UPDATE on CURRENT DRUGS OF ABUSE

Michael F. Nerney
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Michael Nerney and Associates
Post Office Box 93
Long Lake, NY 12847
(518) 624-5351
Fax (518) 624-4203
UPDATE ON MARIJUANA

Now they call it skunk, boom, chronic or indigo, and they smoke it in shotguns, blunts or Phillies. After the intoxicating effects take over, they talk about getting lifted, booted or choked out. It’s not a new drug, but it is a new trend that drug experts say indicates a rise in the popularity of marijuana among junior high school students. For the first time in over a decade, marijuana use rose sharply from 1992 through 1994. By all indicators, 1997 will see a continuation in the increase of marijuana use.

While there are many reasons for this change in the pattern of marijuana abuse, researchers like Lloyd Johnston of the University of Michigan point to the perception of marijuana among students as a relatively harmless, non-addicting recreational drug. In part, that perception comes about from America’s “war on drugs” fascination and emphasis on crack cocaine, ice and heroin. With all the attention on the “big” drugs, information about the problems of marijuana abuse falls by the wayside.

Not only are teens and preteens difficult to convince about marijuana, but their parents are often unwilling to get excited about something they may have tried and liked themselves, in college or in the service. The issue, of course, is that comparing the pot of the seventies to the “high tech” cannabis of the nineties is like comparing the old Royal typewriter that I used in high school to a 586 word processor. It’s just not the same thing.

Using single plant cloning techniques, better growing and harvesting procedures, and hybridization, growers today can produce plants with one to two pounds of resinated buds or colas that are 10 to 20 times more powerful than the pot of the seventies. It costs more to buy, but it takes less of it to get intoxicated. But it isn’t just the marijuana that’s different, it’s also the user.

In the seventies, most marijuana smokers were between 17 and 19 years old. Today the age of onset (the first time a drug is used) is often 11 - 13 years. There is a significant difference in the physical maturation of a 19 year old and an 11 year old. Of critical importance are the differences in liver function, sexual development and emotional and intellectual function. The negative effects of marijuana haven’t really changed, they have become more intense as the potency of the plant has increased. In addition, the bodies of younger users are affected differently than those of their older predecessors. There are newer studies that support much of what we assumed about the negative consequences of marijuana, such as damage to the lungs.

Michael Nerney 2000
In a recent study at the University of Arizona, researchers documented the impact of prolonged marijuana use on lung function. Marijuana smoke closes bronchial pathways, damages lung tissue, reduces oxygen exchange, and leaves the lungs more vulnerable to viral and bacterial infections. The authors of the study speculate about possible lung cancer from long term exposure, since marijuana has more benzopyrene (A), a carcinogen, than tobacco. Like tobacco, marijuana has poly nuclear aromatic hydrocarbons, or tars, which are also cancer causing.

The potential damage from marijuana smoke is not limited to the lungs. Some of the 450 or so chemicals in marijuana smoke are similar to human reproductive hormones. When the brain registers too many of these hormone-like chemicals, it shuts down its own supply source. This can lead to a reduction of the chemistry critical to sexual maturation. If there is one thing an 11 - 13 year old body needs, it's hormones. Since it is unethical to study the effects of drugs on children or women of child bearing age, researchers must rely on anecdotal evidence and animal studies to predict the effects of marijuana on the human reproductive system. The possibilities include delayed or incomplete physical and sexual maturation, reduced fertility in both males and females, and reduced sexual function in males. Depending upon how much, how often and how long a person has smoked marijuana, these effects may or may not be reversible.

In addition to the effects on reproduction and lung function, marijuana also generates a rapid increase in heart rate and blood pressure. This change in cardiac function is related to the presence of carbon monoxide in marijuana smoke. The combination of substantial increases in heart rate and blood pressure, along with the psychoactive effect of marijuana on perception, often leads to emergency room visits on the part of intoxicated teens who believe their hearts are about to leap out of their chests. This problem is particularly acute when the smokers have been indulging in a practice they call "Clambaking" which takes place when four or five kids pile into a small car, close the windows, set the ventilation system on recirculate and fire up a Philly or a Dutchmaster blunt.

