



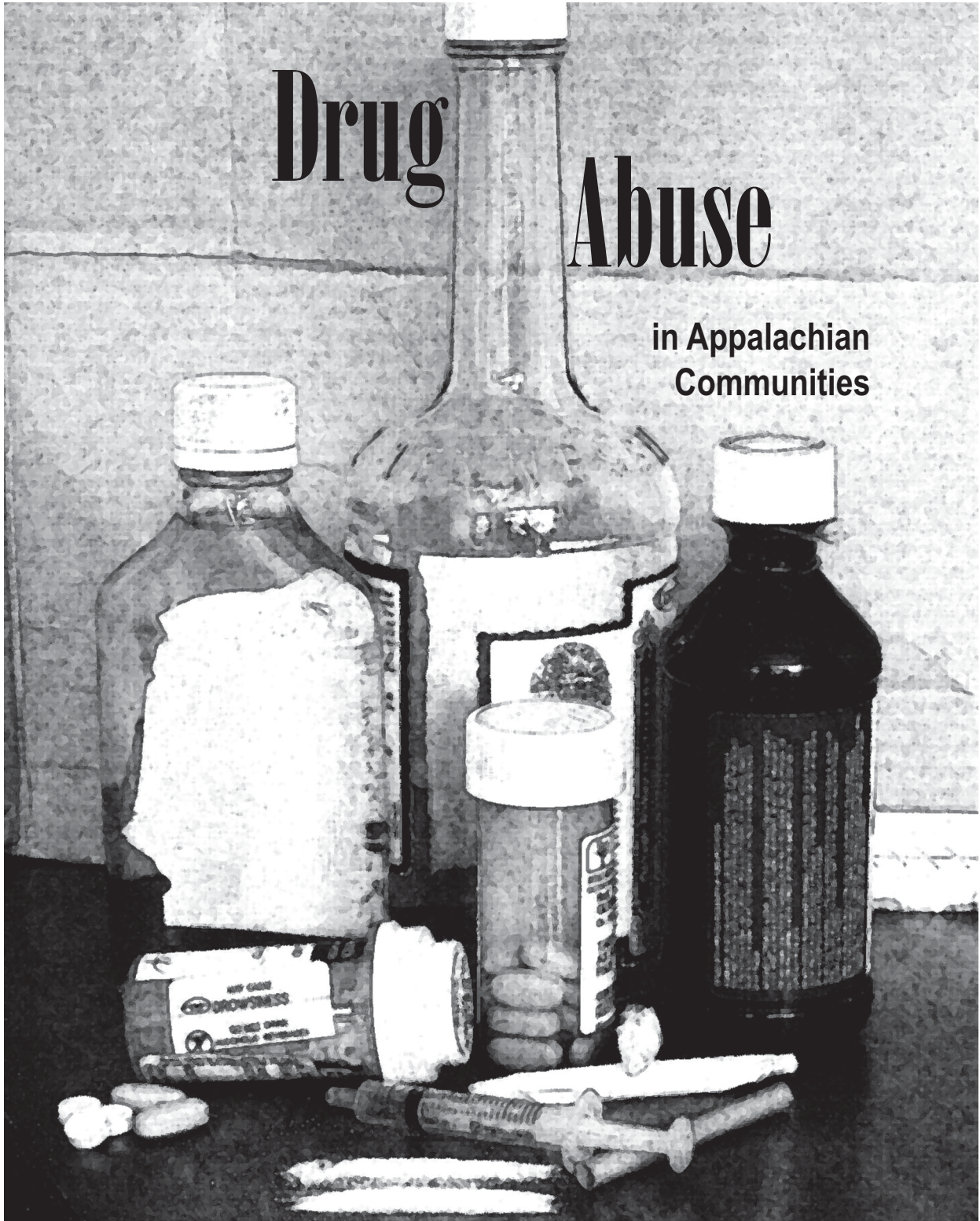
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# Drug Abuse

in Appalachian  
Communities





Appalachian Leadership and Development

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### Mission of Brushy Fork

For more than one hundred years, Berea College has served the people of Appalachia.

The Brushy Fork Institute carries forward this commitment by working to develop strong leadership in the mountains.

Working with both existing and emerging leaders, we draw on local understanding and vision to help communities build for tomorrow.

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# Drug Threat Assessments

## An Overview of Central Appalachian States

by Donna Morgan, Brushy Fork staff

The United States Department of Justice and the Drug Enforcement Agency provide facts and assessments of drug threats for states in the U.S. These reports explore the abuse, availability, distribution, production, and transportation of cocaine, heroin, marijuana, methamphetamine, and other dangerous drugs. The following text is from the executive summaries for each of the states in central Appalachia. The State Drug Threat Assessments from the U.S. Department of Justice can be downloaded at: <[www.usdoj.gov/ndic/topics/states.htm](http://www.usdoj.gov/ndic/topics/states.htm)>. The Drug Enforcement Agency's state fact sheets can be viewed at <[www.usdoj.gov/dea/pubs/state\\_factsheets.html](http://www.usdoj.gov/dea/pubs/state_factsheets.html)>.

### Drugs in Kentucky

According to DEA fact sheets, marijuana, methamphetamine, cocaine and diverted pharmaceutical drugs are the primary drug threats in Kentucky.

**Marijuana** is the most widely available and frequently abused illicit drug in Kentucky and remains the state's foremost cash crop. Generally, Kentucky ranks third nationally in marijuana cultivation. Eastern Kentucky has served as a primary source of marijuana, particularly in the Daniel Boone National Forest. In 2002, 136 acres of the Daniel Boone National Forest were classified as "impacted environmentally because of drug activity," mainly due to destruction of trees and plants in cultivation sites and the use of poisonous chemical fertilizers. The DEA reports that 378,036 marijuana plants were eradicated in Kentucky in 2002.

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### *topic this issue*

## Drug Abuse in Appalachian Communities

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The report notes that most marijuana produced in the state is exported to other states. However, residents of Kentucky are affected by its use as well. In its Drug Threat Assessment, the Department of Justice noted that nearly 50 percent of all drug treatment admissions in Kentucky from fiscal year 1998 through fiscal year 2000 were marijuana-related—more than for any other drug.

According to the U.S. Department of Justice Threat Assessment, **methamphetamine** is the most rapidly emerging threat to Kentucky, particularly in rural areas. The number of treatment admissions for methamphetamine abuse in Kentucky increased 42 percent from fiscal year 1998 through fiscal year 2000, more than for any other drug.

The DEA reports that the number of methamphetamine labs in Kentucky has tripled since 1999. During that year, drug officials seized 84 labs; in 2002, the number seized rose to 300. While the Kentucky production is dominated by Caucasians, Mexican violators are increasingly replacing local manufacturers as suppliers of the drug in rural Kentucky.

**Cocaine**, both powdered and crack, is increasingly available, frequently abused, and poses the greatest threat to most metropolitan areas in Kentucky.

DEA reports show that, after marijuana, cocaine is the primary drug seized in the state, mostly in urban areas that serve as trans-shipment points. Most of the powdered cocaine available is transported from Arizona, California, Florida, Illinois, New York, and Texas by Mexican and African-American criminal groups, according to the Department of Justice.

