schools and those districts in the mixed category.

Seventy percent of all AAA schools reported drug programs for staff members. This was followed by 62 percent in the schools with mixed classifications. The percentage of AA and A schools reporting staff programs fell significantly below the state average. In both AA and A districts, 48 percent of the schools reported offering staff programs.

High school class size also accounted for differences among those schools that provided expanded drug awareness programs for parents and the community. Triple A schools represented a significantly larger portion of schools with parent and community services.

Sixty-eight percent of AAA schools reported providing short-term drug awareness programs for parents. In descending order, the range as reported by school officials included 54 percent for schools with mixed classifications, 45 percent for AA and 40 percent of single A schools.

As a percentage of the total, AAA schools accounted for 40 percent of all school districts providing programs for parents, even though they represented only 30 percent
of the schools responding. Comparatively, Class A schools made up 27 percent of the total sample, but just one-fifth (21%) of the schools that reported a direct service to parents.

The same pattern emerged for total schools that reported providing drug awareness programs for the community. Triple A districts accounted for 41 percent of the state high schools with school-based community drug awareness programs. The figures reported for AA and A schools were 29 and 22 percent, respectively.

Within the school classifications, AAA schools far exceeded the state average of 45 percent. Respondents reported 62 percent of all AAA schools provided community programs on drug awareness. Schools with smaller enrollments fell below the statewide percentage. The figures for AA and single A schools were 41 and 36 percent of the districts, respectively.

Based on the self-reported data, Ohio high schools were actively involved in providing drug awareness programs in their districts. Nevertheless, a school's regional location, type of school, and classification, were found to significantly effect the extent to which school-based programs were offered. The data provided a profile of schools that offer the most comprehensive type of drug
awareness programs. These programs included services for staff, parents, and the community. Once again, these programs were most frequently reported in large, AAA, City school systems in Northeastern Ohio.

**Significant Differences for Survey Items 8a, 8b, 8c**—Drug education in Ohio high schools relied on a variety of resources for program development. Many scholastic programs were based on the results of local surveys on chemical use and dependency. This study investigated the extent to which surveys on student knowledge, attitude, and use were administered in Ohio schools. A second objective was to determine if schools completing local surveys were affected by variables such as regional location, type of school, and school size.

The frequency distribution for these survey items indicated that over half of all Ohio high schools have completed chemical use and dependency surveys. Surveys administered to assess student knowledge were reported in 52 percent of the state's high schools. Local surveys to assess student attitudes, and student use surveys were reported in 54 percent of the school districts.

The regional location of a high school was not found to be significantly related to the use of chemical use and dependency surveys for program development. Statistical
differences based on type of school and OHSAA classification, however, were found for each of the three types of student surveys.

**Differences by Type of School, Survey Item 8a, 8b, 8c**—For the variable type of school, local surveys that assessed student knowledge, attitudes, and use, were significant at the $p < .001$ level.

The range of response within school types was identical for each of the student surveys. City districts reported the highest percentage of schools conducting surveys, followed by Exempted Villages, Diocesan schools, Local systems, and Private schools. Sixty percent of the City schools reported completing surveys to assess student knowledge. Surveys on student attitudes were reported in 62 percent of City schools, while 63 percent indicated using surveys that assessed student use. The respective percentages reported for Exempted Villages were 57, 55, and 55 percent for the three types of surveys. The percentage of response was below the state average for Diocesan, Private and Local school districts for each type of student survey.

**Differences by OHSAA Classification, Survey Item 8a, 8b, 8c**—The size of a high school also affected the frequency with which schools reported using student surveys. The level of significance by school
classification varied according to the type of survey. Data for surveys on student knowledge were significant at the $p < .02$ level. Levels of significance for surveys on student attitudes and student use were; $p < .01$ and $p < .003$, respectively.

A greater percentage of AAA schools reported student surveys in comparison to schools classified AA and A. According to the response rate for classification, as the size of the school increased, so too did the percentage of schools that reported completing student surveys.

Among AAA schools, 57 percent reported completing surveys on student knowledge, 58 percent on student attitudes, and 59 percent on student use. The same surveys were reported, respectively by 56, 57, and 58 percent of AA schools. Schools with mixed classification reported percentages of 52, 57, and 51 percent for the three types of surveys. Student surveys on knowledge, attitude, and use were reported in 44 percent of the single A schools.

Statewide, student surveys were completed in slightly over 50 percent of all Ohio high schools. The self-reported data indicated a greater tendency in AAA, and AA City school districts to use student surveys as a part of their drug and alcohol education program.
Significant Differences, Survey Items 9, 10, 11, 12, 13, 14, 15, & 16--Earlier in this chapter, drug education was described as incorporating educational, informational, and service components. This study identified eight service areas characteristic of a school-based drug program. The effects region, type of school, and OHSAA classification have on these eight program components are presented below.

Differences by OHSAA Region, Survey Items, 9, 11, 13, 14, & 15--Significant regional differences were found in five of the eight program areas. The five areas and their level of significance were as follows: an identification and referral system for students with problems, p< .002; in-school support groups, p< .00; a budget for a district-wide drug and alcohol program, p< .001; building core teams, p< .00; and parent support groups, p< .0001. No significant regional differences were found for schools with ongoing relationships with community counseling agencies and for schools that host AA, NA, or Alanon meetings.

Differences by Type of School and OHSAA Classification, Survey Items 9, 10, 11, 12, 13, 14, & 16--The type of school and its OHSAA classification were significantly related to each of the eight areas identified. The parts of the school program influenced by
these two variables and their level of significance were:
an identification and referral system, p < .0009 and p < .00; ongoing relationships with community counseling agencies, p < .01 and p < .03; in-school support groups, p < .00 for both variables; a preventive education program at grades K-12, other than health, p < .002 and p < .01; a budget for a district-wide program, p < .001 and p < .00; building core teams, p < .00; and AA, NA, and Alanon meetings held in the school, p < .00.

**Differences for Survey Item 9**—Identification and referral systems for students with problems were reported in over 84 percent of the schools responding. The differences noted by region were from the very high percentage of schools in the Central region (94%) and the Northeast (92%) that reported this service. Schools in the Northwest (76%), Southwest (77%), and the East (77%), represented the low end of the range for region. Nevertheless, the statewide percentage for this service indicated that the overwhelming majority of schools were involved in the identification and referral of students with special needs.

Differences by school type and classification offered a clearer distinction between the schools that reported referral systems. The pattern established for other survey
items was repeated here. For type of school, Diocesan (96%) and City schools (93%) represented the type of schools that reported the largest percentage of districts providing this service. Local districts (77%) reported the lowest percentage among type of school. Additionally, they represented 73 percent of the schools that did not report a student referral service.

School size was also significantly related to the use of a referral system. Triple A schools reported a response rate of 94 percent for schools with this service. While the figures for AA and A schools were 88 and 69 percent, respectively.

Differences for Survey Item 10--A related service to establishing an identification and referral system was maintaining an ongoing relationship with community counseling agencies. According to the self-reported data, over 90 percent Ohio high schools incorporated this service into their district's comprehensive drug education program.

No significant differences were found by region for the 91 percent of Ohio high schools that reported maintaining an ongoing relationship with community agencies. Differences, however, were noted for the type of school and OHSAA classification. Among Diocesan and City schools, 98 and 94 percent of the districts reported an ongoing relationship with community agencies. Conversely,
Private schools reported a 62 percent response rate, significantly below the statewide average. This difference may be overstated since Private schools represented less than one percent of the total population.

Differences found by school classification, although statistically significant, were not considered functionally meaningful. Larger school systems reported a higher percentage of their schools with this service (i.e., 94 percent for AAA and 93 percent, for AA), nevertheless, the low range of 86 percent for single A schools, indicated a commitment throughout the state for networking with community resources to better serve young people.

**Differences for Survey Item 11**—Another direct service to students and parents incorporated into many scholastic drug education programs was the use of support groups. Both student and parent groups were designed to provide support and direction for individuals and families affected by chemical abuse.

Schools were found to differ significantly by region regarding the existence of in-school support groups for students. Statewide, 54 percent of the schools reported providing this service. However, that figure is exceeded in only the Northeast (70%) and the Central region (68%). In-school support groups were reported in only 36 percent
of the schools in the East and 37 percent in the Southeast. Schools in Northeast Ohio accounted for close to two-fifths (38%) of all schools reporting support groups for students.

A school's use of in-school support groups was also affected by the type of school. Schools identified as City districts accounted for 46 percent of all schools that reported student support groups. The range for type of school extended from the upper end of 70 percent for City schools, to a low of 43 percent for both Exempted Villages and Local districts. Diocesan and Private schools represented only 10 percent of the total sample, yet, support groups were reported in 66 percent and 50 percent of these types of schools, respectively.

School size was another variable that significantly affected the implementation of student support groups in a school-based drug program. The data reported by staff members indicated a familiar pattern. A much higher percentage of support groups were reported in schools with larger enrollments. Comparatively, this student service was reported in 76 percent of AAA schools, 52 percent of AA, and 32 percent of single A districts.

**Differences for Survey Item 12**—Another program component investigated in this study was the extent to which preventive drug education programs were offered in grades K-12. The data indicated that 52 percent of the
respondents reported their districts provided a prevention based component to the school's comprehensive drug education program. No significant regional differences were reported among the school districts providing this service. Differences, however, were observed among the schools according to type of school and interscholastic classification.

Based on the data reported from school staff, Diocesan and City schools represented the type of schools most likely to provide system-wide preventive drug education. Their respective response rates of 65 and 60 percent were the only figures to exceed the state average for this item. Local districts were in the middle of the range reporting 46 percent of the schools provided preventive education programs. Exempted Village and Private schools completed the range with reported percentages of 45 and 38 percent, respectively.

As a function of class size, preventive education was reported more frequently in AAA districts than in schools with smaller enrollments. Sixty-three percent of the AAA school officials reported K-12 programs in their districts. The percentage of schools reporting this service decreased significantly as class sized was reduced. Forty-nine percent of the schools classified as AA reported
implementing a K-12 prevention curriculum, while in single school districts, 46 percent reported similar programs.  

**Differences for Survey Item 13**—Another aspect of the program component was the extent to which school-based drug programs were funded by a separate budget. The study found that 22 percent of Ohio high schools reported having a budget for drug programming.  

Regionally, the schools in large urban/suburban areas were more likely to report separate funding for drug education. The percentage of respondents by region, that reported program budgets were: Northeast, 33 percent; Southwest, 24 percent; Central, 21 percent; and the Northwest, 16 percent. In the more rural regions of the Southeast and East, only 10 percent of the schools reported a district-wide budget for drug education. Schools in the Northeast also represented 45 percent of the schools statewide that provide this type of funding for drug programs.  

In a similar manner, City schools dominated the type of schools that offer this service. Fifty-four percent of the schools that reported separate funding were City Schools. Within the specific types of schools 33 percent of the City schools indicated a program budget. The remaining types of school reporting this component were: Diocesan Schools, 18 percent; Local Schools, 16 percent;
Private Schools, 14 percent, and Exempted Village Schools, 13 percent.

Schools that reported a budget for district-wide drug and alcohol programs were more frequently larger school districts. This program component was reported in 41 percent of the AAA schools, 18 percent of the AA, and 7 percent of class A schools. In addition, schools classified AAA represented 58 percent of the high schools in Ohio that reported a budget for district-wide drug and alcohol programs.

Differences for Survey Item 14—Other program components were designed to provide direct services to students and/or parents. One type of direct service was the use of building or core teams of trained staff members reported in many high school programs.

School districts in the Northeast reported the most frequent use of core teams. Within this region 68 percent of the schools reported core teams as part of the school program. This contrasted significantly with the East region, where only 10 percent of the schools reported using the core team approach. Within this range only schools in the Southwest region (47%) exceed the state average. Together, the Northeast and Southwest regions accounted for
over 70 percent of the schools that reported using core teams as a component of the school-based drug program.