Better "real life" research has outlined the additional dangers of driving stoned. With visual distortions, and reductions in depth perception and spatial relationships, the potential for short term damage (as in driving around town) dramatically increases. Because marijuana cuts down on divided attention skills, drivers lose the ability to see the big picture, which increases the risk of accidents. More and more often the accident victim is a pre teen out there on a dirt bike, skateboard, or rollerblades who provides the driver with a sudden unexpected obstacle. There is some level of truth in the statement stoned drivers make to the police during the accident investigation when they say "I never saw that kid".
There are also problems which inevitably come in school: loss of interest in studies, sports or extra mural activities; academic failure; absenteeism and truancy; and often a conflict with school officials and parents. This is the beginning of what I believe is a long term serious problem. Conflicts about drug abuse with parents and schools are often managed by kids through a pattern of deception, cheating and manipulation. All of these behaviors make family matters worse and sometimes end up with early acrimonious departures from home.

With all these problems, it’s a wonder that anyone would get involved with this drug, but people are - in escalating numbers. People who don’t use or abuse drugs often have difficulty understanding those who do. When kids and adults smoke marijuana, they don’t do it to get the problems, they do it to get what they perceive are the benefits. Researchers and kids agree on several points about the perceived benefits. Marijuana reduces anxiety in most users. Within the last year, actual sites of action for marijuana were discovered. These numerous sites have been called anandamide receptor sites after the neurotransmitter that is somehow stimulated by marijuana. The limbic system is rich in anandamide sites. Kids see this as a substantial benefit. The chemicals that produce anxiety and apprehension exist at higher levels in the brain of a teenager than in an adult. Couple this higher intensity with a world filled with STDs, HIV, homelessness, poverty, environmental disaster, school failure, social disconnection and violence and there is more than enough anxiety to go around. A secondary effect of marijuana is depersonalization, a stepping back from an all-too-intrusive world, leaving the user mellow and laid back, but unaware of any risks in the immediate environment.

Most teens are well aware of the other major anxiety reducing drug used by their age group: alcohol. Taken together, the combination of alcohol and marijuana can be disastrous: Researchers discovered compounds in marijuana which could reduce nausea and vomiting in cancer patients undergoing chemotherapy. These same compounds create a hazard when teens drink to excess after smoking marijuana. The mechanism in the brain that signals the stomach to dump stored amounts of alcohol, usually by throwing up, will not function under the influence of marijuana. The outcome is often a toxic build-up that may result in an emergency room visit or worse, a fatal overdose of alcohol.

When kids aren’t anxious, they are often bored. One chemical in marijuana impacts on the cortex of the brain, narrowing its range of focus. Under the influence of marijuana, the most mundane things become interesting, fascinating, intriguing...at least for four to six hours.
So for teens and preteens suffering from the twin perils of adolescence, anxiety and boredom, marijuana provides a pretty quick fix. The trouble comes as the effects of the drug clear, and all the problems come back - only bigger. The problems may seem bigger for two reasons: unresolved problems tend to snowball, and the effects of rebound magnify the uncomfortable feelings from which the user was trying to escape in the first place. Well, that's easy enough to fix: just fire up the bong again. And so begins drug dependency.

All the while teenagers are using marijuana to solve their problems, they are getting little or no practice at finding and using appropriate coping mechanisms. Several new research studies term this lack of practice "compressed Adolescence". Unlike theories of the past that assumed that adolescents who were heavily into pot were delayed in their development, some researchers today believe that heavy marijuana users skip over important social and emotional skill building experiences. While these kids will often be perceived by their peers as more independent and adult, they lack significant adult skills like environmental confrontation. This is the kind of skill that helps us figure out the things that are not going well in our lives, confront the issues and find ways to resolve them. Kids, or young adults who lack this skill but smoke a lot of marijuana, don't confront the problems, they get stoned every time a problem comes along. Serious quality of life problems loom on the horizon for these young people.