**Other dangerous drugs**, especially diverted pharmaceuticals, club drugs, and hallucinogens, are an increasing threat to Kentucky. The DEA reports that counties in eastern Kentucky lead the nation in terms of grams of narcotic pain medications distributed on a per capita basis. Officials credit diversion of pharmaceuticals as the most significant drug threat facing Kentucky, aside from marijuana cultivation and distribution.

The Department of Justice Threat Assessment reports that the number of treatment admissions in

**Methamphetamine is the most rapidly emerging threat to Kentucky...**

Kentucky for abuse of oxycodone—mostly OxyContin and Percocet—increased 163 percent from fiscal year 1998 through fiscal year 2000. The increased level of diverted pharmaceutical distribution and

abuse has become so significant that the Kentucky Cabinet for Health Services developed computer software to help physicians, pharmacists, and law enforcement authorities identify patterns of abuse. The DEA noted that diverted pharmaceutical drugs are becoming the primary cause of arrests for driving under the influence (DUI) in eastern Kentucky counties.

OxyContin addiction is the root cause of many criminal activities in these counties, including robbery, theft, assault and prescription fraud. However, the DEA reports that the availability of the drug appears to be decreasing, as evidenced by the recent increase in the street price. There is increasing evidence that OxyContin is being imported into the state from Mexico, where local traffickers obtain legal prescriptions from Mexican doctors.

The abuse of hallucinogens such as ketamine, LSD, and psilocybin mushrooms and of club drugs, especially GHB and MDMA, is increasing, primarily in urban areas. Club drugs and hallucinogens are popular at raves and dance clubs where the drugs are readily available and frequently abused.

**Heroin** poses a low threat to Kentucky because it is rarely available or abused in the state. However, the DEA reports that trends show many former users of OxyContin are switching to heroin as the prescription medication becomes less available.

## **Drugs in Ohio**

The Department of Justice labels the distribution and abuse of illicit drugs as a serious threat to Ohio. The state's transportation infrastructure and its proximity to the U.S.-Canadian border are conducive to drug trafficking. Ohio's well-developed network of highways connects New York City, Cleveland, Toledo, and Chicago, thereby facilitating the transportation of cocaine, heroin, marijuana, methamphetamine, and other

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# Youth & Substance Abuse

## Kentucky's Efforts to Combat the Problems

by D. G. Mawn, Acting Executive Director, Champions for a Drug Free Kentucky and Governor's Agency for Substance Abuse Policy (KY-ASAP)

The disease of substance abuse has been with us for centuries. However, the spread and impact of the disease has grown tremendously over the previous hundred years. Our main focus has been to address the availability of the drug of choice or an individual's access to those drugs. Only over the past generation have we begun to understand substance abuse as a disease that must be treated beyond criminal penalties. To prevent abuse and addiction, we must understand the reasons behind the individual's demand for these substances.

Drug abuse comes in many forms, from using nicotine and alcohol before the legal age to misusing prescription drugs and using illegal substances. Most other drugs of concern are by prescription only or are illegal altogether. Addiction affects our families and our communities in devastating ways. For example, our prisons are filled with individuals who will never be free unless they receive the necessary treatment.

In 1993, the number of prisoners in Kentucky under state or federal jurisdiction numbered over 10,000. By 2003, 15,934 prisoners were solely under the Department of Corrections jurisdiction. In addition, 307 probation and parole officers supervise an active caseload in excess of 22,000 clients. In 2003, 23% of persons in Kentucky's prisons were there for a drug offense. In addition, many of those in prison for other crimes were on drugs or alcohol at the time of their offense.

This brief overview looks at our children and how we, as individuals and communities, can do something now to prevent addiction, to support those addicted in their recovery, and to alleviate the long-term implications of

substance abuse. This article includes information on two Kentucky initiatives: Champions for a Drug Free Kentucky and the Agency for Substance Abuse Policy.

### Our Children and Substance Abuse

Despite the fact that 21 is the minimum legal drinking age, alcohol remains the number one drug of choice among youth, far surpassing illicit drugs. Alcohol use by young people has become America's number one youth health crisis. Early use of alcohol contributes to poor school performance and school dropouts, increases suicide and attempted suicide rates, and leads to early sexual activity, resulting in exposure to sexually transmitted disease and unplanned teen pregnancy.

Research has shown that if the onset of drinking is delayed by 5 years, a young person's risk of serious alcohol problems is decreased by 50 percent. Youth who begin drinking between 9 and 15 are especially vulnerable to alcohol problems in later years, including alcohol dependency.

Our children are starting to use alcohol and other drugs at increasingly younger ages. The state youth Kentucky Incentives for Prevention survey demonstrated that, even in 6<sup>th</sup> grade, some students

#### Table 1

Commonly abused drugs by 8<sup>th</sup> graders:

- 1 out of 20 Kentucky 8<sup>th</sup> graders uses smokeless tobacco on a regular basis;
- 1 out of 10 Kentucky 8<sup>th</sup> graders smokes cigarettes on a regular basis;
- 1 out of 25 Kentucky 8<sup>th</sup> graders drinks alcohol on a regular basis;
- 1 out of 25 Kentucky 8<sup>th</sup> graders uses marijuana on a regular basis.

The percentages escalate when using the common 30 day past use standard for 8<sup>th</sup> graders:

- 1 out of 10 Kentucky 8<sup>th</sup> graders uses smokeless tobacco;
- 1 out of 5 Kentucky 8<sup>th</sup> graders uses cigarettes;
- 1 out of 5 Kentucky 8<sup>th</sup> graders uses alcohol;
- 1 out of 10 Kentucky 8<sup>th</sup> graders uses marijuana.

have begun to use alcohol and tobacco on a 30 day use standard (this is, when asked whether they have used the substance in the past 30 days). The information in table 1 comes from a 2001 sample of communities that have received a significant amount of resources since 1997 to reduce youth use of alcohol, tobacco and other drugs.

The sidebar on the right indicates warning signs that a young person might be abusing drugs or alcohol. Parents and other adults can affect these realities in various ways. Parents can ask themselves:

Has your child begun to skip school or receive lower grades?

Does your child perceive that alcohol, tobacco and other drugs are easily available?

Does your child perceive that the risk of getting caught or harm from drug use is low?

Ask about a child's friends and visit the parents of their friends. Talk to teachers if grades begin to fall or the child has begun to be less involved in school and other activities.

Talk to the child. Stress the harm of drug use, but do not fabricate or over-exaggerate the effects of drugs. Drugs, like most diseases, do not turn your brain to mush on first use, or make you undesirable, but they do progress over time in debilitating the child. Do some research so you can inform the child of the long-term effects of substance abuse. Talk about the importance of obeying laws and not permitting a child to participate in an activity that the law forbids such as cigarette smoking or alcohol use.

Discuss responsibility. For example, young people who consume tobacco and alcohol before it is legal to do so need to be held responsible for their actions, but it is adults who produce, advertise, promote and make alcohol and tobacco accessible to youth in our communities. Talk about actions that you and the young person can take in order to fulfill your responsibilities for keeping our communities safe and healthy.