Among the various school systems, Catholic and City schools reported the highest percentage (57%) of programs employing core teams. These two types of school were followed by Exempted Village schools (39%), Local districts (28%), and other Private and Parochial schools (14%).

The use of building teams within a school-based drug education program were also significantly affected by OHSAA classification. The data indicated that the core teams approach was reported more frequently in the larger school districts. Specifically, 62 percent of AAA, 39 percent of AA, and 18 percent of Class A schools reported providing this service. In addition, 51 percent of the schools with mixed classification reported using this program component.

Differences for Survey Item 15--School programs that included parent support groups followed the same pattern. Nevertheless, this component was not reported as frequently in the schools as student groups. Less than one-third (30%) of Ohio high schools report providing this service for parents.

Schools reporting parent support groups were found most frequently in the Northeast region. Forty-five percent (45%) of schools in the Northeast reported parent support groups as a part of their drug education program.
This was followed by 28 percent of the schools in the Central and Southwest region, 25 percent in the Northwest, 15 percent in the Southeast, and 10 percent in the East. Schools in the Northeast accounted for 45 percent of all districts reporting this type of service. At the opposite extreme, schools in the East represented only 2 percent of districts that reported parent support groups.

Similarly, City schools dominated the type of school most likely to offer this parent service. City districts, followed by Private and Diocesan schools, reported respective response rates of 43, 38, and 33 percent. At the low end of the range were the 26 percent of Exempted Village and the 20 percent of Local school districts that responded. As a percentage of total response for this item, City schools represented 51 percent of the high schools in Ohio that reported providing parent support groups.

According to school classification, parent support groups were reported more frequently among AAA schools than schools classified AA, or A. Within each class, the percentage of schools providing this service decreased as the school enrollment declined. AAA schools represented the highest percentage of schools with a reported response rate of 44 percent. The progression followed with AA
schools reporting 28 percent and single A schools with 17 percent. Schools officials in districts with mixed classifications reported 27 percent of the schools provided this service.

**Differences for Survey Item 16**—Some school districts have responded to the epidemic of adolescent substance abuse by hosting AA, NA, and Alanon meetings at the high school. This type of student service was reported in 12 percent of Ohio schools. No regional differences were found among the schools that reported holding AA meetings at school. Significant differences, however, were found according to type of school and OHSAA classification.

Diocesan (21%) and City (20%) schools reported the highest percentages for schools that host AA and NA meetings in their buildings. Consistent with the pattern established for type of school, Local districts (5%) were the least likely to provide this support service. Statewide, of the 68 high schools reporting this service, 57 percent were City school districts.

Similarly, 50 percent of the schools that reported holding recovery group meetings were classified AAA by the OHSAA. The pattern or school size also remained consistent. According to class size, 20 percent of Class AAA schools, 9 percent Class AA, and 5 percent of Class A schools reported hosting AA and Alanon meetings in school.
In schools with mixed classifications, 19 percent of the respondents reported programs that host meetings for recovering students.

In each of the eight service areas discussed, the same pattern emerged describing the characteristics of high schools reporting comprehensive drug education program. Consistently, the results identified AAA City schools in the Northeast as representative of the schools with drug education programs that provided the most comprehensive services.

Significant Differences for Survey Items, 21, 22, 23, 24, & 25--The information and resource component was the third program area investigated. Five areas were selected as appropriate resources available to school districts. They included colleges and universities, other school districts with programs in place, publicly funded drug and alcohol agencies, private drug/alcohol treatment centers and/or training and education firms, and individuals with expertise in the drug education field.

Significant differences were found by region in three of the five resource areas. The areas where region had an effect were; colleges and universities, $p < .007$; other school districts, $p < .00$; and private treatment centers and/or training programs, $p < .00$. 
Type of school was found significantly related to two of the areas. For private treatment centers and/or training programs, the level of significance was \( p < .0001 \). The level for individuals with expertise was \( p < .008 \).

School size was significantly related to the use of three of the five identified resources. The three areas were; colleges and universities, \( p < .01 \); other school districts, \( p < .002 \); and private treatment centers and/or training programs, \( p < .00 \).

**Differences for Survey Item 21**—Of the five resource areas identified, colleges and universities were consulted the least. Statewide, only 23 percent of the schools reported using the services of colleges and universities in developing a drug education program.

School districts that used higher education resources differed significantly by region. The Central region topped the range of response. Forty percent of the schools in this area reported using the resources of colleges and universities. Schools in the Southeast, Southwest, and the Northwest followed with reported response rates of 28, 25, and 22 percent, respectively. The two regions at the low end were the Northeast with 15 percent, and the East with a rate of 14 percent.

School size was also a factor for this item. Those districts with a mixed classification reported the largest
percentage (32%) of schools that turned to colleges and universities for assistance. Twenty-eight percent of AAA schools reported using these resources, while single A schools were next with a response rate of 23 percent. Only 14 percent of the AA schools reported using the information available from college and universities.

**Differences for Survey Item 22—Other school districts** were reported as a resource in percentages only slightly greater than those found for higher education. According to the reports from school officials, thirty-two percent of Ohio high schools looked to other school districts for information and collaboration. Nevertheless, differences were found among these schools by regional location and class size.

Schools in the Southwest region appeared to rely heaviest on neighboring districts. Close to half (48%) of all schools in this region reported consulting with other schools systems. The figure reported for the Northwest region is also significantly greater than the state average. Forty percent (40%) of the schools in this area indicated using other districts as a source of information. This is followed by schools in the Northwest, 25 percent; Central, 24 percent; and the Southeast, 18 percent. Not
one of the 27 districts in the Eastern region reported using this type of resource.

Differences noted by school size are consistent with the patterns established for this variable throughout the study. As the school size decreased, the percentage of schools reporting other districts as a source of drug information also decreased. Forty-one percent of AAA schools reported using neighboring districts. Other school districts were used less frequently in schools with smaller enrollments. The figures for AA and A districts were 31, and 18 percent, respectively.

Differences for Survey Item 24--Based on the reports from staff, sources of information in other districts were not used as often as resources in the private sector. Private drug and alcohol treatment centers and those organizations providing training and education programs were reported more frequently (59%) by Ohio high schools.

Regionally, schools in the Northeast tended to report the most frequent use of resources in the private sector. Differences among schools that reported using these resources ranged from 78 percent in the Northeast to only 26 percent in the East. Within the range, schools in Central, Northwest, Southwest, and the Southeast regions reported rates of 60, 58, 53, and 30 percent, respectively.
Differences, according to the type of school, were also found among the schools using private treatment centers. Diocesan and Private school officials reported 78 and 71 percent of their schools used the resources mentioned above. This was followed closely by City schools with 69 percent and Exempted Village schools with 61 percent. Local districts were the only type of school to report figures that fell below the state average. Forty-seven percent of the Local schools reported using the resources available through private treatment centers.

According to the differences observed by school size, the larger school systems reported using this source of information more often than smaller districts. Seventy-eight percent of the AAA schools reported using the services of these private organizations. Comparatively, the percentages reported for AA and A schools were 54 percent and 42 percent, respectively. Schools with mixed classifications reported a 57 percent response rate.

Differences for Survey Item 25--Individuals with expertise in the field were reported as frequently as private treatment centers and training programs. Significant differences in this area were reported among the various types of schools studied. Private schools and City districts were much more likely to report using experts in the field to assist in program development.
Respectively, 71 and 70 percent of the schools in these categories reported using this resource. Diocesan and Exempted Village schools reported figures of 58 and 54 percent, while Local districts represented the lowest percentage, with a rate of 51 percent.

**Summary of Differences for Program Survey Items**—The nineteen survey items provided an overview of the service components of a comprehensive drug education program. In cases where significant differences were found among the variables, similar patterns emerged.

The self-reported data from school staff indicated that large City school districts in the Northeastern region of the state offered the most comprehensive school-based programs in Ohio. Conversely, small, Local schools in the Southeast and East appeared to have the most limited drug education programs and services.

In addition, City Schools were significantly more likely to report drug and alcohol programs that included prevention, education, and support services, than Local Schools within a county system. This was also true of schools with the larger enrollments. Triple A schools were more likely to report comprehensive drug programs than smaller districts, classified AA or A.
Theme 4: Inservice

Theme 4, Inservice, involved the sharing and dissemination of drug and alcohol awareness information to students and staff. Inservice training implied a more intensive study of adolescent chemical use and dependency when compared to the short-term awareness programs stated under Theme 3, Programs. Table 11 provides evidence of the extent to which Ohio high schools engage in extensive inservice education on adolescent drug use.

Survey Item 7--Roughly one-third of the school officials reporting indicated their district provided extensive inservice training for staff (35%) and for students (33%). In contrast, only 16 percent of the school districts reported providing the same service to parents and community members. The nature and extent of the inservice training may have prevented many districts from providing this service outside the school setting.

Survey Item 19--Of particular concern was the extent to which school-based drug and alcohol programs provided inservice activities for particular groups of students such as athletes. The data found that 22 percent (125 out of 559) of the high schools reported offering student athletes with training on adolescent chemical use and dependency.
TABLE 11

Distribution of Frequency and Percentages for Theme 4, Inservice Questions for the Chemical Use and Dependency Survey

<table>
<thead>
<tr>
<th>Survey Item</th>
<th>YES</th>
<th>NO</th>
<th>DK</th>
<th>%</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>7. Does your school provide extensive chemical use and dependency inservice training programs for:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>a. Students?</td>
<td>183</td>
<td>361</td>
<td>5</td>
<td>33</td>
<td>66</td>
</tr>
<tr>
<td>b. Staff?</td>
<td>191</td>
<td>353</td>
<td>4</td>
<td>35</td>
<td>64</td>
</tr>
<tr>
<td>c. Parents?</td>
<td>86</td>
<td>440</td>
<td>7</td>
<td>16</td>
<td>83</td>
</tr>
<tr>
<td>d. Community?</td>
<td>84</td>
<td>443</td>
<td>11</td>
<td>16</td>
<td>82</td>
</tr>
<tr>
<td>19. Have student athletes received training on adolescent chemical use and dependency?</td>
<td>125</td>
<td>396</td>
<td>38</td>
<td>22</td>
<td>71</td>
</tr>
<tr>
<td>If yes, how many attended:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3-5 day sessions?</td>
<td>122</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1-2 day sessions</td>
<td>275</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Less than one day?</td>
<td>4047</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>26. My district would be interested in the following drug education services for the athletic program:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>a. A 1 or 2 day workshop?</td>
<td>388</td>
<td>57</td>
<td></td>
<td>87</td>
<td>13</td>
</tr>
<tr>
<td>b. A 3 to 5 day workshop?</td>
<td>98</td>
<td>190</td>
<td></td>
<td>34</td>
<td>66</td>
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Table 11 (continued)

<table>
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<tr>
<th>Question</th>
<th>YES</th>
<th>NO</th>
<th>DK</th>
<th>% YES</th>
<th>% NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>c. Student athlete training programs?</td>
<td>342</td>
<td>62</td>
<td>85</td>
<td>15</td>
<td></td>
</tr>
<tr>
<td>d. Help with ongoing assistance program?</td>
<td>228</td>
<td>84</td>
<td>73</td>
<td>27</td>
<td></td>
</tr>
<tr>
<td>27. Would your drug/alcohol coordinator be willing to provide additional information about your district's chemical use or dependency program?</td>
<td>234</td>
<td>93</td>
<td>55</td>
<td>61</td>
<td>25</td>
</tr>
</tbody>
</table>

Similar to staff training sessions, student athletes could attend 3-5 day sessions, 1-2 day sessions, and sessions lasting less than one day. According to the data reported by school personnel, the majority of student athletes attended the half-day sessions, 4047, while 122 and 275 students attended the 3-5 and the 1-2 day sessions, respectively.

