



# Healthy Campus Community

## NYS College Alcohol and Other Drug Abuse Prevention Manual

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Governor

New York State Office of Alcoholism  
and Substance Abuse Services



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Healthy Campus Communities  
NYS College Alcohol and Other  
Drug Abuse Prevention Manual

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## INTRODUCTION

The New York State Office of Alcoholism and Substance Abuse Services, in partnership with the Statewide College Steering Committee, is proud to release the eighth edition of our college manual. This revision reflects the growing knowledge base of what works in college alcohol and substance abuse prevention. OASAS is committed to bringing the latest prevention research to the practitioners. The new title of the manual, *Healthy Campus Communities*, reflects the latest research suggesting that greater success is achieved through partnerships between the campus and local community and the various systems contained within each. These partnerships working in concert with each other and having a common vision are the fuel that allows common people to attain uncommon results. Our successful Regional Alcohol and Other Drug Consortia Project, Statewide College Consortia Steering Committee, college conferences, and federally-funded initiatives are proof that partnerships do produce positive results.

Part One of the manual offers updated information on national statistics, cultural competency, gender issues, meeting the needs of people with disabilities, and alcohol marketing on campus. Other chapters examine the nature of alcohol problems, substance abuse prevention strategies, including the public health approach to prevention, and drugs other than alcohol that are prevalent on campus.

Part Two outlines the various components of a model campus alcohol and other drug abuse prevention program. You will find details related to establishing a task force, conducting needs assessments, developing prevention and early intervention initiatives, publicizing your program, and evaluating its effectiveness. The manual also includes appendices focusing on prevention program funding, Employee Assistance Programs, and New York State-specific alcohol-related laws, just to name a few.

You are encouraged to use the information provided in this document as it applies to your campus. You may find that some of the material is not applicable, or that the entire book is useful. Therein lies the strength of this manual; in whole or in part, there is something in it for everyone.

As you use this book to complement or fully design your campus' alcohol and other drug abuse prevention program, keep in mind that you are not alone in dealing with this issue. There are others like you around the State and across the nation looking for the best practices of reducing substance abuse on campus.

## Chapter 1 ♦ ALCOHOL AND COLLEGE STUDENTS

A great deal of thought went into this manual as it went through the most recent revision. Many points of view and source documents were taken into account in order to provide the reader with the latest, most accurate information available. One fact that is indisputable: the research continues to identify alcohol as the drug of choice for college students.

Many ask, “What about marijuana, cocaine, heroin, or ecstasy? Aren’t those the worst things that affect our college students?” Without downplaying the seriousness of these drugs, which are addressed in subsequent chapters of this document, it is imperative to understand that the drug most seriously impacting the health and economics of our college campuses is alcohol.

Look at the facts:

- ♦ Of the 48,432 students who reported being under the age of 21, 85.2 percent reported using alcohol within the 30 days prior to completing the CORE survey. <sup>1</sup>
- ♦ Almost 1 in 4 (23 percent) students on college campuses are frequent binge drinkers, which is associated with being eight times more likely to miss a class, fall behind in schoolwork, get hurt or injured, and damage property. <sup>2</sup>
- ♦ More than 60 percent of college men and almost 50 percent of college women who are frequent binge drinkers report that they drink and drive. <sup>3</sup>
- ♦ In schools with high binge drinking rates, 34 percent of non-binge drinkers reported being insulted or humiliated by binge drinkers; 13 percent reported being pushed, hit or assaulted; 54 percent reported taking care of a drunken student; 68 percent were interrupted while studying; and 26 percent of women experienced an unwanted sexual advance. <sup>4</sup>

### *The Definition of Binge Drinking*

There is a current debate around the use of the term “binge drinking.” Professionals in the field of college substance abuse prevention have suggested that “heavy episodic drinking,” “acute alcohol intoxication,” or “high-risk drinking” be used instead of the current vernacular. For the purpose of this manual, the term “binge drinking” has a very specific usage. It defines the level of alcohol consumption at which students begin to experience significantly more alcohol-related problems than those students who drink less. Through comprehensive study of college students’ alcohol use, Dr. Henry Wechsler defined the term binge drinking as 5 drinks in one sitting for men, and 4 drinks in one sitting for women. He has said this about the current debate on the verbiage to be used:

In recent years, some debate has occurred about the five/four measure of binge drinking (five drinks for men, four for women). Does it overstate the problem or label normative behavior as deviant? Findings from this study continue to show that students who drink at

these levels, particularly those who do so more than once a week, experience a far higher rate of problems than other students. For example, frequent binge drinkers are likely to miss classes, to vandalize property, and to drive after drinking. Indeed, the frequent binge drinkers are also more likely to experience 5 or more different alcohol-related problems.<sup>5</sup>

### *What are the Consequences?*

Colleges and universities pay a high economic and social price for alcohol problems that result in academic failure, violence and strained community relations. College administrators estimate that alcohol is a factor in 34 percent of all academic problems and 25 percent of all college dropouts. More than 7 percent of first-year students drop out of college for alcohol-related reasons, and as a result, colleges annually lose more than \$261 million in tuition.<sup>6</sup>

Alcohol abuse is the underlying cause for many campus crimes, from vandalism to assault to rape. Alcohol is involved in 70 percent of violent behavior on campus, and a campus rape is reported every 21 hours.<sup>7</sup> A survey by Towson State University in Maryland documents the relationship of alcohol to student violence, crime and vandalism. Forty-six percent of the students who reported committing crimes said they had been using alcohol at the time. Approximately the same percentage of students who had reported being the victims of a crime also reported that they had been using alcohol or other drugs.<sup>8</sup>

Another area of concern for college students about is the effect alcohol has on social interactions, including personal relationships and sex. Students, in particular, often consume alcohol in dating situations when the likelihood of sexual interaction is high. Under the influence of alcohol or other drugs, people can make sexual decisions that are unwise and unsafe, risking disease and unwanted pregnancy. Reports show that 60 percent of college women diagnosed with a sexually transmitted disease were intoxicated at the time of infection, and two-thirds of college women with unplanned pregnancies were intoxicated at the time of conception.<sup>9</sup> Strategies to address these issues are included elsewhere in this manual.

Today, sex can also be fatal, if impulsiveness and substance abuse prompt people to ignore protecting themselves from possible exposure to the HIV virus. More than 20 percent of people with AIDS are in their twenties. Because the latency period between HIV infection and onset of symptoms is about 10 years, most of these people probably became infected with HIV as teenagers, many while in college.<sup>10</sup> Students may be well aware of the consequences of unsafe sex; however, that knowledge may be rendered useless because their judgment is impaired after using alcohol or other drugs.

### *Rite of Passage?*

Most college students who use alcohol probably started drinking in high school, and their current alcohol use is a continuation of that behavior. However, some drinkers don't start until they reach college, as evidenced by Dr. Wechsler's research. His study found that 22 percent of students did not binge drink in high school, but did engage in this behavior in college; New York State students were slightly higher than the national average at 27 percent.<sup>11</sup>

The culture of the campus, the opportunity to be independent of daily parental control, the need

to conform, and the insecurity of a new and intimidating setting all make a first-year student particularly vulnerable. Another indicator of the greater risk on the college campus is the difference that was found in New York State in the rates of binge drinking between college students who lived at home with their families and those who lived on-campus or in an off-campus apartment. The latter had a binge-drinking rate that was over twice the rate of the former (23 percent versus 11 percent).<sup>12</sup>

### *The Time to Act is Now*

The alcohol connection to academic, social and health-related problems on college campuses is evident. College substance abuse prevention and early intervention programs need to focus on universal as well as selective and indicated populations of alcohol abusers. Education and awareness efforts need to highlight the role of alcohol and other drugs in the problems faced by the campus community. Linking substance abuse to these problems can help the college community understand the importance of and need for a campus-wide commitment to alcohol and other drug abuse prevention programs and networking with local, state, and federal resources and services.

The bottom line is this: Do we remain passive and settle for the way things now stand, or do we take an active role and challenge ourselves to improve the well-being of our students and other campus members? The answer is in our hands.

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## Chapter 2 ♦ THE NATURE OF ALCOHOL PROBLEMS

What causes some people to have problems with alcohol? That question has been at the center of debate for years. For a long time, people thought of alcoholism as a “bad habit” caused by some personal weakness or lack of willpower, but in the 1950s, the American Medical Association and the World Health Organization recognized alcoholism as a disease.

The American Psychiatric Association’s Diagnostic and Statistical Manual currently distinguishes between Alcohol Abuse and Alcohol Dependence (i.e. alcoholism): while both cause significant impairment or distress, substance dependence includes tolerance and withdrawal, both signs of physiological addiction.

Alcohol-related problems can be conceptualized on a continuum, even though there might not be a linear progression of symptoms. High-risk drinking (which impairs judgment, physical coordination, and impulse control) can result in legal difficulties, school or work performance problems, interpersonal conflicts and health problems. Even an isolated incident of excessive alcohol consumption creates serious risks, such as alcohol poisoning, auto crashes and fatalities, and victimization by others or of others. Increased frequency and amount of alcohol use/abuse tend to increase the risks. A simple distinction between alcoholic/non-alcoholic drinking is not useful in addressing the range of drinking problems that exist, particularly on college campuses.

Recent research suggests there are different subtypes of alcoholism, which may have different causes and courses. However, there is agreement in the field that a combination of biopsychosocial influences underlies problems with alcohol. The role of genetics has been repeatedly documented in studies of twins and adoptees. These studies found that children who have a biological parent who is alcoholic are three to four times more likely to develop alcoholism than the children of non-alcoholics. For sons of alcoholic fathers, the risk is even higher. Research also has addressed the factors of family history, developmental issues, motivations to drink, and cognitions about alcohol.<sup>1</sup>

This research has led to an understanding of alcoholism as a complex disease. Most people develop the disease not from one predetermined factor, but as a result of the interaction of several elements, including exposure to alcohol, family history of alcoholism, and cultural and environmental factors. While inherited susceptibility appears to be the most powerful variable in the development of alcoholism, it is still necessary for the susceptible person to use alcohol in sufficient quantity and frequency to initiate the process of addiction.

Some people appear to develop dependency as a result of consuming excessive quantities of alcohol, perhaps to cope with unusual stress or in response to psychological problems. It is also true that many people who become dependent begin with harmful drinking patterns that are either encouraged or tolerated by their social environment. This information has enormous implications for colleges. On many campuses, and among some student groups, heavy and unsafe use of alcohol has been an accepted, if not encouraged, norm. College students also continue to be the targets of aggressive alcohol marketing campaigns and promotional efforts designed to encourage this unhealthy behavior.

People with a genetic vulnerability who become alcoholic typically begin experimenting with alcohol during adolescence. Research has shown that children's drinking behavior is influenced strongly by environmental factors other than their parents' alcohol use (i.e. peer influences).<sup>2</sup>

Many students believe that heavy alcohol use during college is expected of them, and that it is a societal rite of passage. In fact, most of these students state with the utmost determination that they will simply stop this behavior once they graduate. Unfortunately, research shows that this is often not the case. Based on a 27-year follow-up of college students begun in 1950, one-half of those students who drank five or more drinks on four or more days per week while in college experienced alcoholism or other serious alcohol-related problems 20 years later.<sup>3</sup>

It appears that social and cultural factors have the most influence on a person's use of alcohol. These factors are exploited by the alcohol industry to influence alcohol use patterns, primarily to promote sales of alcohol. Similarly, prevention strategies can be developed to discourage alcohol use in specific high-risk groups and situations, just as advertising now targets certain groups to encourage product use.

#### *Alcohol Use and Its Impact on Health*

Some studies have indicated that an association exists between low levels of alcohol use and good health. Studies of this type have shown better general health in those who use alcohol in small quantities over those who abstain. However, it is not clear that these studies consider the varied reasons why people abstain, such as family histories of alcoholism or other unknown variables that later may be found pertinent. The subject of "healthy" levels of alcohol use must be addressed because it has an impact on messages for the general public regarding the desirability and safety of any alcohol use.

For several reasons, two drinks per day appear to represent the point over which daily alcohol use is unsafe for most persons. Some fetal alcohol effects, such as low birth weight, have been associated with consumption levels as low as an average of two drinks per day. None of the studies associating positive health effects with alcohol consumption found benefits over the average levels of two drinks per day. Based on the Dietary Guidelines for Americans set by the U.S. Department of Health and Human Services and the U.S. Department of Agriculture, it is recommended that men who choose to use alcohol should limit their consumption to no more than two drinks per day, and women should not exceed one drink per day.

#### *The Prevalence of Alcohol Use*

While it often seems that "everyone drinks," the fact is that approximately 1/3 of American adults didn't use alcohol within the past year.<sup>4</sup> Some of these people are recovering from the disease of alcoholism and some don't drink as a matter of religious conviction. Many people don't drink because they don't enjoy the taste of alcoholic beverages; while others don't use alcohol because they don't like the way they feel when they drink.

According to the 1998 National Household Survey, of the 10.4 million current drinkers age 12-20, half were binge drinkers (i.e. consumed five or more drinks at one sitting). Young adult (age 18-25) drinkers were the most likely to binge or drink heavily. In addition, this age group, along

with teens, showed the highest levels of associated problems (health, emotional/psychological, and alcoholic dependence) of any age group of alcohol users.<sup>5</sup>

In a New York State Survey conducted in 1996, 81 percent of college students used alcohol on some basis.<sup>6</sup> According to a National Institute of Alcoholism and Alcohol Abuse (NIAAA) study published in January 2000, adolescents who began drinking before age 15 were twice as likely to abuse alcohol as adults than those who began at age 21, and four times as likely to become alcoholic.<sup>7</sup>

Alcohol is a *norm-setting drug*. This is due to the relative societal approval and acceptance of drug use in the form of alcohol consumption as compared to illicit drug use. This is of particular concern for people below the minimum legal drinking age for whom alcohol use is often treated as a “rite of passage” or as somehow “preferable” to illicit drug use. Condoning alcohol use creates mixed messages for young people who will likely be faced with a similar choice about the use of other drugs. As long as use of alcohol is portrayed as less harmful than, or preferable to, illicit drug use, society is condoning the use of a drug.

Several studies have been conducted in New York State on how norm misperceptions influence student alcohol and other drug use. College students have definite perceptions about the alcohol-related behaviors and attitudes of other students, which, in turn, influence their own pattern of use. Yet these beliefs about the substance use of their friends are frequently incorrect. While over two-thirds of the students on most campuses believe that their peers hold relatively permissive attitudes toward alcohol or other drug use, the majority of students are often modest in their own attitudes and behaviors concerning alcohol and other drugs. In other words, most students think that their peers are using more alcohol and other drugs than they really are.<sup>8</sup> While 40 percent of students reported actually using alcohol at least once a week, 89 percent of students believed the average student used that often.<sup>9</sup>

Obviously, a campus’ special resources and needs will shape its response to dealing with alcohol and other drug-related problems. Whether located in urban, suburban, or rural communities, effective prevention and early intervention programs will share common elements. However, prevention programs should be designed to specify a setting and target population. For example, target populations may be based on age, gender or ethnicity. An understanding of the risks faced by a target group provides the focus for identifying appropriate protective factors and developing subsequent prevention strategies.

To be effective, prevention efforts must coordinate resources and services, and should elicit the support of individuals, educational institutions, businesses and organizations and government agencies at every level. A primary goal of prevention programs should be to encourage long-term change in lifestyle, by offering new opportunities, supporting healthy behaviors and changing social norms.

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## Chapter 3 ♦ PREVENTION STRATEGIES

In a very broad sense, we live in a quick fix society. Rather than looking at long-term solutions to specific issues, such as alcohol and other drug abuse, bandages are often applied on the problems, with the hope that they will just go away. Although this approach is often used, it is not very practical, especially in an economic sense. Prevention must be viewed as a viable, cost-effective method of dealing with health and overall wellness.

Perhaps more important is the acknowledgment that prevention works! One example, the recent U.S. record in decreasing alcohol-related traffic fatalities, is remarkable. In 1982, there were 25,165 alcohol related traffic fatalities, which represented about 57 percent of all fatal crashes, according to the National Highway Transportation Safety Administration (NHTSA). In 1995, alcohol was involved in 17, 274 crash fatalities, which were 41 percent of that year's fatalities. Hence, between 1982 and 1995, the number of alcohol-related fatalities dropped by 31 percent, and the proportion of crash fatalities involving alcohol fell by 16 percent. <sup>1</sup> Much of the reduction in crashes related to impaired driving is a result of prevention initiatives at the national, state and local levels. They include raising the minimum drinking age, raising alcohol prices, lowering blood alcohol concentration limits, and establishing roadside sobriety checkpoints. <sup>2</sup>

Prevention initiatives are designed to reduce individual and environmental risk factors and to increase resiliency factors in high-risk populations. Several strategies are used to reach these goals, such as information dissemination, education, identification and referral, community mobilization, and public policy initiatives. There are a number of features that effective prevention programs share. <sup>3</sup>

- ♦ They are targeted.
- ♦ They are designed to effect long-term change.
- ♦ They strengthen the natural support systems of family, school, and community.
- ♦ They can document their success in meeting stated goals and objectives.

### *A Review of Prevention Theory*

Since OASAS' College Program was started in 1982, the field of alcohol and other drug abuse prevention has undergone several evolutions. This is the result of intensive evaluation research that continues to reveal what doesn't work in prevention, and more important, what *does* seem to work.

*Promising Practices: Campus Alcohol Strategies* was initiated in 1995 by Dr. David Anderson (George Mason University) and Dr. Gail Gleason Milgram (Rutgers University) with a primary focus on identifying and disseminating campus-based efforts deemed exemplary for addressing alcohol abuse. This project has published a Sourcebook, a Task Force Planner, a Task Force Planner Guide, and an Action Planner. These publications emphasize the "shared responsibilities" inherent in implementing and institutionalizing a campus alcohol abuse prevention program. <sup>4</sup>

To gain a better understanding of the science of prevention, and an appreciation of what has been achieved over the past 19 years, OASAS offers the following summary of the prevention theories upon which substance abuse prevention strategies have been based, and the program models

derived from them. <sup>5</sup> *Please note:* Although the initial theories have a strong emphasis on adolescents and teenagers, they lead to the highly regarded model that addresses risk and protective factors, which holds special relevance for institutions of higher education and their efforts to reduce collegiate substance abuse. See page 11 for more detail.

*Problem Behavior Theory* is based on the premise that early antisocial behavior can be predictive of adolescent substance abuse, and stresses the importance of young peoples' view of parental or peer attitudes and behavior as causes of their own behavior.

*Social Learning Theory* conceptualizes social behavior as something that is acquired through direct conditioning, or through imitation or modeling of others' behavior. It predicts that young people are more likely to use alcohol or other drugs if their parents, peers, or cultures do, and asserts that people can learn by observing other people's behavior, in addition to direct experience.

*Cognitive Inoculation Theory* holds that young people can be trained in protective life skills to avoid giving in to negative peer and family pressures to start using alcohol and other drugs. All the conflicting attitudes to which young people are likely to be exposed are presented to them at a young age, so they can build up immunity. *Social Inoculation Theory*, an extension of Cognitive Inoculation Theory, addresses the many social influences, attitudes, and beliefs that put pressure on young people to smoke, drink, or use other drugs. Students are introduced to the social pressures they will encounter to use drugs and then they are taught skills to resist those pressures.

*Stage Theory* is a theoretical model suggesting that intervention programs should be tailored to developmental stages, and programs should address the specific issues that young people are likely to be dealing with at the time of the program's introduction. According to Stage Theory, there is a "gateway" pattern of drug use initiation: if you reduce young people's initiation into the use of one drug, you will reduce the subsequent use of another.

*Bio-psychosocial Theory* stresses the importance of the interaction between a person and his or her internal and external environment. It states that adolescent behavior patterns will be more or less deviant depending on the opportunities one is exposed to and the feedback one receives from performing activities. This theory also contends that adolescents turn to the use of alcohol and other drugs in an attempt to cope with their problems.

Now that you have an understanding of the various theories behind substance abuse prevention, it is time to look at the specific prevention models that were developed from these concepts.

The *Information Only Model*, used primarily in the 1960s and 1970s strived to educate young people in classrooms about drugs, assuming that they used them because they were ignorant of the negative consequences associated with drugs. The prevailing wisdom was that increased knowledge would lead to a change in attitude, which would change behavior. Although it has been shown to impact on knowledge, all the evidence seems to indicate that this model used alone does not impact behavior change use very effectively. <sup>6</sup>

The *Alternatives Model* attempts to reduce young people's use of alcohol and other drugs by

involving them in non drug-related activities that keep them busy, productive, and satisfied, with the assumption that such activities will relieve boredom, increase self-esteem, and help the individual to bond with their community. Although school systems and social agencies invest a large part of their resources in these types of programs, there is little published evidence of their effectiveness as deterrents of substance use.<sup>7</sup>

The *Social Competency Model* assumes that adolescents use drugs because they have low self-esteem and inappropriate values, and have inadequate decision-making, problem-solving, or communication skills. It is also assumed that if young people are aided in developing such abilities, they will make correct choices concerning substance use. Programs developed using this model typically target general goals, rather than specifically targeting substance abuse prevention, and aim at enhancing personal and social competency by teaching broad coping skills. As with the two models previously discussed, research evaluations of this model have shown no support of the effectiveness of the strategy to prevent or decrease substance use.<sup>8</sup>

The *Social Environmental Model* asserts that social influence from peers, parents, and the media affect substance use; therefore, strategies are developed to supply young people with skills to perceive and resist those influences. Although different programs have focused on various aspects of the approach, most feature training in identifying and resisting situational pressures, and normative education is addressed. Programs utilizing this approach have shown increasingly encouraging results, especially for alcohol and marijuana use.

The *Risk and Protection Model* aims to promote positive youth development and prevent problem behavior before it happens, it addresses the factors which increase the likelihood of positive behavior and decreases the likelihood of negative behavior. A protective factor is an influence that inhibits, reduces, or buffers the probability of drug use or abuse, or a transition to a higher level of involvement with drugs. A risk factor is a condition that increases the likelihood of substance abuse.<sup>9</sup>

The *Social Norms Model* is a social marketing strategy that is proving effective in reducing high-risk drinking significantly. On some campuses, high-risk drinking rates are down by twenty percent or more from their levels a few years ago. A powerful motivation, according to sociologists, is what we perceive others to be doing, especially others whom we may admire and want to emulate. Campus surveys show that students typically have an exaggerated idea of how much drinking is going on. The secret of the social norms model is to let students know in a convincing way that the norm of alcohol consumption in the campus population is less than what they think. Most students are moderate drinkers or do not drink at all and are not causing a problem to them or anyone else.<sup>10</sup>

The *Environmental Management Model* is a comprehensive strategy for reducing alcohol and other drug use on college campuses. The better alcohol and other drug prevention programs are campus-community efforts that involve as much of the college and surrounding community as possible, including students, staff, faculty and community members. Building coalitions with local community leaders is also key. College campuses do not exist in isolation. Alcohol and other drug prevention planners need to collaborate with local leaders to limit student access to alcohol,

prevent intoxication, and support the efforts of local law enforcement. <sup>11</sup>

### *The Public Health Approach*

The public health model provides a comprehensive and consistent framework for analyzing alcohol and other drug abuse problems and developing appropriate prevention strategies. It is superior to other approaches that look at various substance abuse problems in isolation from one another, or fail to recognize their essential nature as health problems.

A public health approach analyzes substance abuse in the same context used for other diseases: host, agent, and environment. The *host* is the person, along with individual biological and psychological susceptibilities to substance abuse problems, and personal knowledge and attitudes that influence patterns and behaviors. The *agent* is the substance, including its content, characteristics, distribution, and availability. The *environment* is the social and physical context of drinking or other drug use.

Researchers have long recognized the relationship between host, agent, and environment in acute illnesses. Successful eradication of many infectious diseases has been based on interrupting the relationship among the three. For example, the polio vaccine successfully interrupted the relationship between the polio virus and host. This concept also can be applied to chronic disease prevention, even though the relationship between agent, host, and environment is more complex and multifaceted than the infectious disease model.

All three elements of the public health model are interactive and interdependent. Consequently, in approaching the prevention of alcohol or other drug problems, the most effective strategies will be those that deal with all three elements of the model.

Both the agent and host have characteristics that are fixed and others that are malleable. For example, the chemical structure and properties of alcohol are fixed, including its sedative, addictive, and toxic properties that have a potential health impact. On the other hand, the form in which alcohol is available to the user may be changed. Similarly, a person cannot change inherited susceptibility to the addictive properties of alcohol, but can alter individual use patterns.

All environmental factors related to alcohol and other drug problems are malleable and can be changed. Cultural norms are harder to change than fleeting advertising messages or educational curricula, but all are subject to intentional change. Of all factors that significantly contribute to the incidence of substance abuse problems, environmental factors are most easily and effectively changed by public policy or action.

The environmental public policy approach simply seeks to create an environment that promotes the lowest possible level of alcohol and other drug-related problems. Many legal and social policies have demonstrated their effectiveness in changing the environment in which these problems occur. These actions have included raising the minimum legal purchase age, increasing the price of alcohol, and requiring warning labels and posters

In the public health context, promising developments are being found in strategies that target risk factors for substance abuse.

There are two categories of risk factors for substance abuse that colleges should examine in an effort to reduce alcohol and other drug abuse on campus. The chart below outlines these categories that address societal and cultural factors, which provide the legal and normative expectations for behavior, and factors that lie within individuals and their interpersonal environments.<sup>12</sup>

<p><i>Contextual Factors</i></p> <ul style="list-style-type: none"><li>◆ Laws and norms favorable toward behavior</li><li>◆ Availability</li><li>◆ Extreme economic deprivation</li><li>◆ Neighborhood disorganization</li></ul> <p><i>Individual Factors</i></p> <ul style="list-style-type: none"><li>◆ Physiological factors</li><li>◆ Family alcohol and other drug behavior and attitudes</li><li>◆ Poor and inconsistent family management practices</li><li>◆ Family conflict</li><li>◆ Low bonding to family</li><li>◆ Early and persistent problem behaviors</li><li>◆ Academic failure</li><li>◆ Low degree of commitment to school</li><li>◆ Peer rejection in elementary grades</li><li>◆ Association with drug-using peers</li><li>◆ Alienation and rebelliousness</li><li>◆ Attitudes favorable to drug use</li><li>◆ Early onset of drug use</li></ul>
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Preventive work that seeks to address risk factors for drug abuse must clearly consider how a particular intervention is expected to address risk: by directly eliminating or reducing a risk factor, or by moderating its effects through the enhancement of protective factors, such as changing social norms, enforcing school policy, or enhancing critical thinking skills.<sup>13</sup> From a public health perspective, college campuses can serve as unique and important environments to reach young people to promote health and prevent disease.

#### *Prevention Strategies That Work*

Successful implementation of prevention programs is partially dependent on the settings in which the strategies take place. The home, school, community, and workplace are the most likely settings in which targeted prevention services are delivered. However, the most recent research suggests that the community as an inclusive setting increases the potential for positive social norm change, lessening the acceptance of alcohol and other drug abuse.

As established in the research findings, the level of intensity can also greatly influence the ability to achieve positive results. Each strategy must be used at a sufficient level of intensity to reach the

targeted outcomes of prevention. Factors to be considered include the frequency, timing, and communication ratios in relationship to the delivered services.

The strategies essential to the provision of comprehensive prevention services need to be multidimensional and mutually supportive. Research has led to the development of effective strategies that contribute to comprehensive prevention programming.<sup>14</sup> These can be applied easily to college-based prevention programs. These include:

- ◆ Provide accurate alcohol, tobacco, and other drug information (Information Only Model)
- ◆ Promote social competencies and life skills, such as decision-making, problem-solving, communication and resistance skills, and stress management (Social Competency Model)
- ◆ Support activities that focus on fun rather than alcohol or other drug use (Alternatives Model)
- ◆ Train people who have an impact on the behavior of others (e.g., administrators, faculty members, staff, student leaders, campus police, health care staff, etc.) (Social Norm Model and Social Environmental Model)
- ◆ Identify individuals at highest risk as early as possible, with the provision of intervention services and linkages in an appropriate environment
- ◆ Change campus alcohol and other drug social policies and norms (Environmental Management Model)

Effective prevention strategies also require policies that place the interest of public health above the economic, political, and popular student opinion of campus socializing. The success of campus prevention programming requires a significant, direct commitment to these policy choices, as well as the incumbent investment of resources.

### *High-Risk Groups*

Certain individuals, because of special medical problems or unusual sensitivity to alcohol, may be unable to drink alcohol. Diabetics, heart patients, and persons with diseases of the digestive and nervous systems should consult their physicians about alcohol use. People with a family history of alcoholism are three to four times more likely to become alcoholic themselves.

Others fall into the high-risk category only temporarily, such as people under 21 and pregnant women. Children and adolescents differ from adults in terms of body size and the liver's ability to handle alcohol. As a result, it takes less alcohol for a young person to become impaired, and as alcohol users, their tolerance will be lower than that of adults.

Throughout pregnancy the use of alcohol poses a serious risk to the developing fetus. Low birth weight, spontaneous abortion, mental retardation, hearing defects, and physical abnormalities are among the various fetal alcohol effects. Because it is impossible to precisely estimate how much alcohol will damage a developing fetus, the safest course for women is to not use any alcohol when they are pregnant, planning to become pregnant, or nursing.<sup>15</sup>

In addition to these, we know that different campus sub-populations have unique needs, some of which are addressed more than others. Many campuses report working fairly closely with the

unique needs of freshman students, fraternity/sorority members, and student athletes; they are less likely to report attending to the unique needs of persons with disabilities, women, people of color, and gay/lesbian/bisexual/transgender students.<sup>16</sup>

### *High-Risk Situations*

Most people recognize the danger in combining alcohol with driving, but how about while doing homework, playing sports, or studying for finals?