The effects of our action (or inaction) touch us all. We can take action to make changes that affect us all as well. We can work to make our communities healthier environments for our children. According to a report from the Kentucky Long-Term Policy Research Center, "A strong link exists between participation in civil society and higher levels of prosperity and higher achievement in schools. Some research even suggests that members

### **Possible warning signs of youth drug abuse**

Be aware if the young person:  
develops favorable attitudes toward drug use;  
has friends who use drugs;  
has friends whose parents favor under age or illicit drug use;  
changes friends;  
shows loss of interest in family activities;  
has sudden drop in grades;  
is truant from school;  
shows a sudden lack of interest in usual activities;  
exhibits the disappearance of valuable items or money;  
refuses to tell you where he/she has been;  
lies about activities;  
owns drug paraphernalia;  
becomes abusive or violent or has unexplainable mood swings;  
seems depressed;  
seems unusually tired or hyperactive.

from Warning Signs of Teen Drug Abuse at:  
<<http://parentingteens.about.com/library/weekly/aa050300a.htm>>.

of communities with strong civil societies enjoy better health and live longer." Michael T. Childress, *Foresight*, Vol. 9, No. 3 (2002).

The Kentucky Governor's Agency for Substance Abuse Policy and the Champions for a Drug Free Kentucky work together to effect policy and programs at the state and local levels. These offices are placed within the Governor's Executive Cabinet and, with the commitment of the newly elected administration, and in particular, that of Lt. Governor Steve Pence, the ability to address the drug problem across the Commonwealth remains vibrant. Through their work, these offices strive to involve all community members by providing opportunities for leadership and an environment that encourages the

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## Youth and Substance Abuse (continued from page 5)

exercise of civic capacity. The work is both community driven and community appropriate, following the principle that the most productive efforts for community advancement originate at the local level in partnership with the state.

### **KY-ASAP – Planning and Policies**

Appalachian Kentucky communities benefit from the alcohol, tobacco and other drug prevention and treatment resources that are available through the state to deal with substance abuse. However, there is need to strengthen programs through enhanced coordination and additional resources.

KY-ASAP uses its legislative mandate to improve intergovernmental collaborations. The program uses state and local boards to bring together policy makers to address shared planning, funding and evaluation. The process allows both the state and local partners to gain a comprehensive consolidated perspective on the drug abuse problem with the local community as well as statewide impact. In addition, these board meetings provide a forum to share ideas and best practices supported by policy and research.

The local and state boards also strive to enhance civic involvement in efforts to reduce addiction. Since August 2001, nearly \$2.3 million have been invested in 40 of Kentucky's Appalachian counties with another \$300,000 targeted to support 6 additional Appalachian communities. The plan is to be able to support the work of local boards in all 51 Kentucky Appalachian counties. These local boards are mandated by legislation to:

- Assist in planning, overseeing and coordinating the implementation of local programs, both public and private, related to substance abuse;
- Submit reports on the effectiveness, efficiency and efforts of each local program, including recommendations for increased or decreased funding; and
- Develop a long-term strategy, based on an assessment of needs and available services, that is designed to reduce the incidence of illegal youth and young adult smoking and tobacco addiction, promote resistance to illegal smoking, reduce the incidence of substance abuse, and promote effective treatment of substance abuse.

To build on and sustain these formalized coordination efforts we need to follow the guiding principle that the most productive efforts for community advancement are those originating at the local level in partnership with federal, state and regional resources. The work will be long-term as research has indicated that small changes take 6-18 months and real change takes 3 to 10 years. Through this process, the local boards will address access to services, community awareness of affordable services, the use of statistical data to support programs, and the increase of community and institutional commitment to address substance abuse.

### **Champion Coalitions**

Champions for a Drug Free Kentucky is the state affiliate of the Community Anti-Drug Coalitions of America (CADCA). These coalitions focus on substance abuse and related issues of violence in communities. Each fall the coalitions gather for an annual statewide conference to learn about the current topics and to strengthen their ability to affect illegal substance use and abuse by youth and related violence in their communities.

Community groups working closely with the Community Mental Health Centers' Regional Prevention Centers and the Cabinet for Health Services, Division of Substance Abuse are eligible to receive part of the \$300,000 set aside by the Governor's Title IV. Many of these coalitions have integrated their work with the local health departments' tobacco control efforts, those of the Justice Cabinet and other local, regional, state and federal efforts that aim for similar outcomes. Currently, 29 established Champion Coalitions implement anti-drug programs and strategies in 43 of Kentucky's Appalachian counties, with long-term plans to support work in all 51 Appalachian counties.

Working at the federal and state levels makes little difference without the involvement of local citizens. Regardless of your age, background or skills, if you care there is a place for you at the table to help prevent addiction and support those in recovery. Get involved! Contact KY-ASAP and Champions for a Drug Free Kentucky at 502-564-8262 or visit our web site at <http://ky-asap.ky.gov/>.

## Women and Smoking Report Card Finds U.S. Lacking Central Appalachian States Fare Poorly

In September 2003, the National Women's Law Center published a report on women and smoking in the United States. The report ranked states' efforts to reduce tobacco use among women and girls and evaluated health status and health policy indicators related to smoking. Overall, the United States received a failing grade.

In overall state rankings, the central Appalachian states fared poorly—all receiving failing grades. Kentucky tied with Nevada for 50<sup>th</sup> place, while West Virginia came in 49<sup>th</sup>. Tennessee ranked 47<sup>th</sup>, and Ohio showed in 44<sup>th</sup> ranking. The Commonwealth of Virginia held a more favorable ranking, tying with Oregon for 20<sup>th</sup> place.

The report noted several policy indicators, including whether the states had a telephone quitline, provided Medicaid coverage for smoking cessation, had placed restrictions on secondhand smoke, had implemented a cigarette excise tax, had a tobacco prevention fund, and had policies to restrict youth access to tobacco products.

Of the central Appalachian states, only West Virginia offered a telephone smoking quitline. Ohio, Virginia and West Virginia provided Medicaid coverage for smoking

cessation, though only West Virginia fully met policy indicators for this coverage. Only Ohio had some weak policies restricting access to secondhand smoke. Ohio and West Virginia were the two states that also had cigarette excise taxes, though again, this policy was noted as weak. Tennessee was the only central Appalachian state with no designated tobacco prevention funding, and the other states that had this funding provided limited policy at best.

Kentucky and West Virginia also ranked among the poorest states in lung cancer death rates, with 51.7 of every 100,000 women dying of the disease in Kentucky and 51 of every 100,000 women dying of lung cancer in West Virginia.

For more information, go to the Health issues section of the National Women's Law Center at <[www.nwlc.org](http://www.nwlc.org)>, where you can download the full report, *Women and Smoking Report Card*.

### Percentage Who Smoke

|               | <b>Adult<br/>Women</b> | <b>Grades<br/>9-12</b> | <b>When<br/>Pregnant</b> |
|---------------|------------------------|------------------------|--------------------------|
| Kentucky      | 28.0                   | 34.1                   | 24.6                     |
| Ohio          | 26.2                   | 33.7                   | 19.0                     |
| Tennessee     | 23.6                   | 28.4                   | 17.0                     |
| Virginia      | 20.6                   | *14.9                  | 8.3                      |
| West Virginia | 25.6                   | 40.6                   | 26.3                     |

*\*figure for VA reflects ages 15-19*

### Spring Issue Topic

## Aging in Appalachia

As our nation and region ages, we face new issues related to our communities. What services are available to serve aging populations? How has the movement of retirees into the region affected our communities? What other issues arise from our aging? If you have a story or an idea, contact us using the information on page 2. Deadline for the spring issue is March 5, 2004.