Survey Item 26--The self-reported data also summarized the level of interest in Ohio high schools for follow-up services to local athletic or school-based programs. There appeared to be considerable interest among state high schools for a short, 1-2 day workshop on chemical use and dependency for the student athlete. Eighty-seven percent of the school staff reporting were
interested in this type of service. In comparison, only 34 percent of the respondents were interested in workshops lasting 3 to 5 days.

An equally large percentage (84%) of high school personnel expressed interest in developing training programs for the student athlete. In addition, schools with student athlete assistance programs in operation also reported an interest in receiving help with their ongoing service (73%).

Survey Item 27--A final survey item indicated that respondents were willing to share information about the chemical use or dependency program in their school district. Sixty-one percent of the school officials surveyed, reported an interest in developing a network to share policy and program ideas with other school districts.

Significant Differences: Inservice

Based on the self-reported data from school staff inservice activities were found to differ significantly by a school's regional location, type of school and class size. Extensive inservice training included programs for students, staff, parents and the community. Differences were observed in all four areas. Table 12 presents the summary data for the inservice survey items that indicated differences for region, type of school, and classification.
Table 12

Summary Table of the 8 Survey Items Which Indicate Significant Differences for Theme 4, Inservice, by Chi-Square, Degrees of Freedom, and Level of Significance for OHSAA Regional District (R) Type of High School (T) and OHSAA Classification (C)

<table>
<thead>
<tr>
<th>Survey Item</th>
<th>X2</th>
<th>df</th>
<th>p&lt; .05</th>
</tr>
</thead>
<tbody>
<tr>
<td>7a. Extensive inservice training programs on chemical dependency for students.</td>
<td>R = 27.66 10</td>
<td>.002</td>
<td></td>
</tr>
<tr>
<td>7b. Extensive inservice training programs on chemical dependency for staff.</td>
<td>R = 52.28 10</td>
<td>.00</td>
<td></td>
</tr>
<tr>
<td>7c. Extensive inservice training programs on chemical dependency for parents.</td>
<td>R = 32.08 10</td>
<td>.004</td>
<td></td>
</tr>
<tr>
<td>7d. Extensive inservice training programs on chemical dependency for the community.</td>
<td>R = 44.44 10</td>
<td>.00</td>
<td></td>
</tr>
<tr>
<td>Would you be interested in the following services for your school district's athletic program?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>26c. Student athlete training programs.</td>
<td>R = 16.72 6</td>
<td>.0104</td>
<td></td>
</tr>
</tbody>
</table>
Table 12 (continued)

<table>
<thead>
<tr>
<th>Survey Item</th>
<th>X²</th>
<th>df</th>
<th>p &lt; .05</th>
</tr>
</thead>
<tbody>
<tr>
<td>26d. Help with ongoing student athletic assistance programs.</td>
<td>R = 26d. Help with ongoing student athletic assistance programs.</td>
<td>T = 19.15</td>
<td>8</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>27. D/A Coordinator would be willing to provide more information on the school's program.</td>
<td>R = 27. D/A Coordinator would be willing to provide more information on the school's program.</td>
<td>T = 18.84</td>
<td>8</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
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<td></td>
</tr>
</tbody>
</table>

Differences for Survey Item 7a--School systems that offered inservice training for students differed according to region and class size, but not by type of school. Differences found by state region were significant at the p < .002 level. The level of significance for classification was p < .0004.

Extensive training programs for students were reported in 33 percent of the high schools statewide. By region, 47 percent of the schools in the Northeast reported providing student programs, compared to a low of 19 percent of the districts in the Southeast. Schools in the Northeast also accounted for 40 percent of all high schools reporting extensive inservice training for students. The percentage of schools in the other regions were: 33 percent, Southwest; 31 percent, Central; 27 percent, Northwest; and 21 percent in the East.
According to class size, larger schools reported a greater percentage of programs for students than smaller districts. Only AAA schools, with 45 percent, and districts with mixed classifications, with 43 percent, exceeded the state average for schools that reported extensive student inservice. This compared to the 29 percent of AA and 22 percent of class A schools that reported inservice education for students.

Differences for Survey Item 7b--Inservice programs for staff were found in 35 percent of the high schools in Ohio. Differences among schools that provided extensive staff training were reported by region (p< .00), type of school (p<.0003), and by classification (p< .00).

The same pattern reported for student programs emerged when schools with staff programs were compared by region. In the Northeast region, 52 percent of the schools reported providing extensive training for faculty members. This represented 44 percent of all schools involved in this form of inservice education. At the other end of the range were schools in the Southeast and the East region, both with reported response rates of 18 percent.

The 7 Eastern and 9 Southeastern districts with staff inservice represented 4 and 5 percent of the programs statewide. Consequently, 90 percent of the extensive
training programs for school staff were reported in the Northeast, Southwest, Central, and Northwest regions of the state.

Staff development in chemical use and dependency was reported most frequently in City schools. Forty-seven percent of the City districts reported providing extensive inservice for staff. This was followed by Diocesan schools reporting a rate of 44 percent, Local schools, 27 percent; Exempted Village, 16 percent; and Private schools, 12 percent. City schools also represented 48 percent of the districts that reported providing staff inservice programs.

Once again, these programs were reported most often in high schools with large enrollments. Among AAA schools, 51 percent reported having trained staff through extensive inservice programs. Comparatively, 41 percent of mixed classification schools, 31 percent of AA schools, and 20 percent of class A districts reported the same training service. Triple A schools represented 31 percent of all schools under this heading, yet they accounted for 45 percent of the schools that reported extensive training of staff members in substance abuse education.

Differences for Survey Item 7c & 7d--The percentage of schools reporting extensive inservice to parents and the community was significantly lower throughout the state. Only 16 percent of the school officials responding
indicated their district offered these services to groups outside the school. Nevertheless, based on the data reported for parent and community inservice, significant differences were reported among the high schools according to region, type of school, and size of school.

The level of significance found for schools that differed by region was \( p < .004 \) for parents and \( p < .00 \) for community. For type of school, the levels for parent and community programs were \( p < .009 \) and \( p < .007 \), respectively. The differences by classification were found at the \( p < .001 \) level for parent inservice programs and \( p < .00 \) for community programs.

Parent inservice training was reported most often in school districts in Northeastern and Central Ohio. Twenty-nine percent of Northeastern schools and 16 percent of Central region districts reported extensive inservice training programs for parents. Combined, these districts represented close to two-thirds (63%) of the high schools reporting this service statewide. The remaining regions and their percentage of response were; Southwest, 13 percent; Northwest, 10 percent; East and Southeast, 8 percent. Once again, the regions with the state's four largest cities represented 91 percent of the schools that reported inservice education for parents.
Expanding inservice programs beyond the school to include parent groups, was almost exclusively carried out by City, Diocesan, and Local school districts. According to school type, 23 percent of City, 21 percent of Diocesan, 12 percent of Local, and 4 percent of Exempted Village schools reported providing parent inservice programs. No Private schools offered this service and the 4 percent figure for Exempted Village represented one school. Statewide, City schools accounted for 52 percent of the districts that reported extensive parent programs.

The pattern of response for school classification remained constant. Schools classified AAA and AA reported a higher percentage of inservice programs for parents. The range of response extended from 25 percent for AAA, 16 percent for mixed, 15 percent for AA, to 7 percent for class A schools. Once again, almost half (48%) of the schools that offered parent inservice were AAA schools.

The differences reported for community programs followed the same pattern as above. Regional differences were greatest between the urban and rural areas of the state. Schools in the Northeast, Central, Southwest, and Northwest, reported community inservice programs in 31, 16, 11, and 9 percent of the schools, respectively.

The Northeast region accounted for 57 percent of all high schools that reported community inservice training
programs. Comparatively, 6 percent of the schools in the East region and 4 percent in the Southeast reported similar programs in their communities. Schools in these two regions represented only 5 percent of the high schools.

Community inservice programs were also reported more frequently among City districts than in any other type of school. Twenty-five percent of all City schools reported community programs. This was followed by Diocesan, Local, and Exempted Village schools, with 14, 11, and 10 percent, respectively. None of the Private schools reported providing inservice programs for the community. City schools also represented 55 percent of schools in the study that reported providing this service.

According to class differences, inservice training programs for community members were more common in schools with larger student populations. The range of response included 27 percent for AAA schools, 15 percent for AA, 12 percent for schools with mixed classification and 6 percent for single A districts. Of the 84 school officials responding to this item, 44, or 52 percent, represented triple A school districts.

**Differences for Survey Items 26a, 26c, 26d**—The inservice theme also included an opportunity for respondents to indicate their interest in future inservice
activities for their athletic program. The activities offered were; a 1-2 day workshop for staff, a 3-5 day workshop for staff, a student athlete training program, and help with ongoing student athletic assistance programs.

Response for a 1-2 day workshop was overwhelming. Eighty-seven percent of the school personnel surveyed indicated a preference for this type of athletic program inservice. No regional or classification differences were reported for this item. Schools in every part of the state and districts of all sizes appeared interested in this workshop option.

A difference, however, was observed for this item by type of school. Exempted village and Private schools reported a response rate of 72 percent and 75 percent, respectively. Although three-quarters of these schools would like a 1-2 day workshop, their percentage is much lower than the other types of school. Nevertheless, a vast majority of all five types of school indicated an interest in continued service.

Similarly, school districts throughout the state reported interest in developing student athlete training programs. The only area of difference among the 84 percent of Ohio high schools interested in this service was by OHSAA classification. The differences in this area appeared to be between AAA and AA schools, and single A
schools. Over 88 percent of the two larger school classifications reported an interest in student athlete programs. For class A schools, however, the figure was 75 percent, significantly below the state average.

School districts with athletic assistance programs in place also reported an interest in having continued help and support with the emergence of their programs. Differences by type of school and class size, were found among the schools requesting this help.

For type of school, the differences resulted from a low response rate from Private schools. Their 42 percent rate of response significantly differed from the rates for Exempted Village (87%), Diocesan (79%), City (77%), and Local (67%) schools. Private schools represented only 1 percent of the total population.

Help with ongoing student assistance programs was of more interest in AAA and AA schools than in smaller school districts. Statewide, school officials in 73 percent of the districts indicated the desire for assistance with existing programs for athletes. This was true, however, for only 51 percent of single A schools. The request for assistance was reported in 80 percent of AA and 79 percent of the AAA schools.
Differences for Survey Item 27--The final survey item asked respondents if their district's drug/alcohol coordinator would be willing to provide information regarding that school's program. Sixty-one percent of the school personnel reported a desire to share information. Significant differences were reported among the schools responding. The differences were affected by the region, type, and classification of the school.

Differences found for all three variables reflected the general pattern recorded throughout this study. The school districts most likely to report employing drug and alcohol coordinators were those most likely to share information. As a consequence, City districts in the Northeast, were the ones most willing to share information.

Results of the chi-square analyses for the data in Theme 4, indicated that a similar pattern observed for previous themes was again maintained for inservice activities. Extensive inservice education, whether for students, staff, parents, or the community, was significantly more frequent in schools in the Northeast, Southwest, and Central regions of the state. For type of school and OHSAA classification, the pattern was identical. Among school types, City districts reported the most extensive inservice programs. Schools with larger
enrollments, those classified AAA or AA, also tended to provide more extensive inservice activities.

Interest in drug and alcohol education services for school districts was very high. Where significant differences did occur, they fit the same pattern evidenced throughout this study. It appeared that districts reporting the most comprehensive programs also expressed the most interest in providing increased services for the school's athletic program.

SUMMARY

In this chapter the findings of the research study were presented. Survey items were tabulated and the results presented in frequency tables. A chi-square analysis was run for all contingency tables as a test of statistical significance.