Drug abuse prevention is a long term, complex, ongoing process. It seems clear that the junior high school students who are turning to marijuana are telling us something important. We need to invest the time, the money and the energy to help them achieve emotional literacy. We need to help them develop the skills to identify, surface, articulate and manage the powerful emotions that are part of their everyday lives.
UPDATE ON LSD

Like tie-dyes and bellbottoms, LSD is making a comeback in the nineties. This time around, instead of college students at Berkeley or hippies at Woodstock, the users are seventh and eighth graders at Mayberry Central School. According to recent national surveys, LSD use among junior high and high school students has shown a significant increase. What is the attraction of a drug like LSD for these young users? To answer this question, we must understand how LSD impacts on the brain.

LSD increases serotonin levels in the brain. Serotonin is responsible for the integration of sensory stimuli. It helps us make sense of the world around us. Of the five senses, vision and hearing are profoundly influenced by the presence of LSD. At low doses, LSD makes the world an exciting, vibrant place to be. Boredom, the bane of every teenager, can be banished. The mundane surroundings of suburbia are transformed magically into a kaleidoscope of colors and sounds, for six to eight hours. At moderate dose levels, sensory information can be distorted to the point that synesthesia, or cross-sensing, occurs. This is the activation of both vision and hearing from one stimulus, so that someone under the influence of LSD would "hear colors" or "see music". For a tenth grader up in the balcony of the Civic Center at the Phish concert, a few hits of blotter create a new reality. When Trey Anastasio plays a wicked riff on lead guitar during "Tweezer", this kid not only hears it but also sees the notes lift off the guitar, float up to the balcony, and circle around his head, creating the best concert experience he has ever had.

Of course, at slightly higher doses, those same musical notes form into a mass of snakes that drop down on top of our concert-goer and result in a hysterical, screaming fourteen year old, who will shortly be in the hands of the security force. High doses of LSD can produce such disturbing and frightening sensory experiences, that the user often ends up in the emergency room undergoing psychiatric evaluation. In fact, according to data from the Drug Abuse Warning Network (DAWN), LSD overdose is responsible for one quarter of all drug-related emergency room visits by males between the ages of six and seventeen.

The current version of LSD, called LSD 49, while less potent than the original (LSD 25), is both more widely available and less expensive. At rock concerts, hits of LSD sold as "blotter" or "gel caps" go for three dollars apiece, or two for five dollars. Blotter acid is LSD made in a solution of alcohol and water, in which sheets of perforated paper are first soaked then hung to dry. Each smaller-than-postage-stamp sized section constitutes one hit, and contrary to popular mythology, is not absorbed through the skin by handling the paper. Gel caps look like miniscule squares of clear or colored plastic. Both blotter and gel have a variety of brand names and logos, which include "Mr. Natural", "Mickey Mouse" "California Trips", "Black Pyramid", "Bart Simpson", and various Grateful Dead symbols.
Even in its newer format, LSD is still such a powerful chemical that the effective dose is measured in micrograms not milligrams. That means that each gram of LSD must be divided into one million units called "mics". The dose sold today is generally 20-80 mics. It is not possible to tell if the dose purchased is a 20 mic dose or four times more powerful. This difference in dose range is one of the factors in the high number of emergency room visits.

Places in addition to concerts where LSD is commonly used are "house parties" at the homes of college students or younger students whose parents are out of town, or at "Rave" parties, often held in empty warehouses or other large facilities that are rented for the weekend. The attraction of these parties includes the music, the light show, the other kids, and the absence of adult supervision.

In general, LSD is an "occasional" or "weekend" drug. Because tolerance to LSD develops quickly, daily use would be ineffective in a short period of time. In three to five days tolerance wears off, just in time for the upcoming weekend party. The tolerance factor, combined with relatively mild withdrawal symptoms, create a low potential for addiction to LSD. This does not, however, equate with a low potential for problems.

The major problem with LSD remains behavioral toxicity. Under the influence of high doses, when sensory distortions become overwhelming, the user reactions are unpredictable and often jeopardize self or others. Fleeing in panic from the oncoming subway train in a crowded station that suddenly looks like a sixty foot dragon can result in serious injury to the LSD abuser or to anyone in proximity. Unlike the sixties or seventies, many of the current users have neither the peer support systems nor the life experiences to deal with the impact of a bad trip.