There are many high-risk situations where any drinking is unsafe. Many aspects of daily life, particularly working and recreational activities require alertness and coordination. Boating, hunting, climbing stairs, working with machinery, participating in sports, swimming, and similar activities can be dangerous when mixed with alcohol.

Other risky situations include times when one's condition is already impaired by another cause, such as depression or emotional stress. Drinking in these circumstances makes things worse, never better. Combining alcohol and medications, such as tranquilizers, sedatives, and antihistamines, is also risky. The effects of alcohol and these drugs can combine to produce a dangerous state of central nervous system depression.

The context in which drinking alcohol takes place also needs to be addressed. Prevention programmers should examine why students are drinking. Researchers have summarized the reasons for using alcohol through the following five primary drinking factors.<sup>17</sup>

- ♦ Escapism: Avoid boredom, anger, loneliness
- ♦ Relational: Meet members of the opposite sex
- ♦ Pleasure: Celebrate special occasions, liven up parties, quench thirst
- ♦ Sociability: To be polite or feel accepted, or simply because others are doing it
- ♦ Tension Reduction: Relieve nervousness and stress

Many college students drink with the express intention of losing control, rebelling against authority, and creating a counterculture.<sup>18</sup> For campuses to address the issue of substance abuse prevention in a comprehensive manner, it is critical to look at these and other underlying factors that push students to use alcohol or other drugs.

Knowing how much to drink (if at all and if you are over 21) and how often are extremely important to prevent alcohol-related problems. Individuals who belong to a high-risk group for developing alcohol problems, or are participating in any high-risk activity, should not drink alcohol at all.

### *Low-Risk Guidelines*

For people who are not in a high-risk category, there are a few suggested low-risk guidelines to follow that reduce their chances of developing alcohol-related problems. *Please note:* These guidelines do not apply to students under the age of 21, for whom alcohol use is illegal.

- ♦ *Do not exceed two drinks a day.* For low-risk people in low-risk situations, a limit of two drinks a day for men and one drink a day for women appears safe. This is not an average,

but a limit of zero to two drinks a day, not 14 drinks saved up for a one-night binge.

- ♦ *No more than three drinks per occasion.* If you are not a daily drinker and you watch out for individual factors, up to three drinks on an occasion is a safe limit, drinking no more than one drink per hour in a low-risk situation.
- ♦ *Adjust for individual factors.* Age, weight, gender, stomach content, mood, use of oral contraceptives and other drugs, menstruation, and recent illness or tiredness all affect your body's reaction to alcohol and should be considered in one's choice to use alcohol.

Like heart disease, diabetes and cancer, alcoholism is a disease. In other words, people can make choices about the way they live and what they do that increase or decrease their chances of developing that disease. Once people become aware of the risks, they can take steps to avoid developing the disease. People at high risk for heart disease can cut down on high-cholesterol foods, follow an exercise program, quit smoking, and avoid stress. These are all “low-risk” choices that reduce the chances of developing heart problems. In the same way, people can make low-risk choices about using alcohol that reduce their risk of developing alcoholism.<sup>16</sup>

Basically, if you know you belong to a high-risk group or are going to be in a high-risk situation, the best advice is not to drink. We sometimes forget that not drinking is an option. It's your choice if you are over 21. If you don't want to drink, for whatever reason, simply say “no thanks” and expect others to respect your decision.

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## Chapter 4 ♦ FAMILY HISTORY ISSUES

The effects of parental substance abuse do not go away simply because a parent goes into recovery, or because the young person moves away or goes to college. Rather, their feelings, behaviors and roles are often carried with them, like hidden baggage, into the college environment. It is the intention of this chapter to describe the experience of students who grew up with alcohol and/or other substance abuse in the home, and to offer suggestions for campus professionals to identify and address the needs of these students.

### *Definitions*

The terms “children of alcoholics” (COA), and “children of substance abusers” (COSA) are used in a broad sense to refer to any person, adult or child, who has a parent identified as having a significant problem related to alcohol or other drug use. It includes parents identified as having a problem by their children or another concerned person, as well as those who are self-identified. It is not a medical definition, but rather a practical one, which allows us to focus on how others may be affected by someone else’s alcoholism or drug use. The term adult child of an alcoholic (ACOA) is used to refer to any adult who grew up with an alcohol or substance-abusing parent.

For purposes of this chapter, we will utilize the term “Resiliency” to refer to those “traits, conditions, situations, and episodes that appear to alter – or even reverse – predictions of [negative outcome] and enable individuals to circumvent life stressors.”<sup>1</sup>

The term “Protective Factors” refers to those conditions that buffer youth from exposure to risk by either reducing the impact of risks or changing the way young people respond to risks.

### *How Many Children Of Alcoholics And Children Of Substance Abusers Are There?*

The estimate of the total number of children under age 18 living with one or more parents in the U.S. is approximately 75 million.<sup>2</sup> Approximately one in four children (28.6 percent of children 0 – 17 years) are exposed at some time before age 18 to familial alcoholism, alcohol abuse, or both.<sup>3</sup> With regard to illicit substance use, about 11 million children (14 percent) lived with at least one parent who reported past-year illicit drug use, and more than 8 million (11 percent) lived with at least one parent who reported past-month illicit drug use.<sup>4</sup>

Many of these children go on to become college students. In fact, data from the CORE Institute report to college presidents in 1998 indicates that 22.9 percent of college students grew up with a mother or father who had an alcohol or substance abuse problem.

### *Dynamics In Substance Abusing Families*

Alcoholism or other drug addiction affects everyone who lives with it. The health of each family member is joined with and affected by all other members. We see this connection most clearly with life-threatening illnesses. Consider the case of a parent who is dying of cancer. Everyone would expect that such a tragedy would affect everyone in the family. Perhaps because substance abuse is often gradual and insidious, we may not see its far-reaching impact on the family.

Some have referred to alcoholism in a family as the “central organizing factor”, meaning that members become organized around the substance use. So much of family life depends on the status of the substance-abusing family member: Have they been drinking? What will their reaction be if I...? Why does he or she do that? What did I do wrong? Young children, as they are naturally egocentric, often feel particularly responsible for the people in their world. Their sense of responsibility is exacerbated by the fact that the non-alcoholic parent will often involve them in trying to control the alcoholic. The child may believe that if they weren't bad, or if they were smarter and did better in school, their parent wouldn't drink. Once again, this may be reinforced by messages that warn family members not to upset the alcoholic.

In order to forestall a drinking or drugging episode, family members learn to tune in to the prevailing mood and act accordingly. Overt and covert rules are focused on preventing use or buffering the consequences of use. For example, there may be an unspoken rule not to bring up something that needs to be dealt with if the parent has been drinking. Family members try to control the alcoholic or their environment. As efforts to control the drinking or drug use inevitably fail, they may feel ashamed, embarrassed, or angered by the substance-abusing person's behavior; guilty and inadequate about not doing enough or even causing the substance abuse; and often responsible for trying to get the substance-abusing member to stop drinking or using other drugs. Frequently, the substance abuser and their families will deny that there is any problem until the problem has caused serious consequences.

In an effort to minimize conflict, communication shuts down. Feelings go unexpressed and may surface in angry outbursts, depression, or anxiety. The need to deny the unspeakable reality of the worsening situation, the need to protect the alcoholic and the repression of feelings lead to feelings of shame. As shame increases, the family typically becomes more isolated and closed. It is for this reason that families become cut off from the very supports that they need as the addiction progresses. Consequently, the family tends to become more chaotic and unpredictable.

These family dynamics may lead to a myriad of problems including increased family conflict; emotional or physical violence; decreased family cohesion; decreased family organization; increased family isolation; increased family stress including work problems, illness, marital strain and financial problems; and frequent family moves.<sup>5</sup> While all of these conditions may not be present, alcoholism and substance abuse create inordinate demands on family members as they try to deal with the alcoholic.

#### *Impact On Children, Lingering Impact On Adults*

Family members have different ways of responding to stress and develop different coping mechanisms. These personal adjustments, sometimes called “role adaptations” are attempts to cope with the inconsistency and breakdown in the family. For example, some children try to be perfect, some children have angry outbursts, and others stay out of the line of fire. Over time, roles can become fixed so that certain aspects of the role are carried into adulthood even while they interfere with personal fulfillment. For example, the “hero” or super-achiever finds it difficult to abandon their care taking, often going to extremes in caring for others. Picture how this might present a problem in relating to a fellow student who is struggling with their own substance abuse or other personal issues.

Although there is a genetic component to vulnerability for alcohol dependence, COA issues are not related primarily to alcohol use and related problems, but instead to social and psychological issues that may result from growing up in an alcoholic home. Indeed, research indicates that COA are at higher risk of developing physical, emotional and mental health problems than other youngsters.<sup>6</sup>

One indicator of how profound the health effects of parental alcoholism and other drug abuse can be on a child is revealed in a study of Independence Blue Cross/Blue Shield insured, which examined the health care costs of COA in comparison to children who did not live with parental problem.<sup>7</sup> The following findings demonstrate how COA suffer with more health problems:

- ◆ A 24 percent increase in inpatient hospital admissions;
- ◆ A 29 percent greater average stay in the hospital;
- ◆ Hospital utilization rates were 62 percent greater than for non-COA; and
- ◆ Average hospital costs were 36 percent greater than for other children.

This study demonstrates that these children get sick more often, go to the hospital more, and stay longer than children who do not live with alcoholism.

Several studies have documented that children with substance-abusing parents are more at risk than their peers for alcohol and drug use, delinquency and depression, as well as poor school performance.<sup>8,9,10,11</sup>

#### *Factors Which Determine The Impact*

There are a number of factors which influence how a college student may have been affected by their parent's substance abuse. These include the severity and duration of the drinking or drug use, their age during the abuse period, the gender of and relationship to the substance-abusing parent, the level of dysfunction or resiliency of the non-alcoholic parent and their ability to maintain family rituals, the resiliency of the child, the presence of violence and the protective factors in the environment.

Parental substance abuse affects COSA in many of the same ways it affects COA. This is partly due to the similarities in parenting style in both alcohol and substance abuse-affected families. Vaillant and Milofsky<sup>12</sup> have noted that these families have similar unrealistic expectations for their children, take extreme disciplinary measures, provide inadequate supervision, lack cohesion, have psychiatric difficulties in the family, have family conflict, and are socially isolated. Whether alcohol or substance abuse is the cause, the very nature of addiction is that the need to satisfy the addiction will supersede other needs, including those of the children. Parental availability is almost always compromised.

#### *Resiliency and Protective Factors*

Not all children are negatively impacted to the same degree. Many children grow up to be competent, successful adults. In fact, most COA (3 out of 4) do not develop alcohol problems.<sup>13</sup> Resiliency research essentially asks the question, "What accounts for the difference in the way individuals cope with traumatic events?"

Several researchers have studied resiliencies in young people who overcome adversity. Jacobs and Wolin identified seven key resiliencies in children of alcoholics. They are 1) Insight; 2) Independence; 3) Healthy Relationships; 4) Initiative; 5) Morality - the ability to separate their value system from their families and to set their own standards for conduct; 6) Creativity - particularly the ability to express conflict creatively; and 7) Humor. This list can serve as a starting point in identifying resiliencies that may exist in ACOA college students.<sup>14</sup>

#### *The Risks for COA and COSA: Genetics and Alcoholism*

Ever since researchers began studying alcoholism, their findings have shown a higher rate of alcoholism among people who had relatives with alcohol dependence. A 1979 review of 39 alcoholism studies conducted since the 1930s showed that alcoholic people were more likely than others to have an alcoholic father, mother, brother, sister, grandparent, or more distant relative. Study after study has supported the theory that genetics play a significant role in determining who develops the disease of alcoholism.

Researchers have used a variety of methods to separate the effects of heredity and environment by comparing the rates of alcoholism among twins, half-siblings, and adopted children. Studies of children adopted at an early age have shown that adopted children whose biological parents are nonalcoholic have the same low rates of alcoholism regardless of whether or not their adoptive parents are alcoholic. Conversely, biological children of alcoholic parents who have been adopted continue to have an increased risk (2 – 9 fold) of developing alcoholism.<sup>15</sup>

In Sweden, studies of men and women adopted before the age of three years enabled researchers to identify two types of genetic predisposition to alcoholism. The first type occurs in both men and women, and requires both the genetic predisposition and an environment that encourages the development of the disease. The second, more severe type is found only in men and, although less widespread, it seems to be unaffected by the environment.

#### *COA and COSA on Campus*

The effects of parental substance abuse do not go away simply because a child becomes an adult. In fact, the high school to college transition has many inherent challenges that can exacerbate ACOA issues. Students are challenged to handle new freedom while being self-disciplined, to establish new friendships and possibly romantic relationships, to plan for their future, and to make many decisions without the presence of parental influence. For the ACOA student who may have learned that it wasn't safe to trust, and who likely experienced family conflict, the whole area of relationships is a tricky one. Consider the reflection of one student who is struggling with this issue:

#### *I don't like to drink, but it's hard to make friends*

In my freshman dorm, there was a lot of drinking and drug use on my Floor. It bothered me when I saw people doing five or six shots of vodka, or smoking dope all night long. I can't be friends with people who act like that. I don't share their values. But it makes it hard to make friends.

ACOA college students are at higher risk because of environmental influences. As a threat to their biological vulnerability, they are faced with college norms that encourage high-risk drinking. For the ACOA who has been exposed to parental attitudes and behaviors that encouraged drinking, they may find it more difficult to decide not to drink in a high-risk environment. ACOA also tend to experience more problems related to their drinking, such as poor academic performance, problems with friendships and relationships, and trouble with the law than non-COA's.<sup>16</sup>

ACOA college students are also at increased risk because at least one of their parents modeled drinking behavior. They have already experienced the anticipated benefits of alcohol. "Alcohol expectancies (the effects one anticipates before drinking alcohol) appear to be one of the mechanisms explaining the relationship between parental alcoholism and heavy drinking during college."<sup>17</sup>

Whether the student is living at home or on campus, "survival roles" are likely to persist. For example, one student may respond to stress by failing classes, while another may harness their anxiety by studying for perfect grades.

#### *Residential Life Students*

For students who live on campus, this may be the first time living away from home. College students creating new lives for themselves away from home may experience conflicts about their success. They may see their being away as a kind of betrayal of other family members and, particularly if the substance abuse is still an issue, may worry about family members at home. They may have anxiety before going home and after returning from school breaks.

Because residence hall living recreates a family-like environment, the ACOA student's relationship issues are intensified. They may reach to drugs and alcohol to deal with their social anxiety, or they may take on the role of caregiver with their fellow students. Some students may be very controlling with others and find themselves involved in interpersonal conflicts.

#### *Commuters*

For some families, increasing college tuition may force some students to attend a local school and continue to live at home. Young adults who must live at home for economic reasons may have a difficult time transitioning from their familial role and embracing the role of the college student. If the substance abuser is still active, it may be more difficult to distance from family dysfunction.

#### *Your college prevention program*

Any successful college alcohol and other drug prevention program incorporates both environmental approaches that seek to build protective factors with individual approaches that look to enhance the resiliency of students. But because ACOA are at higher than average risk of developing problems and because they have special issues that lend themselves to intervention, they merit special attention in programming efforts. In addition to education about alcohol and other drugs that is a part of most college alcohol and other drug prevention programs, COA and COSA can benefit from the following approaches:

- ◆ Understanding how they have been affected by substance abuse in their family and how it

- may still impact them today
- ◆ Exploring the roles they had in their family and how that may show itself in their current relationships
  - ◆ Learning how to identify, accept, and express their emotions
  - ◆ Coping strategies to deal with current issues, such as going home on school breaks
  - ◆ Clarifying personal values and making healthy choices regarding alcohol and other drug use.

While ACOA may have special issues to be addressed, it is important for prevention programmers to remember that they are not a homogenous group.

### *Talking with high-risk students*

Because of the shame and secrecy that may have surrounded the substance abuse, many young people have learned not to talk about their problems. College students may believe that talking about their experiences makes them disloyal. They may be embarrassed as they mentally compare their families to the families of fellow students, or they may not even be aware that the issues they struggle with in college today are in any way related to growing up with substance abuse in their family. Students who are questioned without sensitivity to these issues may be reluctant to talk openly. The goal of a concerned campus professional is to help students make the connection between their past experience and their current behavior and to help them to more proactive in their decision-making and problem solving.

While academic problems may be the most obvious, it is important to assess for some of the more hidden problems that ACOA are more likely to be experiencing including: depression, anxiety, their own use of alcohol, and difficulty relating with peers.

With regard to individual strengths, the goal is to enhance individual resiliencies. Campus professionals can create an inventory of strengths that college students have used to be successful. It is important to acknowledge the strengths that have helped them to become college students. For example, the fact that they made it to college is, in and of itself, a tribute to their resiliency.

### *Environmental Approaches*

With regard to the college environment, the goal is to increase “protective factors.” Alcohol-free alternatives, substance-free housing, and correcting erroneous norms that encourage high-risk drinking are some examples of environmental approaches that have been shown to be effective.

Organizing campus discussion groups can provide an essential support system for ACOA students. Groups also provide a forum to educate about risks and to explore interpersonal conflicts. Groups may be professionally led or may be of the self-help variety. Members learn to accept alcoholism and other drug abuse as illnesses that affect them and, as they listen to the struggles that other members have faced in their own families, they learn more effective coping responses.

Al-Anon and Nar-Anon are two of the most widely known international organizations offering groups for families and friends of alcoholics or other substance abusers. Some Al-Anon chapters even have special ACOA groups, which are also accessible to Adult Children of Substance

Abusers. Organizing a group on campus offers students a place where they can go that is easily accessible and where they will be with other college students.

### *Summary Statement*

The college years hold the potential for many wonderful learning opportunities and experiences. The campus professional that recognizes the special vulnerabilities and resiliencies of ACOA students can use this knowledge to provide programs that increase the benefit of the college experience for this population.

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## Chapter 5 ♦ GENDER, ALCOHOL AND VIOLENCE

Women and men process alcohol at different rates. Women become more intoxicated than men when drinking identical doses of alcohol. First, women have more body fat and less muscle tissue than men of comparable size. Therefore, women achieve higher concentrations of alcohol in their blood than men do after drinking equivalent amounts of alcohol.<sup>1</sup> Secondly, women produce less of the enzyme dehydrogenase, which is responsible for breaking down alcohol as it passes through the stomach. Since women have about half as much of it as their male counterparts, more alcohol reaches their bloodstream and eventually their brain.<sup>2</sup>

According to the Core Institute, a national study of more than 65,000 college students reported that over 46 percent of undergraduates engaged in binge drinking during the previous two weeks.<sup>3</sup> Another Core Institute report documents the effect that alcohol has on student grades. As shown in the chart below, students who reported D's and F's consumed average of nine and one-half drinks a week, while students who earned A's averaged only three drinks a week.<sup>4</sup>

Average # of Drinks per week – Listed by Grade Reported

Grade Reported	Average # of drinks per week
A	3.4
B	4.5
C	6.1
D/F	9.8

The same study also helped to document the relationship of the grade reported and gender to alcohol.<sup>5</sup> As shown in the chart below, alcohol consumption by a female student may impair her academic performance at a quicker rate and at a lesser quantity than for males.

Average # of Drinks per week – Listed by Grade Reported and Gender

Grade Reported	Males	Females
A	5.4	2.2
B	6.9	2.9
C	8.4	3.7
D/F	12.4	4.9

In addition to the above mentioned academic risks students face when abusing alcohol, additional risks of being involved in a violent act or becoming a victim of a violent act increases for both men and women. In the above-mentioned CORE Survey of over 41,000 students, 2.2 percent have been in an argument or a fight more than 10 times when drinking, and 5.4 percent have driven a car while under the influence. The most striking finding in the report is that over 22 percent of college students report that they have been taken advantage of sexually at least once in the past year.

A recent report of crime statistics on college campuses, compiled by the U.S. Education Department, indicates a 6 percent rise in the number of sex offenses from 1998 to 1999. Arrests for violations of liquor and drug laws increased by 0.4 percent and 5.8 percent respectively.<sup>6</sup> The Harvard School of Public Health, 1999 College Survey, indicates approximately a 20 percent increase in unplanned sexual activities for those students who report frequent binge drinking episodes.<sup>7</sup> The latest available figures from the National Crime Victimization Survey reveal that more than 960,000 incidents of violence against a current or former spouse, boyfriend or girlfriend occur in America each year and about 85 percent of the victims are women. Substance abuse, especially alcohol, was cited as being a major contributing factor to this abuse.<sup>8</sup>

#### *Alcohol's Involvement In Violence On College Campuses*

Student's beliefs of why they use alcohol supports positive norms and expectations. Roughly two-thirds of students believe alcohol breaks the ice, enhances social activity and gives people something to do. One half believes alcohol contributes toward having fun, facilitates male bonding and enhances connections with peers. Half of the students (57 percent of males and 41 percent of females) believe that drinking facilitates sexual opportunities, which can be a setup for serious personal difficulty.<sup>9</sup> Alcohol is involved in one-third to two-thirds of rapes with two recent studies reporting a positive association of victim alcohol use with completed rapes. These studies also found a relationship with the amount of alcohol used by the offender and the severity of the sexual assault to the victim.<sup>10</sup>

In February 1998, the CORE Survey's national study of over 89,000 college students found that 43 percent reported episodes of violence and harassment caused by substance abuse. Among the report's findings are:

Of the 43 percent of students who experienced various forms of violence in the previous year, a high percentage of students were under the influence of alcohol or other drugs during these episodes, especially in incidents of unwanted sexual intercourse (79 percent), forced sexual touching (71 percent), actual physical violence (64 percent) and threats of physical violence (51 percent).

Students who engaged in binge drinking were 3.5 times more likely than their non-bingeing counterparts to be victims of physical violence.<sup>11</sup>

In a CORE Survey of almost 30,000 students in 1995, nearly 8 percent of those college students carried guns, knives or other weapons and one out of eight students reported that they did not feel safe on their campuses. The same survey discovered that 64 percent of college students who were physically assaulted reported that they drank alcohol or took drugs shortly before the attack.<sup>12</sup>

## **Alcohol And Violence Against Women**

Looking at the following statistics, it is easy to see that sexual offenses are the more prevalent, serious crime committed on college campuses. <sup>13</sup>

- ◆ One forcible rape occurs every two minutes according to the U.S. Dept. of Justice.
- ◆ Almost 40 percent of women who had been raped had been raped more than once.
- ◆ Two-thirds (62.6 percent) of all rapes happened during childhood or adolescence.

Sexual assaults occurring in resident halls, fraternity houses, parking lots and other locations are referred to as “campus rapes.” Someone the victim knows perpetrates most campus rapes. These assaults are called “acquaintance rapes.” <sup>14</sup> A legal definition of rape is generally defined as forced sexual intercourse that is perpetrated against the will of the victim. The type of force employed may involve physical violence, coercion, or the threat of harm. The definition applies in both stranger and acquaintance rapes.

Additionally, many college women are victims of unwanted sexual assaults, which are defined as the unwanted touching of an intimate part of another person. Yet another form of sexual assault is sexual harassment, defined as unwelcome and/or unwanted sexual advances that are explicit and implicit, verbal and nonverbal, and include physical touching, gestures, or exposure to sexually explicit materials. <sup>15</sup> When a man forces another person into having sexual intercourse, he is subject to the same criminal penalties whether he is acquainted with the victim or is a total stranger - and whether or not either party is intoxicated. Occasionally, women coerce men into forced sex and same-sex rape also occurs. However, men commit the vast majority of acquaintance rapes against women. <sup>16</sup>

College students are more vulnerable to rape than any other age group. Factors related to college students’ vulnerability are increased freedom, lack of parental supervision, peer pressure, beliefs of invincibility, experimentation with alcohol and other drugs, and strong sexual impulses. Women, ages 16-24 experience rapes at rates 4 times higher than assault rates of all women. Because most college women fall into this age range, they are at a high risk of experiencing sexual assault. When women who were assaulted were asked where the assault took place, the majority reported that it occurred on a college campus. A college campus can be a dangerous place for women students, and rape is a serious crime with long-lasting physical and mental health effects. <sup>17</sup>

## **Alcohol And Violence Against Men**

With National Crime Statistics for violence citing 85 percent of victims are women, 15 percent of violence then, effects men. <sup>18</sup> In a US Department of Justice Survey about violence, 27 percent of violence against men were committed by multiple offenders as compared to 16 percent for women. <sup>19</sup> Research done by the Core Institute gives us only a glimpse of what negative consequences occur for men when alcohol is involved. In their 1996 survey of over 17,000 college males, the following statistics are reported resulting from alcohol or other drug use: <sup>20</sup>

- ◆ Almost 10 percent were in trouble with police or other campus authorities
- ◆ Over 5.5 percent damaged property
- ◆ Over 7.5 percent had been hurt or injured
- ◆ Almost 5 percent had been taken advantage of sexually
- ◆ 12.5 percent got into an argument or fight
- ◆ Over 4 percent had taken advantage of someone sexually

Violent acts and victimization are also associated with hazing rituals with half of all cases of hazing involving alcohol. In a survey conducted by Alfred University of student athletes, 80 percent of all college athletes go through hazing as part of a team initiation process. One in five reported being forced to engage in potentially criminal activities.<sup>21</sup> Although the sample was small with only about 2,000 students responding, 42 percent of male students surveyed reported that consuming alcohol was part of the hazing process and 35 percent had to participate in drinking contests.<sup>22</sup> (For more information, see chapters on Alcohol and Athletes and Alcohol and Greeks). These additional survey results help to further define the scope of the hazing problem.

- ◆ 38 percent of men surveyed reported being verbally abused
- ◆ 32 percent reported being tattooed, pierced, shaved or branded
- ◆ 11 percent reported destroying or stealing property
- ◆ 7 percent reported committing sexual acts
- ◆ 8 percent reported being bound or confined
- ◆ 5 percent reported being paddled, whipped or beaten

#### *Comprehensive Prevention Programs*

Institutions of Higher Education are at different stages in the development of their acquaintance rape prevention efforts and violence prevention programs on campus. When addressing these issues, the following steps will be helpful to conduct as needed:<sup>23</sup>

- |                                     |                                    |
|-------------------------------------|------------------------------------|
| Identify like-minded people         | Gain administrative support        |
| Establish a planning committee      | Develop a public relations plan    |
| Develop an implementation plan      | Decide how to market the program   |
| Conduct a needs assessment          | Secure and educate allies          |
| Select target audiences             | Initiate evaluation and monitoring |
| Select and test pilot interventions | Train facilitators                 |
| Develop a peer facilitation plan    | Announce a program or new service  |
| Identify needed resources           | Change school policies             |

Six principles for developing or enhancing a rape prevention program include:<sup>24</sup>

- ◆ Changing campus norms
- ◆ Incorporating a variety of approaches and activities
- ◆ Reducing student drinking
- ◆ Involving many stakeholders

- ◆ Offering workshops led by trained student facilitators
- ◆ Tailoring approaches to the individual school

Both male and female college students need to be aware of the links between sexual assault and substance abuse, and taught strategies to reduce this risk. Education should include being able to identify potential rapist tactics, manipulations and personality characteristics. Incorporate a “know thy enemy” approach in risk-reduction education.<sup>25</sup> Students also need to know that substance use is not an adequate legal or moral justification for rape. It may be useful for campus-based substance abuse and rape prevention specialists to coordinate their activities and develop campus events and policies that address their mutual concern.<sup>26</sup>

Another prevention strategy focuses on teaching college students, both male and female, how to convey honestly and clearly their sexual intentions and to interpret the intentions of their dates. If these intentions are openly discussed, then misperception is less likely to occur, even when couples have been using alcohol or other drugs.<sup>27</sup>

Research is continually taking place examining the role alcohol and other drugs play in all forms of violence on college campuses. Increased education, prevention and treatment of all forms of violence need to be increased to insure colleges are safe environments for which to learn.

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## Chapter 6 ♦ CULTURAL COMPETENCE ON CAMPUS

### *Diversity On Campus*

No population is immune to substance abuse and its consequences, but there are significant differences in substance use among certain groups. “Young adults are the group more likely to use alcohol, tobacco and illicit drugs...men are more likely than women to use most substances, and they are particularly more likely to be heavy users of alcohol.” Whites are more likely than blacks or Hispanics to drink alcohol and their rates of heavy alcohol use are higher than among blacks but lower than among Hispanics.<sup>1</sup>

In the cultural competency literature available, scholars have acknowledged the important role that cultural factors; such as racial identity, ethnic identity, culturally specific values and acculturation play in shaping the life choices individuals make around alcohol and other drug use. It is no surprise that drug prevention information that is presented in formats and contexts that are meaningful and culturally relevant to various target populations is more likely to be retained by that target population. Strong cultural variables are associated with less drug use and other negative behaviors.<sup>2</sup>

### *African Americans*

African Americans are the largest ethnic/racial minority population in the United States, with an estimated population size of 37 million in 1997. Single parent families consist of 53 percent of the African-American population. The annual high school dropout rate for African Americans has decreased from 11 percent in 1970 to 5 percent in 1993 and African Americans with a higher level of education have shown considerable increases in yearly incomes.<sup>3</sup> Research has shown that this racial group holds specific values and beliefs about themselves and about how to relate to members of their community, as well as showing that African American youths who have internalized Africentric values and who possess a positive racial identity are better able to resist and/or delay drug initiation.<sup>4</sup> Some of those values include: spirituality, interpersonal orientation and communalism, harmony, sensitivity to emotional cues, and expressive communication.