# Out of Apathy & Into Hope

## Battling the War on Drugs

by Tina Rae Collins, Brushy Fork Staff

On Friday, November 7, 2003, the Kentucky Appalachian Commission held a three-hour conference at Jenny Wiley State Park in Prestonsburg, Kentucky, to reflect on the drug use problem in Appalachian Kentucky. In November of 2002 the Commission had considered this issue and discussed how to maximize the benefits of resources available and were given direction to prepare an inventory of available services. The Commission was to “identify and catalog existing efforts to address the drug abuse problem to facilitate consideration of ideas to target the problem.”

During the meeting, the Commission presented its 22-page *Drug Abuse Initiatives Affecting Appalachian Kentucky*. This inventory includes programs that deal with the following categories: Education and Prevention, Rehabilitation, Enforcement, and Professional Training and Development. Among the initiatives listed in this publication are People Against Drugs (PAD), People Encouraging People (PEP, Inc.), Kentucky Agency for Substance Abuse Policy (KY-ASAP), Kentucky River Community Care (KRCC), Unlawful Narcotics Investigation Treatment and Education (UNITE), Kentucky Narcotic Treatment Network (KNTN), and the Center for Substance Abuse Prevention (CSAP).

In view of the findings of the inventory, the Kentucky Appalachian Commission considered the following questions at the meeting:

1. Are the resources currently available to address substance abuse sufficiently coordinated to provide Appalachian Kentucky communities the maximum benefit of the resources? If so, how can this be sustained? If not, how can coordination be improved?
2. What barriers exist, if any, that hinder communities and agencies from engaging partnerships and collaborating to address local substance abuse issues? What actions should be taken to remove these barriers?
3. Do community groups have easy access to applied, practical research that can be employed in designing and operating local substance abuse initiatives?

A group of panelists reviewed the inventory and offered their responses to the above questions. The panel was comprised of Dr. Louise Howell, Director of Kentucky River Community Care; Dr. Rice Leach, Commissioner of Public Health; David Mawn, Deputy Director of Kentucky Agency for Substance Policy; Charles Housley, Executive Director of Appalachian Regional Health Care in Hazard; and Tim Hazlette, Deputy Commissioner of the Kentucky State Police. Other members of the Commission as well as interested people who were in attendance also made comments and offered thoughts and ideas about how to work in Appalachian communities to overcome the problem of drug abuse in Kentucky and surrounding states.

The panel members were fairly unanimous in their thinking that the Kentucky Appalachian Commission is not gaining the maximum benefits from the resources available to it. While independent groups have worked heartily and steadily, very little collaboration is taking place. Kentucky lacks drug courts, effective prevention, treatment money, and professionals to work in the counties and communities. Further, a general apathy sometimes prevents progress.



While resources are more abundant than they were last year, David Mawn noted that sometimes treatment options are far away or help is not readily available from them because of a long waiting list. According to Charles Housley, coordination of programs is only 30-40 percent or less. He suggested that patients need prevention, detoxification, long-term care, and acute care. He sees the best means as prevention, with programs starting in the schools. Good programs are available and he is optimistic, but he added, "Usually when all is said and done, there is more said than done."

"We are outnumbered," Tim Hazlette stated, "but we won't give up the fight. We have to keep the faith, to run the race, to finish the course." The state is attempting to establish an organizational structure, but as programs develop they become a money chase as state and federal programs compete. Hazlette would like to see a task force under an umbrella to funnel resources directly to the source, creating unity of purpose and unity of process.

Dr. Louise Howell asserted that the major barrier to wiping out drug abuse in Appalachian Kentucky is community and family denial. "We here in Appalachia are individuals," she said, "and that has worked against us." She believes the problems exceed anything the state is doing. "We like legal drugs here—tobacco, alcohol—and it doesn't seem to be a problem to us."

David Mawn listed several barriers: access, availability, awareness, and institutional and community apathy. He suggested that Kentucky needs to engage the media and get "out of apathy and into hope—into believing that we can make a difference."

Charles Housley would like to see drug courts in all 29 Appalachian counties. He wants quicker data on prescription drugs and a good online program to monitor legal drugs. He does not think that the state has enough long-term care facilities. Detoxification is five to seven days and then patients receive 30 days of care, and they are generally using drugs again in 30 days. Housley affirmed that patients should be followed for up to 15 months and taken out of their environment. If patients are taken to another county

The panel members defined drug abuse as a chronic illness that must be treated by overcoming family and community denial and by providing long-term support for drug abusers.

and given job training, he is confident that treatment will work. "When they come out, if they have something to do, something to hang onto, we won't see them back like we did."

Tim Hazlette stated that "territorial barriers are not insurmountable, and he is satisfied that with diligence and diplomacy the state can overcome them. "Drugs are no respecter of persons. They find their way to those who are helping, which casts shadows on our programs. Everybody who is supposed to be on the side of the Lord isn't."

In one year in eastern Kentucky \$141,000,000 worth of assets were seized. In one week in southeastern Kentucky \$6,000,000 worth of assets and drug money were seized. Hazlette sees this problem as symptomatic of something larger—a social and economic issue. He wants to start working with younger children and get them into a better environment.

Charles Housley worked with a program in Detroit that helped stem the use of illegal drugs. Patients were sent to the Upper Peninsula and given treatment and a job. They attended meetings and then went out on the job with their supervisor. Housley believes that the drug problem should be treated like a chronic illness.

Karyn Haskell, Director of Substance Abuse in Kentucky, concurs. "We don't turn our backs on people who have chronic diseases such as diabetes," Haskell declared. "If we can see this as a long-term chronic illness and develop recovery communities with long-term options, it will help. We are still focusing on the short term. It would be nice if we could ship them to Australia till they are sober, but they have to learn to live with the illness every day."

Former Governor Paul Patton, who presided over the meeting, commented that the state has treated drug abuse as a criminal problem and not a medical one. He said that Kentucky spends money and time on the criminal justice side of this issue and has seen results. During his administration, incarceration went up 34 percent and probation went up 50 percent. "We have put in more public

## Battling the War on Drugs continued from page 9

defenders, drug courts, family courts, and prosecutors on the legal side,” he said, “but not as much money has been spent on the medical side.”

“We save up to \$18 for every \$1 invested in a social cause,” David Mawn stated. “We see small change in six to eighteen months. We see big change in three to ten years.” The panel concluded that drug abuse is a chronic illness and must be treated as such if Kentucky expects to see drug abuse wane. Birdie Salyer of the Magoffin County Health Department and Social Services summed up the panel’s thoughts. “We know the problems,” she stated. “We need a substance abuse expert in the community to keep the work ongoing. We need a multi-faceted program. We all have to work together. We need collaboration, coordination, and money.”