While actual flashbacks, (that is, a re-entry into the bloodstream of active metabolites), are rare with LSD, powerful negative involuntary memories are not. When an eighth grader has a bad trip on acid one weekend at a friend's house and believes that the chandelier in the entrance hallway has turn into a giant kid-eating spider, the next time he visits his friend, the memory of that experience might be activated, bringing with it all or some of the panic associated with the original event.
Since even experimental use for research was prohibited in the United States in the late seventies, we don’t really know much about the long term consequences of LSD abuse. Recently ophthalmologists in the Eastern United States have had the unusual experience of young adult clients coming in for treatment of a visual disorder known as strobing or trailing. Since these are common visual effects that happen under the influence of LSD, an alert practitioner investigated the drug taking patterns of these patients. Sure enough, all of them were long term users of LSD. At this point it is not known if treatment will be effective or if this bizarre visual defect will be a long term problem.

Even without the long term consequence, the short term impact is worrisome enough. High doses of LSD, or even low doses combined with alcohol or XTC (a designer drug), can generate states of disorientation, delusion and psychosis. This can be particularly dangerous for adolescent males, considering their propensity for risk taking behaviors.
UPDATE ON HEROIN

While some drugs like LSD and marijuana have gone through both highs and lows in popularity and are now swinging back into favor among drug users, other drugs like heroin have maintained a stable but slowly rising degree of popularity. There are a number of factors that influence this rise. Perhaps the most significant factor is the current availability of low priced, high quality heroin.

From the "Black Tar" smokable heroin of the West Coast, to the crystalline white "Golden Triangle" of the Northeast, heroin can be purchased in any medium-sized city in the U.S. The traditional suppliers of Southwest Asia, in Afghanistan, Iran and Pakistan, are in fierce competition with the Southeast Asian "Golden Triangle" of Burma, Laos and Thailand for the dollars of those already addicted and those who can be seduced by the power of the drug. This rivalry is not new, but the change in intensity has put heroin on the streets at previously unheard of potencies. Last year in New York City, Southeast Asian heroin averaged 54.3 per cent purity, while Southwest Asian averaged 69.7 per cent. Considering that within the last ten years, heroin has ranged from 6 to 19 per cent purity, this is a remarkable increase - and without a corresponding increase in price.

Experts from the U.S. Drug Enforcement Agency believe that the feverish pitch of competition is driven by the need to expand and consolidate the illegal drug market before the new kid in town does. The new kid comes from Colombia, where for the past five years the cocaine cartel has been planting, growing and harvesting opium. In the past two years, they have perfected the extraction techniques necessary to produce high grade heroin. This heroin is already showing up on the streets, brought to the U.S. by those same folks who bring in the cocaine.

A second factor in the rise of heroin abuse is the ability of the producers to furnish the product in a smokable format. With the advent of AIDS, and the level of public education regarding AIDS transmission through the use of dirty needles, most new users prefer to smoke heroin. Two groups, women and college students, are smoking heroin at unprecedented levels. Smoking a drug is much more familiar and inviting than putting a needle into a vein.

Once in the bloodstream, heroin finds and occupies sites in the brain normally reserved for our internal supply of morphine, called endorphin. Like endorphin and morphine, heroin is a powerful pain reliever, not only for physical pain, but for emotional and social pain as well. Under the influence of heroin, a person can recognize that his/her life is falling apart, but not be concerned about it at all (for the next six hours, at least). When that high is over and rebound (withdrawal) occurs, all of the pain comes back - with a vengeance. Both parts of this experience are reinforcers for further drug taking.

Michael Nerney 2000
In addition to dealing with rebound, heroin users quickly develop tolerance to the effects of the drug. Soon the dose that once generated freedom from pain, anxiety and the stress of daily life doesn't cut it anymore. It will take larger and larger doses to get the same effect. This is what leads to trouble for most heroin abusers. To get more heroin, they need more money. That money can usually be acquired through some form of criminal behavior: dealing, stealing or wheeling (nonprofessional prostitution).