African Americans who stayed in school were less likely than Anglo-American students to use alcohol and other drugs. 4 percent of African American youth reported cocaine use as compared to 22 percent of Anglo-American; 24 percent of African Americans reported marijuana use as compared to 38 percent of their Anglo-American peers.<sup>5</sup> Several variables related to increased drug use include: *individual factors* such as self esteem and life style choices, *family factors* which includes parental support in the home and single vs. two parent family dynamics, and *peer factors* such as peer pressure as well as individual use and attitudes towards drug use.

Although statistics bear out that African Americans use fewer drugs and alcohol than youth from other ethnic groups, the consequences of use is much more negative. Overall mortality rates from alcohol use are high among black men, even though their use tends to be more moderate than alcohol use reported by Anglo-Americans. Answers to this phenomenon possibly lie with continued inequality in economic opportunity and social policy. In 1994, 27.3 percent of African American families lived below the poverty level compared with only 11.6 percent of all US families combined.<sup>6</sup> Based on this statistic, it is no wonder that alcohol related illnesses are

statistically higher for African Americans than their Anglo-American peers. Inner city communities are often targets of alcohol and tobacco promotional activities. Some radio stations targeted to African Americans have 350 percent more alcohol commercials than other stations.<sup>7</sup> With inadequate access to health care and increased marketing techniques, the use of alcohol and other drugs is a serious problem within the African American community with consequences found in all domains.

The most effective prevention programs are those that focus on counteracting social influences to use drugs. Specific areas to target include individual resistance skills, appraising drug use situations, knowledge of actual social norms and avoidance of drug-using groups and opportunities. Programs need to include coping and support-seeking skills together with the problem solving and assertiveness training. For prevention programmers working with diverse student population at the college setting, strategies include:

- ◆ “person-level” factors such as history of prior substance use, personal skills, and ability to seek support
- ◆ “situation-level” factors such as group influences, peer pressure, family support
- ◆ “environment-level” factors such as media influences, support resources, community norms.<sup>8</sup>

Programs may want to include personal mentoring of students by individuals who are culturally sensitive to specific values and beliefs of students on an individual basis, addressing individual cultural heritage and the sense of community with all groups as well as addressing marketing opportunities that target specific racial groups on college campuses.

### *Native Americans*

Native Americans constitute a diverse population with more than 554 federally recognized tribes.<sup>9</sup> However, Native Americans make up 0.7 percent of the total US population making them the smallest minority group in the United States.<sup>10</sup> Extensive literature examining substance use among Native Americans have reported that youth living both on and off reservations have been more likely than non Native Americans to be moderate or heavy substance users, more likely to use a wide variety of substances, begin using at a younger age and continue to experiment as they get older, moving to “heavier” drugs as well as mixing substances.<sup>11</sup> Compared to other racial/ethnic subgroups, Native Americans report a higher percentage of illicit drug use; 11.9 percent for total US population as compared to 19.8 percent for Native Americans as well as higher percentages for marijuana use with the US population prevalence at 9.0 percent verses Native Americans at 15 percent.<sup>12</sup>

When working with Native Americans it is important to remember that involvement of extended kin relationships and strong peer influences is a powerful determinant of individual substance use. Providing support for non-using students will allow development of positive peer supports. Native Americans build positive personal strengths within a strong group identity and spirituality. Providing programs that will foster this positive group identity and providing an avenue for developing spiritual strengths will also create the needed relationships that will decrease individual substance use among Native American students.<sup>13</sup>

### *Hispanic and Latinos*

There is a perception that both the Hispanic and Latino cultures have a greater rate of alcohol abuse and alcohol related problems than the any other ethnic group. Alcohol is often a big part of traditional celebrations with the majority of alcohol advertising directed towards college students around Cinco de Mayo festivities. In a press release dated August 2001, the National Institute on Alcohol Abuse and Alcoholism (NIAAA) reported findings that have changed the perception of high risk drinking and cirrhosis death that traditionally was associated with black males. Findings suggest, “Hispanic adolescents have the highest prevalence of heavy drinking...and are at greatest risk of cirrhosis death.”<sup>14</sup> The same release reported that both whites and Hispanics have a similar prevalence of drinking and driving but, “Hispanics are more likely to consume greater quantities of alcohol in one sitting.”<sup>15</sup> The machismo concept may also be a contributing factor in Hispanic and Latino drinking behaviors if it is viewed as a “hyper-masculine” response. “Macho attitudes and behaviors such as physical and sexual aggressiveness or alcohol abuse (may be) seen as responses to dependency, powerlessness, feelings of inferiority, or low self-esteem.”<sup>16</sup>

### *Asian and Pacific Islanders*

Asian/Pacific Islander populations in the United States are quite diverse and values and customs differ significantly based on acculturation and assimilation into American culture. This cultural group is viewed as a “model community” when it comes to alcohol and other drug use with a consistently low rate of substance use reported. However, there are issues related to other drug use that are gaining momentum. “Asians and Pacific Islanders in New York State use cocaine at the same rate as African Americans and inhalants at a rate higher than African Americans, similar to Hispanics, but lower than whites.”<sup>17</sup> There are some studies that suggest Southeast Asians rank first of all the Asian groups in cocaine use and there are reported increases in abusing prescription drugs.<sup>18</sup>

Although there is little research in the field regarding Asian-American students and their alcohol use, we need to look at the reasons why this cultural group uses substances. The prevalence of alcohol use in the Asian population may be seen as deeply rooted in a cultural expectation, especially with males. Alcohol use, especially high risk drinking is viewed as the ability to show how much you can control yourself, which in turn relates to a level of masculinity.<sup>19</sup> Asian men look at drinking as socializing with other men from their home region and a way to stay culturally connected. It is very difficult for Asian students to venture outside the family circle to ask for help. Within the Asian culture, “the cry for help is the last stage.”<sup>20</sup>

### *Muslims*

To Muslims alcohol is usually called Khamr, an Arabic for intoxicant According to Islamic literature Khamr refers to any intoxicating beverage that “befogs the mind”. The Qur’an, the holy text for Muslims, brings up the issue of alcohol on more than one occasion. However, none is more expressive of Islam’s stance on Khamr and alcohol than this verse: “They ask you about intoxicants and games of chance. Say: In both of them, there is a great sin and means of profit for men, and their sin is greater than their profit,” (2:219). Alcohol, or Khamr, is not socially acceptable in the Islamic cultures. Not only is it associated with a person’s faith or lack of, but also of their personal morals and ethics.

The Islamic law goes to great lengths to erect barriers such that no opening, either wide or narrow, is left for a person to consume alcohol or even touch it. For example, Muslims are not allowed to sell, buy, manufacture or give it as a gift. They are not allowed to bring it into their homes or shops or serve it at gatherings, and they cannot use it as medicine, unless absolutely necessary. Muslim children are taught from a very early age that self-worth cannot be obtained from a bottle. However, in reality, alcohol is a problem even in Muslim societies, and so are the problems associated with it.

Because of the clear message of the Qur'an, persons with problems find it very difficult to go outside their Muslim community for help. They are most likely to keep it closed to public view. This attitude of privacy creates a serious challenge for treatment professionals. Recognizing the cultural view of alcohol, however, does provide valuable insight for the sensitive therapist.<sup>21</sup>

AOD educational programs can be enhanced if counselors and educators understand the cultural differences that emerge around alcohol use. Risk factors may be different for the wide range of cultures that are represented on college campuses and these risk factors may contribute to elevated risk of increased drinking and other related problems. Training around these risk factors will enhance an AOD program.

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## Chapter 7 ♦ SUBSTANCE ABUSE PREVENTION AND DISABILITY

The passage of the Americans with Disabilities Act (ADA) of 1990 was a significant landmark for people with disabilities. It reaffirmed through government enforcement that people with disabilities have equal access to society, including the right to a full and productive lifestyle. The increased public awareness stemming from the ADA has focused attention on a variety of disability issues that previously were ignored. One such issue is the relationship between disabilities and the risk for alcohol and other drug problems.

The increased focus on alcohol and other drug abuse and disability is timely. Recent studies suggest that a person with a disability is at higher risk for alcohol and other drug problems. For example, alcohol and other drug abuse rates for people with disabilities may range from 15 to 30 percent of all people with disabilities. Alcohol and other drug abuse rates for people with certain disabilities such as spinal cord and head injury exceed 50 percent of those populations.

People with disabilities may abuse alcohol and other drugs for all the same reasons as their non-disabled peers. However, the high risk reflects a number of other reasons directly related to the existence of a disability, including medication use, health concerns, peer group differences, fewer social supports, and enabling.

### *Examples of Risk Factors among the Disabled*

People with disabilities often use medications over extended periods of time. The use of two to five concurrent prescribed medications may be average for some disabilities. Those who use prescribed medication require specialized information on how those drugs influence behavior or interact with other drugs such as alcohol.

The special medical conditions associated with some disabilities can decrease tolerance for alcohol and other drugs. The problems associated with decreased tolerance include dangerous levels of intoxication, especially when medications are combined with alcohol. Also, people who experience chronic pain or discomfort are far more likely to either become dependent on prescribed medications, or use other drugs such as alcohol, to attempt temporary release from discomfort.

People with disabilities, especially those who acquire the disability before adulthood, may have less opportunity for association with peer groups. These social limitations can result in gravitation to peer groups that tolerate abuse of alcohol or other drugs. This also means that people with disabilities may be more vulnerable to alcohol and other drug abuse through peer pressure due to a lack of social experience or a need for acceptance. The following are examples of how one can work with the disabled around this issue:

- ♦ Create or provide challenging, positive experiences in which people can develop self-discipline, confidence, and personal and social awareness. These activities can include recreational opportunities, clubs, leadership camps, urban or rural exploration activities, community involvement, volunteering, etc. These activities need to focus on the development of socialization skills that do not rely on alcohol and other drugs.

- ♦ Set program direction and establish boundaries for acceptable behavior by providing clear and consistent messages, in order to ultimately impact social norms and values. There should be consequences for alcohol and other drug abuse, including implementation of intervention and referral procedures, or termination of services. They must be addressed in all systems and at all levels of an organization, agency, or community.

#### *Chapter Reference*

The information presented in this section is used with the permission of the Resource Center on Substance Abuse Prevention and Disability. The Resource Center was created to raise public awareness of the need for appropriate alcohol and other drug abuse services for people with disabilities. It is an up-to-date source of information about programs, reference materials, and research. For more information, contact the Resource Center on Substance Abuse Prevention and Disability, 1331 F Street NW - Suite 800, Washington, D.C. 20004, 202/783-2900 (voice), 202/737-0645 (TDD). Substance abusers in recovery are protected under ADA.

## Chapter 8 ♦ COLLEGE ATHLETES AND SUBSTANCE ABUSE

Too often the newspapers are full of names of high profile college athletes who have either been suspended and/or arrested for a violation of their school's substance abuse policy. Inevitably, this is followed by the athletes' complaint that they are being treated differently than a regular student and it is not fair. This complaint has some validity - for what regular student is pampered, stays in five star hotels, goes all over the country and sometimes the world and receives first class treatment wherever he or she goes and everything is paid for by the school? While it is also true that the school receives tremendous financial rewards from the successful performances of their athletic teams, the college athlete is often given many more loopholes and receives preferential treatment in all aspects of college life including alcohol and substance abuse.

As discussed earlier in this document, college students are among the nation's largest binge drinkers. And according to a study done by the Core Institute of Southern Illinois University at Carbondale there is a direct correlation linking participation in college sports to increased alcohol use. This survey is the largest yet completed on this topic covering 51,483 students on 125 college campuses. It found that college athletes consumed an average of 7.34 alcoholic drinks per week – 78 percent more than students who were non-athletes, who averaged 4.12 drinks. The lead author in this study, Jami Leichliter, stated, “Students involved in social groups tend to drink more.”

There are many reasons for the problems of increased substance abuse among college athletes. Most have to do with attitudes projected by the coaches and athletic administration of the school and the athletes themselves. The first attitude comes from the athletes. They get an exaggerated sense of their importance and role on the college campus. This is an attitude of “I'm an athlete, I'm special and I don't have to follow the same rules as all the other students.” College athletes need to realize that they have the best scholarships available to any college student. In many cases, athletic scholarships not only include all tuition, books and fees, but also meals, travel expenses, luxury accommodations for road trips and first class travel over much of the United States and in some cases throughout the entire world. With these extra “perks” often the following wrong message is being sent - “important college and professional athletes are often times above the law and can get away with anything, including substance abuse and violence.” College athletes need to understand that they have to be held accountable for their actions just as any other student.

A unique risk to athletes is the use and abuse of anabolic steroids. The use of steroids is related to another prevailing attitude among college athletes, coaches and administrators - the attitude of “do whatever it takes to perform.” This attitude permeates most professional sports teams, many college teams and is now starting to filter its way down to high school and even junior high school athletics. Over the counter muscle stimulants such as creatine are readily available in college locker rooms throughout the United States. These substances are available for the high school and junior high school student athletes. Unfortunately, many times this drug abuse comes with the approval and endorsements of the athletes' parents. Too often parents see athletics as a way for their young athlete to get financial help for college. In reality, the most recent statistics that less than 1 percent of all the young high school athletes across the country actually receive financial help in the form of an athletic scholarship, either partial or full, to a division one college athletic

program. These are not very good odds compared to the permanent damage many of the drugs can do to young people. The serious part of this problem is that many athletes believe that the research that shows some steroids can increase the athletic performance by 15 percent on an immediate basis. Yes, they have heard about the health hazards of these drugs, but most of the serious health repercussions will not occur until later in life. College student athletes are not concerned with what their life may be like when they turn fifty. They want results and success NOW and they are willing to try almost anything to ensure their position on their team. This includes steroids and other performance enhancing drugs.

Dr. William Taylor, a national researcher on the effects of steroid use, stated “that currently in the United States there were an estimated three million steroid users and that steroids were the biggest and fastest growing form of drug abuse in the United States today - an epidemic.” One of the biggest side effects of steroid abuse is uncontrollable rage and violent behavior also known as “Roid Rage.” This is the one side effect of steroid abuse that is immediate and has been proven to be a large contributor to violence against girlfriends and random fights on campus.

A third concept that is universal throughout the United States and is a microcosm on the college campuses throughout the country is the cosmetic “Must Look Good” attitude created by advertisers to sell their products. Men have to get bigger, tougher and stronger to look good for the women. Conversely women have to be slim, sexy, and great looking in order to be happy. This is turning into an obsession among our athletes on all levels of competition. This is big business in the United States. Mail order catalogs offer “growth producing milkshakes,” “growth pills and drugs.” Health stores spring up in our local malls offering a wide variety of drinks, vitamin supplements and other substances guaranteeing quick results. An example of this growing trend is the new *Sports Illustrated For Women* featuring an all male swimsuit issue. America has an obsession with external looks and where more easily marketable if not to college athletes who are constantly weighed, scrutinized, and measured based on their looks. The flip side to this problem is all of the gadget diets, diet pills and creams “guaranteed” to produce instant and permanent weight loss and make the student look and feel great. College students have enough pressures on them already without having to look a certain way in order to fit an image. This is an ongoing problem, which is not going to be solved quickly or easily.

The final negative attitude is that of the “stereotypical” college athlete who believes he needs to prove his machismo by excessively drinking after games or practices. This is not limited to intercollegiate athletes. In fact it is probably more seen with the recreational athletes and the “weekend warriors” on college campuses. These are the people who participate in athletics basically for the party after the game. These students can be extremely dangerous because of the combination of the alcohol, the social setting of an off campus bar after a slow pitch softball game and the lack of rules governing these situations as opposed to the rules set by the college or university controlling alcohol use by intercollegiate athletes.

These attitudes, which are attributed to the college athletes, are directly correlated with the idea that collegiate athletics have become a big business with many big endorsement contract and financial rewards for successful schools. A major college football bowl game generates revenue for the university of over two million dollars. Reality is that big time sports sell products. The

2001 Super Bowl charged companies \$4,000,000 per one minute of commercial time. Many of these commercials were selling alcohol. With this concept in mind, is it any wonder that there is more and more alcohol and substance abuse among college athletes than ever before? This is not limited or unique to college campuses. We now also have the official National Hockey League beer, the official beer of the National Basketball Association and at the last Olympics in Australia we also had the official United States Olympic beer. These beer companies are paying millions and millions of dollars to the NCAA to get their endorsements. Some organizations are now trying to remove beer as a possible sponsor for the next Olympics. However, the colleges need to recognize the influence and importance of money to their athletic programs and somehow have to know where to draw the line.

Having stated these negative attitudes and having painted a picture of “doom and gloom” the reader must be wondering if there is any hope for the college athletics? ABSOLUTELY! However, there is a definite and immediate need to change these attitudes before the United States loses any more of our college athletes. Student athletes all over the United States and the professionals who coach them have a need for continued education concerning not only the impact of alcohol and other drugs on athletic performance but also the correlation of substance abuse and violence among athletes. Education is the key to prevention and there are many excellent prevention programs for college athletes. The following objectives should be included in any program being considered for college athletes:

- ◆ Increased knowledge that abstinence is an acceptable drinking choice for both college students under the age of 21 and for all college athletes
- ◆ Increase the awareness of the impact of alcohol and other drugs on athletic performance
- ◆ Provide an increased knowledge for professionals working with athletes concerning the correlation of violence and substance abuse with a heavy focus on steroid abuse
- ◆ Provide factual information about alcohol and other drugs and their impact on the careers of many professional athletes whom our students know about and sometimes use as role models
- ◆ Highlight the positive actions of athletes, which very often are overlooked, and discuss positive alternative activities for youthful athletes
- ◆ Involve the local college in a community athletic program for youth where they can see first hand the impact they can have on younger athletes as role models. The college student athletes discuss often alcohol and drug issues. The colleges and universities need to emphasize their athletes who are positive role models within the community

In addition to finding specific prevention programs for athletes, there are internal strategies which different colleges and universities have successfully implemented with their athletes. First and foremost is a clear and well-defined substance abuse policy, which the school compliance officers and coaches all agree, should be implemented. This is extremely important because the coaches must feel like they have 100 percent support from their administration in order to implement any disciplinary action and/or prevention program.

Other program possibilities included “Peer Athlete Educators” and “Captains Clubs.” The “Peer Athlete Educator” program operates basically the same as any other peer education program with the exception that the peers are within one specific team and are not limited to academic issues but rather deal with a wider variety of topics including alcohol and substance abuse.

The “Captains Club” is an organization including all of the captains for the different teams that function during a specific season. These young men and women discuss rules and policies about alcohol and substance abuse and share different cases where there are inequities in the rules or policies. These groups, while confidential for the student athletes, can also act as liaisons between the athletes and coaches.

These are just a few suggestions of programs, which have been successful at some different colleges and universities. There are certainly many other programs which different institutions use to address the problem of alcohol and drug abuse among college athletes.

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## Chapter 9 ♦ GREEKS AND ALCOHOL

The Greek system, traditionally viewed as a conservative movement, enjoyed tremendous popularity during the 1950s. The sixties' antiestablishment theme brought disfavor to the Greek system, which was viewed as part of "the machine." The late 1970s and 1980s saw the beginning of resurgence in the popularity of Greek life, which has continued well into the 21<sup>st</sup> century.<sup>1</sup>

A well-run Greek system can be a valuable component on a university's community, providing numerous leadership and social development opportunities for students, as well as providing housing, meals, and mentoring for the students.

However, the Greek image is often tarnished by a reputation of heavy drinking. While recent research continues to show that Greeks drink more than non-Greeks, the Greek system as a whole has begun proactive steps to change not only their image, but their behavior as well.

### *Fraternities, Sororities, and High Risk Drinking*

According to research conducted by the Harvard School of Public Health, living in a fraternity or sorority house is by far the strongest indicator of binge drinking in college. Fully 86 percent of men and 80 percent of women who live in fraternity and sorority houses are binge drinkers. These figures raise the question of whether Greek societies attract or create binge drinkers. The national data suggests that both dynamics are responsible.<sup>2</sup>

Sixty percent of those who lived in fraternity houses had been binge drinkers in high school, and more than three out of four fraternity residents who had not binged in high school became binge drinkers in college. Conversely, sororities do not seem so much to attract binge drinkers; one in three women who lived in sororities had binged in high school, only slightly higher than the proportion among other students. But three out of every four women who had not binged in high school became binge drinkers while in residence in sororities.<sup>3</sup> Henry Wechsler, principal investigator for the study, notes that "Four or five drinks doesn't mean they're drunk or alcoholic, but it puts them in a group that has problems related to drink, such as missing classes, getting hurt, or having trouble with the police."<sup>4</sup>

### *Policy's Role in the Greek System*

The national sorority system, governed by the National Panhellenic Conference (NPC), has a strict no-alcohol stance. Chapters may not sponsor alcohol events, and alcohol cannot be involved in any pledging or initiation activities. Chapters are allowed to have alcohol at a semiformal dance, if it is provided and managed by the establishment where the event is held. National sororities and/or individual chapters may have stricter rules.

The international fraternity system is governed by the National Interfraternity Conference (NIC). The NIC risk management policy was approved in 1990, and "urges [all] college administrators, campus Interfraternity Councils (IFCs) and local fraternity chapters to adopt and implement a comprehensive risk management policy similar to the one [listed below]"<sup>5</sup>

### *NIC Risk Management Policy - Alcohol and Drugs*

- ◆ The possession, use, and/or consumption of alcoholic beverages, while on chapter premises, during an official fraternity event, or in any situation sponsored or endorsed by the chapter, must be in compliance with any and all applicable laws of the state, province, county, city, and institution of higher education.
- ◆ No alcoholic beverages may be purchased through the chapter treasury nor may the purchase of same for members or guests be undertaken or coordinated by any member in the name of or on behalf of the chapter. The purchase and/or use of a bulk quantity of such alcoholic beverages (i.e., kegs) is prohibited.
- ◆ No chapter members, collectively or individually, shall purchase for, serve to, or sell alcoholic beverages to any minor (i.e., those under the legal “drinking age”).
- ◆ The possession, sale, and/or abuse of any illegal drug or controlled substance at any chapter house, sponsored event, or at any event that an observer would associate with the fraternity, is strictly prohibited.
- ◆ No chapter may cosponsor an event with an alcohol distributor, charitable organization, or tavern (defined as an establishment generating more than 1/2 of annual gross sales from alcohol) where alcohol is given away, sold, or otherwise provided to those present.
- ◆ No chapter may cosponsor or co-finance a function where alcohol is purchased by any of the host chapters, groups, or organizations.
- ◆ All rush activities associated with any chapter will be a dry function.
- ◆ Open Parties where alcohol is present, meaning those with unrestricted access by nonmembers of the fraternity, without specific invitation, shall be prohibited.
- ◆ No member shall permit, tolerate, encourage, or participate in “drinking games.”
- ◆ No alcohol shall be present at any pledge/associate/member/novice program or activity of the chapter.

The National Pan-Hellenic Council (NPHC), which governs the eight historically black fraternities and sororities, requires chapters to follow all federal, state, local, and school policies when planning events that involve alcohol. The NPHC does not allow alcohol to be included in any intake activities, their equivalent of the pledging process.

Another influential force in the Greek system is the Fraternity Insurance Purchasing Group (FIPG). Prior to the formation of this group, most Greeks believed that protection against risk and damage was a simple process; just get liability insurance. Yet as insurance companies became reluctant to provide coverage to Greeks, a new way of looking at insurance was necessary. The original concept behind FIPG was simple and twofold. First, adopt a risk management plan that would help reduce exposure to risk. Second, use the group buying power of many national organizations as leverage to obtain more extensive coverage at lower premiums. Through the policies of FIPG, risk management became a way of thinking, a way of making sure that individual members, chapters, and national organizations were not necessarily exposed to risk.<sup>6</sup>

Today, though the title has remained the same, FIPG is actually a risk management group. Greek organizations join FIPG, adopt its risk management policy, and make every effort to reduce their exposure to claims. The letters FIPG are now perhaps the most recognizable in the entire Greek world. In a system that looks more like alphabet soup than anything else, those four letters have

changed the Greek movement and have become synonymous with an attempt to make the chapter environment a safer one for all members and guests.<sup>7</sup>

### *Programming Strategies*

Historically, each member of a fraternity paid “social dues,” to pay for kegs used at an “open party,” where anyone, or only invited males and any female, could attend. The system then progressed to closed parties, and although guest lists were required, the chapter still provided alcohol. Depending on the chapter and school, there may have been some training for servers and people checking student IDs. The key element was that the fraternity was purchasing and providing alcohol for their guests that increased their liability.

There has been strong support from the NIC to adopt a system that allows only “bring your own beverage” (BYOB) or catered events/parties. This initiative removes the fraternity from purchasing the alcohol, and consequently reduces their risk. A catered event would involve alcohol distribution by a licensed and insured catering company (called a third-party vendor) that would be responsible for:

- ◆ checking identifications upon entry
- ◆ collecting all money
- ◆ refusing to serve people under 21
- ◆ refusing service to individuals who appear intoxicated
- ◆ maintaining control of alcohol containers
- ◆ collecting all remaining alcohol at the end of the event
- ◆ removing all alcohol from the premises

The difference between closed parties and catered events is that third-party vendors are required to be trained, and their licenses (i.e., business) are at risk of being revoked for noncompliance. The FIPG has developed a “Catering Agreement” with which all third-party vendors must comply.<sup>8</sup>

The NIC has provided step-by-step instructions on “bring your own beverage” events in the booklet, *BYOB: Making Bring Your Own Beverage Events Happen*. Only persons over 21 are allowed to bring alcohol to an event, and the quantity and type of alcohol are limited. Students receive a punch card or ticket in exchange for their alcohol, which the chapter collects. One central distribution center is used and people are only allowed to redeem for as much alcohol as they brought. Chapters are responsible for providing food and nonalcoholic beverages.

The primary focus of these two plans is that the chapter does not use its funds for the purchase of alcohol, which helps to reduce their risk. Of course, they are still responsible for the property, facility, and management of people, but they are controlling the service of alcohol.

### *Recommendations*

To achieve a healthy improvement in its campus and community relationships, OASAS offers the following recommendations to members of the Greek system.

- ◆ Recognize that a well-run Greek system can be a healthy component of campus

- ◆ Develop a strong relationship with the campus' Greek advisor and the leadership of the Greek system.
- ◆ Encourage the Greek system on campus to adopt the BYOB and/or third party guidelines. The national organizations can help you make this happen.
- ◆ Provide server training and party planning workshops. There are several server training programs available (e.g., TIPS, TEAM), and the costs of these programs can be shared by fraternity members or paid outright by the chapter.
- ◆ Encourage individual chapters, or campus-wide Greek systems, to join a nationwide trend of disallowing alcohol at all house events to reduce risk.

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## Chapter 10 ♦ OTHER DRUGS ON CAMPUS

It's very clear than alcohol is the drug of choice on the nation's college campuses, but that doesn't minimize the need to prevent abuse of other drugs, including marijuana, cocaine, heroin, and club drugs, just to name a few. This chapter outlines some basic information about these drugs and others, so that if necessary, you are better equipped to address the problems that are associated with these substances. The information included in this chapter was compiled from a variety of sources, namely the Drug Enforcement Administration (DEA), the National Institute on Drug Abuse (NIDA), National Drug Intelligence Center, and the U.S. Department of Justice DEA Diversion Control Program.

### Club Drugs

This term refers to drugs being used by young people at all-night dance parties such as “raves” or “trances”, dance clubs, and bars. MDMA (Ecstasy), GHB, Rohypnol, ketamine, methamphetamine, and LSD are some of the club or party drugs gaining popularity. NIDA supported research has shown that use of club drugs can cause serious health problems and, in some cases, even death. Used in the combination with alcohol, these drugs can be even more dangerous.

Club Drugs is a vague term that refers to a wide variety of drugs. Uncertainties about the drug sources, pharmacological agents, chemicals used to manufacture them, and possible contaminants make it difficult to determine toxicity, consequences, and symptoms that might be expected. No club drug is benign. Because some club drugs are colorless, tasteless, and odorless, individuals who want to intoxicate or sedate others can add them unobtrusively to beverages.

What follows is an overview of the scientific data NIDA has on several of the most prevalent club drugs. Because many of these drug-use trends are still emerging, some of the data presented here are preliminary.

### *Methylenedioxyamphetamine (MDMA)*

Slang or Street Names: Ecstasy, XTC, X, Adam, Clarity, Lover's Speed

MDMA was developed and patented in the early 1900's as a chemical precursor in the synthesis of pharmaceuticals. Chemically, MDMA is similar to the stimulant amphetamine and the hallucinogen mescaline. MDMA can produce both stimulant and psychedelic effects.

- ♦ Methylenedioxyamphetamine (MDA) and methylenedioxyethylamphetamine (MDEA) are drugs chemically similar to MDMA.
- ♦ MDMA is taken orally, usually in a tablet or a capsule. MDMA's effects last approximately 3 to 6 hours, though confusion, depression, sleep problems, anxiety, and paranoia have been reported to occur even weeks after the drug is taken.
- ♦ MDMA can produce a significant increase in heart rate and blood pressure and a sense of alertness like that associated with amphetamine use.

- ◆ The stimulant effects of MDMA, which enable users to dance for extended periods, may also lead to dehydration, hypertension, and heart or kidney failure.
- ◆ MDMA can be extremely dangerous in high doses. It can cause a marked increase in body temperature (malignant hyperthermia) leading to the muscle breakdown and kidney and cardiovascular system failure that have been reported in some fatal cases at raves. MDMA use may also lead to heart attacks, strokes, and seizures in some users.
- ◆ MDMA is neurotoxic. Chronic use of MDMA was found, first in laboratory animals and more recently in humans, to produce long-lasting, perhaps permanent, damage to the neurons that release serotonin, and consequent memory impairment.

MDMA use has been reported across the country, including many of the 21 cities that comprise NIDA's Community Epidemiology Work Group (CEWG), a network of researchers that provide ongoing community-level surveillance of drug abuse. CEWG cities in which MDMA use has been reported include: Chicago, Denver, Miami, Atlanta, New Orleans, San Francisco, Austin, Seattle, Boston, Detroit, New York, St. Louis, Dallas, and Washington, D.C.