Survey items under Theme 1, Policy examined the extent to which Ohio high schools have established drug and alcohol policies for students and staff. Second, policy questions referred to the extent that school board policies had been enforced during the 1984-85 school year.

Based on the data reported from school officials, Ohio high schools were significantly more likely to adopt these policies for students than comparable policies for employees. The data indicated that school boards were four
times more likely to adopt drug and alcohol policies for students than for staff.

Student athletes were specifically affected by the enforcement of school chemical use policies. The self-reported data indicated that students in violation of the school policy were either suspended from athletic participation, referred for assessment, counseling, and/or chemical dependency treatment. According to the data reported by school personnel, over 40 percent of Ohio high schools have suspended student athletes for violations of the school's drug and alcohol policy.

The only regional difference observed for the policy questions were reported for schools with board adopted student policies. Regional differences were also reported for schools that referred student athletes for chemical use assessment, counseling, and treatment. The nature of these differences indicated that school districts in the Northeastern and Central regions were most likely to adopt and to enforce student policies.

The type of school significantly influenced the differences found among schools with employee policies and employee assistance programs. Private schools were reported as most likely to provide these services for employees.
Policy enforcement was also reported to be affected by the type of school. In each of the four areas studied, policies were enforced more frequently in City school districts. Based on the self-reports from school officials, Local districts had the lowest percentage of response for each of the enforcement items studied.

The size of a school was also found to significantly relate to the degree in which drug and alcohol policies are adopted and enforced. Student and staff policies, and employee assistance programs, were reported more often in schools classified AAA. Triple A schools also reported a greater tendency to suspend student athletes for policy violations as well as refer them for counseling, assessment, and treatment.

The second theme in the study investigated the extent to which Ohio high schools have hired individuals to function as program coordinators. A second issue of this theme was the extent to which schools have trained staff members to deal with the problems associated with adolescent chemical use.

School officials reported that only one-third of Ohio schools have hired a drug/alcohol coordinator for their district. The self-reported data also indicated that schools have spent time training staff in adolescent chemical dependency. Statewide, 70 percent of the schools
were reportedly involved with staff training. In addition, school staff reported that athletic coaches have been trained in 45 percent of the schools responding to the study.

Regional differences were found among the schools in all three staffing areas. The nature of the differences were consistent for each survey item. School districts in the Northeast reported a greater tendency to hire drug/alcohol coordinators, train staff, and to train interscholastic coaches.

The type of school was significantly related a school's staffing concerns. Reports from City school officials indicated this type of school was more frequently involved in hiring specialized staff, and in training existing staff in adolescent chemical dependency. Diocesan schools were also found to employ specialists and train staff in substance abuse education, at rates greater than in other Ohio schools.

The third theme investigated by this study dealt with the multidimensional nature of drug education. Specifically, these items endeavored to discover the type of drug education programs available in Ohio high schools.

The program questions identified three areas of investigation. One area concentrated on system-wide
program concerns. A second area covered the specific components of a high school program. Third, the resources used in program development were assessed.

General program concerns included a school's development of a K-12 written guidance plan that addressed drug, alcohol, and tobacco education, the development of short-term programs on chemical awareness for students, staff, and the community, and the use of local surveys in program development. The reports from school officials indicated greater involvement in providing short-term programs in substance abuse for students than in the other general program areas.

A second area studied the extent to which the various program components existed in Ohio schools. Of the eight components identified, the self-reported data indicated that identification and referral services for students, and an ongoing relationship with community agencies were reported in 84 and 91 percent of the schools respectively. Conversely, the components reported least often were schools with separate budgets for district-wide drug programs and those districts that host AA and NA meetings.

The resources used by schools in program development indicated a significant number of schools rely on the services of publicly funded drug and alcohol agencies. According to the reports from school officials, public
agencies were used most often, followed by private drug
treatment/training centers, and individuals with expertise.

The regional differences reported for these items
follow a general pattern. School districts in the
Northeast reported the most frequent use of short-term
programs for staff, parents and the community, while
schools in the Southeast consistently reported sparse use
of this program service. This pattern held true for
significant differences reported among the program
components studied. In all areas of statistical
differences for program items, schools in regions
containing major metropolitan areas reported more
comprehensive program services than districts in rural
regions.

Program differences reported among the various types of
school were consistently repeated. Officials from
City schools and Diocesan districts reported significantly
more frequent use of short-term awareness and comprehensive
program services than Local, Private, or Exempted Village
schools.

High school size was found to significantly relate to
the type of drug education programs existing in Ohio
schools. Once again, a consistent pattern emerged for
those items where significant differences were computed.
Schools classified AAA by the OHSAA reported more frequent use of programs for athletes, staff, parents, and the community. In addition, the type of program components reported in AAA and AA schools far exceeded those in operation in the smaller Class A districts.

The fourth area of investigation concerned the staff development activities as reported in Ohio schools. The data indicated that schools throughout the state were less involved in offering extensive inservice activities. Statewide, just one third of the schools reported extensive inservice activities for students and staff. Inservice programs for parent and community groups were reported in less than 20 percent of the schools responding. Finally, specific inservice programs for students athletes were reported in only 22 percent of the high schools.

The results of the chi-square analysis for the inservice items indicated a consistent pattern observed throughout this study. Significant differences by region were skewed toward schools in the Northeast. Officials in Northeastern school districts reported much greater use of extensive inservice for all groups in the study. These districts accounted for over half of the schools involved in providing extensive inservice programs to parents and the community.
The differences reported for type of schools were significant. City districts, as indicated from the self-reported data, were more frequently involved in intensive staff development activities than other type of schools. Over half of the schools reported inservice activities for staff, parents, and the community were City districts.

School size, as determined by OHSAA classification, was found to significantly influence extensive staff development in the schools. The schools with the largest student populations reported the most frequent use extensive inservice activities. Triple A school districts accounted for over 40 percent of all the schools with inservice training programs for students, staff, parents, and the community.

The findings in this study indicated an uneven response by Ohio high schools to the problems associated with adolescent chemical use and abuse. The statewide figures for the survey items indicated active involvement by schools in developing drug education programs and policies. As the self-reported data was further analyzed, significant differences were observed according to the location, type, and size of the school responding.

A clear and consistent pattern emerged from this data. Schools that reported the most comprehensive school-based chemical use and dependency programming were
City and Diocesan schools in the Northeast and Central regions of Ohio, and were classified AAA by the OHSAA.

Chapter V will present a discussion of these findings. The discussion will include the conclusions drawn from the data and recommendations based on the findings presented in this chapter.
CHAPTER V

SUMMARY, CONCLUSIONS, AND RECOMMENDATIONS

This chapter presents a summary of the findings of this study. It also includes conclusions that can be drawn from the data and recommendations for future programming and further research.

SUMMARY

Drug use has reached epidemic proportions in the United States. The impact of widespread chemical use has spread through all facets of society. Of particular concern are the alarming trends in adolescent drug use (Gallup, 1986; Johnston et al., 1986; Miller et al., 1983).

The federal government has initiated a response to this problem by forming a national policy through legislative action. Members of Congress have proposed to spend two billion dollars to slow the growth in the production, sale, and use of drugs (Congressional Quarterly, 1986). The federal program called for greater efforts in a number of key areas. Among them were attempts to block the flow of drugs into this country, put pressure on the pushers, and educate the youth.
The need to respond to this issue has also been recognized by leaders of organized sports at the professional, collegiate, and interscholastic level. In professional sports, management and individual athletes have unleashed a public relations campaign encouraging young people to "Just Say NO" to drugs (Talarigo, 1986). Neff and Sullivan (1986) report random drug testing is being sought by officials of the National Football League, and testing clauses are becoming commonplace in many professional contracts. School officials at the collegiate level are also actively involved in developing programs for athletes. In 1984 the NCAA conducted a survey on drug use among college athletes. The self-reported results revealed that, of the over 2,000 athletes surveyed, 36 percent used marijuana, 17 percent used cocaine, 8 percent used amphetamines, and 7 percent reported using anabolic steroids (NCAA, 1984).

At the scholastic level, the response is directed more toward education and prevention. Although drug testing for high school athletes has been proposed in the Hawkins, Texas school systems, this approach remains the exception rather than the rule ("Special Report," 1986). Most school districts prefer to address this issue through drug education.
The National Institute on Drug Abuse (1983b) estimates that 72 percent of the nation's 45 million elementary and secondary school children are offered some type of drug education program. Models for comprehensive school-based prevention programs were presented by the U. S. Department of Education (1986) in their action plan, What Works: Schools Without Drugs.

While a great deal of research exists regarding drug education and prevention, and trends in student chemical use (Johnston et al., 1986; Miller et al., 1983; Ryser, 1983), little data are available that describe the status of drug education at the state and local levels. This is particularly true for specific groups of students like the high school athlete.

The purpose of this study was to determine the status of drug and alcohol prevention activities in Ohio high schools as they related specifically to student athletes. A second purpose was to use the information obtained to generate recommendations for a comprehensive drug and alcohol education program at the state and local levels. The focus of the research was self-reported data from school officials in Ohio's 821 high schools.

The research questions were divided into four themes, Policy, Staffing, Programs, and Inservice. The following research questions were addressed under each theme.
Theme 1: Policy

1. What percentage of Ohio high schools are adopting policies that respond to student substance use and abuse?

2. What percentage of Ohio school districts are adopting policies that respond to the use and abuse of chemicals by employees?

3. Do Ohio high schools currently have chemical use and dependency policies that specifically affect the student athlete?

4. To what extent have school policies on student athlete use been enforced during the 1984-85 school year?

Theme 2: Staffing

1. What percentage of Ohio high schools have provided staff members with training in drug/alcohol prevention programs?

2. What percentage of Ohio high schools have a drug/alcohol coordinator position available as a member of the certified school staff?

Theme 3: Programs

1. What percentage of Ohio high schools are offering programs in drug education awareness and prevention?

2. What are the specific components of a school-based drug awareness/prevention program available in Ohio high schools?

3. What percentage of Ohio high schools provide drug awareness training programs for the student athlete?

4. What percentage of Ohio high schools use available resources to assist current drug education programs?

5. Does a need exist among Ohio high schools to develop new drug education programs or to add to programs currently in operation?
Theme 4: Inservice

1. What percentage of Ohio high schools are providing inservice activities in drug/alcohol education?

2. What percentage of Ohio high schools provide teachers and staff members training in chemical use and dependency prevention programs?

3. What percentage of Ohio high schools provide interscholastic athletic coaches with training in chemical use and dependency prevention programs?

These research questions were addressed by the Chemical Use and Dependency Survey. This instrument was developed by the author, and the Ohio High School Athletic Association Committee on Chemical Awareness, to provide information regarding school-based drug/alcohol programs and to determine the implications these programs have for the student athlete.

The Chemical Use and Dependency Survey was mailed to high school principals in each of Ohio's 821 high schools. Each principal was instructed to fill out the survey, or refer the survey to the individual in the school district most familiar with the school's drug policies and procedures. After the first mailing, 552 surveys were returned. A second mailing netted an additional 11 surveys, for a total return of 563, and a response rate of 69 percent.

High school principals were the individuals most likely to respond to the Chemical Use and Dependency
Survey, with 60 percent of the respondents, who indicated their school position, being principals. Other school personnel contributing to the study were athletic directors (23%), drug/alcohol coordinators (5%), other administrators, including superintendents (4%), school counselors (3%), other certified staff (3%), and high school coaches (2%).

Demographic data were also collected for the study. The pertinent demographics included a school's regional location, the type of school system, and the OHSAA interscholastic classification of the school. Those data were crosstabulated with each survey item to determine the effect these variables had on drug prevention activities in Ohio high schools.