Other changes take place in the way the addict now uses the drug. As the high loses its power, money becomes scarce, and the addict is trying to score just to avoid being sick, the route of administering the heroin will often change from sniffing and smoking to injecting. Researchers now estimate that half of all heroin smokers end up injecting within two years. Many of them will avoid intravenous injecting at first, thinking it unsafe, and will use techniques like subcutaneous injection, known on the street as skin popping. Recent findings in California point out the serious dangers for poppers. Of the 200 or so known cases of flesh eating disease, 100 or fifty percent have been skin popping heroin users.

Besides the legal problems that often await heroin abusers, the dangers of overdose, addiction, liver damage, endocarditis (an inflammation of the mitral valve of the heart), and pulmonary dysfunction also loom. Serious problems usually develop in personal relationships, at home and at work. As many as half a million people in the United States are currently addicted to heroin, and that number is expected to rise.
UPDATE ON COCAINE AND CRACK

The dangers of crack/cocaine have been repeated often enough in drug education classes, on television and in the popular press that most Americans are fully aware of the risks. New users of crack are declining in the adult population. Even high school students seem to have gotten the message: the number of new users of cocaine in grades 10 through 12 has declined, according to a national survey. That's the good news. The bad news is a thirty percent increase in the use of cocaine/crack among eighth graders, as reported by an annual survey administered by Lloyd Johnston at the University of Michigan.

Perhaps we have concentrated too exclusively on sending the message to older teens and young adults. Or perhaps younger teens have a seemingly unshakable belief in their own invincibility. In any case, eighth graders in small but increasing numbers are willing to gamble with the drug that most experts rate as number one in addiction potential. The widespread availability and affordability of crack, and the fact that it is smokable (a route of administration with which they are familiar) guarantee in some areas of the country that when junior high kids try cocaine, crack will be the format they encounter.

As if crack weren't enough to deal with, readily made versions of methamphetamine are now available in most of the U.S. Other advances in stimulant technology are also showing up for the first time: "CAT" is the name of a smokable drug made by chemically converting over-the-counter Sudafed into a moderately powerful stimulant.

Another stimulant problem showing up is the abuse of a popular drug for the treatment of ADD and ADD/HD: Ritalin. When older students buy Ritalin from their younger counterparts, crush it, then snort it into the nasal cavity, the resulting effect is highly stimulatory.

One of the clear lessons emerging from the latest survey is this: it is never too early to start drug abuse prevention programs. Rather than banning the sale of Herbal XTC, or Cloud Nine, as New York State has proposed, wouldn't it make more sense to teach kids that any drug taken in high doses is dangerous. Children need continuous, up to date information from a credible source regarding the dangers of drug abuse. But they also need, and we must provide them with, positive role models, alternative drug-free activities and the resources necessary for emotional literacy, healthy peer selection and peer refusal skills.
UPDATE ON XTC

Picture this: All the parents have gone home, leaving most of the freshmen feeling incredibly lonely, isolated and insecure. The upper class students walk around campus like they own the place. To make matters worse, this afternoon the college president told them that 30% of them would flunk out or drop out by the end of the year. Is it any wonder that this group finds attractive a popular new drug that makes them feel affection for, trust of, and affiliation with their fellow students?

XTC is an analog of a drug from the 60's known as MDA, or the "love drug". The slightly altered version known as MDMA was first used in the early 80's in psychotherapy, specifically in counseling married couples. Counselors found that the drug created a sense of trust, bonding, and intimacy that helped couples quickly break through the barriers that normally slow down the therapeutic process. Use of this drug to enhance therapy became so popular that it was featured on the Donahue Show. After the show, the network was deluged with calls from viewers wanting more information about where to get the drug and how to use it at home. Thousands of callers wanted to know if they could give a dose to a spouse or partner and create immediate intimacy.

The drug quickly became popular with young adults and a number of overdose fatalities occurred. The FDA banned the drug in 1984. Since that time, MDMA has moved from uptown apartments to college dorm rooms, where it is known as XTC, ADAM, or Rhapsody.

The problems with XTC lie in its chemical construction. MDMA, or methylenedioxy methamphetamine, is a powerful stimulant similar to the "speed" of the 60's. The methamphetamine component generates enough energy to dance or party all night, but it also has the potential to cause cardiac problems or seizures at high doses.