Do community groups have access to the programs and initiatives that are available? According to Dr. Rice Leach, they do. He believes that each community should solve its own problems and be given the resources to solve them. “We need to ask the communities how they need help so we can know how to help them,” he said. He wants to see drug courts and boys and girls clubs in each county. He thinks the treatment side can be handled but he is doubtful about the long-term care. He cited an example of a family that mortgaged their home and spent \$10,000 to send their child out of state for 30 days of treatment, only to discover that their child was back on drugs 15 days after the treatment ended.

Tim Hazlette stated that enough information is available to communities on local substance abuse initiatives but an equal amount of information on how to make drugs is also available. “If you see a lot of people at a house,” he said, “they are not selling Tupperware.”

The state has 15 drug protection dogs. The first six have paid for the rest of them and Hazlette considers them to be “worth their weight in gold.” Former Governor Patton commented that Kentucky is on the leading edge with regard to actions being taken to prevent and control illegal drug use. He charged those in attendance at the meeting to take the programs that are effective and get in touch with

**Former Governor Paul Patton noted drug abuse prevention as the most important social policy during the term of the next governor.**

health departments and lobby to get them to work together to gain momentum in the fight against drugs. “Get in touch with police departments in other states,” he urged. “Stop the leakage around the borders.”

“This is going to be the most important social policy during the term of the next governor,”

Patton continued. “I wish we could have addressed more, but we have at least raised awareness.”

“We have a long way to go in the war on drugs,” David Mawn stated. “We have many programs but we need more. We need to come together. We need to look at the data and remove the programs that don’t work and keep the ones that do.”

Dr. Leach agreed. “Ain’t no such thing as your side of the canoe leaking,” he stated. He too believes that the state has made progress. “Kids are beginning to smoke less. To pull that off in Kentucky takes leadership. Fewer babies are born with problems from drugs. Abuse and neglect of kids is down. We’ve made real progress in controlling HIV. We have power tools now instead of hand tools.”

Former Governor Patton ended the discussion with a challenge and a charge to the community leaders of Appalachian Kentucky. “I challenge the county judges that are here today to get involved and consider this issue a high priority,” he urged. “I want to give a charge to all of you. Take this on as a major social issue.”

New programs will be implemented in the near future, such as Neighborhood Watch programs and better online following of prescription drugs. Kentucky is indeed on the leading edge of the war on drugs, and the Kentucky Appalachian Commission and other organizations are determined not to give up the fight. Every Kentuckian is affected in some way by this problem. If it is not a son or daughter, it is someone out there on the highways meeting a son or a daughter head on. Every citizen must enter the fray and work to win the war on drugs, for every citizen has a stake in the outcome. The canoe can be mended. The leaks can be stopped. Kentucky can win this war. But as Birdie Salyer said, and the panelists resolved, “We all have to work together.”

## Drug Threat Assessments continued from page 3

dangerous drugs to drug markets within and outside the state.

The DEA notes that **cocaine and crack** constitute the greatest drug threat to Ohio. The drug is readily available throughout the state, and its distribution and abuse consistently have been linked to violent crime. According to the Ohio Department of Alcohol and Drug Addiction Services data, the number of treatment admissions for cocaine abuse was 9,672 in 2002.

**Heroin** is widely available and poses another serious drug threat to Ohio, states the Department of Justice Threat Assessment. The heroin user population is growing and includes an increasing number of young people. In the southern Ohio region, Mexican black tar heroin is predominant. The drug is shipped into the state from major distribution centers such as Chicago, Detroit and New York and is often transported on commercial flights. The Department of Alcohol and Drug Addiction Services reported that the number of treatment admissions for heroin abuse increased from 5,769 in 2001 to 6,878 in 2002.

While **methamphetamine** production and abuse rates in Ohio are comparative to abuse in other states, the rate is increasing. The DEA notes the most notable trend as the upsurge in methamphetamine laboratories, up from 5 lab seizures in 1997 to 88 lab seizures in 2002.

**Marijuana** is the most widely available and commonly abused illicit drug in Ohio. The rural areas of the state, particularly those in the southern portion, provide adequate growing conditions for marijuana, so Ohio serves as a source area for the drug. Mexican marijuana is also shipped into the state from the southwest border states.

**Other dangerous drugs** such as MDMA, GHB, ketamine, LSD, PCP, and diverted pharmaceuticals are emerging threats in Ohio, according to the Department of Justice Threat Assessment. The DEA says MDMA (also known as Ecstasy) represents the greatest future threat to Ohio's youth. Retail dealers of this drug are typically high school or college students who sell the pills for an average of \$25 each.

Ohio serves as a base for trafficking of **pseudoephedrine**, a precursor chemical in the production of methamphetamine. Trafficking cells

...cocaine and crack constitute the greatest drug threats to both Tennessee and Ohio.

controlled primarily by Middle Easterners, according to the DEA, coordinated trans-shipment of the drug from Canada to "super labs" in California.

### Drugs in Tennessee

Drug trafficking organizations and criminal groups transport large quantities of drugs through Tennessee en route to other states. The state is bordered by eight other states and has a number of major highways that carry large volumes of traffic, making it an ideal hub for trafficking.

**Cocaine**, particularly crack, is the greatest drug threat to Tennessee, notes the Department of Justice Threat Assessment. Crack cocaine is readily available and commonly abused, leading Tennessee to have more cocaine-related treatment admissions and federal sentences than for any other drug.

The distribution and abuse of crack are associated with more violent crime than any other drug. Kilogram quantities of powdered cocaine generally are available only in the four major metropolitan areas of Tennessee—Chattanooga, Knoxville, Memphis, and Nashville. Hamilton, Davidson and Shelby Counties are considered to be the distribution hubs, according to the DEA.

Mexican criminal groups and African American street gangs both based in Tennessee are the primary transporters and wholesale distributors of powdered cocaine. African-American street gangs and local independent dealers convert most of the powdered cocaine in Tennessee to crack cocaine locally and are the primary retail distributors. Caucasian criminal groups and outlaw motorcycle gangs, among others, distribute retail quantities of powdered cocaine in Tennessee. The DEA notes that these groups respond to control elements in Atlanta, Los Angeles, Houston and Mexico.

**Marijuana** is the second greatest drug threat to Tennessee. Marijuana is the most readily available and commonly abused drug in the state; however, its distribution and abuse are generally not associated with violent crime. The DEA reports that Tennessee is a major supplier of domestically grown marijuana, often ranking among the top three producers.

continued on page 14

# Citizens' Attitudes of Youth Alcohol, Tobacco, and Other Drug Problems in the Buffalo Trace Region

Study done by David Rudy, Robert Bylund, Loretta Carroll, and Rebecca Katz  
Institute for Regional Analysis and Public Policy, Morehead State University

During the spring of 2003 the Institute for Regional Analysis and Public Policy was commissioned by the Buffalo Trace Agency for Substance Abuse Policy (ASAP) Board to conduct a phone interview of adults in the Buffalo Trace Region (Bracken, Fleming, Lewis, Mason, and Robertson Counties) in northeastern Kentucky. The 52-item interview schedule measured adults' attitudes regarding youth alcohol, tobacco, and other drug (ATOD) use, access, and problems.

Community tobacco issues (smoking during pregnancy, secondhand smoke, tobacco advertising), personal orientation toward tobacco and alcohol use, and demographic items were also assessed. A quota sample of 522 households was interviewed by telephone.