The response for the six OHSAA regions showing, in parentheses, the total schools for each region and the percentage of total schools statewide, and the number of schools responding and the percentage of total response, are as follows; Central, (95, 12%); 65, 12 percent; East (59, 7%); 39, 7 percent; Northeast, (252, 31%); 167, 30 percent; Northwest, (170, 21%); 130, 22 percent; Southeast, (76, 9%); 53, 9 percent; and the Southwest, (169, 21%); 109, 20 percent.
The response for the five types of schools in the study, showing statewide figures in parentheses, are as follows; City schools, (279, 34%); 202, 36 percent; Exempted Village, (48, 6%); 31, 6 percent; Local schools, (388, 47%); 275, 49 percent; Diocesan schools, (83, 10%); 47, 8 percent; and Private schools, (21, 3%), 8, 1 percent.

A similar comparison is made for the third demographic variable. The response for the three OHSAA classifications are as follows; Class A (270, 33%); 154, 28 percent; Class AA, (263, 33%); 180, 33 percent; Class AAA (266, 33%); 173, 31%.

Both descriptive and inferential statistics were computed for this study. Initially, frequency and percentage tables were computed for each variable. Second, a chi-square analysis was computed for all contingency tables suggested by the research questions. The chi-square analysis tested the independence of the samples in the analysis at the .05 level of significance.

SUMMARY OF FINDINGS

Policy-- A summary of the policy questions indicated that Ohio high schools were almost four times as likely to report providing board adopted chemical use and dependency policies for students as they were for employees. The
extent to which board adopted policies have been
implemented in Ohio schools is presented below:

Eighty percent of Ohio high schools have
implemented, through board action, chemical use
and abuse policies for students.

In 23 percent of the schools, similar
policies for employees were reported.
Additionally employee assistance programs were
reported in only 9 percent of the high schools.

High school student athletes were also affected by the
chemical use and dependency policies established by the
schools. Violations of the chemical use policy resulted in
student athletes being suspended from athletic
participation, referred for counseling or assessment,
and/or referred for treatment. The results of the self-
reported data for those items affecting the enforcement of
school policy are presented below:

In Ohio, 42 percent of the high schools
reported suspending student athletes from
interscholastic participation due to drug
and alcohol policy violations.

In 33 percent of the schools, athletes
in violation of the school chemical use policy
were referred for counseling.

In 29 percent of the schools, officials
reported student athletes were referred for
chemical dependency assessment.

In 18 percent of Ohio high schools,
student athletes were referred for in/out
patient treatment for chemical dependency.
The chi-square analysis revealed significant differences among the policy questions for OHSAA region, type of school, and OHSAA classification. The following differences were observed from the data reported by school officials:

High schools in the Northeast, Central, and Southwest regions were significantly more likely to have adopted a chemical use policy for students.

No regional differences were noted for employee policies and schools with EAP's.

Schools in the Northeast, Central, and Southwest regions of Ohio were significantly more likely to have referred student athletes for counseling, assessment, and/or chemical dependency treatment.

No significant differences were found by region for suspension of student athletes.

The type of school was significant for schools with policies for employees and for schools with employee assistance programs.

Private schools and city districts were the type of systems most likely to provide these employee services.

City School districts were the type of schools representing the largest percentage of systems enforcing chemical use policy violations for student athletes.

This was true for each of the four variables measuring the enforcement of school policy.

High schools classified AAA by the OHSAA were much more likely to have drug/alcohol policies for students and employees, as well as to provide EAP's, than smaller, AA and A school districts.

Triple A schools were also much more likely to suspend student athletes, refer them for counseling or assessment, and/or refer them for treatment, than schools classified AA or A by the OHSAA.
Staffing-- The second set of research questions addressed the issue of staff development approaches used by Ohio high schools to combat adolescent chemical use. The response by schools to address the staffing concerns for effective drug prevention activities included creating a staff position for a drug/alcohol coordinator, training teachers and other school personnel, and training interscholastic coaches.

The results of the self-reported data concerning the various approaches to staff development are presented below:

- Thirty-two percent of Ohio high schools reported having a drug/alcohol coordinator on staff in their school district.

- Staff members in 70 percent of Ohio high schools have received training on adolescent substance abuse.

- Interscholastic coaches in 45 percent of the schools have also received training on adolescent chemical use and dependency.

Significant differences were found by region, type of school, and classification for the three survey items under Theme 2, Staffing. The nature of the differences follow the same pattern observed for the policy data described above. Results of the chi-square analysis are presented below:
School districts in the Northeast reported having significantly more drug/alcohol coordinators on staff than schools in other regions of the state.

Schools in the Northeast, Central, and Southwest regions also provided training for staff and coaches more frequently than districts in the East, Northwest, and Southeast.

City schools represented the largest percentage of schools with drug/alcohol coordinators, as well as the type of school providing the most training for staff and coaches.

The larger the school classification, the greater the involvement with staff development activities.

Triple A schools were more likely to report drug/alcohol coordinators on staff as well as to provide special training for staff members and coaches.

Programs-- Theme 3, Programs, addressed the extent to which Ohio high schools are involved in providing drug education prevention programs and activities. School officials reported providing a wide range of services that encompass drug education programs. Program components included direct educational and support services to students, and indirect services to the school and the community.

The self-reported data indicated that a large percentage of high school programs provided direct educational services in substance abuse education to students. Educational services were also provided for
special groups like athletes, staff, parents and the community, but in significantly smaller percentages.

The frequency with which these services were reported in Ohio schools is presented below:

Eighty-nine percent of the schools provided short term programs to develop drug and alcohol awareness programs for students.

Respondents in 58 percent of the schools indicated their district had a K-12 written guidance plan that included chemical use and dependency issues.

Fifty-seven percent of the schools provided short term programs to develop drug and alcohol awareness programs for athletes.

Similar programs for staff members were found in 56 percent of the schools.

In 52 percent of the schools, preventive education programs, exclusive of the school health curriculum, in grades K-12, were reported.

Fifty-one percent of the respondents reported short-term programs for parents, while 45 percent indicated programs for the community.

Program components that identify troubled students and provide for their referral to community agencies, were evident in most school districts. Other direct support services, however, were not reported as frequently in the schools. These services included in-school support groups, core or building teams, AA or Alanon meetings held in the school, and a separate budget for drug and alcohol programs.
The statewide percentages for these services are provided below:

In 84 percent of the schools, respondents reported an identification and referral system for students.

In 91 percent of the schools, an ongoing relationship with community counseling agencies was maintained for the purpose of student referrals.

In 55 percent of the schools in-school support groups were held. Support groups for parents were available in 30 percent of the districts.

In 41 percent of the schools, core teams were reported as part of a chemical use or dependency program.

Twenty-two percent of the high schools reported a separate budget for a district-wide drug and alcohol program.

Thirteen percent of the schools in Ohio reported hosting AA, NA, and/or Alanon meetings at school for recovering students.

The research questions for Theme 3 also investigated the type of resources used to provide services to the school's drug/alcohol program. The results reported from school staff indicated that publicly funded drug and alcohol agencies were used most frequently. Conversely, less than one-third of the respondents reported using the resources available in other school districts, and in local colleges and universities.
A review of the findings reveal the following percentages statewide:

Seventy-six percent of the schools reported using publicly funded drug and alcohol agencies as a source of information.

In 59 percent of the schools, private treatment centers and/or training/education centers were used.
In addition, the 59 percent of the districts reported utilizing individuals with expertise in adolescent chemical dependency.

Thirty-two percent of the respondents reported using the resources available in other school districts.

Twenty-three percent of the schools reported using colleges and universities as a source of chemical use and dependency information.

The test of significance for the 19 survey items concerned with drug programs in Ohio schools resulted in differences among the schools according to region, type of school, and classification. The nature of the differences were very similar to the patterns found under the policy and staffing questions. A summary of the results of the chi-square analysis is presented below:

Schools in the Northeast, Southwest, and Central regions reported significantly more services than schools in the East and Southeast regions.
Schools with a comprehensive drug education program, incorporating most of the direct and indirect services to school and community, were found most frequently in the Northeast region of the state.
This district, along with the Southwest and Central region, is more representative of the major urban/suburban areas of the state.

Significant differences were found in 18 of the 19 survey items for type of school. The highest percentage of program components were reported from staff in Diocesan districts, followed by either private or City schools. City schools were more likely to report providing direct and indirect student services as a part of the drug education program.

School size was also found significantly related to 18 of the 19 survey items for Theme 3, Programs. Schools with the largest enrollments were most likely to provide the program components investigated. Triple A high schools tended to provide a drug program that offered more education, prevention, and support services than schools classified either A or AA.

Inservice—According to the reports of school officials, data for the research questions under Theme 4, Inservice, indicated that extensive inservice training is not widely available in Ohio high schools. Nevertheless, the data indicated that a significant number of schools expressed interest in inservice workshops and training programs for their high school athletic program.

In Ohio, schools were more likely to report providing extensive inservice training for teachers and students than for parents and the community. A summary of the frequency and percentage of response is presented below:
Thirty-five percent of the schools reported extensive inservice training for staff, while training programs for students were reported in 33 percent of the high schools.

Student athletes in 22 percent of the schools received extensive inservice training. This service was offered to parents and the community in 16 percent of the schools.

Eighty-seven percent of the districts indicated an interest in a one or two day workshop for student athletes.

In 85 percent of the schools, interest in extensive training in adolescent chemical use was indicated for athletes.

In 73 percent of the schools with ongoing programs, respondents indicated an interest in further assistance with their student athlete training program.

Significant differences were reported among the schools that provide extensive inservice training for students, staff, parents, and the community. A summary of the chi-square analysis indicated the nature of the differences according to region, type of school, and OHSAA classification. The results are presented below:

The frequency of schools reporting extensive inservice programs was greatest in the Northeast region.

Schools in the Southwest and Central regions were also more likely to report extensive inservice programs than districts in the Northwest, Southeast, and the East.

The type of school was a significant variable among schools with inservice training for staff, parents, and the community, but not for schools with student inservice program.
Programs of this type were found most frequently in City schools districts, followed by Diocesan and Local schools. Private schools represent the type of school least involved with providing inservice education to non-student groups.

OHSAA classification was found to be significantly related to inservice training programs in Ohio high schools. Once again, AAA schools provided inservice activities for all four variables more frequently than schools classified AA or A.

The summary of the data suggest that Ohio high schools have been actively involved in providing policies, programs, and staff development activities in the area of chemical use and dependency. It is also clear that drug education is significantly affected by a school's regional location, type of school district, and class size.

CONCLUSIONS

The following conclusions can be drawn from the findings in this study. The conclusions are presented under the four thematic headings investigated.

Theme 1: Policy

First, it can be concluded that high schools throughout Ohio have actively adopted chemical use and abuse policies for students. This is based on the fact that 8 out of 10 schools have reported establishing guidelines regulating the use, possession, and sale of a
controlled substance on school grounds or at school 
events. School board policies on chemical use and abuse 
were reported in place equally among the various types of 
schools in the state, regardless of region, type, and OHSAA 
classification.

Second, it can be concluded that a school's response 
to the chemical use and dependency needs of staff members 
was less evident. This is based on the fact that less than 
one-quarter of Ohio schools reported a board adopted 
chemical use policy for employees. In addition less than 1 
in every 10 school systems reported offering a employee 
assistance program for certified and classified staff 
members.

Third, it can be concluded that the student athlete is 
being affected by the enforcement of drug and alcohol 
policies in Ohio high schools. The effect of a school's 
policy on student athletes often resulted in the individual 
being suspended from athletic participation. This type of 
response was the most frequent consequence reported by 
school officials. Other consequences included student 
referrals for chemical dependency assessment, referrals for 
counseling, and recommendations for drug treatment. Each 
approach included either complete or partial termination of 
the athlete from his/her sport.
One implication of these policy conclusions is that such punitive consequences may inhibit coaches from directly intervening with a troubled athlete. As a consequence, alternative plans and policies that stress education and prevention, must be considered for special groups such as student athletes.