A more powerful attraction is created by the first component, methylene dioxide, which impacts on the emotional center of the brain, generating a sense of bonding, trust, affection and intimacy. Let's go back to the college campus and all those lonely students. Here is a ready made market for this drug, sold and consumed at dorm and fraternity parties, or off campus at "RAVE" parties. In a progression we have seen before with other drugs, this drug has already moved into the high schools.

This point can be illustrated by observing trends in the illegal importation of drugs into the United States. In 1997, U.S. Customs agents seized more than 318,000 hits of XTC coming in to this country from Western Europe. By comparison, more than 3,000,000 hits were confiscated in 1999, just two years later. By all accounts, interdiction is successful in stopping less than 20% of any illegal drug from entering the U.S.
The dangers of XTC include rebound, addiction and impaired judgment. Since rebound consists of feelings opposite of those that the drug induces at a greater intensity, withdrawal from XTC involves even more loneliness, depression and alienation. The potential for suicide increases dramatically at this time. Of course, users soon figure out that the way to avoid rebound is to take more of the drug. This sets up a pattern which can quickly lead to addiction.

Another serious problem may happen when the desired effects of trust and intimacy seriously impair good judgment. Young people may become vulnerable to trusting the wrong person at a party. At many colleges, an increase in the popularity of XTC has been accompanied by an increase in the incidence of date rape.

Two other "date rape" drugs currently used on campus include Rohypnol ("Roofies") and Gamma Hydroxy Butyrate ("GHB"). Roofies are structurally similar to Xanax. While often used for anxiety reduction or disinhibition, at high doses it will generate a zombie-like state; that is, the brain stem continues to function but the cortex virtually shuts down. Anyone who has been given this drug without their knowledge is highly vulnerable to rape or other victimizations. A common after-effect is diminished recall, which makes identifying assailants difficult. Last year the manufacturer of Rohypnol agreed to include a chemical that will turn a distinctive blue color when added to an alcoholic beverage. This is a great step forward but will provide no warning for the young people who are at the club, bar, or party and drinking non-alcoholic soft drinks.

Less is known about GHB, but one of its street names, "Easy Lay", is indicative of the motivation of those who give the drug to unsuspecting people. GHB is an odorless, colorless, tasteless liquid, which renders it undetectable, and generate a highly vulnerable victim. At high doses the drug can and has caused fatalities. Since a person giving this drug to a victim is highly unlikely to match dose to size and weight, the risk of fatality is high.
UPDATE ON ALCOHOL

When one third of American adolescents readily admit to being intoxicated in the past ninety days, there can be no doubt that alcohol continues to be the most popular drug among teens. This trend has its beginnings in very early adolescence: thirteen percent of fifth graders say they have used alcohol at least once to get intoxicated. The increase in these numbers is startling: 39% of 7th and 8th graders, 56% of 9th and 10th graders, and a whopping 74% of 11th and 12th graders have used alcohol in the past 6 months for the purposes of intoxication. Even the "best and brightest", reasonably responsible kids that we send off to college are not immune to the lure of alcohol. Between 50% and 75% of college students admit to regular binge drinking. Most experts agree that alcohol plays a major role in accidental deaths of adolescent and young adults, including auto fatalities, drownings and fatal falls. Alcohol is also involved in 30% of suicides and as many as 50% of homicides involving adolescents.

In spite of these problems, alcohol continues to be one of the drugs most readily accessible to adolescents. Adolescents have remarkable access to beer, wine coolers and "hard liquor". Seven out of ten minors are able to purchase alcohol themselves. Fake identification cards are realistic and readily available. Older kids and adults are often willing to provide teens with alcohol. Parents are often unwittingly providing alcohol at home: raiding the household liquor cabinet is a common activity for some teens.

Also, much has changed in the alcohol market: new alcoholic beverage products such as "Zima", "Breezers" and "Cisco" are often sweet or fruity tasting, and marketing strategies target young people. Distillers like St. Ides have led the way in producing clarified malts. "Special Brew", for example has five different flavors containing fruit punch, lemon and lime, orange, coconut and pineapple, and mixed fruit. All sweet and fruity with a 6% alcohol kick in a 20 ounce bottle. Roughly 35% of all clarified malts and wine coolers purchased are consumed by teenagers. "Jello Shots" have become popular at parties: flavored gelatin is made with vodka and water and allowed to set, then is cut into cubes, roughly equivalent to a shot glass of liquor. Unsuspecting parents may assume the Jello is a harmless snack, right up there with pretzels and potato chips.