### ***Gamma-hydroxybutyrate (GHB)***

Slang or Street Names: Grievous Bodily Harm, G, Liquid Ecstasy, Georgia Home Boy

GHB can be produced in clear liquid, white powder, tablet, and capsule forms, and it is often used in combination with alcohol, making it even more dangerous. GHB has been increasingly involved in poisonings, overdoses, date rapes, and fatalities. The drug is used predominantly by adolescents and young adults, often when they attend nightclubs and raves. GHB is often manufactured in homes with recipes and ingredients found and purchased on the Internet.

GHB is usually abused either for its intoxicating/sedative/euphoriant properties or for its growth hormone-releasing effects, which can build muscles.

Some individuals are synthesizing GHB in home laboratories. Ingredients in GHB, gamma-butyrolactone (GBL) and 1,4-butanediol, can also be converted by the body into GHB. These ingredients are found in a number of dietary supplements available in health food stores and fitness centers to induce sleep, build muscles, and enhance sexual performance.

- ◆ GHB is a central nervous system depressant that can relax or sedate the body. At higher doses it can slow breathing and heart rate to dangerous levels.
- ◆ GHB's intoxicating effects begin 10 to 20 minutes after the drug is taken. The effects typically last up to 4 hours, depending on the dosage. At lower doses, GHB can relieve anxiety and produce relaxation; however, as the dose increases, the sedative effects may result in sleep and eventual coma or death.

- ◆ Overdose of GHB can occur rather quickly, and the signs are similar to those of other sedatives: drowsiness, nausea, vomiting, headache, loss of consciousness, loss of reflexes, impaired breathing, and ultimately death.
- ◆ GHB is cleared from the body relatively quickly, so it is sometimes difficult to detect in emergency rooms and other treatment facilities.

CEWG cities in which GHB use has been reported include: Detroit, Phoenix, Honolulu, Miami, New York, Atlanta, Minneapolis/St. Paul, Dallas, Seattle, San Francisco, San Diego, New Orleans, Newark, Los Angeles, Baltimore, Boston, and Denver.

### ***Ketamine***

Slang or Street Names: Special K, K, Vitamin K, Cat Valiums

Ketamine is an injectable anesthetic that has been approved for both human and animal use in medical settings since 1970. About 90 percent of the ketamine legally sold today is intended for veterinary use.

- ◆ Ketamine gained popularity for abuse in the 1980s, when it was realized that large doses cause reactions similar to those associated with use of phencyclidine (PCP), such as dream-like states and hallucinations.
- ◆ Ketamine is produced in liquid form or as a white powder that is often snorted or smoked with marijuana or tobacco products. In some cities (Boston, New Orleans, and Minneapolis/St. Paul, for example), ketamine is reportedly being injected intramuscularly.
- ◆ At higher doses, ketamine can cause delirium, amnesia, impaired motor function, high blood pressure, depression, and potentially fatal respiratory problems.

Low-dose intoxication from ketamine results in impaired attention, learning ability, and memory. CEWG cities in which Ketamine use has been reported include: Seattle, Miami, New York, Chicago, Minneapolis/St. Paul, Newark, Boston, Detroit, New Orleans, and San Diego.

### ***Rohypnol***

Slang or Street Names: Roofies, Rophies, Roche, Forget-me Pill

Rohypnol® (flunitrazepam) belongs to the class of drugs known as benzodiazepines (such as Valium®, Halcion®, Xanax®, and Versed®). It is not approved for prescription use in the United States, although it is approved in Europe and is used in more than 60 countries as a treatment for insomnia, as a sedative, and as a pre-surgery anesthetic.

- ◆ Rohypnol is tasteless and odorless, and it dissolves easily in carbonated beverages. The sedative and toxic effects are aggravated by concurrent use of alcohol. Even without alcohol, a dose of Rohypnol as small as 1 mg can impair a victim for 8 to 12 hours.
- ◆ Rohypnol is usually taken orally, although there are reports that it can be ground up and

snorted.

- ◆ The drug can cause profound “anterograde amnesia,” individuals may not remember events they experienced while under the effects of the drug. This may be why one of the street names for Rohypnol is “the forget-me pill” and it has been reportedly used in sexual assaults.
- ◆ Other adverse effects associated with Rohypnol include decreased blood pressure, drowsiness, visual disturbances, dizziness, confusion, gastrointestinal disturbances, and urinary retention.

CEWG cities in which Rohypnol use has been reported include: Miami, Houston, and along the Texas-Mexico border.

### ***Methamphetamine***

Slang or Street Names: Speed, Ice, Chalk, Meth, Crystal, Crank, Fire, Glass

Methamphetamine is a toxic, addictive stimulant that affects many areas of the central nervous system. The drug is often made in clandestine laboratories from relatively inexpensive over-the-counter ingredients. Diverse groups, including young adults who attend raves, in many regions of the country, are using methamphetamine.

Available in many forms, methamphetamine can be smoked, snorted, injected, or orally ingested.

- ◆ Methamphetamine is a white, odorless, bitter-tasting crystalline powder that easily dissolves in beverages.
- ◆ Methamphetamine is not sold in the same way as many other illicit drugs; it is typically sold through networks, not on the street.
- ◆ Methamphetamine use is associated with serious health consequences, including memory loss, aggression, violence, psychotic behavior, and potential cardiac and neurological damage.
- ◆ Methamphetamine abusers typically display signs of agitation, excited speech, decreased appetite, and increased physical activity levels.
- ◆ Methamphetamine is neurotoxic. Methamphetamine abusers may have significant reductions in dopamine transporters.
- ◆ Methamphetamine use can contribute to higher rates of transmission of infectious diseases, especially hepatitis and HIV/AIDS.

CEWG cities in which Methamphetamine use has been reported include: San Diego, San Francisco, Phoenix, Atlanta, St. Louis, Denver, Honolulu, Los Angeles, Minneapolis/St. Paul, Philadelphia, Seattle, Dallas, and many rural regions of the country.

### ***Lysergic Acid Diethylamide (LSD)***

Slang or Street Names: Acid, Boomers, Yellow Sunshines

LSD is a hallucinogen. It induces abnormalities in sensory perceptions. The effects of LSD are unpredictable depending on the amount taken, on the surroundings in which the drug is used, and on the user's personality, mood, and expectations.

- ◆ LSD is typically taken by mouth. It is sold in tablet, capsule, and liquid forms as well as in pieces of blotter paper that have absorbed the drug.
- ◆ Typically an LSD user feels the effects of the drug 30 to 90 minutes after taking it. The physical effects include dilated pupils, higher body temperature, increased heart rate and blood pressure, sweating, loss of appetite, sleeplessness, dry mouth, and tremors.
- ◆ LSD users report numbness, weakness, or trembling, and nausea is common.
- ◆ There are two long-term disorders associated with LSD, persistent psychosis and hallucinogen persisting perception disorder (which used to be called “flashbacks”).

CEWG cities in which LSD use has been reported include: Boston, Detroit, Seattle, Chicago, Denver, New Orleans, San Francisco, Atlanta, and Phoenix.

### ***Tobacco***

If you suspect that an increasing number of college students are smoking for the first time, you are correct. As tobacco companies have come under close scrutiny for their targeting our children and teenagers to smoke; college students have emerged as a new population to pursue. In addition, they can legally obtain tobacco. Bars frequented by college students have become fertile ground for the tobacco companies to sponsor events and recruit new smokers. At many campuses around the country, tobacco companies recruit college students to become “Ambassadors”, that is work for the tobacco company in promoting smoking among their peers. It used to be that if a person was not smoking by age 18, there was a good chance that he or she would not become a smoker. But not anymore:

- ◆ A recent national study found that 25 percent of college students surveyed had tried smoking and an additional 22 percent were current smokers. <sup>1</sup>
- ◆ In New York State, 29.2 percent of adults aged 18 to 24 reported being smokers in 1998, up 3.8 percent from the previous year. <sup>2</sup>
- ◆ A 1996 survey of New York State colleges and universities revealed that 59 percent of students had used tobacco products in their lifetime, with 20 percent using it often. <sup>3</sup>

- ◆ New York State's college smoking rate is higher than the national average – 29.2 percent versus 27.9 percent. <sup>4</sup>
- ◆ From 1997 to 1998, New York State female college smokers increased from 21.5 to 22.8 percent, while their male counterparts rose slightly, from 24.9 to 25.6 percent. <sup>5</sup>

While tobacco companies appear to be successfully promoting addiction to young adults, college administrators are increasingly aware of emerging liability issues in allowing smoking in their facilities. Smoking is one of the leading causes of fatal fires in the United States. In addition, there is ample evidence demonstrating the short-term and long-term health consequences of secondhand smoke exposure to non-smokers.

Throughout the United States, smoke-free residence halls are a growing trend on college campuses. In New York State, the NYS Clean Indoor Air Act prohibits smoking in most of the classrooms, office and public locations on college campuses. It is well understood that making all buildings on campus smoke-free would result in diminishing cigarette and cigar use. Smoke-free policies have the potential to discourage new students from taking up smoking, make it easier for current smokers to stop and overall reduce fire hazards.

Throughout New York State there are Tobacco Control and Prevention Coalitions working in communities to educate the public about prevention, cessation, and secondhand smoke. These coalitions are funded partly by the Centers for Disease Control (CDC) as well as a portion of the NYS Tobacco Settlement Monies from the National Tobacco Settlement. Coalition personnel are excellent resources and are available to assist college personnel in developing campus policy and education strategies addressing tobacco use.

Contact the following agencies for more information:

- ◆ County Health Departments to learn more about the Tobacco-Free Coalition in your area.
- ◆ The NYS Task Force For Tobacco-Free Women and Girls has developed a free booklet to assist colleges in New York, "Helping Build a Smoke-Free College Campus ... How Others Have Done It, and You Can Too!" Call (716) 845-8080 to order it.
- ◆ The American College Health Association (ACHA) has produced a position statement on Tobacco on College and University Campuses. It is available at (410) 859-1500 or [www.acha.org](http://www.acha.org)
- ◆ American Cancer Society at 1-800-ACS-2345
- ◆ American Lung Association at 1-800-LUNG-USA
- ◆ NYS Quitline at 1-888-609-6292

## *Marijuana*

Marijuana is the most commonly used illicit drug in the United States. A dry, shredded green/brown mix of flowers, stems, seeds, and leaves of the hemp plant *Cannabis sativa*, it usually is smoked as a cigarette (joint or nail) or in a pipe (bong). It also is smoked in blunts, which are cigars that have been emptied of tobacco and refilled with marijuana, often in combination with another drug. Use also might include mixing marijuana in food or brewing it as a tea. As a more concentrated, resinous form it is called hashish and, as a sticky black liquid, hash oil. Marijuana smoke has a pungent and distinctive, usually sweet-and-sour odor. There are countless street terms for marijuana including pot, herb, weed, grass, widow, ganja, and hash, as well as terms derived from trademarked products, such as Bubble Gum®, Northern Lights®, Juicy Fruit®, Afghani #1®, and a number of Skunk varieties.

The main active chemical in marijuana is THC (delta-9-tetrahydrocannabinol). The membranes of certain nerve cells in the brain contain protein receptors that bind to THC. Once securely in place, THC kicks off a series of cellular reactions that ultimately lead to the high that users experience when they smoke marijuana.

### *Extent of Use*

In 2001, over 12 million Americans age 12 and older used marijuana at least once in the month prior to being surveyed. That is more than three quarters (76 percent) of the total number of Americans who used any illicit drug in the past month in 2001. Of the 76 percent, more than half (56 percent) consumed only marijuana; 20 percent used marijuana and another illicit drug; and the remaining 24 percent used an illicit drug or drugs other than marijuana.

### *Effects on the Brain*

The short-term effects of marijuana use can include problems with memory and learning; distorted perception; difficulty in thinking and problem solving; loss of coordination; and increased heart rate. Research findings for long-term marijuana use indicate some changes in the brain similar to those seen after long-term use of other major drugs of abuse. For example, cannabinoid (THC or synthetic forms of THC) withdrawal in chronically exposed animals leads to an increase in the activation of the stress-response system and changes in the activity of nerve cells containing dopamine. Dopamine neurons are involved in the regulation of motivation and reward, and are directly or indirectly affected by all drugs of abuse.

### *Effects on the Heart*

One study has indicated that a user's risk of heart attack more than quadruples in the first hour after smoking marijuana. The researchers suggest that such an effect might occur from marijuana's effects on blood pressure and heart rate and reduced oxygen-carrying capacity of blood.

### *Effects on the Lungs*

A study of 450 individuals found that people who smoke marijuana frequently but do not smoke tobacco have more health problems and miss more days of work than nonsmokers. Many of the extra sick days among the marijuana smokers in the study were for respiratory illnesses.

Even infrequent use can cause burning and stinging of the mouth and throat, often accompanied by a heavy cough. Someone who smokes marijuana regularly may have many of the same respiratory problems that tobacco smokers do, such as daily cough and phlegm production, more frequent acute chest illness, a heightened risk of lung infections, and a greater tendency to obstructed airways.

Marijuana use has the potential to promote cancer of the lungs and other parts of the respiratory tract because it contains irritants and carcinogens. In fact, marijuana smoke contains 50 to 70 percent more carcinogenic hydrocarbons than does tobacco smoke. It also produces high levels of an enzyme that converts certain hydrocarbons into their carcinogenic form — levels that may accelerate the changes that ultimately produce malignant cells. Marijuana users usually inhale more deeply and hold their breath longer than tobacco smokers do, which increases the lungs' exposure to carcinogenic smoke. These facts suggest that, puff for puff, smoking marijuana may increase the risk of cancer more than smoking tobacco.

#### *Other Health Effects*

Some of marijuana's adverse health effects may occur because THC impairs the immune system's ability to fight off infectious diseases and cancer.

#### *Effects of Heavy Marijuana Use on Learning and Social Behavior*

Depression, anxiety, and personality disturbances are all associated with marijuana use. Research clearly demonstrates that marijuana use has the potential to cause problems in daily life or make a person's existing problems worse. Because marijuana compromises the ability to learn and remember information, the more a person uses marijuana the more he or she is likely to fall behind in accumulating intellectual, job, or social skills. Moreover, research has shown that marijuana's adverse impact on memory and learning can last for days or weeks after the acute effects of the drug wear off.

Students who smoke marijuana get lower grades and are less likely to graduate from high school, compared to their non-smoking peers. A study of 129 college students found that, for heavy users of marijuana (those who smoked the drug at least 27 of the preceding 30 days), critical skills related to attention, memory, and learning were significantly impaired even after they had not used the drug for at least 24 hours. The heavy marijuana users in the study had more trouble sustaining and shifting their attention and in registering, organizing, and using information than did the study participants who had used marijuana no more than 3 of the previous 30 days. As a result, someone who smokes marijuana once daily may be functioning at a reduced intellectual level all of the time.

#### *Addictive Potential*

Long-term marijuana use can lead to addiction for some people; that is, they use the drug compulsively even though it often interferes with family, school, work, and recreational activities. Drug craving and withdrawal symptoms can make it hard for long-term marijuana smokers to stop using the drug. People trying to quit smoking report irritability, sleeplessness, and anxiety. They also display increased aggression on psychological tests, peaking approximately one week after the last use of the drug.

### *Genetic Vulnerability*

Scientists have found that whether an individual has positive or negative sensations after smoking marijuana can be influenced by heredity. A 1997 study demonstrated that identical male twins were more likely than non-identical male twins to report similar responses to marijuana use, indicating a genetic basis for their response to the drug. It also was discovered that the twins' shared or family environment before age 18 had no detectable influence on their response to marijuana. Certain environmental factors, however, such as the availability of marijuana, expectations about how the drug would affect them, the influence of friends and social contacts, and other factors that differentiate experiences of identical twins were found to have an important effect.

### ***Heroin***

Heroin is an illegal, highly addictive drug. It is both the most abused and the most rapidly acting of the opiates. Heroin is processed from morphine, a naturally occurring substance extracted from the seedpod of certain varieties of poppy plants. It is typically sold as a white or brownish powder or as the black sticky substance known on the streets as "black tar heroin." Although purer heroin is becoming more common, most street heroin is "cut" with other drugs or with substances. Because heroin abusers do not know the actual strength of the drug or its true contents, they are at risk of overdose or death. Heroin also poses special problems because of the transmission of HIV and other diseases that can occur from sharing needles or other injection equipment.

#### *What are the immediate (short-term) effects of heroin use?*

Soon after injection (or inhalation), heroin crosses the blood-brain barrier. In the brain, heroin is converted to morphine and binds rapidly to opioid receptors. Abusers typically report feeling a surge of pleasurable sensation, a "rush." The intensity of the rush is a function of how much drug is taken and how rapidly the drug enters the brain and binds to the natural opioid receptors. Heroin is particularly addictive because it enters the brain so rapidly. With heroin, the rush is usually accompanied by a warm flushing of the skin, dry mouth, and a heavy feeling in the extremities, which may be accompanied by nausea, vomiting, and severe itching.

After the initial effects, abusers usually will be drowsy for several hours. Mental function is clouded by heroin's effect on the central nervous system. Cardiac function slows. Breathing is also severely slowed, sometimes to the point of death. Heroin overdose is a particular risk on the street, where the amount and purity of the drug cannot be accurately known.

#### *What are the long-term effects of heroin use?*

One of the most detrimental long-term effects of heroin is addiction itself. Physical dependence develops with higher doses of the drug. With physical dependence, the body adapts to the presence of the drug and withdrawal symptoms occur if use is reduced abruptly. Withdrawal may occur within a few hours after the last time the drug is taken. Symptoms of withdrawal include restlessness, muscle and bone pain, insomnia, diarrhea, vomiting, cold flashes with goose bumps ("cold turkey"), and leg movements. Major withdrawal symptoms peak between 24 and 48 hours after the last dose of heroin and subside after about a week. However, some people have shown persistent withdrawal signs for many months.

### ***Crack and Cocaine***

Cocaine is a powerfully addictive drug of abuse. Once having tried cocaine, an individual cannot predict or control the extent to which he or she will continue to use the drug.

The major routes of administration of cocaine are sniffing or snorting, injecting, and smoking (including free-base and crack cocaine). Snorting is the process of inhaling cocaine powder through the nose where it is absorbed into the bloodstream through the nasal tissues. Injecting is the act of using a needle to release the drug directly into the bloodstream. Smoking involves inhaling cocaine vapor or smoke into the lungs where absorption into the bloodstream is as rapid as by injection.

“Crack” is the street name given to cocaine that has been processed from cocaine hydrochloride to a free base for smoking. Rather than requiring the more volatile method of processing cocaine using ether, crack cocaine is processed with ammonia or sodium bicarbonate (baking soda) and water and heated to remove the hydrochloride, thus producing a form of cocaine that can be smoked. The term “crack” refers to the crackling sound heard when the mixture is smoked (heated), presumably from the sodium bicarbonate.

There is great risk whether cocaine is ingested by inhalation (snorting), injection, or smoking. It appears that compulsive cocaine use may develop even more rapidly if the substance is smoked rather than snorted. Smoking allows extremely high doses of cocaine to reach the brain very quickly and brings an intense and immediate high. The injecting drug user is at risk for transmitting or acquiring HIV infection/AIDS if needles or other injection equipment are shared.

### ***Health Hazards***

Cocaine is a strong central nervous system stimulant that interferes with the reabsorption process of dopamine, a chemical messenger associated with pleasure and movement. Dopamine is released as part of the brain's reward system and is involved in the high that characterizes cocaine consumption.

Physical effects of cocaine use include constricted peripheral blood vessels, dilated pupils, and increased temperature, heart rate, and blood pressure. The duration of cocaine's immediate euphoric effects, which include hyper-stimulation, reduced fatigue, and mental clarity, depends on the route of administration. The faster the absorption, the more intense the high. On the other hand, the faster the absorption, the shorter the duration of action. The high from snorting may last 15 to 30 minutes, while that from smoking may last 5 to 10 minutes. Increased use can reduce the period of stimulation.

Some users of cocaine report feelings of restlessness, irritability, and anxiety. An appreciable tolerance to the high may be developed, and many addicts report that they seek but fail to achieve as much pleasure as they did from their first exposure. High doses of cocaine and/or prolonged use can trigger paranoia. Smoking crack cocaine can produce a particularly aggressive paranoid behavior in users. When addicted individuals stop using cocaine, they often become depressed. This also may lead to further cocaine use to alleviate depression. Prolonged cocaine snorting can result in ulceration of the mucous membrane of the nose and can damage the nasal septum enough

to cause it to collapse. Cocaine-related deaths are often a result of cardiac arrest or seizures followed by respiratory arrest.

#### Added Danger: Cocaethylene

When people mix cocaine and alcohol consumption, they are compounding the danger each drug poses and unknowingly forming a complex chemical experiment within their bodies. NIDA-funded researchers have found that the human liver combines cocaine and alcohol and manufactures a third substance, cocaethylene, that intensifies cocaine's euphoric effects, while possibly increasing the risk of sudden death.

#### ***Steroids (Anabolic-Androgenic)***

Anabolic-androgenic steroids are man-made substances related to male sex hormones. “Anabolic” refers to muscle building, and “androgenic” refers to increased masculine characteristics. Steroids refers to the class of drugs that are available legally only by prescription, to treat conditions that occur when the body produces abnormally low amounts of testosterone, such as delayed puberty and some types of impotence. They are also used to treat body wasting in patients with AIDS and other diseases that result in loss of lean muscle mass. Abuse of anabolic steroids, however, can lead to serious health problems, some irreversible.

Today, athletes and others abuse anabolic steroids to enhance performance and also to improve physical appearance. Anabolic steroids are taken orally or injected, typically in cycles of weeks or months (referred to as “cycling”), rather than continuously. Cycling involves taking multiple doses of steroids over a specific period of time, stopping for a period, and starting again. In addition, users often combine several different types of steroids to maximize their effectiveness while minimizing negative effects (referred to as “stacking”).

#### *Health Hazards*

The major side effects from abusing anabolic steroids can include liver tumors and cancer, jaundice (yellowish pigmentation of skin, tissues, and body fluids), fluid retention, high blood pressure, increases in LDL (bad cholesterol), and decreases in HDL (good cholesterol). Other side effects include kidney tumors, severe acne, and trembling. In addition, there are some gender- and age-specific side effects:

- ◆ For men – shrinking of the testicles, reduced sperm count, infertility, baldness, development of breasts, and increased risk for prostate cancer.
- ◆ For women – growth of facial hair, male-pattern baldness, changes in or cessation of the menstrual cycle, enlargement of the clitoris, and deepened voice
- ◆ For adolescents – growth halted prematurely through premature skeletal maturation and accelerated puberty changes. This means that adolescents risk remaining short the remainder of their lives if they take anabolic steroids before the typical adolescent growth spurt

In addition, people who inject anabolic steroids run the added risk of contracting or transmitting HIV/AIDS or hepatitis, which causes serious damage to the liver.

Scientific research also shows that aggression and other psychiatric side effects may result from abuse of anabolic steroids. Many users report feeling good about themselves while on anabolic steroids, but researchers report that extreme mood swings also can occur, including manic-like symptoms leading to violence. Depression often is seen when the drugs are stopped and may contribute to dependence on anabolic steroids. Researchers report also that users may suffer from paranoid jealousy, extreme irritability, delusions, and impaired judgment stemming from feelings of invincibility.

### ***Methylphenidate (Ritalin)***

Methylphenidate is a medication prescribed for individuals (usually children) who have an abnormally high level of activity or attention-deficit hyperactivity disorder (ADHD). According to the National Institute of Mental Health, about 3 to 5 percent of the general population has the disorder, which is characterized by agitated behavior and an inability to focus on tasks. Methylphenidate also is occasionally prescribed for treating narcolepsy. For additional information see Chapter 11, Mental Health and Psychotropic Drugs.

### ***Health Effects***

Methylphenidate is a central nervous system (CNS) stimulant. It has effects similar to, but more potent than, caffeine and less potent than amphetamines. It has a notably calming effect on hyperactive children and a "focusing" effect on those with ADHD.

Recent research at Brookhaven National Laboratory may begin to explain how methylphenidate helps people with ADHD. The researchers speculate that methylphenidate amplifies the release of dopamine, a neurotransmitter, thereby improving attention and focus in individuals who have dopamine signals that are weak, such as individuals with ADHD.

When taken as prescribed, methylphenidate is a valuable medicine. Research shows that people with ADHD do not become addicted to stimulant medications when taken in the form prescribed and at treatment dosages. Another study found that ADHD boys treated with stimulants such as methylphenidate are significantly less likely to abuse drugs and alcohol when they are older than are non-treated ADHD boys.

Because of its stimulant properties, however, in recent years there have been reports of abuse of methylphenidate by people for whom it is not a medication. Some individuals abuse it for its stimulant effects: appetite suppression, wakefulness, increased focus/attentiveness, and euphoria. When abused, the tablets are either taken orally or crushed and snorted. Some abusers dissolve the tablets in water and inject the mixture - complications can arise from this because insoluble fillers in the tablets can block small blood vessels.

Because stimulant medicines such as methylphenidate do have potential for abuse, the U.S. Drug Enforcement Administration (DEA) has placed stringent, Schedule II controls on their manufacture, distribution, and prescription. For example, DEA requires special licenses for these

activities, and prescription refills are not allowed. States may impose further regulations, such as limiting the number of dosage units per prescription.

### ***Dextromethorphan***

Street Names: DXM, DM, Robo, Velvet, Rojo

There have been reports of sporadic abuse of dextromethorphan (DXM), with isolated case reports of overdose and death. Many users of DXM have opted for a powdered form of the drug because of the large volumes of cough syrup that need to be ingested in order to achieve intoxication. DXM-intoxication is typically referred to as “Robo-ing”; the term derived from the most typical form of DXM - Robotussin. Recent sales of the powder, dextromethorphan hydrobromide, and the publication of a recipe-like extraction procedure used to separate DXM from cough syrups have become available on the World Wide Web.

Dextromethorphan has the useful property of cough suppression without the traditional opiate central nervous system effects. Dextromethorphan, when taken in prescribed doses, does not produce many side effects and has a long history of safety and effectiveness. It is one of the active ingredients in many over-the-counter cough syrups.

The abuse of DXM by teenagers and young adults seems related to its over-the-counter availability and more recently to the sale of the powdered form over the Internet. The abusers report a heightened sense of perceptual awareness, altered time perception, and visual hallucinations. Internet sites inform the young users to drink the syrup expeditiously in order to absorb enough DXM from the drink prior to the impending incidence of vomiting which will occur as a result of the ingestion of the large volume of syrup required for intoxication. Typical DXM intoxication involves hyper-excitability, lethargy, ataxia, slurred speech, sweating, and hypertension.

The majority of abuse occurs among teenagers and young adults. DXM alone, or mixed with other ingredients, such as ephedrine or phenylpropanolamine, has been sold as “ecstasy”. It has been identified as “filler” in confiscated samples of “bogus heroin” and “bogus ketamine”.

The highest incidence of abuse has been with the over-the-counter cough preparations. However, with the recent incidence of powder sales on the Internet, there have been reports of capsule, powder, and pill forms of the drug.

### ***OxyContin***

Diversion and abuse of the prescription pain reliever OxyContin is a major problem, particularly in the eastern United States. The Drug Enforcement Administration (DEA) reports that, in the United States, oxycodone products, including OxyContin, are frequently abused pharmaceuticals.

OxyContin is a trade name product for the generic narcotic oxycodone hydrochloride, an opiate agonist. Opiate agonists provide pain relief by acting on opioid receptors in the spinal cord, brain, and possibly in the tissues directly. Opioids, natural or synthetic classes of drugs that act like morphine, are the most effective pain relievers available. Oxycodone has a high abuse potential

and is prescribed for moderate to high pain relief associated with injuries, lower back pain, and cancer. Percocet, Percodan, and Tylox are other trade name oxycodone products. Oxycodone is a central nervous system depressant. People who take the drug repeatedly can develop a tolerance or resistance to the drug's effects. Most individuals who abuse oxycodone seek to gain the euphoric effects, mitigate pain, and avoid withdrawal symptoms associated with oxycodone or heroin abstinence.

OxyContin is an oral, controlled-release oxycodone that acts for 12 hours, making it the longest lasting oxycodone on the market. OxyContin is designed to be swallowed whole; however, abusers ingest the drug in a variety of ways. OxyContin abusers often chew the tablets or crush the tablets and snort the powder. Because oxycodone is water soluble, crushed tablets can be dissolved in water and the solution injected. The latter two methods lead to the rapid release and absorption of oxycodone. The pharmacological effects of OxyContin make it a suitable substitute for heroin; therefore, it is attractive to the same abuser population.

Law enforcement reports indicate heroin abusers are obtaining OxyContin because the pharmaceutical drug offers reliable strength and dosage levels. Conversely, OxyContin abusers who have never used heroin may be attracted to the lower priced heroin when their health insurance no longer pays for OxyContin prescriptions or when they cannot afford the high street-level price of OxyContin. The strength, duration, and known dosage of OxyContin are the primary reasons the drug is attractive to both abusers and legitimate users. The abuse of oxycodone products in general has increased in recent years and it is likely to continue to increase. Oxycodones, including OxyContin, are Schedule II drugs under the Federal Comprehensive Drug Abuse Prevention and Control Act.

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The information included in this chapter was compiled from a variety of sources, namely the Drug Enforcement Administration (DEA), the National Institute on Drug Abuse (NIDA), National Drug Intelligence Center, and the U.S. Department of Justice DEA Diversion Control Program.