**Theme 2: Staffing**

A fourth conclusion drawn from this study addresses the extent to which Ohio schools have trained staff members to meet the special needs of the student population. Based on the self-reported data, it is clear that schools are actively involved in providing teachers and staff with training in adolescent chemical use and dependency. Seven out of 10 schools in the state have provided their staff members with training in drug education and prevention.

A fifth conclusion, is that school systems have not yet recognized the need for expanded training to include other support staff such as scholastic coaches. High schools in Ohio are equally divided among those that have provided substance abuse training for coaches and those that have not. The figures show 45 percent of the schools reported offering training for coaches. The same percentage of schools (45%) indicated they did not provide specific training in adolescent chemical dependency for
coaches. This split suggests the next wave of chemical use training may be directed toward coaches and other support staff.

Sixth, while on a general level, the self-reported data indicated a positive trend in staff development, nevertheless, it can be concluded that, for the most part, schools have failed to employ specialists to coordinate drug education programs. Less than one-third of Ohio schools reported having a drug/alcohol coordinator on staff. This figure was significantly lower for those smaller school districts in the rural regions of the state.

A second implication can be drawn from these conclusions. While the plan for many school districts appears to lie in the training of staff members, there is little evidence that schools are interested in adding a staff position to coordinate comprehensive drug programing and planning. As a consequence, many school-based programs lacked district-wide organization and coordination.

Theme 3: Programs

A seventh conclusion drawn from the data indicate that drug education programs in Ohio high schools were multifaceted. At the same time, there were also clear common denominators that link many individual programs with those in other districts. Specific program areas, like
student/staff development, and program emphases, like intervention/referral, were consistently reported in over half of the schools responding to the survey.

The use of short-term substance abuse programs for students was one program area reported in most Ohio schools. This was reported in roughly 90 percent of the schools, regardless of regional location, type of system, or school size. A significant number of drug awareness programs were also reported for student athletes and staff members. In some schools these programs were available for parents and the community as well, but at rates much less frequent than those for school personnel. Drug education programs in the schools were clearly designed for the student first, and then expanded to other support personnel.

In addition, there appeared to be significant agreement among schools regarding the essential components of a school-based drug education program. The three components reported most frequently by school officials were (a) the maintenance of an ongoing relationship with community agencies, (b) an identification and referral system for students with problems, and (c) in-school support groups for students.

Eighth, it can be concluded from the data that there is sufficient evidence for defining significant elements of
a comprehensive, K-12 drug and alcohol prevention program. In addition to the components listed above, those districts with comprehensive programs tended to report a broader range of services. Although reported less frequently in Ohio high schools, the districts with broad based programs tended to include the following components.

In the area of education/prevention, comprehensive programs included (a) K-12 curriculum infusion activities, (b) a K-12 written guidance program, (c) student leadership programs, and (d) programs for parent and community involvement. Components that emphasized intervention/referral included (a) student and employee assistance programs, (b) support groups for students and staff, and (c) athletic/co-curricular programs. In addition, many of the schools with comprehensive services reported having a district-wide budget for drug education programming and planning.

Nine, it can be concluded that Ohio high schools have not taken advantage of either the resources available in local colleges and universities, or collaboration with other school systems regarding prevention programs in operation. This finding suggests that these two sources of information need to be cultivated to assist in the development or expansion of drug education in Ohio schools.
Tenth, it can be concluded that drug and alcohol prevention programs in Ohio high schools are significantly different according to OHSAA region, type of school, and OHSAA classification. Regardless of the survey item investigated, when schools differed they tended to differ in the same direction, according to region, type of school, and size.

Regionally, districts in the Northeast section of the state reported school-based programs that were more developed and provided a wider range of services. They were followed by schools in the Central and Southwest regions, and sometimes by schools in the Northeast. Typically, schools in the Eastern and Southeastern regions lagged far behind in terms of program development.

The type of school also provided a clear picture of those schools with broad based programs and those with limited services. City schools and Diocesan schools tended to report a more complete approach to drug programming in their districts, while Local schools reported the most limited programs.

School size was another variable crosstabulated with each of the survey items. The data demonstrated that schools with the larger classifications tended to offer more in the area of drug policy, staffing, programming, and inservice. In most cases, the size of the school was
directly proportional to the extent of the drug education program. As a consequence, schools classified AAA reported the most comprehensive drug programs compared to AA and single A districts.

**Theme 4: Inservice**

Eleventh, it can be concluded that high schools appeared to prefer short-term awareness activities to extensive inservice training. Extensive training for students and staff were reported in just over one-third of the high schools. Less than 20 percent of the schools reported extensive inservice to parents and the community. Short-term programs for students, staff and others were used much more frequently.

This was also true of training programs for student athletes. Short-term programs for this population were reported in 57 percent of the schools. Reports of extensive training for athletes were found in 22 percent of the schools. In those schools that reported training, over 4400 athletes were involved. Of that group, 4047 student athletes were trained in sessions lasting less than one day.

Schools were not inclined to allocate large blocks of time to the extensive training and education of students and staff in the area of adolescent chemical abuse. This
was reinforced when schools indicated three times as much interest in a 1 or 2 day workshop for athletes rather than a workshop lasting 3 to 5 days.

Twelfth, it can be concluded from the inservice data that given the differences among the schools, there still exists an interest among school districts to develop or expand drug education services. This is particularly true for services related to the student athlete. Eighty-seven percent of the schools indicated an interest in a 1 or 2 day chemical use and dependency workshop for the athletic program. In addition, 85 percent of the schools also expressed interest in developing a student athlete training program that would address chemical use and dependency among adolescents.

A profile of the high schools reporting the most comprehensive programs can be concluded from the self-reported data in this study. City School districts in the Northeast, Central and Southwest regions of Ohio, with large student populations, consistently reported the most comprehensive prevention programs for students and staff as well as for special at-risk groups like the student athlete.
RECOMMENDATIONS

The findings in this study can be used to develop a statewide agenda for drug education in Ohio high schools. The information can be used as a point of departure that frames the current status of drug education activities within a statewide context. Additionally, the findings may be used to guide the process of developing programs, at the state and local level, for the student athlete.

Theme 1: Policy

According to the self-reported data from school officials, chemical use and abuse policies were in place in most schools for the general student population. The enforcement of this policy to specific student groups, like student athletes was, at best, inconsistent. In addition, the percentage of athletes penalized under the school policy was significantly less than expected frequencies based on trends reported in student use surveys for athletes (American Association of Youth Sports, 1983; U. S. Department of Justice, 1984c). Based on this data, the following policy recommendations are made.

First, it is recommended that the Ohio High School Athletic Association (OHSAA) develop a procedure for addressing statewide consistency among policies for
athletes. In addition to establishing criteria for academic eligibility, the OHSAA must also set minimum standards in response to chemical use and abuse in interscholastic sports.

This policy must not rely solely on punitive measures like suspension or expulsion from athletic participation. Rather, the guidelines must include provisions for the education/prevention, intervention/referral, and the treatment/follow-up areas associated with chemical use problems by the student athlete.

A model for this plan is in operation at the state level in Minnesota. The Minnesota State High School League (MSHSL) forbids students to use alcohol and tobacco, and forbids them to use, possess, purchase, or give away any other controlled substance (MSHSL, personal communication, September 7, 1985).

Students in violation of this policy, at any time during the school year, receive specific penalties for first, second, and third offenses. Each penalty includes a loss of eligibility for a specified amount of time and a recommendation for drug education activities and/or treatment. Penalties are accumulative throughout the individual's participation on a varsity, junior varsity or sophomore team activity.
This study has demonstrated that many high schools are searching for chemical use policies for student athletes that are firm and fair and that can be effective deterrents to adolescent chemical use. In addition, in the literature review section of this study, it was noted that a number of Ohio high schools have moved in the direction of establishing codes of conduct for athletes and students participating in other extracurricular activities.

Statewide procedures, developed and regulated by the OHSAA, would provide continuity and clarity from school to school, regarding the use of mood-altering chemicals by high school athletes. The flow chart illustrated in Figure 2 outlines the recommended procedures for the OHSAA.

The athletic policy is a two-step process of education and intervention that affects all student athletes, not just those in violation of the school policy. It is introduced by school personnel during pre-season education activities for coaches, players, and parents. The rules and the code of conduct are discussed at this time.

The code of conduct policy involves a three-step process of non-participation and education for athletes in violation of the stated policy. The severity of the penalty is determined by the nature of the violation and the number of previous infractions by the student athlete.
Figure 2. Athletic policy flow chart (Quaranta, 1987)
Penalties for the first offense are not as severe as those for repeated violations. In the same manner, a student making a self-referral for assistance is penalized less than a student who has been reported for violating the athletic policy.

Nevertheless, students at the first step of the policy will be required to participate in specific services or programs related to chemical use and dependency. These may include education sessions for the player and his/her family, counseling or support groups, and peer activities for athletes.

Violation of the code a second time will result in the student athlete being required to participate in more intensified prevention and intervention activities. Completion of these activities may become a prerequisite for a student athlete's reinstatement on the team.

A third violation within a school year will result in automatic expulsion from the activity. The student may be required to enter an in-patient treatment center before provisions for reinstatement are considered. This consideration is a part of the appeal process available to the student at this step.
Theme 2: Staffing

Second, it is recommended that school officials throughout the state develop a plan to coordinate comprehensive drug education programs in their district. If feasible, a drug/alcohol coordinator is recommended for each district to direct the planning and programming for a K-12 plan.

Two types of data support the need for intensive and extensive coordination. One, a review of the literature on student use indicated that adolescent chemical use has reached epidemic proportions (Buchanan, 1984; Johnston et al., 1986; Miller et al., 1983). Two, substance abuse programs are becoming more developmental in nature as they stress prevention. Therefore, comprehensive programs now deal with positive issues like self-concept, decision-making, and peer and family relationships, in addition to drug specific information (Charlotte Drug Education Center, 1981; Lerner & Naiditch, 1982).

Three levels of coordination are recommended in this plan. The first level involves the district-wide coordination of a K-12 program. The second level of coordination is at the elementary school, middle/junior high school, and senior high school levels. Building level coordination is the third type recommended.
Through comprehensive coordination, schools can establish the guidelines and direction for a K-12 plan for education, prevention, and intervention. It is recommended that the coordination efforts or the drug/alcohol coordinator work either in concert with, or as a part of, the school's guidance department.

Where drug/alcohol coordinators are employed, they facilitate the development of a comprehensive drug education program that incorporates counseling, consulting, and coordination services. Working closely together, school counselors and drug/alcohol coordinators can maintain compliance with state standards for both guidance services and programs in drug education. In addition, schools with coordinators have networked effectively with other school districts to coordinate use of materials, identify gaps in services, and to provide synergy in program development.

Third, it is recommended that the Ohio High School Athletic Association become actively involved in the staff development of coaches, regarding issues related to adolescent athletes and mood-altering chemicals. It is recommended that the OHSAA require all coaches to receive training on adolescent chemical use and its implications for the student athlete. In addition, this training shall
be updated every two years to provide coaches with the most current information in the field.

Certification for this type of training would be similar to the present requirements for coaches inservice education in Sports Medicine and Cardiopulmonary Resuscitation (CPR) training. Currently the OHSAA requires every first year coach to participate in six hours of training in injury prevention and medical care for the student athlete. Every year coaches in Ohio are further required to take a three hour refresher course in this area. Additionally, coaches must also receive certification in CPR training once in their coaching career.

This recommendation is based upon current practices within the OHSAA and the data reported in this survey. The self-reported data indicated that over 85 percent of the respondents expressed interest in attending workshops on adolescent chemical use and the high school athlete.

Theme 3: Programs

The data reported from school officials indicated that a wide-range of drug education programs are in operation in Ohio schools. The extent of the school-based programs ranged from those districts reporting comprehensive
services for students, staff, and the community, to those schools with very limited programs.