In addition, many parents don't consider alcohol a drug, so they are not as worried about it as they should be. Adults need to understand the impact of alcohol on the underdeveloped adolescent nervous system. A "red flag" should go up for parents and other adults who find themselves minimizing children's behavior by thinking or saying things like, "as long as he's not doing drugs"; "it's OK if she drinks in the house"; and "kids will be kids". This reinforces that alcohol is merely a social drug, and therefore low risk. Nearly every weekend, a fatality involving alcohol and teens tells us otherwise. Also, adults need to be aware of the dangerous impact of mixing alcohol with other drugs such as marijuana.
Sometimes adults simply acquiesce to the social climate which encourages alcohol use by adolescents. This posture of powerlessness is characterized by beliefs such as: "what's the use?"; "every kid is going to find a way to drink"; and "how can I compete against the influence of peers, the media, athletes and other role models?". This stance can also include the assignment of blame: "the police, the schools, and/or the other parents aren't doing their jobs". We must remember that in the same way we climb a mountain one step at a time, we can begin to work in our own families, which will contribute to the movement toward a drug-free neighborhood, county, state, country, and world. Youth leaders, youth officers, counselors, teachers and other adults who work with kids can exemplify the following characteristics, and can be instrumental in teaching them to parents. Parents need to be:

Assertive - as a parent, you have the responsibility to provide not just material goods, but values, beliefs and role models of good character. As such, you have the right to know about your kids' lives, the right to intervene, set limits and boundaries, and the right to enforce consequences. YOU, after all, are the grown up.

Aware - hello adolescence, goodbye communication. Use a variety of techniques to keep aware of the following: full names and addresses of any friends, and the names of their parents; and your child's whereabouts at all times. If your child is sleeping at a friend's house, call the parents and ask: Can I/my child bring snacks, pillow and blanket, anything else? Will you be there at all times? Would you mind if I call once during the evening to see how my child is doing? What will the kids be doing? If they are to see a movie, which one? If the parents will not be home, your child should not visit. By all means, offer to be the host of a sleep over. You also need to know: where is the dance, concert or party? If they are going to a concert, go along (sit elsewhere, but drive them there and meet them at a designated spot immediately after the show). Be the driver as often as you can - this allows you to get to know the people, places and things in your child's life.

Alert - be observant of any changes in behavior beyond the range of normal adolescence, e.g., trouble in school, secret friends, deception, manipulation, clothing and hair style changes beyond the fringe, increase in sleep beyond normal needs, gross changes in music/video tastes.

Awake - keep in touch with them. As children get older, they are out more often without you, so make the effort to stay in contact. Greet them personally when they come home with a hug. Many teens have learned to hold their breath for the duration of the homecoming hug, so interacting for a few minutes of conversation is advisable ("did you have fun?", "what was the movie about?", "see you in the morning")

Affirming - the Journal of the American Medical Association published an article on September 10, 1997 validating what most parents know. Kids need us to show through word and action that we love them, want them, and care for them. This means keeping them safe from circumstances that could put them in danger. The message must be clear that you love your children and that you do what you do out of that love. Kids need to know that you love them so much you are willing to risk their anger, their scorn, their sulking, and their "bad mouthing" about you to their friends - because you are unwilling to lose them to the dangers of alcohol and other drugs.

Michael Nerney 2000
UPDATE ON INHALANTS

What do spray paint, nail polish remover, lighter fluid, "Scotch-gard" and "Wite-out" have in common? These and other solvents constitute a group of substances which are readily accessible for use as inhalants. This class of drugs gets its name from the route of administration used to get the chemical into the brain: the vapors from volatile hydrocarbons are inhaled deeply into the lungs, quickly absorbed, pass into the bloodstream and impact directly on the brain. As is true with many drugs, inhalants produce a range of effects, some perceived by the user as positive, and some negative.