## Chapter 11 ♦ MENTAL HEALTH AND PSYCHOTROPIC DRUGS

Psychoactive drugs may be used in the treatment of mental disorders. This type of treatment is referred to as psychopharmacotherapy.<sup>1</sup> The substances prescribed are referred to as psychotropic medications or sometimes as psychiatric medications. Psychotropic medications rarely cure a psychiatric problem. More typically, they reduce symptoms or serve a prophylactic purpose of preventing development of more severe symptoms. In many cases, the use of these medications is most effective in combination with psychological therapies. There is a wide range of psychotropic medications. In college populations there are several classes of medications most likely to be used by students, either by prescription or taken illicitly. This section describes the more frequently encountered psychotropic medications, along with their risk for misuse and abuse.

The term “abuse” can be somewhat ambiguous when applied to psychiatric medications. Mild amounts of alcohol use can be considered non-abusive, while use of mild amounts of an unauthorized medication could be considered abuse (even though it might not meet actual diagnostic criteria for “abuse”). On the other hand, heavy alcohol use is widely considered to be abusive, but heavy sedative medication use can be acceptable if it is under a physician’s care. Psychotropic medications can alter mind, mood, and behavior, but they do so in a controlled manner and are accepted as standard medical practice. Generally, if the use of a medication is unauthorized, or if it is used differently or in higher doses than directed, this would be considered a misuse of the medication.<sup>2</sup> As this misuse interferes more intensively with a person’s functioning and causes clinically significant impairment or distress, it would begin to be considered as abuse or dependence.<sup>3</sup>

### *Antidepressants*

While stimulants have sometimes been used to treat depression, the most commonly prescribed medications for depression are antidepressants. These include three major classes: monoamine oxidase inhibitors (MAOI’s), tricyclic antidepressants, and the most frequently described class, the serotonin selective reuptake inhibitors (SSRI’s). The SSRI’s include fluoxetine (trade name Prozac), paroxetine (Paxil), and sertraline (Zoloft). Antidepressants have minimal addiction potential and are not typically abused by college students. However, people taking antidepressants sometimes face risk if they use substances in conjunction with their medication.<sup>4</sup>

### *Anxiety Medications*

Commonly referred to as anxiolytic drugs, these medications are prescribed for a variety of anxiety disorders, including generalized anxiety, panic disorder, and obsessive-compulsive disorder. It should be noted that some of the antidepressants described above are also used in managing anxiety symptoms. Other anti-anxiety medications may also be prescribed. The most common medications for anxiety are benzodiazepines, which include Alprazolam (Xanax), the medication most commonly used in treating panic disorder. Other commonly prescribed benzodiazepines include lorazepam (Ativan), clonazepam (Klonopin), and diazepam (Valium). These substances do present users with a risk of developing drug dependence, and are often prescribed only as needed, or at the lowest possible dose for the shortest period of time. Furthermore, students with alcohol problems present a particular complication in prescribing

anxiolytics, for several reasons. One is that people with histories of substance abuse do have a higher potential than non-abusers for developing addiction to benzodiazepines. Another reason is that there can be “cross-tolerance” where persons with tolerance to alcohol also show a tolerance to the benzodiazepines, rendering them less effective.<sup>5</sup> A different class of medications, the short-acting barbiturates (Nembutal, Seconal), are more rarely prescribed for anxiety because of addiction potential and the potential for overdose.

### ***Sleep Medications***

Certain benzodiazepine drugs described above under “anxiety medications” may also be used for sleep difficulties. Temazepam (Restoril) and Trizolam (Halcion) are commonly used sleep-inducing medications. Another sleep medication no longer used in the U.S. is Rohypnol, discussed under that heading in Chapter 10. This substance was banned in the U.S. because of its abuse, particularly as a sedative in “date rape.”

### ***Pain Medications***

Although pain is the most common reason people visit the doctor, physicians face the dilemma of how to relieve suffering without making the patient susceptible to dependence on pain medication. Opiates, which include morphine and codeine as well as synthetic opioids, work by mimicking the body’s own pain-relieving chemicals, the opioid peptides. Synthetic opioids prescribed for pain include meperidine (Demerol), hydromorphone (Dilaudid), hydrocodone (Vicodin), and oxycodone (Percodan, Oxycontin). These substances are taken in the pill form and therefore produce less of a rush than snorted or injected opioids such as heroin.<sup>6</sup> Even in pill form, opioids do produce tolerance and have a potential for addiction. However, studies indicate that most patients who receive opioids for pain do not become addicted. Those who do develop rapid and marked tolerance are often those with a history of substance abuse. There is considerable research under way to develop new pain medications which are not addictive or which soothe pain without euphoria.<sup>7</sup>

### ***Ritalin (Attention Deficit Hyperactivity Disorder)***

Ritalin is the brand name for methylphenidate, a medication prescribed for people with unusually high levels of activity or with attentional deficits. While its action is not fully understood, it is known that the substance is a central nerve system stimulant that actually has a calming and focusing effect on those with ADHD. People with ADHD do not become addicted to stimulant medications at the level prescribed by doctors. However, for those who do not have ADHD, Ritalin and similar medications can have a stimulant effect. See discussion in Chapter 10. Therefore, these substances are subject to misuse, particularly by students who may have friends with a Ritalin prescription. The medication is typically taken orally, although there are reports of students crushing the pills and snorting them. Stimulant medications do have a potential for abuse. Ritalin does have some addiction potential.<sup>8</sup> It is of moderate strength, stronger than caffeine but considerably weaker than an amphetamine. While Ritalin is misused by some students, anecdotal reports suggest that Ritalin is often no longer as sought-after by college students, who may consider it as a “beginner” drug used by those without access to other substances.

### ***Substance Use And Self-Medicating***

It is commonly understood that some students are not simply using a substance in order to get a

euphoric effect or a “high,” but instead, to seek regulation of their mood or their mental state. Such activity is sometimes referred to as “self-medicating.” Although there is some debate over whether all substance use could then be considered self-medicating, there is often a clear distinction between using a substance for self-regulation rather than recreation. For example, students who are highly anxious may use alcohol as a sedative to soothe their anxiety. Some marijuana users seek the drug’s dissociative, distancing, or calming effect and use it to modulate their explosive anger. Depressed students sometimes use stimulants to attempt to elevate their energy or their mood. These attempts at equilibrating mental state through licit or illicit substances may be a conscious effort or an unwitting attempt at psychological regulation. Unfortunately, many of the substances also have a strong potential for addiction, and their use is haphazard in comparison with the careful calibration of psychotropic medications.

Students may also delay seeking treatment when they self-medicate, masking a disorder that could be better treated with professional intervention. Another disadvantage of self-medication with psychoactive substances is that people can limit the development of their own psychological resources by seeking a substance as a short-term “vacation” from difficulties. Mental health concerns require assessment by mental health professionals who can then determine the likelihood of the need for psychotropic medication. It is ironic that some students who appear to be using substances excessively (and ineffectively) to self-medicate are reluctant to entertain the possibility of psychotropic medication, which would be far safer, more effective, and have fewer risks and side effects.

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## Chapter 12 ♦ ALCOHOL MARKETING ON COLLEGE CAMPUSES

Does advertising actually influence student alcohol consumption, and if so, how much? Although the answer to this question is not clearly known, it remains a source of debate and concern. As a prevention programmer trying to reduce the high risk drinking on your campus, or in your community, it is important to consider some of the facts around alcohol marketing, especially as they relate to college students.

- ♦ The alcohol industry spends between \$15 and \$20 million annually on advertising targeted at college students.<sup>1</sup>
- ♦ The “college scene” is where 5 percent of the American population is estimated to generate 10 percent of all brewers’ revenues.<sup>2</sup>
- ♦ While beer ads have largely disappeared from college newspapers, the average number of column-inches devoted to advertising by local alcohol outlets has increased more than fifty percent.<sup>3</sup>
- ♦ About 35 percent of all college newspapers’ advertising revenue comes from alcohol-related ads.<sup>4</sup>

Alcohol marketing, including advertisements and other promotions, must be viewed in light of the target audience, college students, who consist largely of people under the legal drinking age.

Alcohol advertising sells a specific image: drinking is fun, and an ingredient to achieve social, athletic, and even sexual success. What we do not see are the violence, vandalism, acquaintance rapes, and other problems related to alcohol abuse. The primary reason for this one-sided portrayal is because alcoholic beverage producers are able to market a potentially addictive drug with very few restrictions. The alcoholic beverage industry has developed specific marketing approaches to maximize the new drinker market and capture the attention of entry-level consumers, seeking to develop a lifetime brand loyalty and to sell large quantities of alcohol.

Alcohol advertising does generate revenue for college newspapers, whether by the industry itself, or by local retailers, bars, taverns and distributors. Undoubtedly, many campus editors will defend alcohol advertising on the grounds that the income it provides contributes to the financial viability of their newspapers.

OASAS suggests that campus substance abuse prevention programmers and newspaper editors collaborate to eliminate advertisements from the alcoholic beverage industry or local bars that promote high-risk use of alcohol. This recommendation is consistent with a national initiative that addresses campus alcohol advertising.

A coalition coordinated by the Center for Science in the Public Interest (CSPI) has urged the National Licensed Beverage Association to adopt voluntary college newspaper advertising standards. A spokesperson for the CSPI states “too many campus newspapers fail to recognize

that these binge pushing ads and promotional gimmicks subvert the academic mission of the university and the well-being of students.” Promotions that the coalition cite as encouraging heavy drinking include penny-and-nickel-drink nights, all-you-can-drink specials, ladies’ nights, “crawls” with specials at several different bars, and ads that expand drinking to include traditional “study nights.”<sup>5</sup>

While brewers continue to rely on logos and images of their products to increase brand awareness, local purveyors often blatantly encourage high-risk drinking, and do so in a variety of marketing techniques other than newspaper ads. They often rely on handbills, flyers, bulletin board notices, and student mailboxes to list weekly specials and social events. Safe rides home and free non-alcoholic beverages for designated drivers also encourage more drinking.

One of the challenges we face is to develop methods for attracting alternative advertisements to support the cost of the campus newspaper. There are various types of businesses that offer products or services appealing to college students that would benefit from advertising in a college newspaper. Popular restaurants, coffeehouses, theaters, bus lines, hairstylists, clothing stores, pet shops, music stores, sporting goods venues, or medical service establishments are but a few. A second and perhaps more difficult challenge is not only to ban alternative means of alcohol advertising on campuses, but also to strive to achieve consistent enforcement of such policy. This can be a powerful goal of effective community coalitions.

Running counter-advertising and warnings is another alternative to alcohol advertising. There is support for this concept among the general public and young people in particular. Responding to a national survey about requiring health warnings on alcohol advertising, nearly 70 percent of 18 to 24-year-olds said that such warnings would have an effect on alcohol consumption.<sup>6</sup>

Marketers are well aware that another effective method of appealing to young adults is through entertainment and other promotions. Sponsoring athletic events and concerts enable the alcohol industry to reach a large number of young consumers at once. The intensive nature of campus life makes this an attractive and effective marketing approach, since college lifestyle inherently encourages camaraderie and interaction. Sponsorships and promotions on college campuses by alcohol producers and the use of celebrities and youth-oriented musical groups in advertising create a pro-use drinking environment.<sup>7</sup>

The alcohol industry has an almost exclusive monopoly on these non-advertising campus marketing techniques. Colleges and universities need to look carefully at campus-based marketing efforts, including event sponsorship and the sale of alcohol-related promotional items (posters, mugs, T-shirts, etc.) that may be sold at campus stores or events. Campuses may also want to examine the use of the college’s logo on such items as beer mugs and shot glasses, which are often sold in the campus bookstores. Should college bookstores be selling such paraphernalia in the first place?

New product lines are further enhancing the pro-use drinking environment on campuses. The advent of “alcopops,” such as Mike’s Hard Lemonade and Anheuser-Busch’s “Doc” Otis, pack a beer’s worth of alcohol (about 5 percent) in a drink that goes down like soda. The Marin Institute

for the Prevention of Alcohol and Other Drug Problems calls these beverages “learner drinks.” A CSPI pollster attested to student knowledge of these new and attractive products in a February 19, 2001 *Newsweek* article.<sup>8</sup> When asked what the appeal of a drink like hard lemonade was, one student explained, “It’s an opportunity for someone who doesn’t like beer to get the same effect.”

Another prime example of alcohol marketing that targets college students is the popular annual event known as “Spring Break.” Thousands of college students, and a significant number of high school students have for years traveled to Florida, Texas, California, and more recently to Mexico, Cancun, and Baja, where marketers offer students a variety of products and entertainment in an attempt to get students to identify with their brands.

A newer venue for alcohol-related promotion is web advertising. These ads, such as <http://www.beresponsible.com>, <http://www.docotis.com>, <http://www.mikeshardlemoade.com>, to name only a few, offer free promotions for products and trips as well, making them even more attractive to students.

Proactive measures to address the issues raised in this chapter continue to develop on campuses statewide and across the nation. For example, surveys indicate that 21 percent of colleges prohibit alcohol advertising in their campus newspapers, and 25 percent do not allow the alcohol industry to sponsor campus events.<sup>9</sup> Perhaps media literacy campaigns aimed at assisting students in the skills of ad deconstruction could be part of the freshman experience. A resource to consider is [www.camy.org](http://www.camy.org).

One thing remains clear: Allowing alcohol advertising in all its forms to continue unchecked on college and university campuses can actually undermine alcohol abuse prevention efforts and may even be damaging to the health of students.

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## **Chapter 13 ♦ EATING DISORDERS**

Estimates suggest that 5-10 million men and women suffer from eating disorders or borderline conditions annually. <sup>1</sup> Eating Disorders affect men and women of all ages, and college students tend to commonly express concerns with body image, body shape, body size and weight control. <sup>2</sup> Research has shown that disordered eating behaviors and attitudes are increasingly prevalent among undergraduate students as well as specialized populations including athletes, sorority women and counseling clients. <sup>3</sup> Over the last decade a public and professional awareness of eating disorders has increased, paralleling the increased prevalence of such disorders. Health Educators and National Prevention Agencies have implemented eating disorder awareness and prevention campaigns from elementary age children through college students. Specialized treatment centers have become increasingly available with various treatments to aid those with eating disorders in their recovery. <sup>4</sup> However, eating disorders, and body-image concerns continue to be a major concern for college students. Increased prevention and awareness campaigns and college specific treatment options are needed.

### *Statement of the Problem*

The most common features associated with eating disorder and body image concerns among college students is a pattern of distressing or dysfunctional over-concern about body image and self-esteem, usually with day-to-day stress and intermittent depression. <sup>5</sup> These distressing and consuming issues threaten the health and wellness of college students and has a negative impact on their academic success. The need for awareness and prevention efforts in the field of eating disorders and body image is clear:

- ♦ 91 percent of women on college campuses report dieting; 22 percent have dieted often or always
- ♦ 35 percent of normal dieters progress to pathological dieting
- ♦ 95 percent of ALL dieters will regain their lost weight in one to five years
- ♦ 5-10 million women and men suffer from an eating disorder or borderline conditions

### *Definition of Terms*

Eating disorders are a multi-dimensional construct and include the specific disorders Anorexia Nervosa, Bulimia Nervosa and Binge-Eating Disorder.

- ♦ Anorexia Nervosa is an eating disorder that is characterized by “a refusal to maintain body weight at a minimally healthy level and an intense fear of gaining weight or becoming fat; self starvation.”
- ♦ Bulimia Nervosa is an eating disorder that is characterized by “recurrent episodes of binge eating and purging: overeating and then using compensatory behaviors such as vomiting and excessive exercise to prevent weight gain.” It is important to note that purging is defined as self-induced vomiting, excessive exercise, fasting, laxatives, alcohol-induced nausea, supplements, diet pills, enemas and diuretic. These are all methods of compensation that may be used following a binge episode.

- ◆ Binge-Eating Disorder is an eating disorder that is characterized by “binge eating and a lack of control over eating behavior in general.”<sup>6</sup>

### *Etiology*

The etiology of eating disorders is a complex interaction between biological, psychological and socio-cultural factors.<sup>7</sup> Pathology may begin in one dimension and invade the others to form a full-blown eating disorder. Psychological factors including low self-esteem, body image issues, lack of identity, abuse, depression and an obsessive-compulsive nature, all play a role in the development of eating disorders.<sup>8</sup> Biological causes may begin as a food aversion due to an unrelated illness, or other physical characteristics including body-frame, body fat content, set-weight and metabolism.<sup>9</sup> Factors such as the objectification of women in a sexist, racist and ageist society where thinness is glorified is one example of the socio-cultural factors.<sup>10</sup> What may begin as a desire to lose weight may be coupled with personal or social issues to result in a life threatening clinical problem. The associated health problems resulting from eating disorders are as complex and varied as the etiology. Therefore, prevention efforts and treatment must address the physical, psychological and socio-cultural factors through a team of physicians, psychotherapists, nutritionists and educators.

### *Recommendations for a Campus Response*

Prevention and education activities that focus on eating disorders must involve two levels of prevention: universal and targeted approaches. Universal or primary prevention must raise awareness for the entire community, and targeted, or secondary prevention, must promote the early identification of an eating disorder. Furthermore, the entire prevention package must reflect the complex dynamics that cause the disordered behaviors. Therefore prevention and awareness activities must move beyond educating students only about the causes, signs, symptoms and risks associated with eating disorders and instead address the following issues:

#### Universal Prevention

- ◆ promote healthy body image
- ◆ empower students to become critical viewers of the media
- ◆ build self-esteem
- ◆ enhance communication skills
- ◆ promote healthy relationships (familial and intimate)
- ◆ educate on basic nutrition and healthy physical activity
- ◆ discuss the role of dieting as a precursor to eating disorders
- ◆ socio-cultural obsession with the thin ideal
- ◆ gender roles

#### Targeted Prevention

- ◆ work with at risk groups to recognize the early warning signs of eating disorders
- ◆ through specific training programs, increase the awareness of health care providers, counselors, nutritionists, coaches, faculty and other professional campus staff on the early warning signs of eating disorders
- ◆ develop “how to help a friend” programs, manuals, and information pieces to assist those

who know someone who has an eating disorder

All prevention approaches must address the psychological, biological and socio-cultural components of eating disorders and it is best if such programs be coordinated with opportunities for participants to speak confidentially with a trained professional when necessary referral is appropriate. In addition, eating disorders cut across all socioeconomic, ethnic and cultural groups and affect both men and women; therefore prevention specialists must tailor their prevention packages to meet the demands of the entire campus community.

#### Programming Strategies:

- ◆ conduct a comprehensive needs assessment to define the problem specific to your campus (pre-test)
- ◆ consult with an eating disorder content specialist
- ◆ develop an eating disorder and body image concerns task group that includes student representatives, health care providers, counselors, nutritionists, health educators, faculty and athletics
- ◆ develop universal and targeted prevention objectives with a team of professionals and students
- ◆ implement prevention programs ~ these may include, but are not limited to, trainings, continuing education programs, workshops, curriculum infusion, campus newspaper, campus radio, campus TV, public service announcements, ribbon campaigns, awareness weeks, guest lecturers, poster campaigns, brochures, pamphlets, flyers, support groups, body image enhancement workshops, nutrition & physical activity workshops, communication, sexuality, self-esteem programs, etc.
- ◆ establish community partnerships and referral sources
- ◆ evaluate prevention programs (post-test)

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## Chapter 14 ♦ GAMBLING

Some would say that gambling, whether it is bingo, OTB, casino, lottery or sports, is as much a part of our American way of life as social drinking. Today it is rare to find someone who hasn't heard the quote "taken a chance," bet on the Super Bowl, bought a lottery ticket, or visited a casino. It doesn't mean they have a problem or need an intervention for treatment. It simply means they participate for social and recreational reasons. It goes without saying; the stated purpose of gambling is to win, in most cases, that means money. Current statistics show that at least half our population gambles at least once a year and at least three percent of the adult population can be classified as Compulsive Gamblers in need of intervention and treatment. With respect to students, a 1996 study showed that 87 percent had gambled for money at least once in their life.

There are people who can drink and people who can gamble without consequences. However, there is always a small percentage that will become dependent, addicted, or compulsive in their gambling behavior. Who and when will depend on a number of factors not dissimilar to alcoholism and substance addiction. More and more, research is showing that brain chemistry and genetics play a significant role in explaining gambling addiction.

With respect to college students, gambling can have significant negative effects on their academic performance and students who gamble excessively are more likely to abuse substances and visa versa. Alarmingly, the rate of gambling among students significantly exceeds the rate for adult problem gamblers.

Why do students gamble?

- ♦ to win money
- ♦ for fun and entertainment
- ♦ for excitement
- ♦ to socialize with peers
- ♦ because of boredom

What are signs of Problem Gambling?

- ♦ When students feel compelled to return or increase bet amount to win back money lost.
- ♦ When gambling causes problems with other students.
- ♦ When class attendance and grades significantly change.
- ♦ When promises to others will stop and does not.
- ♦ When borrows money from other students and can not pay back.
- ♦ When moods and behaviors swing from outgoing to isolating.

*What criteria should be used for a clinical assessment?*

It is helpful to use the DSM IV criteria in which 5 (five) of the following criteria must exist from the following 10, for a diagnosis of Pathological Gambler.

- ◆ Preoccupied with gambling, e.g., preoccupied with reliving past gambling experiences, handicapping, or planning the next venture or thinking of ways to get money with which to gamble
- ◆ Needs to gamble with increasing amounts of money in order to achieve the desired excitement
- ◆ Has repeated unsuccessful attempts to control, cut back, or stop gambling
- ◆ Is restless or irritable when trying to cut down or stop gambling
- ◆ Gambles as a way of escaping from problems or relieving a dysphoric mood (e.g., feelings of helplessness, guilt, anxiety, and depression)
- ◆ After losing money gambling, often returns another day to get even (called “chasing ones losses”.)
- ◆ Lies to family members, therapists, or others to conceal the extent of involvement with gambling
- ◆ Has committed illegal acts such as forgery, fraud, theft, embezzlement to finance gambling
- ◆ Has jeopardized or lost a significant relationship, job, education, or career opportunity because of gambling
- ◆ Relies on others to provide money to relieve a desperate financial situation caused by gambling

#### *Treatment and Recovery Options*

Since the DSM IV describes Pathological Gambling as an “Impulse Control Disorder,” few insurance plans will cover treatment. In many cases, persons suffering from compulsive gambling will have co-occurring disorders, (e.g., alcoholism, depression), which should be covered by most health plans. In addition, Gamblers Anonymous is available in most communities. It is crucial that persons struggling with recovery be encouraged to participate in the fellowship of GA.

Similar to other addictions, recovery should emphasize “One Day At A Time.”

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PART TWO

The Campus Alcohol and Other  
Drug Abuse Prevention Program

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## Chapter 15 ♦ THE CAMPUS TASK FORCE

Campus alcohol and other drug abuse prevention programming can be challenging and exciting. Organizing a task force is an important element of this effort. Developing a clear picture of the problem, enlisting the support of key people, and significantly increasing administrative, faculty member, staff, and student involvement are just a few examples of what a campus' task force should attempt to achieve. Ultimately, the task force should direct the implementation of the campus' substance abuse prevention activities.

While no specific task force model is applicable to every campus, due to varying organizational structures, there are some important basic elements. The chief administrator should designate one department, division, or individual to be responsible for the prevention program's implementation and coordination.

Representation on the task force is critical. As the task force strives to be comprehensive and include a cross-section of the college community, the more effective its planning and success should be. Individuals from the following groups should be considered for appointment to the task force.

- ♦ Office of the President and other Campus Administrators
- ♦ College Council/Board of Trustees
- ♦ Student Services
- ♦ Residence Life
- ♦ Students - undergraduate, graduate, single, married
- ♦ Faculty Members
- ♦ Regional College Consortium
- ♦ Campus Ministry/Chaplains
- ♦ Campus Health Services
- ♦ Counseling Center
- ♦ Campus Judicial System
- ♦ Campus Media - radio, newspaper, and educational television
- ♦ Campus Activities
- ♦ Fraternities and Sororities
- ♦ Campus Public Safety and Security Officers
- ♦ Student Government
- ♦ Alumni/ae Association
- ♦ Campus Pub Operations
- ♦ Athletic Departments and Coaches
- ♦ Campus Bookstore
- ♦ Employee Assistance Program
- ♦ Parent/Family Organizations

There are four important organizational steps that should be taken at the first task force meeting.

- ◆ Elect or appoint a chairperson.
- ◆ Develop a needs assessment survey. Chapter 16 outlines this process in greater detail.
- ◆ Designate individuals or subcommittees to study and report to the task force on the following areas: research (i.e., needs assessment survey), campus substance abuse policy and regulations, judicial/disciplinary procedures, media/publicity issues, education and prevention programs, and early intervention programs.
- ◆ Decide the frequency and dates of subcommittee meetings. Set a date for the next task force meeting.

*One final point to consider:* There are several regional college consortia located throughout New York State as part of OASAS' Regional College Alcohol and Other Drug Consortia Project, which is explained in more detail later in this manual. At least one campus task force representative should be designated to attend the consortium meetings in their region.

## Chapter 16 ♦ THE NEEDS ASSESSMENT SURVEY

Examining both the extent and nature of alcohol and other drug abuse, and the level of attitude, knowledge, and behavior on campus should aid colleges and universities in better understanding their campus' alcohol or other drug issues. Survey data can answer many questions.

- ♦ How much do the administrators, faculty members, staff, and students know about campus use and abuse of alcohol or other drugs?
- ♦ What are the attitudes toward alcohol and other drug abuse on campus?
- ♦ Are there problems on campus related to student alcohol or other drug abuse? If so, what are they?
- ♦ How well does the campus community understand New York State's minimum legal possession age, zero tolerance law, and other legislation?

By providing hard data, the survey should provide a focus for program planning efforts, offer a wealth of information for future prevention activities, and minimize negative emotional reactions. Campus data can be viewed in perspective with state and national statistics, thus lessening the reaction that your campus has a unique problem that it fears becoming public.

Even if task force members are not experienced in survey design and statistical methodology, implementing a campus survey does not have to be overwhelming. Many campuses have research personnel or faculty members who can provide assistance with design, implementation, and analysis. In many instances, they can provide access to the campus computer system. Even a large representative sample of the campus does not have to create an overwhelming demand on staff time.

There are a number of areas to consider as you plan and design a campus needs assessment survey.

You will want to answer the following questions:

- ♦ Are there norm misperceptions that you want to address (e.g., the majority of our students binge drink, males drink more than females, etc.)?
- ♦ What questions will be asked to test knowledge?
- ♦ How will behavior and related consequences be assessed (e.g., binge drinking has had a negative effect on grades)?

You will want to include questions related to:

Age	Type of residence
Gender	Family demographics
Class year	Precollege alcohol/other drug use
Academic major	Changes in alcohol/other drug use during college
Where, when, why, and with whom is alcohol consumed?	

*How many people will be surveyed?*

For optimum results, the survey should be administered to the entire administration, faculty members, staff, and student body. If this is not possible, a random sample may provide sufficient information. If you choose a random sample, you must have a valid selection process. Your research director or faculty members may be able to assist in this effort.

*How will the survey be distributed and collected?*

Here are some options:

- ◆ Via direct mail
- ◆ Through Resident Assistants
- ◆ Classroom distribution in mandatory courses for *all* students
- ◆ Faculty paycheck envelopes
- ◆ Through organizations willing to distribute and collect the survey
- ◆ Student distribution through courses where credit is awarded for survey design, distribution, and collection (e.g., sociology, statistics, etc.)

Remember

- ◆ Keep your survey short and specific
- ◆ Always pretest your survey
- ◆ Use the survey instrument as an education and awareness tool, as well as a means of data collection
- ◆ Obtain Institute Review Board (IRB) approval if necessary

If the task force chooses a distribution method involving outside assistance, it is beneficial to train the individuals who will be conducting the survey. In this training, you will want to clearly explain the survey's purpose. Be sure that trainees understand the need to identify the task force and most important, *assure survey respondents of confidentiality*. In a direct mail or anonymous return situation, the same information should be included in a cover letter. Don't forget to include a "thank-you" to respondents for participating.

If you wish to expand your database, you also may want to identify the following alcohol and other drug-related information.

- ◆ Campus vandalism statistics
- ◆ Campus discipline records
- ◆ Campus security reports
- ◆ Non-confidential Health or Counseling Center data
- ◆ College-operated ambulance service data
- ◆ Statistics from other campuses
- ◆ Data on student withdrawals, academic dismissals, or disciplinary expulsions related to alcohol or other drug use.

Once the task force has administered the survey and collected the data, the next step is to analysis. Your survey can serve a variety of purposes, but only if the appropriate constituencies are informed of the results. The task force has the responsibility of providing feedback on the survey data to all those who contributed to the needs assessment survey. Oral and/or written reports should be made to the same campus groups listed in Chapter 15 of this manual.

Although one standard report could suffice for all groups, specially tailored reports might be more appropriate. The suggestions listed below may offer some guidance.

- ◆ Statistics regarding classes missed due to hangovers, attendance at class while impaired, lower grades, etc. are relevant to faculty members and may encourage them to participate in your campus prevention program.
- ◆ Statistics related to vandalism, violence, or roommate problems are of special concern to Student Services staff and Public Safety and Security Officers.
- ◆ Information related to accidents due to impairment and the frequency of alcohol use in combination with other drugs is important for Health Services staff.
- ◆ Statistics regarding incidents of driving while intoxicated or impaired, or riding with an impaired driver, are of particular concern to campus Public Safety and Security Officers.
- ◆ Results showing significant alcohol or other drug abuse on campus can help convince administrators of the need for alcohol and other drug prevention and early intervention programs.

Straightforward reporting of survey data should raise awareness of campus problems or concerns and lead to specific activities addressing these issues. Some colleges have conducted the efforts listed on the next page as a result of their findings.