This report examines which ATOD usage citizens perceive as problematic in their communities. Next, it examines citizens' attitudes with respect to community problems and issues associated with ATOD. Finally, the report describes the vision of the Buffalo Trace ASAP in developing prevention programming based on periodic youth drug surveys combined with data on community norms.

## Perception of Greatest Youth Substance Abuse Problem

Chart 1 shows respondents' perceptions of which substance they felt caused the greatest problems among teenagers. Alcohol and illegal drugs ranked high as causing the greatest problems, with about 47% indicating alcohol and 43% indicating illegal drugs. Tobacco was a distant third choice at about 8%, followed by prescription drugs indicated by only 2% of the respondents. While media attention often sensationalizes and overemphasizes illegal drug use as a problem,

these findings indicate that adults in the Buffalo Trace view alcohol as the "single" greatest problem with respect to youth.

Charts 2 and 3 elaborate on respondents' perception of youth alcohol and drug usage. A large majority, 82.2%, agreed that alcohol use among teens had increased in the past few years. An even larger majority, 86.3%, either agreed or strongly agreed with the statement that drug use had increased over the past few years.

It is noteworthy that tobacco is still perceived as a serious problem, just not as serious as drugs or alcohol. Eighty-three percent of adults either agree or strongly agree with the statement that youth tobacco use is a serious problem in their communities. In a similar fashion, more than 76% of adults believe that marijuana use by teens is a serious problem in their communities and 56% believe that prescription drug abuse is a serious problem.

## Perception of Community Problems Related to ATOD Use

Respondents were asked their views with respect to deleterious community consequences of ATOD use. Interview highlights include:

Chart 1. Greatest Youth Substance Abuse Problem

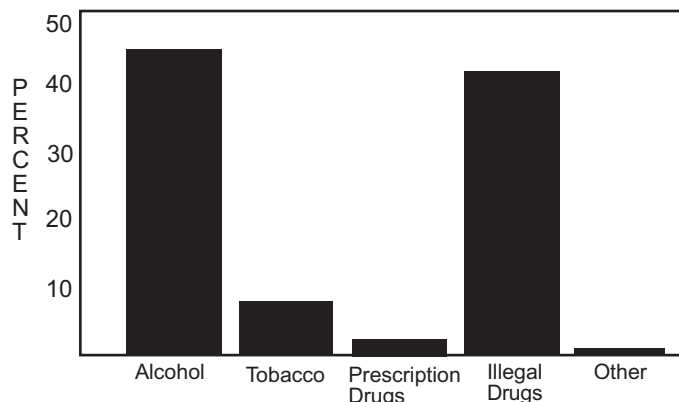
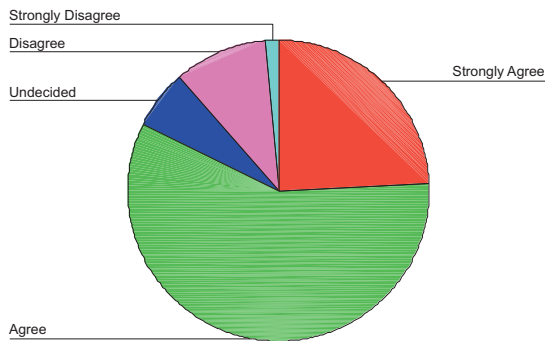


Chart 2. Youth Alcohol Use Has Increased



- 91% believe that alcohol use by teens contributes to traffic accidents;
- 76% believe that alcohol use by teens contributes to increased crime;
- 61% believe that smoking by pregnant women is a problem in their community;
- 49% believe that tobacco leads teens to use other drugs;
- 79% believe that alcohol leads teens to other drug use.

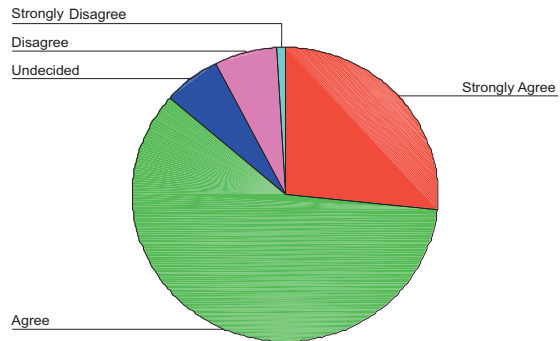
Other findings of interest with respect to adult attitudes include:

- 99% think that it is wrong to purchase or supply underage teens with alcohol but 82% believe that some parents give their teens alcohol;
- 62% believe that tobacco and alcohol advertising should be banned;
- 69% believe that prevention programs help reduce problems;
- 76% wish there were more prevention programs available in their communities;
- 89% often see teens using tobacco products in public;
- 87% believe that teens often have adult siblings or friends buy them alcohol.

When responses were analyzed in terms of characteristics of the respondents (gender, education, age, parenthood, drinking and smoking orientation), only three characteristics showed significant differences:

- Women are more likely than men to perceive higher prevalence of ATOD use, problems, and consequences;

Chart 3. Youth Drug Use Has Increased



- Respondents at lower educational levels are more likely than those at higher levels to perceive ATOD use, problems, consequences, and issues;
- Respondents who self identify as drinkers or smokers are less likely than abstainers or non-smokers to perceive ATOD use, problems, consequences, and issues.

### Community-Based Prevention

This study and other research literature demonstrate that ATOD initiation, use, and prevention are shaped within social networks. Youth obtain alcohol and tobacco from siblings, friends, and sometimes adults, including parents. Prevention and treatment programs should target each of these constituencies as well as continuing to train and monitor local vendors of these products. While having youth, peers, and parents in the same prevention programs may not be practical, they should be engaged simultaneously with different prevention education.

Systematic research allows programming to address and involve all the links that adolescents and young adults share with parents, peers, and communities. Efforts in the Buffalo Trace ASAP have included the collection and analysis of data on middle and high school students through periodic drug surveys. In addition, through assessment of attitudes, beliefs, and orientations of adults, the Buffalo Trace ASAP is more effectively developing interventions and programming to target community-based influences on ATOD behaviors.

# Drug Threat Assessments continued from page 11

Cannabis is grown in the Appalachia-Cumberland Plateau region in eastern and central Tennessee, one of the most productive cannabis growing regions in the country. However, Mexican criminal groups based in Tennessee also transport marijuana produced in Mexico into and through Tennessee.

**Methamphetamine** is the third greatest drug threat to Tennessee. Methamphetamine increasingly is available; however, the number of methamphetamine-related treatment admissions and federal sentences is significantly lower than those associated with cocaine and marijuana. According to the DEA, officials anticipate an increase in methamphetamine use in Tennessee as the drug gains popularity over crack cocaine.

The DEA reports that Tennessee accounts for 75 percent of the methamphetamine lab seizures in the Southeast. Numbers have risen from 2 lab seizures in 1996 to 461 lab seizures in 2001. While the labs seized are generally small and unsophisticated, they pose a significant threat because the lab operators are frequently armed and directly involved with the drug's distribution. Southeast Tennessee has seen significant increase in structured Mexican methamphetamine trafficking groups.