Fourth, given the variance in high school programs, it is recommended that the Ohio State Department of Education assist in the development of a K-12 comprehensive drug education program for the state's schools. A written plan for drug education is the first step in a statewide assault on the problem of adolescent chemical use.

A comprehensive program sets policy, coordinates services, and provides staff development. Under these three main headings, the target areas of school programming need to be identified. The general program areas in a school-base plan includes the following components; education/prevention, intervention/referral, and treatment/follow-up.

Drug and alcohol prevention activities are developed from the target areas discussed above. They are infused within the total school context through the K-12 curriculum and as a component of a K-12 written guidance plan.

A model for a school based program is offered in Figure 3. This model provides a framework for a comprehensive plan for school-based drug prevention.

The specific services offered in this comprehensive plan are divided into program areas that provide direct and indirect service to students, staff, and parents.
SCHOOL PROGRAMMING FOR SUBSTANCE USE AND ABUSE

K-12 COMPREHENSIVE PROGRAM
POLICY COORDINATION STAFF DEVELOPMENT
EDUCATION INTERVENTION TREATMENT
PREVENTION REFERRAL FOLLOW-UP

K-12 CURRICULUM INFUSION

K-12 WRITTEN GUIDANCE PROGRAM

STUDENT ASSISTANCE PROGRAM
ATHLETIC/CO-CURRICULAR ASSISTANCE PROGRAMS

EMPLOYEE ASSISTANCE PROGRAM

STUDENT LEADERSHIP PROGRAMS

STUDENT/STAFF SUPPORT GROUPS

PARENT INVOLVEMENT PROGRAMS

COMMUNITY INVOLVEMENT PROGRAMS

Figure 3. Model of school programming for substance use and abuse (Quaranta, 1987)
One component of the school program is the student assistance program (SAP). The goal of this service is to identify those students whose school or extracurricular performance has been negatively affected by alcohol, other drugs, or personal family problems (NIAAA, 1984).

The student assistance program, within a school context, aims to prevent students from using alcohol and other drugs. A second goal is to teach students abusing chemicals about the negative consequences of their use. Student participation in this program is addressed through the school's referral policy. Mandatory referrals, or self-referrals by the student, are made with strict adherence to confidentiality.

Programs for specific groups of students, like the high school athlete, are also a part of the student assistance component. Procedures and activities in the athletic/co-curricular assistance program are similar to those in the SAP's.

Other program areas within the school context are, employee assistance programs, student leadership programs, and student/staff support groups. The employee assistance program coordinates the intervention and referral services for staff members with alcohol or other drug problems.
Student leadership programs address the prevention and education needs of students through the use of positive peer influence. Program activities include the training of peer-counselors and peer-education group leaders.

The student/staff support group component is involved with both the education and intervention aspects of the school program. Support groups are educational when they address skill development activities to facilitate drug-free decisions by students. They also serve as an appropriate intervention by offering support to groups confronting issues related to chemical use and abuse.

A comprehensive school program must also include support from parent and community groups. According to the self-reported data in this study, there existed a paucity of school-based programs that extended services to parents and members of the community. The plan recommended in this study incorporates programs for parent and community involvement.

The responsibilities for providing these services outside the school are shared between school personnel and community members. The development of an effective network between the school, parents and the community is essential for successful school programming.

The components of the model recommended above are organized into a planning grid for school programs.
(Quaranta, 1987). The planning grid is recommended for use by the State Department of Education to facilitate the development of a comprehensive school-based substance abuse program. The school program and planning grid is presented in Figure 4.

The State Department of Education can use the planning grid in three ways. First, it can assess the current status of programs across a consistent framework. Second, it could be useful in identifying current programs needing further development, eliminating overlap, and extending programs through collaboration with other districts. The third use could be for developing a comprehensive plan for evaluation that is both formative and summative.

A fifth recommendation is that school districts allocate funds specifically for the school's drug education program. A separate budget for drug education would serve a dual purpose. First, it would provide the program the flexibility to offer drug awareness programs and inservice activities in a timely and consistent manner. Second, this would confirm the district's commitment to addressing the issues of substance abuse in the schools and community.
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Figure 4. School program and planning grid (Quaranta, 1987)
Theme 4: Inservice

Sixth, it is recommended that the Ohio High School Athletic Association develop and offer training workshops on adolescent chemical use and dependency for coaches and student athletes. The OHSAA can coordinate and develop training workshops by first identifying those districts with outstanding programs already in place. This study can generate both the names of schools with comprehensive programs and the individuals willing to assist in the development of statewide workshops.

According to the data, the two sources of drug and alcohol information used least by schools in developing their programs were colleges and universities, and other school districts. The OHSAA can facilitate the development of the training workshops by tapping into these two valuable resource areas.

A resource list of college and university personnel as well as individuals from schools throughout the state with exemplary programs can be generated by the OHSAA. These support people can provide direction and assistance to local schools in their region of the state. The Ohio High School Athletic Association can provide low cost training for school systems that would be both economically feasible and educationally sound.
In addition it is recommended that these training workshops be designed to service those schools in greatest need of developing a drug/alcohol program for student athletes. According to the data in this study, the schools with the most limited programs for students and athletes can be identified. They are the Local School districts, classified Class A, that are located in the Eastern and Southeastern regions of the state.

Initially, workshops conducted by the OHSAA can be directed to the schools identified in this study as either having limited programs for drug and alcohol education and/or those with no program in operation. When every high school in the state has provided programs for student athletes on chemical use and dependency, then training in specific areas such as athlete code of conduct policies can be provided.

RECOMMENDATIONS FOR FURTHER RESEARCH

Specific recommendations for further research are drawn from the conclusions of this study. The areas requiring further investigation are offered below.

First, it is recommended that a study be conducted which addresses the following questions. What is the current status of athletic/activity codes of conduct in Ohio high schools? What is the relationship of these codes to the program goals for athletic participation and extracurricular involvement?
Second, it is recommended that a study be conducted which examines if athletic codes of conduct reduce the incidence of adolescent chemical use during the school year in general, and during the period of extracurricular participation, in particular?

Third, it is recommended that a study be conducted which addresses the following question. Do schools with comprehensive drug and alcohol education programs for athletes differ by such variables as co-educational schools vs. single-sex schools, per-pupil expenditure, county, and success of the athletic program?

Fourth, it is recommended that a study be conducted which addresses the following questions. To what extent are athletic codes of conduct enforced in Ohio high schools? How does the enforcement of these codes differ according to school size, per-pupil expenditure, success of athletic program, and county or regional location?

Fifth, it is recommended that a study be conducted which examines if high schools within large city districts differ in the type and extent of drug prevention activities for students and athletes?

Sixth, it is recommended that a study be conducted which examines the extent to which interscholastic athletic participation provides special risk for the wholistic development of students?

The incidence of drug use among young school aged students has reached crisis proportions in this country. The literature in this field covers various studies on patterns of adolescent drug use, the effects of chemical use on student achievement, the efficacy of drug education as a means of prevention, and the use of drugs in sports by both professional and amateur athletes.

The findings in this study have hopefully contributed to an understanding of the response by Ohio high schools to
the problem of adolescent chemical use. Further, this study has offered a look at how school-based policies and programs can impact a specific student group such as the high school athlete.
APPENDIX A

COVER LETTER
CHEMICAL USE AND DEPENDENCY SURVEY
AND
FOLLOW-UP LETTER
Dear OHSAA Member School Principal,

Recognizing that a serious problem exists in our schools today with the use of alcohol and other drugs, the Ohio High School Athletic Association, in cooperation with Heitzinger and Associates and The Ohio State University, is offering a series of two-day workshops in the fall on chemical dependency for coaches and team captains. As a part of this workshop series, follow-up services will be provided to schools who wish to continue with student athletic assistance programs.

In order to better determine the current status of programs in Ohio schools, a survey is being conducted by the Ohio State University. The results will be used to assist member schools with ongoing program activities. Enclosed is a survey requesting information specific to your school district. Please complete or refer the form to your drug/alcohol coordinator or counselor for completion and return in the enclosed envelope (22c postage required). A summary of the results will be provided to you by the Ohio State University.

Your cooperation in returning the survey by May 6, 1985, will be greatly appreciated. We feel this data will provide a good foundation for effective state wide program for dealing with chemical use and dependency among students and athletes. We believe the workshop series and the follow up services will be most helpful to you in your future plans for dealing with this serious problem.

Thank you very much for your help and cooperation.

Sincerely,

Chemical Awareness Committee of the OHSAA
CHEMICAL USE AND DEPENDENCY SURVEY

RETURN TO:
Ohio High School Athletic Association
80 Roselea Place
Columbus, Ohio 43214

CHEMICAL USE AND DEPENDENCY SURVEY

School District: __________________________  Respondent: Name: _______________________

Position: ______________________

PLEASF RESPOND TO EACH OF THE ITEMS BELOW BY PLACING A CHECK MARK ( ) IN THE APPROPRIATE SPACE AT THE LEFT OF THE ITEM.

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
<th>Don’t Know</th>
<th>Does your school district provide the following:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>1. Board adopted chemical use or dependency policy for students?</td>
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<tr>
<td></td>
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<td></td>
<td>2. Board adopted chemical use or dependency policy for employees?</td>
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<td></td>
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<td></td>
<td>3. An Employee Assistance Program?</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>4. A K-12 Written Guidance Program regarding chemical use or dependency?</td>
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<td></td>
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<td></td>
<td>5. A drug and alcohol coordinator position... Full-time? ___ Part-time? ___</td>
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<td></td>
<td>6. Short term programs to develop drug and alcohol awareness for...</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>a) Students?</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>b) Athletes?</td>
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<td></td>
<td></td>
<td></td>
<td>c) Staff?</td>
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<td></td>
<td></td>
<td></td>
<td>d) Parents?</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>e) Community?</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>7. Extensive inservice training programs on chemical use or dependency for...</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>a) Students?</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>b) Staff?</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>c) Parents?</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>d) Community?</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>8. Locally conducted surveys on chemical use and dependency to assess...</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>a) Student knowledge?</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>b) Student attitudes?</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>c) Student use?</td>
</tr>
</tbody>
</table>

With regard to a chemical use and dependency program, does your school district provide the following:

9. Identification and referral system for students with problems?
10. Ongoing relationship with community agency(ies) for counseling?
11. In-school support groups for students?
12. Preventive education program at grade K-12, other than health?
13. Budget for a district-wide drug and alcohol program?
14. Core teams or building teams as a part of its chemical use or dependency program?
15. Parent support groups?
CHEMICAL USE AND DEPENDENCY SURVEY (Continued)

Yes No Don’t Know

16. Does your school district host meetings for Alcoholics Anonymous,
Narcotics Anonymous and/or Al-Anon?

17. Have staff members received training on adolescent chemical use
or dependency? If yes, how many attended...
3-5 day sessions? 1-2 day sessions? Less than 1 day?

18. Have coaches in your district received training on adolescent
chemical use or dependency? If yes, how many attended...
3-5 day sessions? 1-2 day sessions? Less than 1 day?

19. Have student athletes in your district received training on
chemical use or dependency? If yes, how many attended...
3-5 day sessions? 1-2 day sessions? Less than 1 day?

20. Drug/alcohol policy violations: During the 1984-85 school year,
how many student athletes in your district were:

a) Suspended from athletic participation?

b) Referred for assessment?

c) Referred for counseling?

d) Entered in an in- or out-patient program?

Please indicate resources used by your district for chemical use
or dependency related services.