- ◆ Survey statistics formed the basis for a series of campus newspaper articles, radio spots, substance abuse prevention posters, and short "Did you know?" statements for faculty newsletters.

- ◆ Ambulance service and health center statistics regarding alcohol- and other drug- related medical emergencies led to a refined reporting system and a new method of planned intervention with students who endangered themselves and others. This was done before the Health Insurance Portability and Accountability Act (HIPAA) went into effect.
- ◆ Local statistics were compared with state and national data for activities during National Collegiate Alcohol and Health and Wellness Awareness Weeks.
- ◆ Local police reports transmitted daily to the Vice President for Student Affairs resulted in the formation of a “town-gown” group that met regularly to discuss community and campus concerns related to student alcohol abuse and crime.
- ◆ Statistics noting students’ inability to handle peer pressure and academic workload led to workshops on assertiveness training and peer counseling.
- ◆ Campuses have used Information about student alcohol and other drug abuse and the related problems to justify budget requests for alcohol abuse prevention and early intervention program appropriations.
- ◆ Data concerning students’ lack of knowledge about alcohol and other drugs has convinced some colleges to develop an alcohol and other drug education curriculum or elective course.

A simple survey or more complex assessment can be conducted regardless of institution size, budget availability, or staff expertise. If you cannot do a formal survey, you might draw on existing information such as security reports, police logs, vandalism statistics, faculty member and staff reports, and discipline statistics. Whatever your method, the goal is to present factual information for the purpose of raising campus awareness on alcohol and other drug use and abuse.

## Chapter 17 ♦ GOALS, OBJECTIVES, AND THE PROCESS EVALUATION

Once the needs assessment survey is completed and the results have been examined, the task force should develop program goals and objectives.

The purpose of establishing goals and objectives for your alcohol and other drug abuse prevention program is to provide direction to your efforts and to clarify the who, what, where, when, and why of your activities. A shortcoming of many programs is that goals and objectives are described in broad, generalized, nonspecific terms. Consequently, the statements are not useful for evaluation purposes because they are difficult to measure.

In order to demonstrate what a task force intends to accomplish; goals and objectives must be clearly stated, specific, timely, and measurable. Begin by identifying your major campus concerns as outlined in your survey findings. Then develop goals and objectives in accordance with the results of the needs assessment survey.

A task force with a realistic perspective will reject unattainable goal statements such as “to eliminate alcohol abuse on the campus,” and ask the following questions.

- ♦ What is the priority of concerns?
- ♦ What do students know about alcohol and other drugs? What should they know?
- ♦ How do alcohol and other drug abuse affect the campus (e.g., student retention, vandalism, violence, poor community relationships, etc.)?
- ♦ What specific drinking behaviors are evident on the campus?
- ♦ What message does the college want to communicate about alcohol and other drug (e.g., policies, standards, rights and responsibilities, etc.)?
- ♦ What human and fiscal resources can be committed to the program?

*Goals* articulate the overall purpose or direction of your program. However, this is not to say that your goals should be sweeping and vague. Be sure to develop specific and realistic goals.

The following statement is an example of a realistic long-term goal: To educate and sensitize the campus community about the issues of alcohol and other drug abuse.

An *objective* is in essence a “subgoal.” Each objective should move you closer to achieving a specific goal. Objectives are long- or short-term depending upon the duration of activities and the intended range of impact.

The following statement is an example of a realistic long-term objective: Through the use of workshops, public education material, and pre-post testing, the campus community will improve by 20 percent its knowledge on alcohol and other drugs.

*Activities* are the steps used to fulfill the stated objective. Some of the activities that apply to this objective may include:

- ◆ designing and conducting alcohol education workshops
- ◆ designing and disseminating public education materials
- ◆ designing and implementing a pre-post test on alcohol and other drug knowledge

The following statement is an example of a realistic short-term objective is: Through the use of campus assessment surveys and subsequent public education, the campus community will be able to identify at least four current alcohol-related behaviors or health problems on campus.

Some of the activities which apply to this objective may include:

- ◆ collating the campus assessment survey results
- ◆ publishing and disseminating results of the assessment survey to the college community (e.g., college paper, faculty newsletters, etc.)
- ◆ designing and distributing posters which focus on the most dramatic findings of the survey
- ◆ using the campus radio station to broadcast a panel discussion on the implications of the survey results. Invite administrators, faculty, staff, and students to participate

Once the task force has developed goals and objectives, you should consider a *process evaluation*. A process evaluation will help you measure how effectively specific activities you've undertaken have met your goals and objectives. The following questions may be helpful in determining this process.

- ◆ Was the objective accomplished?
- ◆ How was it accomplished and by whom?
- ◆ How many people participated?
- ◆ Were reactions positive or negative?
- ◆ Were there any unanticipated outcomes?
- ◆ Will this activity or objective be continued, revised, or dropped?

Regardless of the structural approach to the process evaluation, it is easy to measure your efforts using goals and objectives. You should consider the following items in your process evaluation.

- ◆ Goals
- ◆ Objectives
- ◆ Methods or activities to accomplish the objectives
- ◆ Time frame for accomplishment
- ◆ Designation of staff responsible for implementation
- ◆ Report of objective attainment (numbers, changes, positive and negative outcomes, future

needs, recommendations, etc.) - *This step becomes your process and outcome evaluation.*

The process evaluation enables the task force to take an objective and critical look at the program's structure: what was done; how many participants attended; number of program activities; and the dates and times of those activities. You will then be able to evaluate the success or failure of particular activities and make appropriate decisions about improvements and/or changes to your program.

## Chapter 18 ♦ CAMPUS ALCOHOL AND OTHER DRUG POLICY

Colleges and universities are not exempt from federal, state, and local laws. All institutions should adopt a campus alcohol and other drug policy, consistent with relevant laws that will guide the entire campus community.

For the purposes of this manual, an alcohol and other drug policy is a formal written statement of the college's position on the use of alcoholic beverages or other drugs. Some colleges have adopted policy statements, which prohibit any drinking of alcoholic beverages on campus. An effective policy clearly sets forth regulations, specific guidelines, and rules to carry out the intent of the policy.

### *Relevant Laws*

On December 1, 1985, the legal minimum age to purchase alcoholic beverages in New York State was raised to 21. Under the law, no person can sell, deliver, or give away alcoholic beverages to any person under 21 years of age. Violation of the law is a class B misdemeanor.

As of January 1, 1990, the Alcoholic Beverage Control Law was amended to include unlawful possession of alcoholic beverages. Under this law, no person under the age of 21 can possess any alcoholic beverage with the intent to consume. Violators of the law may be summoned to court by a peace or police officer; the court may impose a fine not exceeding \$50, and/or require attendance at an approved Alcohol Awareness Program, and/or require an appropriate amount of community service not to exceed 30 hours.

Another important law affecting students involves the fraudulent use of ID to purchase or secure alcohol. Violators can be fined up to \$100, and/or require attendance at an approved Alcohol Awareness Program, and/or require community service for up to 30 hours. Further, if a New York State driver's license is used to fraudulently purchase alcohol, the license may be suspended for 90 days. Relevant sections of these and other New York State laws are reprinted in Appendix 5 of this manual.

As of November 1, 1996, a new law, also known as the "Zero Tolerance" law, went into effect, and it provides that after a minor has been stopped by police, and is found to have a blood alcohol level in excess of .02 percent, but not more than .07 percent, they would be charged with this new offense. Under existing law, anyone with a blood alcohol level of .07 percent or more is subject to criminal prosecution.

If after a hearing by the Department of Motor Vehicles it is found that the minor had consumed alcohol prior to driving, they would lose their license for six months for a first-time offense. For a second or subsequent offense, the minor would lose their license for one year or until age 21, whichever is greater.

The New York State Education Law prohibits hazing that involves the forced consumption of alcohol. In addition, some local governments have enacted "open container" statutes that prohibit individuals from having open containers of alcoholic beverages in a public place. Such local laws

may or may not apply to private property or state land within the community.

The Drug-Free Schools and Communities Act Amendments of 1989 require colleges and universities to certify to the U.S. Department of Education that they have implemented alcohol and other drug abuse prevention programs for students and employees. Institutions also must conduct biennial reviews of their programs to evaluate effectiveness and implement any necessary changes, and to ensure that they consistently enforce all sanctions.

*At a minimum, programs must annually distribute the following to each student and employee, or risk losing federal financial assistance.*

- ◆ Standards of conduct that clearly prohibit, at a minimum, the unlawful possession, use, or distribution of alcohol and other drugs by students and employees on their property or as part of their activities.
- ◆ A description of applicable federal, state, or local legal sanctions concerning the unlawful possession or distribution of alcohol and other drugs.
- ◆ A description of the health risks associated with the use of alcohol and other drugs.
- ◆ A description of any alcohol or other drug counseling, treatment, or rehabilitation or reentry programs that are available to employees or students.
- ◆ A clear statement that the institution will impose sanctions on students and employees consistent with federal, state, and local laws, as well as a description of those sanctions.

The Higher Education Act Amendments of 1986 require all colleges and universities receiving federal financial student aid to certify that they have substance abuse prevention programs for administrators, employees, and students. The Drug-Free Workplace Act of 1988 expands this provision to require employers to establish a policy of maintaining a drug-free workplace by communicating the dangers of workplace drug abuse and providing information about drug counseling, rehabilitation, and Employee Assistance Programs. In essence, this law requires colleges and universities to make good-faith efforts to establish and maintain a drug-free workplace for employees covered under federal contracts and grants.<sup>1</sup>

Raising the purchase age to 21, the zero tolerance legislation, and other laws were never intended to be a panacea to end alcohol- and other drug-related problems among young people. However, they have proven to be important initial steps, when followed by public awareness and education, increased enforcement, and enhanced cooperation among colleges, prevention providers, and other community organizations through efforts such as the Regional College Alcohol and Other Drug Consortia Project.

#### *Developing and Implementing Policy*

The task force cannot develop and implement prevention and intervention strategies until a policy and regulations are in place. It is important to note that policies and regulations must be carefully

thought out and discussed among all committee members. Policies and regulations that are not enforceable can create greater problems, undermining the intended goals of the campus' substance abuse prevention program. Chapter 20 discusses various disciplinary actions your campus could adopt for those students who violate the college's alcohol and other drug policy.

Prior to implementation, a comprehensive campus substance abuse policy needs to address several important questions.

- ◆ Is the policy consistent with federal, state, and local laws? Campuses should not be seen as “safe havens” where applicable laws are not enforced.
- ◆ Does the policy address both individual and group behavior and events? Individuals must know precisely which policies govern their behavior and how each individual will be held accountable. Similarly, student and faculty organizations must know what policies apply to their events and activities, and how they will be held accountable.
- ◆ Does the policy apply to all campus property, and events sponsored by the school?
- ◆ Does the policy apply to the entire campus community? A comprehensive, effective policy applies not only to students, but to administrators, faculty members, staff, and visitors as well.
- ◆ Does the policy address both on- and off-campus behavior? All institutions must assume full accountability for on-campus behavior. However, some institutions also may wish to develop policies pertaining to off-campus alcohol and other drug abuse. The institution may find this helps improve relations with the local community. However, off-campus regulations may backfire if the institution is unwilling to enforce them.
- ◆ Is the policy clearly stated and not contradictory about the consequences of noncompliance? The campus alcohol and other drug policy should describe the penalties for violating regulations. For example, a policy might state that violations will result in referral to the college's judicial system.
- ◆ Are those charged with enforcing campus alcohol and other drug regulations supported by the administration? Is their authority clearly defined?

The campus alcohol and other drug policy should be published in all college and university materials, including admissions publications, faculty and student handbooks, and promotional or awareness materials for the general public. It also should be circulated widely to the full campus constituency, including:

- |                                |                                  |
|--------------------------------|----------------------------------|
| - Administrators               | - Maintenance and Clerical staff |
| - Students and Student Leaders | - Food Services staff            |
| - Faculty Members              | - Clubs and Organizations        |
| - Parents                      | - Student Services staff         |

- Community Leaders
- Campus Police and Public Safety -
- Campus Health Services staff
- Campus Pub staff

An individual or committee should be assigned by the task force to publicize the policies and regulations. In addition to those mentioned above, there are a variety of mechanisms to disseminate this information, including, but not limited to:

- Mailings (including email)
- Student Orientation
- Parent/Family Orientation
- Classroom presentations
- Newsletters
- Employee paycheck stuffers
- Campus-Community meetings
- Faculty meetings and training
- Campus Media and Posters
- Residence Hall meetings
- Student Leadership training
- Resident Director and Assistant training
- Campus Pub staff training
- Campus or program web site

There is no standard campus policy applicable to all institutions. Each college and university must develop a policy and regulations that reflect its basic philosophy and unique needs. This manual presents several sample policy statements and regulations as examples only. *OASAS does not endorse any specific policy or regulation, recognizing that different ones fit individual campus needs.*

### *Sample Policy Statements*

Selected sections of alcohol and other drug policy statements from New York State colleges, effective as of Fall 2002, are listed below as examples:

#### *Sample from a Private Four-Year Residential College*

##### Policy

It is the University's policy to prohibit the unlawful distribution, dispensing, possession or use of illicit drugs or alcohol on the University campus.

The University will take into consideration, when determining sanctions, the case of a student who is a drug user or who abuses alcohol as long as he or she is willing to undergo medical treatment in a sincere attempt toward rehabilitation. In the case of any student who is not willing to undergo such treatment, the University reserves the right to take investigatory and disciplinary action up to and including dismissal.

The University will not penalize any student or applicant for admission who has been in the past, but no longer is, a drug user.

##### Violations/Sanctions

The University is obligated to take preventive or prohibitory action, whether or not civil authorities act, in reference to any student whose behavior is adjudged to be potentially harmful to him or herself or to others.

Violations of University policies or civil law concerning alcoholic beverages or situations evolving directly from the sale, consumption, distribution or transportation of alcoholic beverages will be dealt with through University disciplinary procedures as described in the Student Handbook and/or through civil authorities.

Any student distributing or selling illicit drugs on campus will be subject to dismissal through the University judiciary procedures.

Students who violate University policy will be subject to sanctions described in the Student Handbook.

#### Legal Sanctions

Controlled Substances- Federal law makes it a criminal offense to manufacture, distribute, or dispense, or possess with intent to manufacture, distribute, or dispense, or simply possess a controlled substance. The New York Penal Law makes it a criminal offense to possess, possess with intent to sell, or actually sell various drugs. The drugs to which this law applies include marijuana.

The possible sanctions for violation of federal and state and local law involving controlled substances and drugs depend upon the particular offense violated. The various offenses are premised on factors which include the type and quantity of drugs involved. Depending upon the particular circumstances involved, violations of said law could result in sanctions ranging from a monetary fine to life imprisonment.

A person need not be in actual physical possession of a controlled substance to be guilty of a crime. The unlawful presence of a controlled substance in an automobile is presumptive evidence of knowing possession of each passenger, unless the substance is concealed on the person of one of these occupants. Similarly, the presence of certain substances, including marijuana, in open view in a room under circumstances demonstrating an intent to prepare the substance for sale is presumptive evidence of knowing possession of anyone in close proximity.

Alcohol- New York law also prohibits the misuse of alcohol. Alcohol may not be sold, delivered, or given away to anyone under 21 years of age, nor may someone under the age of 21 present false evidence of age to purchase alcohol. A fine of up to \$25 or imprisonment for up to five days can be imposed for consuming an alcoholic beverage in a public place or for public possession of an open container of an alcoholic beverage with intent to consume. Operating a motor vehicle while intoxicated, or impaired by the use of drugs, is a crime for which a sentence of up to one year in prison can be imposed.

#### Parental Notification Policy for Alcohol and/or Drug Abuse

Excessive, abusive, illegal and /or repetitive use of alcohol and/ or drugs is inconsistent with the maintenance of an educational environment. Such behavior threatens the well-being of persons and property and tends to diminish students' prospects for personal and intellectual development and academic success. When student's under the age of 21 are found to have committed serious or repetitive violations of University policies related to the possession, use, or distribution of alcohol and/or drugs, the Dean of Students or his/her designee has the authority to determine when and by what means to notify parents or guardians. Whenever possible, students will be informed that parental notification is planned in advance of their parents receiving the notice. The Dean of Student Life will follow these guidelines in determining whether or not to notify parents

Notification of Parents is indicated when:

The violation involves harm or threat of harm to person or property.

The violation involves an arrest in which the student was taken into custody.

The student requires hospitalization as a result of alcohol consumption or drugs.

The violation results in or could result in the students being suspended from the University and or/ dismissal from the residence halls.

The student has shown patterns of violence - even if they are minor. Two or more violations associated with drugs or alcohol use would be reasonable cause for notification.

#### *Sample from a Public Four-Year Residential College*

The College hereby prohibits the unlawful possession, use, or distribution of illicit drugs and alcohol by students and employees on our property or as any part of our institutional activities.

The College will impose sanctions on students and employees who violate this policy consistent with local, state, and federal law. Students will be subject to the judicial procedures specified in this publication. Other corrective action may include the completion of an appropriate rehabilitation program.

The College will interpret local, state, and federal regulations in the strictest sense to assure a drug free work place.

The College, on an annual basis, will provide to each student and employee information describing the health risks associated with the use of illicit drugs and the abuse of alcohol.

The College is committed to offering employees and students counseling and/or referral to the appropriate agencies for problems associated with drugs and alcohol. For students, the campus Counseling Center is available for confidential counseling and referrals.

#### College Regulations Regarding Alcoholic Beverages

The College has an obligation to develop policies and procedures that reflect our relationships to the larger Oneonta community and to New York State. The campus alcohol policy has been revised because of legislative amendments to the New York State Alcohol Beverage Control Law. The College will, however, continue to stress the importance of alcohol education within the campus community. As is true with any policy or regulation, voluntary compliance is essential for its successful implementation.

While procedures have been developed for addressing violations of the campus alcohol policy, respect for issues of student privacy and security from unreasonable intrusions will be consistent with policy and past practice.

The College will comply with the requirements of the New York State Alcohol Beverage Control Law. Amendments to the law provide that, "No person under the age of 21 shall possess any alcoholic beverage with the intent to consume such beverage."

Violation of this policy will result in appropriate disciplinary sanctions up to and including dismissal, as provided for under established College judicial procedures. While students are subject to the provisions of campus alcohol policy, the following information is provided regarding provisions of the Alcohol Beverage Control Law:

- \*Violators are subject to a fine of up to \$50 per offense, but are not subject to arrest. Alcoholic beverages involved in alleged violations of this law may be seized by authorized law enforcement officials, including campus police officers. Disposal and destruction of seized alcoholic beverages are also authorized but cannot be carried out until three days after the initial appearance date, unless otherwise ordered by a court.

- \* Persons under the age of 21 who present falsified or fraudulently altered proofs of age for the purpose of purchasing or attempting to purchase alcoholic beverages are guilty of a violation, punishable by a fine up to \$100 and a community service requirement of up to 30 hours. Previously, violations of this section were punishable only by the imposition of a one year probationary period and a fine.

- \* A person under the age of 21 who represents an altered New York State driver's license for the purpose of illegally purchasing an alcoholic beverage may be subject to a suspension of that driver's license for up to 90 days and may also be required to apply to the Department of Motor Vehicles for a restricted use driver's license following the suspension.

- \* No person shall sell, deliver, give away, permit, procure to be sold, delivered, or given away, any alcoholic beverages to any intoxicated person or any person under the influence of alcohol.

- \*Any person who shall be injured in person, property, means of support or otherwise by an intoxicated person, or by reason of the intoxication of any person, whether resulting in his/her death or not, shall have a right of action against any person who shall, by unlawfully selling to or unlawfully assisting in procuring liquor for such intoxicated person, have caused or contributed to such intoxication; and in any such action, such person shall have a right to recover actual and exemplary damages.

### *Sample Regulations*

The following is a list of various regulations in effect at colleges and universities throughout New York State.

- ◆ All guests in residence halls are subject to all campus rules and policies.
- ◆ When alcohol is served at a party, a nonalcoholic beverage also must be served. The minimum proportion of nonalcoholic to alcoholic beverages must be 50 percent nonalcoholic to 50 percent alcoholic. Food also must be served at all student and faculty parties at which alcohol is served.
- ◆ Consumption of alcohol will not excuse a person from the legal or disciplinary consequences of disorderly or unlawful conduct.
- ◆ Individuals must not be forced to drink alcoholic beverages at any time.
- ◆ A system for checking IDs must be enforced. This will protect the organizers from unknowingly serving alcohol to underage persons.
- ◆ The Office of Student Affairs will respond immediately to reported incidents of illegal drug use or distribution. These incidents will follow regular discipline procedures or will be referred to the local police agencies.

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## Chapter 19 ♦ PREVENTION PROGRAMMING ON CAMPUS

The prevention strategy of healthy lifestyle choices can serve as an important guide in planning effective programs and activities for your campus. The six themes listed below are all derived from this strategy and its focus on substance abuse prevention.

- ♦ Promote a positive valuing of health and wellness, and a complete understanding of the relationship between alcohol, other drugs, and health.
- ♦ Discourage alcohol use by students under 21 and delay its onset.
- ♦ Discourage any alcohol or other drug use by high-risk groups, such as children of alcoholics, children of substance abusers, and persons who suffer illnesses or take medications that contraindicate the use of alcohol and other drugs.
- ♦ Discourage any alcohol or other drug use in high-risk situations, where injury to self or others would be more likely due to impaired judgment or coordination.
- ♦ Discourage any alcohol use in quantities sufficient to produce impairment.
- ♦ Promote an understanding of effective strategies for identifying and helping people with alcohol or other drug problems.

### *The Language of Prevention*

When developing prevention materials, it is critical to provide straightforward, factual information about alcohol and other drugs in language that avoids sending mixed messages. Underlying the formation of all prevention messages must be the clear understanding that *alcohol is a drug*. To emphasize this fact, OASAS recommends that the phrase “alcohol, tobacco, and other drugs” be used where appropriate.

How we present a message is often as important as what we say. Since use of the term “abstinence” frequently evokes a negative response, OASAS has adopted alternatives such as “nonuse” or “choosing not to use” as more positive approaches in health promotion. Saying “choosing not to use” reflects an active process that lets people know they have a choice. Using the term “abstinence” implies that there is a rule about alcohol use that one cannot change or act upon.

OASAS has identified messages that are essential for comprehensive, effective alcohol and other drug abuse prevention education. Underlying these messages is the recognition of alcohol's role as a gateway drug, as well as alcohol's connection to a wide range of problems. These messages guide OASAS in developing print and broadcast materials, and they also are consistent with editorial guidelines adopted by the Center for Substance Abuse Prevention and the Substance Abuse and Mental Health Services Administration. Appendix 5 outlines CSAP's *Internal Editorial Guidelines*.

- ◆ Alcohol is a drug.
- ◆ Alcoholism is a preventable and treatable disease.
- ◆ Alcohol is the drug most widely used by young people.
- ◆ Alcohol use by underage youth is unacceptable. Further, when referring to young people under age 21, the term “abuse” should not be used; we recommend the phrase “prevent alcohol and other drug use.”
- ◆ Alcohol use is not recommended for specific high-risk groups (e.g., children of alcoholics, pregnant women, recovering alcoholics and addicts, etc.).
- ◆ Alcohol use in high-risk situations is unsafe (e.g., driving, boating, at work, etc.).
- ◆ Impairment under *any* circumstance is dangerous (“Getting Drunk Is Never Safe”)
- ◆ The combinational use of alcohol with any other drug is dangerous.
- ◆ Nonuse of alcohol is *always* an acceptable choice.
- ◆ A drink is a drink - beer, wine, wine coolers, and distilled spirits (equivalency).
- ◆ Fetal Alcohol Syndrome is recognized as the leading known cause of mental retardation in the Western World and the only one that is totally preventable.

Your campus needs, as identified in the needs assessment survey, should guide the task force in developing and targeting prevention programming that is specific to your campus. *It is important to note that prevention programs are far more effective if they involve students in the brainstorming and development of the promotional, educational, and social activities undertaken as part of the program.* Student involvement will increase their understanding of program philosophy and objectives, and help to build overall student support and acceptance.

#### *A Word About “Responsible Drinking”*

On the surface, the strategy of responsible drinking may appear to represent a straightforward approach to alcohol abuse prevention. However, the concept of responsible drinking is much more complicated than it appears. There are many factors involved, including what was drunk and how rapidly; the social setting; what, if anything, was eaten; heredity disposition; and environmental and psychological factors.<sup>1</sup> An additional complication is that, as people drink and reach stages of critical decision-making, their ability to make an unimpaired decision is lessened by the amount of alcohol that has been consumed.

The philosophy of responsible drinking virtually puts the entire public health burden on the individual student as opposed to the environment. Someone who drinks too much is often labeled as “irresponsible.” The host of the party isn’t the irresponsible agent; the alcohol marketers are

not the irresponsible ones; the school isn't irresponsible; only the drinker bears responsibility. And so, in the responsible drinking model, the drinker is blamed, who in turn blames the alcohol.<sup>2</sup> The word "responsible" itself suggests that some "irresponsibility" is at the root of alcohol problems, something we know is inaccurate. In fact, nonuse is the only certain way to prevent alcohol problems.

Some responsible drinking programs do not discourage alcohol use in any quantity or frequency except prior to driving an automobile, implying that driving while intoxicated is the sole alcohol problem facing society. These messages fail to consider alcohol's connection to a wide range of health and social problems including addiction, deaths and injuries, domestic violence, homicides, and suicides.

While many prevention professionals now view the responsible drinking approach as a subtle form of alcohol promotion, it is clear that responsible drinking messages are at the least mixed and potentially misleading. Consequently, many responsible drinking educational efforts may have a neutral, if not negative, impact on preventing alcohol problems. Educational campaigns will be ineffective in campus environments that encourage drinking and deny or ignore the risks associated with drinking.<sup>3</sup>

### *Addressing Special Populations*

As discussed in Part One of this manual, there are several populations for whom you may want to design strategies when dealing with alcohol and other drug issues.

Some strategies that educators can use to help students who have a family history of alcoholism or other drug abuse include:<sup>4</sup>

- ◆ helping students distinguish between what they can control (their own behavior) and what they cannot control (other people's behavior);
- ◆ assisting students in developing special interests, hobbies, or talents that can be sources of gratification and self-esteem;
- ◆ organizing a discussion to help students understand issues associated with alcoholism and other drug abuse by family members. Point out that everyone in the family can be affected if one person is dependent on alcohol or other drugs; and
- ◆ handling discussions about substance abuse and other sensitive topics carefully. If a student becomes agitated and talkative, encourage him or her to speak about the topic being discussed. Avoid questions that may put students on the spot. Let all students know that you are available if they want to speak privately.

If you focus substance abuse prevention education efforts toward women, there are several topics you can address that will effectively connect alcohol, tobacco, and other drug issues to women's issues, including:

- ◆ Fetal Alcohol Syndrome
- ◆ Acquaintance Rape
- ◆ Self-image
- ◆ HIV/AIDS
- ◆ Domestic Violence
- ◆ Eating Disorders

When you begin planning cultural diversity workshops or educational series, it should enhance your efforts if you keep the following ideas in mind.

- ◆ Actively recruit students, administrators, faculty members, and staff to join in the development and implementation of your program.
- ◆ Publicize support groups located on campus or in the community that deal with specific cultural issues.
- ◆ Obtain culturally-specific materials for campus distribution.

### *Peer Education*

Peer training and education have proven to be highly effective among the college population. Students seem more willing to accept the principle of low-risk drinking when shown by peer example that it is acceptable, preferable behavior.

Peer education is most effective when it incorporates both pre- and in-service training. Pre-service training is designed to provide newly selected peer educators with a conceptual and practical understanding of their role. Ongoing in-service training is aimed at refining helping skills and regularly reinforcing sensitivity to and awareness of special populations and problem areas, as well as the needs of individual students and the campus at large.

One of the most frequent mistakes made in substance abuse prevention programming is the failure to provide sufficient factual information on alcohol and other drugs before attempting to change students' attitudes, values, and behavior. However, facts by themselves will not change behavior.

The presentation of factual information, coupled with values clarification and critical thinking skills, can enhance awareness and sensitivity to the impact of alcohol or other drugs. Programs that include these components can be difficult to implement because they compete with, and often contradict, values and attitudes learned from families and peers over a lifetime. Begin with small, informative, and appealing activities, working your way toward highly visible events that will attract campus-wide participation. Remember that the elements of fun, enjoyment, and high interest help to ensure the success of your efforts and become a drawing card for future programs. In addition to formal peer education presentations, students can enhance social norms campaigns

by becoming voices for the actual norms and reinforce them when it is questioned by peers. This is often an effective use of busy student leaders and athletes who can perform this role in their everyday interactions with other students. They become carriers of the true social norms of the college.

### *Substance-Free Living*

Student drinking and other drug use is a complex problem with no easy single solution. To address the problem effectively, college administrators need to develop a comprehensive plan that includes multiple prevention approaches and attempts to change campus norms regarding the acceptability of binge drinking. Setting up and expanding substance-free living areas is one significant approach colleges can take to reduce binge drinking and modify inappropriate drinking norms.

In substance-free housing most schools prohibit alcohol, other drugs, and cigarettes in their substance-free living areas. However, some colleges and universities have floors or halls where illicit drugs and smoking are prohibited but drinking is not, while some others permit smoking but not drinking. Colleges and universities generally do not prohibit students in alcohol-free halls from drinking elsewhere. However, several administrators reported that they prohibit students from returning to substance-free residence halls after drinking elsewhere if their behavior upon return creates a disturbance for other students.