Initial effects perceived as beneficial include feelings of weightlessness, disorientation, euphoria, giddiness and exhilaration. The negative effects are nausea, numbness, nosebleeds, loss of motor control and severe headache. Because tolerance to inhalants usually develops in a short period of time, users will require larger and larger doses to get high.

As the dose increases, so does the risk of additional adverse effects. At high doses, loss of motor control can result in "dead weight falls". These are incidents in which the user has lost not only motor control but spatial or three dimensional awareness. The result might be a fall in which the person does nothing to protect him or herself from impact. In many cases, the person who falls while high on inhalants sustains head or spinal cord injury.

Another risk of high dose inhalant abuse comes from hallucinations or delusional thought distortions. Users become paranoid and often act in an aggressive, hostile or even violent manner. This behavior can be problematic by itself, but in combination with another risk factor, it can result in fatality. Death may occur when an individual is highly susceptible to the effects of solvents on the cardiovascular system, particularly in the presence of adrenaline. Adrenaline is a "fight or flight" chemical, increasing heart rate in everyone. For an individual predisposed to this heightened effect, solvents and adrenaline together can increase heart rate to the point of cardiac failure. This is known as "Sudden Sniffing Death". The Centers for Disease Control estimate that 800 to 1200 teens and preteens die through this mechanism each year.

The implications of this are alarming, as it is nearly impossible to know if a person is predisposed to high sensitivity to inhalants and adrenaline. A recent example of this involved a teenage girl from Massachusetts who died from Sudden Sniffing Death. While she was inhaling vapors from lighter fluid with two other teens, she became frightened by the belief that they were going to be caught. So if adult authority figures see teens abusing inhalants - in the shop, classroom in school, in the garage, or the basement at home- it is important to avoid an immediate confrontation. Shouting, running toward the teens, or approaching them in any way while they are using solvents may cause panic, and an increase in adrenaline. We can't predict which teen may be sensitized and end up in cardiac arrest. Intervention after the inhalant intoxication has cleared will be safer and more effective.
Some signs and symptoms of inhalant abuse might include the aroma of solvents or petroleum products on clothing; the presence of rags with spray paint, lighter fluid or nail polish remover on them; and red and irritated skin around the mouth and nose.

Solvents are not the only chemicals in the inhalant category. Others include Amyl Nitrite, a prescription drug formerly used in the treatment of angina; Butyl Nitrite, an analog of Amyl which has no medical application and is often sold in "adult" book stores as a "room odorizer". Brand names for Butyl Nitrite include: "Locker Room", "Rush", "Bullet", and "Jack-aroma". Amyl and Butyl Nitrite are most often abused by young adults as companion drugs to sexual activity.

Nitrous oxide, the "laughing gas" used as an anesthetic in the dentist office, is another form of inhalant drug. The same kind of euphoria that some dental patients experience is a common effect of this drug when its vapors are inhaled into the lungs. Nitrous quickly enters the bloodstream replacing oxygen in the brain. Oxygen deprivation, combined with the intoxication from nitrous, creates a sensation of pleasant well-being and a free-floating detachment from the cares and worries of the real world. Adolescents and young adults get their supplies of nitrous oxide from medical suppliers in thirty pound canisters, or in smaller CO2 sized canisters known on the streets as "whippets", purchased from restaurant suppliers. Nitrous oxide is the propellant used in products like "Redi Whip". Many supermarkets have moved canned whipped cream from the open shelves of the refrigerated section to the staffed deli section, because neighborhood kids have been opening the cans in the store, carefully releasing the nitrous oxide without ejecting the whipped cream, then discarding the now dead container on the way out the door. Along with the possibility of death from oxygen deprivation, nitrous oxide also affects motor control and three dimensional spatial relationships, making riding a bike or driving a car a dangerous endeavor.

Since inhalants are often legal, household items, they are easily overlooked by adults as a source of intoxication. A sound prevention strategy should educate parents, teachers and adults who work with solvents that inhalants can readily be abused by adolescents. Household solvents should be kept under lock and key, and foodstuffs in spray cans with propellants should be monitored.