21. Colleges and Universities. Please specify_______________________

22. Other school districts. Please specify__________________________

23. Publicly funded drug/alcohol agencies. Please specify___________

24. Private drug/alcohol treatment centers or training/education
programs. Please specify______________________________

25. Individuals with expertise in chemical use or dependency Please
specify__________________________

26. I would be interested in the following chemical use or dependency
services for the athletic program in my district:

a) A 1- or 2-day workshop.

b) A 3- to 5 day extensive workshop.

c) Student athlete training programs.

d) Help with ongoing student athletic assistance program.

e) Other. Please specify__________________________

27. Would your drug/alcohol coordinator be willing to provide additional
information about the chemical use or dependency program in your district?
If yes, Name__________________________ Phone__________________

Address______________________________
Early in May, the OHSAA surveyed member schools for information on alcohol/other drug education and prevention activities. The response was excellent and survey information is currently being tallied and analyzed.

Because we would like our report to reflect as complete a view as possible, this follow-up letter and attached form are being sent to schools from which (1) no survey was returned, and (2) the form was received but did not identify the school, principal, or athletic director.

If you did not complete the first survey, we would greatly appreciate your help in completing the form enclosed with this letter. If you did complete the first form but did not identify your school, the data will be included but we will be unable to provide a complete analysis of statewide activities. Therefore, we would like either a new survey form completed, or an indication from you that you did complete and return the first survey.

We understand that this time of year is a busy one, however, we would very much like your district's activities to be represented in our statewide information on alcohol/other drug education activities.

Thank you for your help in this important effort.

Sincerely,
APPENDIX B

DEMOGRAPHIC SUMMARY RESULTS
OF THE
CHEMICAL USE AND DEPENDENCY SURVEY
DEMOPGRAPHIC SUMMARY
RESULTS OF THE CHEMICAL USE AND DEPENDENCY SURVEY

1. OHSAA Regional District

<table>
<thead>
<tr>
<th>Region</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Central</td>
<td>12%</td>
</tr>
<tr>
<td>Northeast</td>
<td>29%</td>
</tr>
<tr>
<td>Southwest</td>
<td>9%</td>
</tr>
<tr>
<td>East</td>
<td>7%</td>
</tr>
<tr>
<td>Northwest</td>
<td>21%</td>
</tr>
<tr>
<td>Southwest</td>
<td>21%</td>
</tr>
</tbody>
</table>

2. Type of School District

<table>
<thead>
<tr>
<th>Type of School District</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>City School District</td>
<td>34%</td>
</tr>
<tr>
<td>Exempted Village School District</td>
<td>6%</td>
</tr>
<tr>
<td>Local School District Within a County System</td>
<td>47%</td>
</tr>
<tr>
<td>Diocesan School District</td>
<td>10%</td>
</tr>
<tr>
<td>Other Non-Public School District</td>
<td>3%</td>
</tr>
</tbody>
</table>

3. OHSAA Classification for Boys Team Sports

<table>
<thead>
<tr>
<th>Classification</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>33%</td>
</tr>
<tr>
<td>AA</td>
<td>33%</td>
</tr>
<tr>
<td>AAA</td>
<td>33%</td>
</tr>
</tbody>
</table>

4. OHSAA Classification for Girls Team Sports

<table>
<thead>
<tr>
<th>Classification</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>33%</td>
</tr>
<tr>
<td>AA</td>
<td>33%</td>
</tr>
<tr>
<td>AAA</td>
<td>33%</td>
</tr>
</tbody>
</table>

5. Public, Private, or Parochial School District

<table>
<thead>
<tr>
<th>Type of School District</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Public</td>
<td>87%</td>
</tr>
<tr>
<td>Private</td>
<td>2%</td>
</tr>
<tr>
<td>Parochial</td>
<td>11%</td>
</tr>
</tbody>
</table>

6. Survey Response Received

<table>
<thead>
<tr>
<th>Type of Response</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mailed</td>
<td>821</td>
</tr>
<tr>
<td>Returned</td>
<td>563 (69%)</td>
</tr>
<tr>
<td>Not Returned</td>
<td>258 (31%)</td>
</tr>
</tbody>
</table>
APPENDIX C

SUMMARY RESULTS

OF THE

CHEMICAL USE AND DEPENDENCY SURVEY
1. Does your school district provide a Board adopted chemical use or dependency policy for students?

445 (80%) YES
101 (18%) NO
9 (2%) DK (DON'T KNOW)

2. Does your school district provide a Board adopted chemical use or dependency policy for employees?

128 (23%) YES
375 (68%) NO
48 (9%) DK

3. Does your school district provide an Employee Assistance Program?

50 (9%) YES
458 (83%) NO
46 (9%) DK

4. Does your school district have a K-12 Written Guidance Plan regarding chemical use and dependency?

318 (58%) YES
190 (35%) NO
36 (7%) DK

5. Does your school district have a drug and alcohol coordinator position?

182 (32%) YES
373 (66%) NO
6 (2%) DK

55 FULL TIME COORDINATORS
147 PART TIME COORDINATORS
6. Does your school district provide short term programs to develop drug and alcohol awareness for the following groups:

<table>
<thead>
<tr>
<th>Group</th>
<th>Yes (%)</th>
<th>No (%)</th>
<th>DK (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>STUDENTS?</td>
<td>503 (89%)</td>
<td>57 (10%)</td>
<td>5 (1%)</td>
</tr>
<tr>
<td>ATHLETES?</td>
<td>304 (57%)</td>
<td>228 (42%)</td>
<td>5 (1%)</td>
</tr>
<tr>
<td>STAFF?</td>
<td>308 (56%)</td>
<td>232 (43%)</td>
<td>7 (1%)</td>
</tr>
<tr>
<td>PARENTS?</td>
<td>278 (51%)</td>
<td>255 (47%)</td>
<td>9 (2%)</td>
</tr>
<tr>
<td>COMMUNITY</td>
<td>244 (45%)</td>
<td>284 (53%)</td>
<td>9 (2%)</td>
</tr>
</tbody>
</table>

7. Does your school district provide extensive inservice training programs on chemical use or dependency for the following groups:

<table>
<thead>
<tr>
<th>Group</th>
<th>Yes (%)</th>
<th>No (%)</th>
<th>DK (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>STUDENTS?</td>
<td>183 (33%)</td>
<td>361 (66%)</td>
<td>5 (1%)</td>
</tr>
<tr>
<td>STAFF?</td>
<td>191 (35%)</td>
<td>353 (64%)</td>
<td>4 (1%)</td>
</tr>
<tr>
<td>PARENTS?</td>
<td>86 (16%)</td>
<td>440 (83%)</td>
<td>7 (2%)</td>
</tr>
<tr>
<td>COMMUNITY</td>
<td>84 (16%)</td>
<td>443 (82%)</td>
<td>11 (2%)</td>
</tr>
</tbody>
</table>

8. Has your school district conducted local surveys on chemical use or dependency to assess the following areas:

<table>
<thead>
<tr>
<th>Area</th>
<th>Yes (%)</th>
<th>No (%)</th>
<th>DK (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>STUDENT KNOWLEDGE?</td>
<td>292 (52%)</td>
<td>243 (43%)</td>
<td>23 (5%)</td>
</tr>
<tr>
<td>STUDENT ATTITUDES?</td>
<td>298 (54%)</td>
<td>233 (42%)</td>
<td>23 (4%)</td>
</tr>
<tr>
<td>STUDENT USE?</td>
<td>298 (54%)</td>
<td>234 (42%)</td>
<td>22 (4%)</td>
</tr>
</tbody>
</table>
With regard to a chemical use and dependency program, does your school district provide the following:

9. Identification and referral systems for students with problems?
   476 (84%) YES
   78 (14%) NO
   7 (2%) DK

10. An ongoing relationship with community agencies for counseling?
    510 (91%) YES
    40 (7%) NO
    12 (2%) DK

11. In-school support groups for students?
    307 (55%) YES
    249 (44%) NO
    5 (1%) DK

12. A preventive education program in grades K-12, other than health?
    292 (52%) YES
    234 (42%) NO
    30 (6%) DK

13. A budget for district-wide drug and alcohol programs?
    123 (22%) YES
    399 (72%) NO
    34 (6%) DK

14. Core teams or building teams as a part of the chemical use or dependency program?
    232 (41%) YES
    314 (56%) NO
    14 (3%) DK

15. Parent support groups?
    168 (30%) YES
    371 (66%) NO
    22 (4%) DK
16. Does your school district host meetings for Alcoholics Anonymous, Narcotics Anonymous, and/or Alanon?

68 (13%) YES
463 (83%) NO
27 ( 4%) DK

17. Have staff members in your district received training on adolescent chemical use or chemical dependency?

391 (70%) YES
142 (25%) NO
25 ( 5%) DK

Of those responding yes, how many staff members attended...

...3-5 day sessions 2104
...1-2 day sessions 1803
...less than 1 day 2146

18. Have coaches in your district received training on adolescent chemical use or dependency?

254 (45%) YES
254 (45%) NO
52 (10%) DK

Of those receiving training, how many coaches attended...

...3-5 day sessions 296
...1-2 day sessions 602
...less than 1 day 321

19. Have student athletes in your district received training on chemical use or dependency?

125 (22%) YES
396 (71%) NO
38 ( 7%) DK

Of those receiving training, how many students attended...

...3-5 day sessions 122
...1-2 day sessions 275
...less than 1 day 4047
20. During the 1984 - 1985 school year, did your school district impose any of the following actions as a result of drug/alcohol policy violations?

A. Did your school district suspend students from athletic participation? If yes, how many were suspended?

229 (42%) YES 676 athletes suspended
257 (47%) NO
55 (11%) DK

B. Did your school district refer student athletes for assessment? If yes, how many were referred?

156 (29%) YES 511 athletes referred for assessment
315 (59%) NO
60 (12%) DK

C. Did your school district refer student athletes for counseling? If yes, how many were referred?

176 (33%) YES 698 athletes referred for counseling
302 (56%) NO
62 (11%) DK

D. Did your school district have any student athletes enter either an in-patient or out-patient treatment program during the year. If yes, how many athletes entered treatment?

95 (18%) YES 237 athletes entered treatment
375 (70%) NO
67 (12%) DK

Please indicate if your school district used the following resources for chemical use or dependency related services:

21. Colleges and Universities?

97 (23%) YES
271 (64%) NO
58 (13%) DK
22. Other school districts?

133 (32%) YES
235 (56%) NO
53 (12%) DK

23. Publicly funded drug/alcohol agencies?

366 (76%) YES
67 (14%) NO
46 (10%) DK

24. Private drug/alcohol treatment centers for training/education programs?

265 (59%) YES
130 (29%) NO
53 (12%) DK

25. Individuals with expertise in chemical use or dependency?

257 (59%) YES
128 (29%) NO
50 (12%) DK

26. Would you be interested in the following chemical use or dependency services for the athletic department in my school district:

A. A 1 or 2 day workshop?

388 (87%) YES
57 (13%) NO

B. A 3 to 5 day extensive workshop?

98 (34%) YES
190 (65%) NO

C. A student athlete training program?

342 (84%) YES
62 (15%) NO

D. Help with ongoing student athletic assistance programs?

228 (73%) YES
84 (27%) NO
27. Would your drug/alcohol coordinator be willing to provide additional information about the chemical use or dependency program in your school district? If yes, please provide their name, address, and telephone number.

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
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</thead>
<tbody>
<tr>
<td>YES</td>
<td>234</td>
</tr>
<tr>
<td>NO</td>
<td>93</td>
</tr>
<tr>
<td>DK</td>
<td>55</td>
</tr>
</tbody>
</table>

229 Names given

821 Surveys Sent
563 Returned
69% Return Rate
LIST OF REFERENCES


Bellizio, E. (1985). Drugs, sports and our athletes: are most educators blocking their minds about the possibility? National Federation News, 3(1), 16.


264


Dayton agency to aid parents in detecting drug use in kids. (1986, September, 7). *The Cleveland Plain Dealer.*


Hostetler, J. (1981, November). Substance abuse: A family affair. Paper Presented at the All Ohio Focus on Guidance, Columbus, OH.