Substance-free residence halls provide important benefits to colleges and students. By establishing substance-free housing, administrators send a message to the entire campus community that many, probably most, students do not engage in binge drinking or drink at all. Substance-free residence halls enable administrators to provide a safe haven for students who may be susceptible to peer pressure to drink and use other drugs. Prohibiting alcohol use in a residence hall can help cut the college's vandalism-related repair costs. Substance-free housing may increase enrollment because it gives the students more options that may make your school a more attractive place to enroll. In addition, by establishing substance-free residence halls, administrators can respond to widespread customer demand among students who want a quiet place to live.

There are many reasons why students choose substance-free housing. The top reasons for choosing this type of housing include: avoiding roommate problems associated with drinking or other drug use (78%), academic issues (e.g. wanting a quiet atmosphere in which to study) (59%), parental influence (26%), religious preference or beliefs (22%), family member with alcohol or other drug problem (6%) and recovery from an alcohol or other drug problem (<1%). Combine these students with the existing population on campus, and you have created a unique and beneficial environment on campus.

Substance-free residence halls are no panacea. Establishing substance-free residence halls may reduce vandalism and create desirable living environments for many-interested student. However, these buildings and corridors will have only limited impact by themselves on under-age and binge drinking. In part, their influence may be limited because these halls may attract primarily those students who are least likely to drink to excess in the first place, leaving the binge-drinking students untouched in the other residence halls. In addition, students living in these halls are free

to drink socially outside the building, in other halls, or in fraternity and sorority houses, as long as they do not create a disturbance when they return to their living quarters. Despite these limitations, it is likely that substance-free living areas discourage some students from getting drunk - or getting drunk as often - because the students are removed from much of the peer pressure to drink and from students who represent role models for frequent intoxication.

Note: The above information on substance-free housing was provided by the US Department of Education's Higher Education Center for Alcohol and Other Drug Prevention. For further information on establishing a substance-free housing area please visit the Center at [www.edc.org/hec](http://www.edc.org/hec)

### *Training*

Along with your programming activities, don't forget the important element of training, which should ideally be provided for administrators, faculty members, and staff. For your program to be effective, the campus must be fully educated and supportive of the program's goals and objectives. Staff that may require training are those who come in contact with students on a regular basis, including:

- ◆ Residence Hall staff
- ◆ Campus Activities staff
- ◆ Faculty Members (e.g., advisors)
- ◆ Student Leaders
- ◆ New Student Orientation
- ◆ Campus Safety and Security Officers
- ◆ Campus Pub staff
- ◆ Counseling Center staff
- ◆ Campus Health Services staff

OASAS believes that combining all of these elements promotes program development that is appropriate, comprehensive, and responsive to the diverse needs of colleges and universities.

### *Commuter Students*

The image of the typical college student as an 18- to 21-year-old campus resident is a myth, which continues to persist despite documentation identifying 80 percent of all college students as commuters.<sup>5</sup> This myth is often reinforced in the development and implementation of a campus' substance abuse prevention program by focusing on programming efforts and intervention strategies in residence halls only.

Because of this population's diversity, commuter students present many challenges to an alcohol and other drug abuse prevention program. As prevention programmers, it is essential to identify and understand the:

- ◆ needs that are common to commuter students in general, and their impact on programs
- ◆ specific needs to subgroups within the commuter population and their implications on

## programming efforts

As a group, commuter students experience a unique set of life demands. Most commuters deal with the stresses inherent in getting to and from campus, including traffic, bad weather, and the reliability of their transportation. Also, commuter students share the struggles of having multiple life roles and time demands, lack a sense of belonging on campus, and have support systems that are oriented off-campus. But within the commuter population, two distinct subgroups can be identified: dependent commuters who live at home with parents or relatives, and independent commuters living off-campus but not with relatives.

For many commuter students, there is not a lot of spare time to be involved in college activities outside of the classroom. Therefore, most programs will not have an impact on these students. In fact, most commuter students seldom know that such activities exist or are available. But to be comprehensive, campus-based substance abuse prevention programmers must do their best to reach and impact on these students.

To reach commuters with alcohol and other drug information, a plan was developed at one campus using the following principles:

- ◆ Direct-mail to home addresses is the best way to reach commuting students.
- ◆ The Union is the primary location for commuting students to eat on campus.
- ◆ Commuting students are primarily on campus during the day.

By utilizing these principles, four specific strategies were developed:

- ◆ Direct-mail newsletter
- ◆ Free luncheon/speaker series in the Union
- ◆ Computerized information systems promoting leisure opportunities in convenient places on campus
- ◆ Alcohol-free space on campus for students to spend leisure time

Many commuter colleges and universities also have identified curriculum infusion as an effective programming activity for their campuses. Curriculum infusion is the process of integrating substance abuse prevention content into courses that are regularly offered across the curriculum. Because faculty members are responsible for the development and delivery of curriculum, this strategy requires the participation of faculty members who design prevention content for their courses. This content may comprise a two or three-week unit of a course, or wind thematically throughout a course.

Examples of prevention content that can be incorporated into courses include:

- ◆ Business and Management - Address ways in which alcohol and other drug abuse by employees and managers negatively affects workers and greatly increases business costs.
- ◆ Teacher Education - Ask students to study the effects of alcohol and other drugs on the communities where they will teach, and design prevention curriculum for classes they will be student-teaching.
- ◆ Media - Address the ways that advertising by the alcohol industry targets college students to create brand loyalty.
- ◆ Biology - Examine Fetal Alcohol Syndrome and other biological effects of alcohol and other drugs.
- ◆ Women Studies - Explore relationship between binge drinking and sexual assault.

As mentioned previously in this manual, alcohol and other drug abuse prevention programming on the college campus is a challenging experience. It requires a person to be imaginative, patient, and persistent; however, being rewarded with a healthier campus community is well worth the effort.

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## Chapter 20 ♦ EARLY INTERVENTION & DISCIPLINARY PROCEDURES

Up to this point, this manual has specifically addressed prevention programming. However, it's no secret that on any college campus there are students who already have alcohol or other drug-related problems. If the college has not already done so, the task force should encourage the development and implementation of early intervention efforts, which would enable staff to refer students who require help.

In Gilda Radner's book *It's Always Something*, she recounts her battle with ovarian cancer. One of the themes in her book is, as we go through life, things just seem to happen. Unfortunately, there is a much greater chance that things can go wrong, very quickly, when alcohol or other drugs are added to the mix of an evening. This is particularly true in the campus environment, where students may reach points of impairment that is both unhealthy and dangerous. Incidents caused by such impairment frequently find their way onto the campus public safety blotter, running the gamut from illegal possession to vandalism to violence to acquaintance rape, and the list goes on.

Although an incident may involve alcohol, it doesn't mean that an individual has developed sufficient symptoms to meet the diagnostic label of alcoholic, as defined by the *Diagnostic Statistical Manual IV*. What it does indicate is that a student has had alcohol affect him or her in a negative manner. Despite the student's intelligence, grade point average, or SAT scores, the drug alcohol caused him or her to act out in a way that does not mirror their true essence. In some cases, a mild, socially correct student has chosen actions which were in direct violation to institutional policy or local and state laws.

When these situations come to the attention of student personnel staff, they often include many plot twists and turns. The rationalizations and defenses can fly around at a rate exceeding the speed of sound. Despite the rhetoric, there is a surefire way to reach a safe point from which to logically assess the situation. A simple answer to the following question may help the confused administrator: Would this have happened if the student hadn't been drinking? Resulting strategies should flow from the answer given.

If the answer you received was "no," than it is time to explore the issue.

- ♦ Was there, or is there, a potential for physical or emotional harm to the student?
- ♦ Was there, or is there, a potential for physical or emotional harm to others?
- ♦ Does the student have a past history of alcohol or other drug use?
- ♦ Is there a current pattern of alcohol or other drug abuse, which has resulted in other disciplinary interventions?

Since each campus has its own disciplinary system in operation, it would be impossible to list the many different ways that the situation can be acted upon. The key to the process is holding the

student accountable for his or her behavioral choices. “A” caused “B” with no likelihood of “B” occurring unless there had been drinking involved. There is no need to argue with the student about the details of the incident nor make allegations regarding alcoholism.

It is helpful in such situations to stick with reportable facts that address the specific behavior of the student in the episode in question. Naturally, there will be reasons and context from the student’s perspective that would seem to nullify the entire event to the point of it being harmless. Campus safety documentation, Residence Life staff reports, and pertinent medical documentation provide the framework to evaluate the incident. Sharing the record helps the individual to see the context of his or her behavior more objectively. The intoxication is framed against the reality that high-risk drinking choices were made which precipitated the event. It wasn’t the 13th beer that did it; it was the quantity and frequency over the entire evening.

It is highly unlikely that the student who is in trouble planned to have something negative happen to him or her when he or she went out. For example, since it is a boring Thursday, one doesn’t wish for a DWI to liven things up. Despite the best intentions, drinking began “with the expectation of having a rewarding experience,”<sup>1</sup> but then it didn’t work out that way and an unrewarding experience was the result. Our role in this intervention is to suggest the need for the student to develop a better perspective on what happened. The more that’s known, the greater the opportunity that it won’t happen again.

What dictates the administrative response to an incident involve the specifics, as outlined earlier in this chapter, and whether or not a student has had prior counseling or hospitalization for an alcohol or other drug abuse problem. If the disease of alcoholism or other drug addiction has been diagnosed earlier, there is a distinct possibility that the observed behavior is indicative of a relapse. Although the nature of the event cannot be totally dismissed by this fact, it can indicate that the disease is no longer in remission, necessitating more of an aggressive response than a sign-off of campus policies.

The current generation of college students is probably one of the most enlightened group of students on the dangers of alcohol or other drug abuse. The information they have received has been battle-tested, and it didn’t serve them well. It is time for something different.

There are many college-level curricula on the market today that address the needs of providing education to mandated students. In selecting the program best suited for an individual school, it is wise to take some time to see where in the intervention process one is planning to connect with the student. An educational format uses a mix between research-driven data and personal exercises to develop a better understanding between low-risk and high-risk drinking; the approach is nonjudgmental. A lot of personal disclosure at the onset may not evoke the long-range goal of understanding drinking choices.

Formal evaluations result from a more serious violation, past medical history, or administrative familiarity. The evaluator should have a thorough understanding of the progressive nature of alcoholism and other drug addiction as well as an awareness of the developmental processes of late adolescence and early adulthood. Students should be informed of what is entailed in a formal

evaluation so that they are aware of the process. Federal confidentiality requirements should be presented to the students and their rights explained, which should help in lowering defenses. A signed release should be obtained to allow communication between the evaluator and the referral source.

In the standard loop of administrative disciplinary referrals, Deans need to know of compliance with the mandate but not the particulars of an individual's history, to ensure confidentiality. This should be fully understood by the student. The results of the evaluation should be discussed with the student first. If he or she disagrees with the recommendation, that disagreement can be transmitted to the Dean.

In a perfect world, the student would be so responsive to a counseling option that his or her life is totally turned around for the better. Unfortunately, most cases don't follow the ideal script. There have been many arguments laid out for decades as to whether or not therapists should work with a client who does not want to engage in the therapeutic process. In the field of alcoholism and substance abuse, a resistant client is the norm rather than the exception. Some have had bad experiences with counselors in the past. Many do not know what is involved in counseling, and therefore resist the unknown.

What does the therapist do with this resistance? Acknowledge it. The individual is in a difficult spot. Being in the substance abuse counselor's office was not part of the plan; however, the student can be helped to realize that their substance abuse got him or her in their present situation. More personalized education can provide room to clarify questions. How long one contends with the resistance is a judgment call that can be made only by the therapist. There are extremes of "we hang on until they let go" to "when you're ready, come back." Alcoholics and other drug-addicted individuals in denial need time to work through their defenses and begin to see their powerlessness.

What to do in counseling, and how to do it, is not something that can be easily explained within these pages. Counseling with a defended, active alcoholic or other substance abuser is a difficult task, but it can be done quite successfully.

Two things to consider: First, early intervention works! Many college students don't see themselves as having an alcohol or other drug abuse problem, buying into the myth that getting drunk regularly in college is a rite of passage, or a phase that they will "grow out of." Since many young people live in the "here and now," perhaps concerned only with the immediacy of their lives, it is important for educators to continue stressing the potential long-term consequences of students' actions. The physical signs of alcoholism and other drug addiction, such as cirrhosis or pancreatitis, don't occur until the later stages of the disease; however, addressing these issues now helps to prevent them from occurring in the first place.

Secondly, discipline works. Most alcohol or other drug-abusing people will not seek help on their own. However, faced with disciplinary actions as a result of their behavior, these individuals may be more motivated to seek help. The disciplinary process helps to break down the denial that prevents an individual from seeing the negative consequences of their actions.

Ultimately, early intervention and disciplinary procedures benefit the individual and the agencies, institutions, or organizations that provide such services. Early intervention averts the need for more comprehensive and costly treatment and the related medical, professional, legal, social, and other problems that are linked to alcoholism and other drug addiction. <sup>2</sup>

By using early intervention techniques, problem drinkers/users are made to focus on present behavior, helped to accept responsibility for that behavior, and guided in learning to fulfill needs without causing harm to themselves or others. The person who intervenes needs to build an emotional relationship with the individual and take an active role in the helping process, firmly guiding that person toward a healthy course of action.

In interventions it is important to call attention to the behavior pattern that has developed. The alcohol or other drug abuser needs to recognize that the various use episodes are not isolated incidents but rather a pattern of behaviors that could lead to dangerous consequences. Because of the abuser's strong denial system, documentation must be used.

#### *Documentation*

Documentation is essential when confronting or intervening with a person who has exhibited problematic behavior due to alcohol or other drug use. *Documentation must be specific, concise, and focus solely on behavior.* Documented, observed behavior must be described in a factual, nonjudgmental way, and include dates, times, and the specific connection to drinking.

Counselors should remember these tips about the documentation information that is collected.

- ◆ If you choose to speak with the student, you will need to display evidence that you care enough to be concerned about his or her behavior.
- ◆ If you choose not to speak with the student, the information you recorded can be given to someone who is comfortable in this role.

Don't be afraid to talk to a student who is suspected of having a problem. Be a friend and try to provide support. The best advice, regardless of the situation, is to keep calm and not to panic. Think through what is to be said and done before seeing the student. If the helping person appears nervous, their anxiety may be transferred to the student being confronted. Confrontation is sometimes difficult for students to accept, so be prepared for resistance and denial. It can be very helpful to role-play the situation with someone else ahead of time. Learning confrontation techniques is essential for people in supervisory positions. Appendix 6A provides a list of guidelines to assist in the development of these skills.

Another situation that may arise is the need to deal with intoxicated or impaired students. If students smell of alcohol, are unsteady, slur words, or appear sick, stay with them, even if they fall asleep. *If you have any doubt that a student is in physical danger, send for appropriate medical help immediately.* If a student is rowdy and aggressive, speak in a clear, firm voice; do not laugh or ridicule the student, as this is apt to provoke anger. It is important to reassure the student that you are there to help.

It is essential to have a list of community emergency and crisis resources readily available. There should be a referral link to the campus health center, counseling services, and safety and security staff so that a system is in place for crisis situations. It is recommended that the campus system include an alcoholism/substance abuse counselor on staff.

#### *Initiating an Effective Intervention Program*

Training and educating the campus' Residence Hall and Judicial System staff to recognize a student in need of alcohol or other drug education, counseling, and/or referral for treatment is the first step in developing an effective intervention program.

When Residence Hall staff has documented a student more than once, the forms should be forwarded to the Resident Director of the building. After reviewing the forms, the Director can choose from among several options:

- ◆ All incidents are a matter of coincidence, no action taken.
- ◆ Refer for review by the campus disciplinary board.
- ◆ Recognize a potential problem with alcohol or other drugs and confront the student or refer the student to the Counseling Center or Health Center staff.

Nonresidential colleges can apply these same steps by instructing appropriate college staff and faculty members to refer reports to the college's Director of Health Services or Director of Campus Activities.

#### *Disciplinary Boards*

College disciplinary boards, commonly referred to as campus judicial boards, often receive alcohol- or other drug-related cases for review. The board members should be aware of disciplinary choices when an alcohol or other drug problem is suspected. The ideal system incorporates a direct link between the disciplinary board and the campus' alcoholism or substance abuse counselor, so that a referral for assessment can be made efficiently. The counselor then presents a series of recommendations to the disciplinary board, based on solid documentation, outlining the suggested course of action. Recommendations are not enforceable per se because the student has the choice of accepting either the counselor's recommendation or more serious disciplinary actions. Recommendations might include the following items:

- ◆ Assign the student to volunteer a specific number of hours working on prevention activities around campus
- ◆ Require the student to attend alcoholism/substance abuse counseling
- ◆ Require the student to attend an alcohol and other drug education program
- ◆ Require the student to read a book on the issue, write a reflection paper, and discuss it with their hearing officer or the health educator
- ◆ Recommend that the student attend a self-help group meeting

- ◆ Mandate an assessment for alcoholism or substance abuse treatment, with suspension as the consequence for lack of compliance or refusal
- ◆ Require the student to participate in community service

### *Referral Policy*

Identifying an alcohol or other drug problem is only part of the intervention process. Campuses must establish and publicize a referral system within the campus community. All administrators, faculty members, staff, and students should have access to this system and feel comfortable using it. Local alcoholism and substance abuse counselors can work with the task force and community services to set up a workable system. Contacts that can be made with local community-based prevention providers or other service providers within OASAS' Regional College Alcohol and Other Drug Consortia Project can be a big asset in building a referral program.

Students should be notified in writing of the option to enter a substance abuse education program and instructed to make an appointment with the coordinator.

Upon acceptance into the program, the student must sign a contract to attend the program and complete specific tasks, such as keeping a daily log and staying alcohol- and other drug-free while in the program. When the required sessions are completed, the student is evaluated again. Based on the results, the student is referred back to the program, enters a support group, or returns to his or her former status.

Finally, every college and university program should have a referral system.

OASAS gratefully acknowledges the University of Maryland and the Seaway Valley Council for Alcohol/Substance Abuse Prevention for their help with this chapter.

### *Chapter Bibliography*

1. McAuliffe, Robert M. and McAuliffe, Mary B., *Essentials for the Diagnosis of Chemical Dependency*, American Chemical Dependency Society, 1975.
2. New York State Office of Alcoholism and Substance Abuse Services, 1992 Draft Update to the Five-Year Comprehensive Plan for Alcoholism Services in New York State.

## Chapter 21 ♦ PROGRAM PUBLICITY

Now that you have begun to develop and implement the various components of a campus alcohol and other drug abuse prevention program, it's important that you publicize the program and its efforts to the campus and surrounding community. Every facet of the program should be publicized, from the formation of the task force to a sneak preview of activities and programs scheduled for the upcoming academic year. Along the way you will want to publicize the needs assessment survey and report its results; post rules and regulations; announce your alcohol and other drug awareness and education efforts; and advertise workshop topics, dates, and locations.

The task force, through the subcommittee in charge of publicity and media, needs to inform the campus and surrounding community about the substance abuse prevention program, what it can do for them, and how they can become involved. Campus and community understanding and support will not be a reality unless publicity is an integral part of the program's planning process. By informing as many people as possible of the program's goals and objectives, the task force may uncover resources and organizational support that it did not know were accessible.

Several factors should be considered as you design your publicity campaign.

- ♦ What are your campus' needs, attitudes, knowledge base, etc. as documented by the needs assessment survey?
- ♦ Who are the target audiences you want to reach? Target audiences can include students (on- and off-campus residents), parents, faculty members, administrators, off-campus neighbors, and local government agencies, among others.
- ♦ What production and media outlet resources are available to your campus? The resources you should inventory include the available budget for media development and production; broadcast and print media outlets; cost-effective mechanisms to distribute information; and production capabilities. Be sure to research both campus and community resources to decide which ones will be the most effective and provide the greatest exposure for the program.
- ♦ How will you incorporate an evaluation component and collect data?

Many colleges and universities have on-campus marketing, advertising, or media experts who can be a source of ideas and assistance. You also might try enlisting the cooperation of students enrolled in communications and journalism courses to help write press releases, announcements, and advertisements. Art and design students can help develop attractive publicity and information materials. Your publicity efforts can effectively promote alcohol and other drug abuse prevention efforts.

The task force can downplay drinking using similar marketing techniques as those used by the alcohol beverage industry, though on a smaller scale. For example, attractive and well-composed ads, colorful and informative posters, and factual editorials can raise awareness and have a positive influence on the entire campus community. News releases for campus and local newspapers can be written, poster campaigns designed, and radio spots prepared, providing overall yearly coverage of the program's planned events. Creative techniques for publicity are easily developed when programmers are encouraged to brainstorm and consider new approaches. *Be sure the messages you develop are accurate, articulate, and relevant to the target audience you've selected.*

It is useful to meet with media representatives to discuss your communications needs and efforts during the planning stage, particularly if you have not worked with them before. Early and direct hands-on involvement of media “gatekeepers” should increase your chances of receiving their support and participation. Media outlets and organizations also can be valuable cosponsors for campus programs. Below is a list of some media resources, outlets, and products available to most colleges.

#### *Campus*

- ◆ Campus newspaper and/or magazine: articles, editorials, advertisements, notices
- ◆ Radio and television: PSAs, news coverage, talk shows
- ◆ Official college publications: orientation fliers, health service publications, catalogs
- ◆ Newsletters: administration, alumni associations, student organizations, faculty members, fraternities and sororities
- ◆ Other: posters, bulletin boards, T-shirts, mailings to parents, paycheck stuffers, email, websites

#### *Community*

- ◆ Newspapers and penny shoppers: articles, editorials, advertisements, notices
- ◆ Radio: PSAs, news coverage, talk shows
- ◆ Television - local network affiliates, independent stations, cable companies: PSAs, talk shows, public affairs programs, news coverage
- ◆ Other: billboards, business publications, direct mail, community organizations' newsletters, public meetings, email, websites

Copies of all your ads, newsletters, editorials, and other publicity materials should be saved for future reference and to assist the media committee in their end-of-year evaluation. Chapter 22 explains the evaluation process and the benefits of conducting this research.

## Chapter 22 ♦ PROGRAM EVALUATION

The final component of the campus alcohol and other drug abuse prevention program brings the task force full circle back to evaluation. Conducting an end-of-year program evaluation is an important tool in assessing program impact on the campus community. This type of evaluation is called an “impact evaluation.” As explained in Chapter 17, evaluations can help you measure how effectively the task force is meeting program goals and objectives.

Some questions that should be addressed in an impact evaluation are:

- ♦ What did the program try to do?
- ♦ What did the program accomplish?
- ♦ How did it affect the campus community?
- ♦ What changes did the program stimulate?

An evaluation matrix is an effective tool to evaluate all facets of the campus program. This type of matrix groups methods of evaluation into four categories. The sample matrix on the next page describes a range of possible evaluation elements found in each category.<sup>1</sup> The task force should substitute appropriate elements to measure its own program efforts.

When the matrix is completed for the year's activities, the task force will be able to judge the successes and failures of individual program components and identify those prevention and education efforts that are working on the campus. The task force should use the evaluation results to see if staff time, funds, and resources were used in the most cost-effective manner. Evaluation data also will help you analyze which program efforts were the most productive and made the best use of time and budget. This information then provides the framework for planning future programming efforts, showing the task force where to make needed changes and improvements.

For example, if your response to reduce alcohol-related health consequences included measures to reduce alcohol promotional messages, such as bulletin board fliers or radio advertising that emphasize high-risk drinking practices, you need to assess the environment to determine whether you were successful in meeting your objective. That means you need to collect and analyze information on bulletin board and radio station messages again. You may find that nothing has changed, or that change has occurred but at a low level. Or you may find substantial changes in promotional activities, but not necessarily in problem levels. Regardless, assessment helps you determine whether you are being successful in building a sense of campus community in responding to problems by helping you learn who is now participating in prevention that may not have been involved before.<sup>2</sup>

If the evaluation process is built into the structure of all program activities at the planning stage, gathering the data needed for your impact evaluation will be routine, rather than a high-pressure crisis at the end of each year. Having this information readily available may also enable you to address questions about the program that may arise during the year.

Most campus programs compete for limited funds and staff time. If the task force can demonstrate that significant positive behavior changes have resulted from the program, such as decreased campus violence or residence hall damage, you should be in a position to justify the program's continued existence and secure future funding. Obviously, this necessitates that the task force present the evaluation results to the college administration and those who control funding allocations. It is also imperative that you inform the campus community about the evaluation if you are to maintain and, more important, increase campus support and involvement.

### *Evaluation Matrix*

#### *Direct Measures*

##### *Objective (Quantitative)*

Survey - knowledge of alcohol/other drug facts  
 # of referrals for treatment  
 # of parties with food, nonalcoholic beverages  
 Alcohol's relation to health reports  
 Campus records (Public Safety Office)

##### *Subjective (Qualitative)*

Survey - personal attitudes and behavior  
 Discussion groups  
 Reported frequency of student substance use by  
 RDs, RAs  
 Participant satisfaction - programs

#### *Indirect Measures*

##### *Objective (Quantitative)*

Attrition rate  
 Grade Point Averages  
 # of counseling sessions  
 Contact hours of programs  
 # of brochures picked up  
 Level of residence hall damage  
 # of police reports - fighting, noise, etc.  
 # of people contributing time and/or money  
 # of people requesting further information

##### *Subjective (Qualitative)*

Structured interviews (RDs, RAs)  
 Survey - students, administrators, faculty, and  
 staff (perceptions and awareness)  
 Program visibility  
 Results of staff training  
 Cooperation with local service providers  
 Interventions for students with alcohol-  
 and other drug-related problems

### *Chapter Bibliography*

1. Anderson, D. Evaluation Matrix Sample. FIPSE New Grantee Training Institute, US Department of Education, 1993.
2. Ryan, B., et al. College Alcohol Risk Assessment Guide. UC-San Diego, 1994.

## Chapter 23 ♦ ADDITIONAL SOURCES OF INFORMATION

### ***Regional College Alcohol and Other Drug Consortia Project***

To assist campuses in finding the budget and expertise to effectively expand their alcohol and other drug abuse prevention programs, OASAS monitors the Regional College Alcohol and Other Drug Consortia Project. Regional consortia are groups of representatives from local colleges and universities, community-based prevention providers, and other service providers, located throughout New York State. Networking through the consortia has been found an effective way to build better working relationships between colleges and providers.

The goal of the Project is to assist campuses in developing and implementing comprehensive substance abuse prevention and early intervention programs, as outlined in this manual. To accomplish this goal, three objectives must be met:

- ♦ All consortia members must obtain a working knowledge of, and sensitivity to, the diversity of services, concerns, and philosophies of the groups represented.
- ♦ Each regional consortium must identify specific campus substance abuse concerns through regularly scheduled meetings.
- ♦ Networking between campuses, community-based prevention providers, and other service providers must be developed and/or enhanced.

Once established, consortia members work together to strengthen and improve campus substance abuse prevention programming on a regional basis, with strong ties to their local community resources.

In 1990, OASAS expanded the Consortia Project by developing a Statewide College Consortia Steering Committee, which consists of representatives from each regional consortium. Meeting regularly enables the Steering Committee to narrow regional gaps among the various consortia, and ensures a more consistent and dedicated effort in providing effective college alcohol and other drug abuse prevention and intervention programs throughout New York State.

For more information about the college consortium in your region, contact the Bureau of Prevention and Intervention Policy and Resource Development, c/o NYS OASAS, 1450 Western Avenue, Albany, NY 12203-3526, 518/485-2132.

### ***The Network: Addressing Collegiate Alcohol and Other Drug Issues***

In 1987, the U.S. Department of Education responded to the higher education community's need for assistance with alcohol and other drug abuse prevention programming by calling for a network of institutions willing to commit time, energy, and resources to eradicate substance abuse on their campuses. The stated goals were to collect and disseminate research- and practice-based knowledge about successful programs; provide a forum and mechanism for continuing communication and collaboration among institutions of higher education; and identify areas and problems for further research and development.

The Network seeks the participation of colleges and universities who have made a solid commitment throughout their institutions to achieve the following goals:

- ◆ Establish and enforce clear policies that promote an educational environment free from the abuse of alcohol and use of other drugs.
- ◆ Educate members of the campus community for the purpose of preventing alcohol abuse and other drug use, as well as educate them about the use of legal drugs in ways that are not harmful to themselves or to others.
- ◆ Create an environment that promotes and reinforces healthy, responsible living; respect for community and campus standards and regulations; the individual's responsibility within the community; and the intellectual, social, emotional, spiritual or ethical, and physical well being of its community members.
- ◆ Provide for a reasonable level of care for alcohol abusers and other drug users through counseling, treatment, and referral.

If your institution is not presently a member of the Network but would like to join, have your president write a letter indicating the institution's commitment to implementing the Network Standards. The letter should be addressed to The Higher Education Center for Alcohol and Other Drug Prevention, EDC, Inc., 55 Chapel Street, Newton, MA, 02138. In addition, please include the name, address, and phone number of the contact person for the institution.

### ***Videotapes***

With an inventory of more than 650 titles, OASAS' Video Vault offers some of the best videos currently available about alcohol, tobacco, and other drugs. For borrowing information, contact the Bureau of Communication, NYS OASAS, 1450 Western Avenue, Albany, NY 12203-3526, 518/485-1768.

### ***Training***

The New York State Office of Alcoholism and Substance Abuse Services' Academy of Addiction Studies has compiled a list of education and training events, which may be of interest to individuals seeking to enhance professional development. To receive a copy of the *Education and Training Calendar*, call the Academy at 518/485-2027.

### ***Information and Referral***

Community-based prevention providers are nonprofit organizations supported by a variety of sources including private gifts, contributions, grants, and contracts, as well as local United Way chapters. They provide a variety of programs and services including public education, information and referral, speaker bureaus, and other special programs. Many community-based providers also offer programs aimed at early intervention including Drinking Driver Programs, Employee Assistance Programs, Student Assistance Programs, and family-based intervention. They also may sponsor certified treatment and rehabilitation services for alcohol or other drug-abusing persons and their families.