**Other dangerous drugs** are a minimal but increasing threat to Tennessee. Stimulants such as MDMA and khat and diverted pharmaceuticals such as Dilaudid and, more recently, OxyContin make up this category. MDMA is the drug most commonly abused in Tennessee. Dilaudid and OxyContin are two of the most frequently diverted and abused pharmaceuticals.

**Heroin** is the least significant illicit drug threat to Tennessee. The availability, abuse, and violence associated with heroin are limited and concentrated primarily in Memphis and, to a lesser extent, in Chattanooga and Knoxville. Most of the heroin seized in the state is destined for other markets, according to the Department of Justice Threat Assessment.

## Drugs in Virginia

The Department of Justice notes that the distribution and abuse of illicit drugs pose a serious threat to Virginia mainly because the state has a well-developed transportation infrastructure that includes two major north-south interstate highways (Interstates 81 and 95), five international airports,

two international seaports, and various forms of public transportation. Most of the illicit drugs available in the state are transported overland from New York City or southwestern states, but some drugs are transported from other domestic and various foreign locations. Private and rental vehicles are the primary conveyances used to transport illicit drugs into and through Virginia. Commercial vehicles; couriers aboard buses, passenger railcars, and commercial aircraft; and package delivery services also are used to transport illicit drugs into the state.

**Cocaine** poses one of the most significant drug threats to Virginia because it is readily available, often abused, and frequently associated with violent crime. Colombian and Dominican drug trafficking organizations in New York City are the primary sources for most of the cocaine in the state. However, according to the DEA, many local traffickers are becoming reliant on Mexican sources in the southwestern states, North Carolina and Georgia.

**Marijuana** is the most widely available and abused illicit drug in Virginia. While cannabis is grown outdoors during the spring and summer, the plant is increasingly being grown indoors. However, the primary source for Virginia's marijuana is the southwest United States.

Low cost, high purity South American **heroin** poses a serious threat to the state because abuse and availability levels are high, particularly in urban areas. Eastern Virginia hosts a consistent, long-term heroin abuse population, according to the DEA. The problem is less pronounced in the southwestern part of the state.

The production, distribution, and abuse of **methamphetamine** is a low but increasing threat to Virginia. The DEA reports that the majority of methamphetamine production takes place in the southwestern section of the state, bordering West Virginia, North Carolina and Kentucky. Only five labs were seized in 2001, up from one lab in 1996. The Shenandoah Valley region contains the highest percentage of methamphetamine abusers.

Cocaine poses one of the most significant drug threats to Virginia...

The availability and abuse of **other dangerous drugs**, principally diverted pharmaceuticals, MDMA, and PCP, pose a significant drug threat to the state, although the threat is less severe than that associated with cocaine, marijuana, and heroin. However, the DEA notes that Virginia was one of the first states to record extraordinary levels of OxyContin diversion and abuse. The abuse of this prescription pain killer was initially limited to the southwestern portion of the state but has spread to include most of western and much of central and northern Virginia.

### Drugs in West Virginia

West Virginia's most pronounced drug problems involve methamphetamines, marijuana and pharmaceutical drug diversion. Drug distributors in the state are uniquely placed to take advantage of supply sources from nearby eastern cities like Baltimore, Pittsburgh and Washington, DC. Law enforcement officials report that drug transporters primarily use private and commercial vehicles to transport illicit drugs into and through West Virginia.

**Cocaine**, particularly crack, is widely available in West Virginia cities, commonly abused, and frequently associated with violent crime. There were more cocaine-related offenses in the state than offenses for any other illicit drug in 2002. Further, more than 57 percent of drug-related federal sentences in West Virginia in fiscal year 2001 were cocaine-related. Much of the powdered cocaine transported into the state is converted into crack locally.

**Diverted pharmaceuticals** are an enormous concern, particularly in southern West Virginia, according to the DEA. Abuse of prescription drugs rivals that of cocaine in many areas of the state. OxyContin, Vicodin, and Dilaudid are readily available, commonly abused, and frequently associated with property crimes. Further, treatment data indicate that there were more pharmaceutical-related treatment admissions in 2000 than admissions for any illicit drug except marijuana.

Diverted pharmaceuticals are an enormous concern, particularly in southern West Virginia...

Both imported and locally cultivated **marijuana** is the most widely available and commonly abused illicit drug in West Virginia. However, the drug generally is regarded as a lower threat than cocaine and diverted

pharmaceuticals because it is less often associated with crime. According to the Department of Justice Threat Assessment, much of the marijuana available in West Virginia is produced in Mexico, but the state still ranks consistently in the top ten states for marijuana production.

**Methamphetamine** poses an increasing drug threat to West Virginia and is the primary drug threat in Wood County, based on the Department of Justice Threat Assessment. While statewide treatment data indicate low levels of methamphetamine abuse, the Department of Health and Human Resources reports that the level of abuse likely is not reflected in the number of treatment admissions because methamphetamine is a relatively new abuse problem.

Most of the methamphetamine available in West Virginia is produced locally. Over the past three years, meth lab activity has increased three-fold. Originally, the activity was focused in the panhandle region but has expanded to include the southeastern portion of the state. Caucasian local independent dealers and loosely organized criminal groups produce and distribute most of the methamphetamine in West Virginia. Out-of-state criminal groups, primarily Mexican, increasingly are distributing methamphetamine, particularly in Charleston and the eastern panhandle.

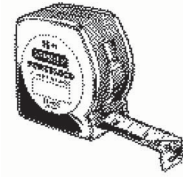
**Heroin** poses a low but increasing threat to West Virginia, notes the Department of Justice. While heroin abuse levels are low, state and local law enforcement officials report that abuse is increasing in cities such as Martinsburg and Weirton where the drug is being abused as a substitute for OxyContin. Most of the heroin is transported into West Virginia via private vehicles from metropolitan areas in the northeastern U.S.



toolbox

## Seeking Consensus

Productive groups need effective decision-making processes. Many groups use **voting**, but voting has some shortcomings. Seeking **consensus** is an alternative approach.

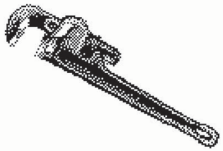


For groups of volunteers, consensus has advantages. If you have ten people, and have a six to four vote, you might have a decision but you don't have an agreement.

**Consensus means** “shared sense,” or “the same idea.” Seeking consensus is a process of working through ideas until we have a shared sense of how best to proceed.

**It is not compromise.** If one person wants to paint a wagon red and another wants to paint it blue, we could compromise and paint it purple—and both people might hate the color. Compromise is a **lose/lose** solution. Consensus seeking involves looking for a **win/win** solution.

It is important in seeking consensus to look beyond apparently opposing **positions** and try to understand each other's **interests**. In the example of painting the wagon, I might learn that you have red paint you want to use up and you might learn that I have blue cloth I want to use for the top. Then we might end up painting the wagon red and the wheels blue to match the top—a win/win solution.




Often groups that use consensus will have specific procedures for what to do if they are unable to reach consensus. Each group member has the right to **block consensus**. This means the individual feels strongly that the proposed course of action is wrong and that the group must not pursue it.

When people seek to block consensus, it is important to **understand why**. If we listen to their reasons, we will have more information to improve the idea to make it work.

**We don't hammer on an individual** until he goes along with what we want. **We hammer on the idea** and try to include everyone's perspectives. We have reached consensus when the proposal being considered is improved to the point where everyone can go along with it, even if it isn't everyone's first choice.



 In this process of refining the group's thinking, it is often helpful to look for a **third alternative**—not the lowest common denominator but a better idea, as in the case of painting the wagon.

In seeking consensus, it is important to make creative and effective use of basic group process skills. So **be aware of the process**.





# Current News About Drugs in the Region

## West Virginians Pay More for Illegal Drugs

According to a study produced by the National Drug Intelligence Center, residents of West Virginia pay more for illegal substances like powder and crack cocaine than do residents of other states.

While prices varied based on purity and potency, West Virginia drug dealers paid about \$24,000 wholesale for a kilogram (2.2 pounds) of powder cocaine. Dealers usually sold the drug back for \$100 a gram, netting as much as \$75,000 in profit.

West Virginia residents also paid above average prices for other substances: \$300 a gram for heroin, \$2 for a marijuana joint, \$150 a gram for methamphetamine, and \$80 to \$200 a gram for crack cocaine.

U.S. Attorney Kasey Warner credited the state's remoteness and small population with the inflated prices. He noted that the study underscores how much money goes into the drug trade.

From "West Virginians Pay More for Illegal Drugs." Charleston Gazette, January 14, 2004.

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## Meth Arrests Leave Children Caught in the Middle

With the proliferation of illegal methamphetamine labs across Appalachia, many small towns are finding their youngest residents caught in the middle. When authorities raid methamphetamine labs, they must decontaminate the area and the people who are found in the residence.

Many times these residents include children. According to a January 1 article in the Christian Science Monitor, small children are often found playing on the floor, where dangerous fumes can congregate when a household member is "cooking" methamphetamine. When children are found in this

situation, officials must use hoses, scrubs and soap to decontaminate them on the spot.

In Tennessee, the article notes, some 500 children have been placed in foster care because their parents were arrested for producing methamphetamine. Russ Dedrick, a U.S. attorney in Knoxville, notes, "Our system is overwhelmed right now."

Meanwhile, communities are taking measures to help these children. For example, Cumberland County, Tennessee, recently bought an old church and turned it into a foster group home mainly for "meth orphans."

From "Towns Pitch in to Save 'Meth Orphans' of Appalachia." Christian Science Monitor, January 1, 2004.

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## Tennessee Launches MethWatch Program

The Drug Investigation Division of the Tennessee Bureau of Investigation, the Governor's Office, the Tennessee Police Chiefs Association, the Sheriff's Association, and the Tennessee Retail Association have partnered to launch the Tennessee MethWatch Program.

The program combines a public information campaign with an intelligence collection system, based around a 24-hour meth hotline, 1-877-TNN-METH (1-877-866-6384).

The program aims to educate the public about the meth problem and then solicit the help of retailers and the community in identifying and reporting suspicious behavior. Suspicious activity reported through the hotline will be investigated by state and local law enforcement.

The program is being praised by law enforcement and by members of the Tennessee General Assembly.

From "MethWatch Designed to Crack Down on Drug." Tulahoma News, January 26, 2004.

# 2003-2004 Leadership Development Program Team Projects Underway

by Kierca Kimbel, Brushy Fork Student Staff

The 2003 Leadership Program teams are at the mid-term point on their county projects. Here's an overview of what the teams are working on:

## Barbour County, West Virginia

Choosing the name Best of Barbour, this group wants to promote the best of Barbour County. For their six-month project, the team will produce a pamphlet of information about the county, including highlights such as camping sites, fairs, arts and crafts events, and historical sites of interest. The pamphlets will not only be targeting tourists and visitors to the county, but also new residents and possibly old residents that might be unaware of the best of Barbour. The team's long-term goal is to bring pride and unity to their county.



Best of Barbour (BoB)



Estill Educates to Empower (E<sup>3</sup>)

## Estill County, Kentucky

The members of the Estill County team named their project E<sup>3</sup> for Estill Educates to Empower. Their project focuses on educating county residents about the local government. They plan to have educational programs in which they will teach about government officials and their roles. The team also hopes to increase voter turnout, as in the past it has been very low. The group hopes to educate residents about how to effect local change, from contacting local officials to using petitions and other courses of action. Estill County's long-term goal is to empower county residents to understand and use local government.

## Berea College Team

The Berea College team would like to produce a business plan for their six-month project. They plan to research what it would take to have a store for odds and ends on or close to campus so that students and visitors to the college will have a locally owned option for day-to-day shopping. The team hopes the college will promote such an investment, or use the plan to attract entrepreneurs to the idea. They also expect such a shop to have an effect on the college's car policy and possibly help improve the parking situation. By providing the college with such a plan, the students envision that the college will be better able to improve student and community life.



Meigs Visionary Players (MVP)



Youth Empowerment Solutions (YES)

### Meigs County, Ohio

Team members of Meigs County decided to improve the friendliness of their county by welcoming visitors with a new information kiosk and new welcoming signs. The signs and kiosk will be placed on a recently built road that enters the county. Team members will design the kiosk, which will provide information about attractions and events such as a historical reenactment. The team will also provide trash cans at this site to cut back on littering on the highways. The group has received approval and their signs are ready to post. They are currently trying to involve local schools in designing the kiosk.

### Randolph County, West Virginia

The Randolph County group adopted the name Youth Empowerment Solutions. Team members adopted the long-term goal of meeting the ongoing needs of youth for recreation and activities in the county. The team originally planned to fund and implement a youth-driven study to produce a clear plan for activities and recreation. However, as the group got into the project, the focus changed to creating a service that empowers youth to create and implement projects that benefit the community. Youth Empowerment Solutions will strive to provide funding, technical assistance and support to young people who want to do these community projects.

clip and mail

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Return to Brushy Fork Institute, CPO 2164, Berea College, Berea, KY 40404. **Thank you!**

# Welcome to Jane Higgins, New Program Associate

Brushy Fork welcomes our new Program Associate, Jane Higgins. Jane will coordinate the Brushy Fork Leadership Development Program and work with our other programs as well.

Jane comes to Brushy Fork from Georgetown College in Lexington, Kentucky, where she has worked for the past five years as coordinator of Center for Leadership and Ethics. Previous to that position, she worked in sales and nonprofit careers.

Born and raised in Big Stone Gap, Virginia, Jane is a 1981 graduate of Georgetown College. She currently resides in Lexington with her husband, George. Both are golf enthusiasts. Jane also enjoys reading and outdoor activities.

Jane replaces Van Gravitt, who served as Program Associate for nearly ten years. We wish Van the best as he takes on new endeavors.



## County Selection Underway for 2004 Leadership Cycle

Our new Program Associate, Jane Higgins, is beginning the county selection and recruitment process for the 2004 Leadership Development Program cycle.

If you know of an Appalachian county in Kentucky, Ohio, Tennessee, Virginia or West

Virginia, that might be a good match for the Brushy Fork program, contact Jane at 859-985-3436 or e-mail her at [jane\\_higgins@berea.edu](mailto:jane_higgins@berea.edu).

The opening workshop for this cycle takes place from September 16-18. The closing workshop will be April 8-9, 2005.

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