For the name of the community-based prevention provider nearest you, call OASAS' Bureau of Prevention and Intervention Policy and Resource Development at 518/485-2132.

### *General Information*

Material about alcohol or other drugs is available from the following organizations.

African-American Family Services  
2616 Nicollet Avenue South  
Minneapolis, MN 55408  
(612) 871-7878  
[www.aafs.net](http://www.aafs.net)

Al-Anon Family Group Headquarters, Inc.  
P.O. Box 862 - Midtown Station  
New York, NY 10018-0862  
(800) 356-9996 **OR** (212) 302-7240  
[www.al-anon.org](http://www.al-anon.org)

AA General Service Office  
Box 459 - Grand Central Station  
New York, NY 10163  
(212) 870-3400  
[www.alcoholics-anonymous.org](http://www.alcoholics-anonymous.org)

Center on Addiction and Substance Abuse at  
Columbia University  
633 3<sup>rd</sup> Avenue  
Floor 19  
New York, NY 10017-6706  
(212) 841-5200  
[www.casacolumbia.org](http://www.casacolumbia.org)

Children of Alcoholics Foundation, Inc.  
164 W. 74<sup>th</sup> Street  
New York, NY 10023  
(212) 595-5810, ext. 7760  
[www.coaf.org](http://www.coaf.org)

The Core Institute  
Southern Illinois University  
Carbondale, IL 62901  
(618) 453-4366  
[www.siu.edu/departments/coreinst/public\\_html](http://www.siu.edu/departments/coreinst/public_html)  
The Higher Education Center for Alcohol

and Other Drug Prevention  
c/o Education Development Center, Inc.  
55 Chapel Street  
Newton, MA 02458  
(800) 676-1730  
[www.edc.org/hec](http://www.edc.org/hec)

National Association for Children of  
Alcoholics  
11426 Rockville Pike - Suite 100  
Rockville, MD 20852  
(301) 468-0985  
[www.nacoa.net](http://www.nacoa.net)

National Association for Native American  
Children of Alcoholics  
P.O. Box 2708  
Seattle, WA 98111-2708  
(206) 903-6574

National Black Alcoholism Council  
1101 14<sup>th</sup> Street NW - Suite 630  
Washington, D.C. 20005  
(202) 296-2696  
[www.borg.com/~nbac/](http://www.borg.com/~nbac/)

National Clearinghouse for Alcohol and  
Drug Information  
P.O. Box 2345  
Rockville, MD 20847-2345  
(800) 729-6686  
[www.health.org](http://www.health.org)

National Council on Alcoholism and Drug  
Dependence, Inc.  
20 Exchange Plaza - Suite 2902  
New York, NY 10005  
(800) 622-2255  
[www.ncadd.org](http://www.ncadd.org)

National Institute on Drug Abuse  
National Institutes of Health  
6001 Executive Boulevard  
Room 5213  
Bethesda, MD 20892-9651  
(301) 443-1124  
[www.nida.nih.gov](http://www.nida.nih.gov)

National Institute on Alcohol Abuse and  
Alcoholism  
6000 Executive Boulevard - Willco Building  
Bethesda, MD 20892-7003  
(301) 443-3860  
[www.niaaa.nih.gov](http://www.niaaa.nih.gov)

## Appendix 1 ♦ FINDING PREVENTION PROGRAMMING \$\$\$

Each of these sources listed below is involved in compiling and distributing information about grant or contract funds. The job of seeking funds is one usually carried out by your institution's grants and contracts office.

ARIS Funding Reports  
Academic Research Info. Systems, Inc.  
2940 16<sup>th</sup> Street - Suite 314  
San Francisco, CA 94103  
(415) 558-8133  
[www.arisnet.com](http://www.arisnet.com)

The Federal Register  
Superintendent of Documents  
U.S. Government Printing Office  
Washington, D.C. 20402  
(202) 512-1800  
[www.nara.gov/fedreg](http://www.nara.gov/fedreg)

Catalog of Federal Domestic Assistance  
Superintendent of Documents  
U.S. Government Printing Office  
732 N. Capitol Street  
Washington, D.C. 20402  
(202) 512-1800  
[www.cfda.gov](http://www.cfda.gov)

The Foundation Center  
79 Fifth Avenue  
New York, NY 10003  
(212) 620-4230  
[www.fdncenter.org](http://www.fdncenter.org)

The Chronicle of Philanthropy  
1255 23<sup>rd</sup> Street, NW  
Washington, D.C. 20037  
(202) 466-1200  
[www.philanthropy.com](http://www.philanthropy.com)

The Grantsmanship Center  
1125 W. 6<sup>th</sup> St. - 5<sup>th</sup> Floor  
P.O. Box 17220  
Los Angeles, CA 90017  
(213) 482-9860  
[www.tgci.com](http://www.tgci.com)

Council on Foundations, Inc.  
1828 L Street, NW  
Washington, D.C. 20036  
(202) 466-6512  
[www.cof.org](http://www.cof.org)

Health Grants and Contracts Weekly  
Capitol Publications, Inc.  
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Alexandria, VA 22314  
(703) 683-4100

Federal Grants Management Handbook  
Grants Management Advisory Service  
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Washington, D.C. 20006  
(202) 872-4000  
[www.dc.thompson.com/tpg/gran.html](http://www.dc.thompson.com/tpg/gran.html)

Join Together  
441 Stuart Street  
Boston, MA 02116  
(617) 437-1500  
[www.jointogether.com](http://www.jointogether.com)

New York State Department of Economic  
Development  
New York State Contract Reporter  
One Commerce Plaza  
Albany, NY 12245  
(800) 724-0973 **OR** (518) 486-4141

Robert Wood Johnson Foundation  
P.O. Box 2316  
College Road East and Route 1  
Princeton, NJ 08543-2316  
(609) 452-8701 **OR** (888) 631-9989  
[www.rwjf.org/index.jsp](http://www.rwjf.org/index.jsp)

The New York State Library system is a part of The Foundation Center's Cooperating Collections Network, and has many of the Center's foundation and fund-raising directories available for reference. For more information, contact your local public library.

## **Appendix 2 ♦ WORKPLACE SERVICES and EMPLOYEE ASSISTANCE PROGRAMS**

Employees with alcohol and other drug problems cost the nation's employers billions of dollars in lost productivity and increased health care expenses.

Alcoholism and alcohol abuse cost at least \$2.3 billion in lost productivity and other work-related losses in New York State each year.<sup>1</sup> Also, nearly one in every four male workers (22 percent) drinks during the workday on one or more occasions each year, compared with 12 percent of employed females.<sup>2</sup>

Employees with alcohol or other drug problems, or who have family members with these problems, have a major impact on staff morale, profits, and labor-management relations. Their hidden illness is often responsible for:

- ♦ **Declining Performance:** poor concentration; confusion in following directions; noticeable change in the quality of work; inability to meet deadlines; errors in judgment affecting the health and safety of others.
- ♦ **Increased Costs:** three times the average sick and accident benefits; higher job turnover, replacement, and training costs; greater compensation and health insurance payments; three to four times more on-the-job accidents.
- ♦ **Absenteeism and Tardiness:** double the normal absence rate; repeatedly being late for work and often leaving early; extended lunch hours; frequent illness both on-and off-the job.
- ♦ **Damaged Relationships:** emotional outbursts; overreaction to criticism; mood swings; complaints from coworkers, associates, and the public, often leading to damaged relations with customers and the public.

Regardless of campus size, all this adds up to a loss of productivity and unmanageable personnel problems and decreased co-worker morale. If allowed to continue, valuable, trained, and loyal employees continue to decline, often lose their jobs, and may even lose their lives.

College administrators have a legitimate concern about the ability of faculty and staff to perform their jobs. If alcohol or other drugs interfere with that ability, you can intervene as part of your rightful concern about the performance and health of your employees or union members.

Various services delivered in the workplace can help to prevent alcohol and other drug abuse as well as enhance the health and well being of all faculty and staff. By far, the least effective and most expensive responses are to ignore the problem or fire the employee.

One of the approaches is to develop an Employee Assistance Program (EAP). An EAP is designed to assist in the identification and resolution of life difficulties that impact on job performance. Examples include, health, marital, family, financial, substance abuse, legal, emotional stress, or other personal concerns. <sup>3</sup>

Core activities of the typical Workplace Services/EAP include: expert consultation and training to labor and management about drug free workplace policy development, violence prevention and critical incident responses, to name a few, assistance to employees in the identification and resolution of job performance issues related to the personal concerns that affect job performance; referrals for appropriate diagnosis, treatment, and assistance; the formation of linkages between workplace and community resources that provide such services; and follow-up services for employees who use those services; health and wellness programs for all employees on such subjects as nutrition and exercise, parenting skills, stress management, etc. <sup>4</sup>

Implementing effective Workplace Programs/EAPs is not complicated or expensive. The Employee Assistance Professionals Association, Inc. has offices located in regions throughout the state to assist colleges, universities, and businesses to develop workplace services. For more information on Workplace Services/EAPs contact the Regional representative in your area.

Employee Assistance Professionals Association

[www.EAP-ASSOCIATION.com](http://www.EAP-ASSOCIATION.com)

[EAPAMAIN@aol.com](mailto:EAPAMAIN@aol.com)

703-387-1000

If you are a New York College or University, please call the NYS Employee Assistance Program at 1-800-822-0244 for information or call the OASAS Contact, Ms. Lucy Maynard, CASAC, CEAP, 518-485-2132, [LucyMaynard@oasas.state.ny.us](mailto:LucyMaynard@oasas.state.ny.us)

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1. New York State Office of Alcoholism and Substance Abuse Services. OASAS Facts: The Workplace and Alcohol. 1992.
2. Barnes, G. and Welte, J. Alcohol Use and Abuse Among Adults in New York State. New York State Office of Alcoholism and Substance Abuse Services, Research Institute in Addictions, 1988.
3. Center for Substance Abuse Prevention. Prevention Primer. US Department of Health and Human Services, 1993.
4. Center for Substance Abuse Prevention. Prevention Primer. US Department of Health and Human Services, 1993.

## Appendix 3 ♦ ALCOHOL-RELATED LAWS

*NOTE: This Appendix contains only certain subsections of these laws.*

### **Alcohol Beverage Control Law**

*Section 65. Prohibited sales.*

No person shall sell, deliver or give away or cause or permit or procure to be sold, delivered or given away any alcoholic beverages to:

1. Any person, actually or apparently, under the age of twenty-one years;
2. Any visibly intoxicated person;
3. Any habitual drunkard known to be such to the person authorized to dispense any alcoholic beverages.
4. Neither such person so refusing to sell or deliver under this section nor his employer shall be liable in any civil or criminal action or for any fine or penalty based upon such refusal, except that such sale or delivery shall not be refused, withheld from or denied to any person on account of race, creed, color or national origin. In any proceeding pursuant to subdivision one of this section, it shall be an affirmative defense that such person had produced a photographic identification card apparently issued by a governmental entity and that the alcoholic beverage had been sold, delivered or given to such person in reasonable reliance upon such identification. In evaluating the applicability of such affirmative defense, the authority shall take into consideration any written policy adopted and implemented by the seller to carry out the provision of paragraph (b) of subdivision two of section sixty-five-b of this article. \*NB Effective until January 1, 2004 \*

After January 1, 2004 ~ 4. Neither such person so refusing to sell or deliver under this section nor his employer shall be liable in any civil or criminal action or for any fine or penalty based upon such refusal, except that such sale or delivery shall not be refused, withheld from or denied to any person on account of race, creed, color or national origin. In any proceeding pursuant to subdivision one of this section, it shall be an affirmative defense that such person had produced a photographic identification card apparently issued by a governmental entity and that the alcoholic beverage had been sold, delivered or given to such person in reasonable reliance upon such identification. In evaluating the applicability of such affirmative defense, the authority shall take into consideration any written policy adopted and implemented by the seller to carry out the provision of paragraph (b) of subdivision one of section sixty-five-b of this article. \* NB Effective January 1, 2004 \*

5. The provisions of subdivision one of this section shall not apply to a person who gives or causes to be given any such alcoholic beverage to a person under the age of twenty-one years, who is a student in a curriculum licensed or registered by the state education department and is required to taste or imbibe alcoholic beverages in courses which are part

of the required curriculum, provided such alcoholic beverages are used only for instructional purposes during classes conducted pursuant to such curriculum.

6. In any proceeding pursuant to section one hundred eighteen of this chapter to revoke, cancel or suspend a license to sell alcoholic beverages at retail, in which proceeding it is alleged that a person violated subdivision one of this section, it shall be an affirmative defense that at the time of such violation such person who committed such alleged violation held a valid certificate of completion or renewal from an entity authorized to give and administer an alcohol training awareness program pursuant to subdivision twelve of section seventeen of this chapter. Such licensee shall have diligently implemented and complied with all of the provisions of the approved training program. In such proceeding to revoke, cancel or suspend a license pursuant to section one hundred eighteen of this chapter, the licensee must prove each element of such affirmative defense by a preponderance of the credible evidence. Evidence of three unlawful sales of alcoholic beverages by any employee of a licensee to persons under twenty-one years of age, within a two year period, shall be considered by the authority in determining whether the licensee had diligently implemented such an approved program. Such affirmative defense shall not preclude the recovery of the penal sum of a bond as provided in sections one hundred twelve and one hundred eighteen of this chapter.

*Section 65-a.* Procuring alcoholic beverages for persons under the age of twenty-one years.

Any person who misrepresents the age of a person under the age of twenty-one years for the purpose of inducing the sale of any alcoholic beverage, as defined in the alcoholic beverage control law, to such person, is guilty of an offense and upon conviction thereof shall be punished by a fine of not more than two hundred dollars, or by imprisonment for not more than five days, or by both such fine and imprisonment.

*Section 65-b.* Offense for one under age of twenty-one years to purchase or attempt to purchase an alcoholic beverage through fraudulent means.

1. As used in this section: (a) “A device capable of deciphering any electronically readable format” or “device” shall mean any commercial device or combination of devices used at a point of sale or entry that is capable of reading the information encoded on the magnetic strip or bar code of a driver’s license or non-driver identification card issued by the commissioner of motor vehicles;
- 1b. “Card holder” means any person presenting a driver’s license or non-driver identification card to a licensee, or to the agent or employee of such licensee under this chapter; and
- 1c. “Transaction scan” means the process involving a device capable of deciphering any electronically readable format by which a licensee, or agent or employee of a licensee under this chapter reviews a driver’s license or non-driver identification card presented as a precondition for the purchase of an alcoholic beverage as required by subdivision two of this section or as a precondition for admission to an establishment licensed for the on-premises sale of alcoholic beverages where admission is restricted to persons twenty-one years or

older.

- 2a. No person under the age of twenty-one years shall present or offer to any licensee under this chapter, or to the agent or employee of such licensee, any written evidence of age which is false, fraudulent or not actually his own, for the purpose of purchasing or attempting to purchase any alcoholic beverage.
- 2b. No licensee, or agent or employee of such licensee shall accept as written evidence of age by any such person for the purchase of any alcoholic beverage, any documentation other than: (i) a valid driver's license or non-driver identification card issued by the commissioner of motor vehicles, the federal government, any United States territory, commonwealth or possession, the District of Columbia, a state government within the United States or a provincial government of the dominion of Canada, or (ii) a valid passport issued by the United States government or any other country, or (iii) an identification card issued by the armed forces of the United States. Upon the presentation of such driver's license or non-driver identification card issued by a governmental entity, such licensee or agent or employee thereof may perform a transaction scan as a precondition to the sale of any alcoholic beverage. Nothing in this section shall prohibit a licensee or agent or employee from performing such a transaction scan on any of the other documents listed in this subdivision if such documents include a bar code or magnetic strip that that may be scanned by a device capable of deciphering any electronically readable format.
- 2c. In instances where the information deciphered by the transaction scan fails to match the information printed on the driver's license or non-driver identification card presented by the card holder, or if the transaction scan indicates that the information is false or fraudulent, the attempted purchase of the alcoholic beverage shall be denied.
3. A person violating the provisions of paragraph (a) of subdivision two of this section shall be guilty of a violation and shall be sentenced in accordance with the following:
  - 3a. For a first violation, the court shall order payment of a fine of not more than one hundred dollars and/or an appropriate amount of community service not to exceed thirty hours. In addition, the court may order completion of an alcohol awareness program established pursuant to section 19.25 of the mental hygiene law.
  - 3b. For a second violation, the court shall order payment of a fine of not less than fifty dollars nor more than three hundred fifty dollars and/or an appropriate amount of community service not to exceed thirty hours. The court also shall order completion of an alcohol awareness program as referenced in paragraph (a) of this subdivision if such program has not previously been completed by the offender, unless the court determines that attendance at such program is not feasible due to the lack of availability of such program within a reasonably close proximity to the locality in which the offender resides or matriculates, as appropriate.
  - 3c. For third and subsequent violations, the court shall order payment of a fine of not less than fifty dollars nor more than seven hundred fifty dollars and/or an appropriate amount of

community service not to exceed thirty hours. The court also shall order that such person submit to an evaluation by an appropriate agency certified or licensed by the office of alcoholism and substance abuse services to determine whether the person suffers from the disease of alcoholism or alcohol abuse, unless the court determines that under the circumstances presented such an evaluation is not necessary, in which case the court shall state on the record the basis for such determination. Payment for such evaluation shall be made by such person. If, based on such evaluation, a need for treatment is indicated, such person may choose to participate in a treatment plan developed by an agency certified or licensed by the office of alcoholism and substance abuse services. If such person elects to participate in recommended treatment, the court shall order that payment of such fine and community service be suspended pending the completion of such treatment.

- 3d. Evaluation procedures. For purposes of this subdivision, the following shall apply: (i) The contents of an evaluation pursuant to paragraph (c) of this subdivision shall be used for the sole purpose of determining if such person suffers from the disease of alcoholism or alcohol abuse. (ii) The agency designated by the court to perform such evaluation shall conduct the evaluation and return the results to the court within thirty days, subject to any state or federal confidentiality law, rule or regulation governing the confidentiality of alcohol and substance abuse treatment records. (iii) The office of alcoholism and substance abuse services shall make available to each supreme court law library in this state, or, if no supreme court law library is available in a certain county, to the county court law library of such county, a list of agencies certified to perform evaluations as required by subdivision (f) of section 19.07 of the mental hygiene law. (iv) All evaluations required under this subdivision shall be in writing and the person so evaluated or his or her counsel shall receive a copy of such evaluation prior to its use by the court. (v) A minor evaluated under this subdivision shall have, and shall be informed by the court of, the right to obtain a second opinion regarding his or her need for alcoholism treatment.
4. A person violating the provisions of paragraph (b) of subdivision two of this section shall be guilty of a violation punishable by a fine of not more than one hundred dollars, and/or an appropriate amount of community service not to exceed thirty hours. In addition, the court may order completion of an alcohol training awareness program established pursuant to subdivision twelve of section seventeen of this chapter where such program is located within a reasonably close proximity to the locality in which the offender is employed or resides.
5. No determination of guilt pursuant to this section shall operate as a disqualification of any such person subsequently to hold public office, public employment, or as a forfeiture of any right or privilege or to receive any license granted by public authority; and no such person shall be denominated a criminal by reason of such determination.
6. In addition to the penalties otherwise provided in subdivision three of this section, if a determination is made sustaining a charge of illegally purchasing or attempting to illegally purchase an alcoholic beverage, the court may suspend such person's license to drive a motor vehicle and the privilege of an unlicensed person of obtaining such license, in accordance with the following and for the following periods, if it is found that a driver's

license was used for the purpose of such illegal purchase or attempt to illegally purchase; provided, however, that where a person is sentenced pursuant to paragraph (b) or (c) of subdivision three of this section, the court shall impose such license suspension if it is found that a driver's license was used for the purpose of such illegal purchase or attempt to illegally purchase:

- 6a. For a first violation of paragraph (a) of subdivision two of this section, a three-month suspension.
- 6b. For a second violation of paragraph (a) of subdivision two of this section, a six-month suspension.
- 6c. For a third or subsequent violation of paragraph (a) of subdivision two of this section, a suspension for one year or until the holder reaches the age of twenty-one, whichever is the greater period of time. Such person may thereafter apply for and be issued a restricted use license in accordance with the provisions of section five hundred thirty of the vehicle and traffic law.
- 7a. In any proceeding pursuant to subdivision one of section sixty-five of this article, it shall be an affirmative defense that such person had produced a driver's license or non-driver identification card apparently issued by a governmental entity, successfully completed the transaction scan, and that the alcoholic beverage had been sold, delivered or given to such person in reasonable reliance upon such identification and transaction scan. In evaluating the applicability of such affirmative defense, the liquor authority shall take into consideration any written policy adopted and implemented by the seller to carry out the provisions of this chapter. Use of a transaction scan shall not excuse any licensee under this chapter, or agent or employee of such licensee, from the exercise of reasonable diligence otherwise required by this section. Notwithstanding the above provisions, any such affirmative defense shall not be applicable in any other civil or criminal proceeding, or in any other forum.
- 7b. A licensee or agent or employee of a licensee may electronically or mechanically record and maintain only the information from a transaction scan necessary to effectuate the purposes of this section. Such information shall be limited to the following: (i) name, (ii) date of birth, (iii) driver's license or non-driver identification number, and (iv) expiration date. The liquor authority and the state commissioner of motor vehicles shall jointly promulgate any regulation necessary to govern the recording and maintenance of these records by a licensee under this chapter. The liquor authority and the commissioner of health shall jointly promulgate any regulations necessary to ensure quality control in the use of transaction scan devices.

8. A licensee or agent or employee of such licensee shall only use the information recorded and maintained through the use of such devices for the purposes contained in paragraph (a) of subdivision seven of this section, and shall only use such devices for the purposes contained in subdivision two of this section. No licensee or agent or employee of a licensee shall resell or disseminate the information recorded during such scan to any third person. Such prohibited resale or dissemination includes, but is not limited to, any advertising, marketing or promotional activities. Notwithstanding the restrictions imposed by this subdivision, such records may be released pursuant to a court ordered subpoena or pursuant to any other statute that specifically authorizes the release of such information. Each violation of this subdivision shall be punishable by a civil penalty of not more than one thousand dollars. \* NB Repealed January 1, 2004 \*

*Section 65-b.* Offense for one under age of twenty-one years to purchase or attempt to purchase an alcoholic beverage through fraudulent means.

- 1a. No person under the age of twenty-one years shall present or offer to any licensee under this chapter, or to the agent or employee of such licensee, any written evidence of age which is false, fraudulent or not actually his own, for the purpose of purchasing or attempting to purchase any alcoholic beverage.
- 1b. No licensee, or agent or employee of such licensee shall accept as written evidence of age by any such person for the purchase of any alcoholic beverage, any documentation other than:
  - (i) a valid driver's license or non-driver identification card issued by the commissioner of motor vehicles, the federal government, any United States territory, commonwealth or possession, the District of Columbia, a state government within the United States or a provincial government of the dominion of Canada, or
  - (ii) a valid passport issued by the United States government or any other country, or
  - (iii) an identification card issued by the armed forces of the United States.
2. A person violating the provisions of paragraph (a) of subdivision one of this section shall be guilty of a violation and shall be sentenced in accordance with the following:
  - 2a. For a first violation, the court shall order payment of a fine of not more than one hundred dollars and/or an appropriate amount of community service not to exceed thirty hours. In addition, the court may order completion of an alcohol awareness program established pursuant to section 19.25 of the mental hygiene law.
  - 2b. For a second violation, the court shall order payment of a fine of not less than fifty dollars nor more than three hundred fifty dollars and/or an appropriate amount of community service not to exceed thirty hours. The court also shall order completion of an alcohol awareness program as referenced in paragraph (a) of this subdivision if such program has not previously been completed by the offender, unless the court determines that attendance at such program is not feasible due to the lack of availability of such program within a reasonably close proximity to the locality in which the offender resides or matriculates, as appropriate.

- 2c. For third and subsequent violations, the court shall order payment of a fine of not less than fifty dollars nor more than seven hundred fifty dollars and/or an appropriate amount of community service not to exceed thirty hours. The court also shall order that such person submit to an evaluation by an appropriate agency certified or licensed by the office of alcoholism and substance abuse services to determine whether the person suffers from the disease of alcoholism or alcohol abuse, unless the court determines that under the circumstances presented such an evaluation is not necessary, in which case the court shall state on the record the basis for such determination. Payment for such evaluation shall be made by such person. If, based on such evaluation, a need for treatment is indicated, such person may choose to participate in a treatment plan developed by an agency certified or licensed by the office of alcoholism and substance abuse services. If such person elects to participate in recommended treatment, the court shall order that payment of such fine and community service be suspended pending the completion of such treatment.
- 2d. Evaluation procedures. For purposes of this subdivision, the following shall apply: (i) The contents of an evaluation pursuant to paragraph (c) of this subdivision shall be used for the sole purpose of determining if such person suffers from the disease of alcoholism or alcohol abuse. (ii) The agency designated by the court to perform such evaluation shall conduct the evaluation and return the results to the court within thirty days, subject to any state or federal confidentiality law, rule or regulation governing the confidentiality of alcohol and substance abuse treatment records. (iii) The office of alcoholism and substance abuse services shall make available to each supreme court law library in this state, or, if no supreme court law library is available in a certain county, to the county court law library of such county, a list of agencies certified to perform evaluations as required by subdivision (f) of section 19.07 of the mental hygiene law. (iv) All evaluations required under this subdivision shall be in writing and the person so evaluated or his or her counsel shall receive a copy of such evaluation prior to its use by the court. (v) A minor evaluated under this subdivision shall have, and shall be informed by the court of, the right to obtain a second opinion regarding his or her need for alcoholism treatment.
3. A person violating the provisions of paragraph (b) of subdivision one of this section shall be guilty of a violation punishable by a fine of not more than one hundred dollars, and/or an appropriate amount of community service not to exceed thirty hours. In addition, the court may order completion of an alcohol training awareness program established pursuant to subdivision twelve of section seventeen of this chapter where such program is located within a reasonably close proximity to the locality in which the offender is employed or resides.
4. No determination of guilt pursuant to this section shall operate as a disqualification of any such person subsequently to hold public office, public employment, or as a forfeiture of any right or privilege or to receive any license granted by public authority; and no such person shall be denominated a criminal by reason of such determination.

5. In addition to the penalties otherwise provided in subdivision two of this section, if a determination is made sustaining a charge of illegally purchasing or attempting to illegally purchase an alcoholic beverage, the court may suspend such person's license to drive a motor vehicle and the privilege of an unlicensed person of obtaining such license, in accordance with the following and for the following periods, if it is found that a driver's license was used for the purpose of such illegal purchase or attempt to illegally purchase; provided, however, that where a person is sentenced pursuant to paragraph (b) or (c) of subdivision two of this section, the court shall impose such license suspension if it is found that a driver's license was used for the purpose of such illegal purchase or attempt to illegally purchase:
  - 5a. For a first violation of paragraph (a) of subdivision one of this section, a three-month suspension.
  - 5b. For a second violation of paragraph (a) of subdivision one of this section, a six-month suspension.
  - 5c. For a third or subsequent violation of paragraph (a) of subdivision one of this section, a suspension for one year or until the holder reaches the age of twenty-one, whichever is the greater period of time. Such person may thereafter apply for and be issued a restricted use license in accordance with the provisions of section five hundred thirty of the vehicle and traffic law. \* NB Effective January 1, 2004

Section 65-c. Unlawful possession of an alcoholic beverage with the intent to consume by persons under the age of twenty-one years

1. Except as hereinafter provided, no person under the age of twenty-one years shall possess any alcoholic beverage, as defined in this chapter, with the intent to consume such beverage.
2. A person under the age of twenty-one years may possess any alcoholic beverage with intent to consume if the alcoholic beverage is given:
  - a. to a person who is a student in a curriculum licensed or registered by the state education department and the student is required to taste or imbibe alcoholic beverages in courses which are a part of the required curriculum, provided such alcoholic beverages are used only for instructional purposes during class conducted pursuant to such curriculum; or
  - b. to the person under twenty-one years of age by that person's parent or guardian.
3. Any person who unlawfully possesses an alcoholic beverage with intent to consume may be summoned before and examined by a court having jurisdiction of that charge; provided, however, that nothing contained herein shall authorize, or be construed to authorize, a peace officer as defined in subdivision thirty-three of section 1.20 of the criminal procedure law or a police officer as defined in subdivision thirty-four of section 1.20 of such law to arrest a

person who unlawfully possesses an alcoholic beverage with intent to consume. If a determination is made sustaining such charge the court may impose a fine not exceeding fifty dollars and/or completion of an alcohol awareness program established pursuant to section 19.25 of the mental hygiene law and/or an appropriate amount of community service not to exceed thirty hours.

4. No such determination shall operate as a disqualification of any such person subsequently to hold public office, public employment, or as a forfeiture of any right or privilege or to receive any license granted by public authority; and no such person shall be denominated a criminal by reason of such determination, nor shall such determination be deemed a conviction.
5. Whenever a peace officer as defined in subdivision thirty-three of section 1.20 of the criminal procedure law or police officer as defined in subdivision thirty-four of section 1.20 of the criminal procedure law shall observe a person under twenty-one years of age openly in possession of an alcoholic beverage as defined in this chapter, with the intent to consume such beverage in violation of this section, said officer may seize the beverage, and shall deliver it to the custody of his or her department.
6. Any alcoholic beverage seized in violation of this section is here-by declared a nuisance. The official to whom the beverage has been delivered shall, no earlier than three days following the return date for initial appearance on the summons, dispose of or destroy the alcoholic beverage seized or cause it to be disposed of or destroyed. Any person claiming ownership of an alcoholic beverage seized under this section may, on the initial return date of the summons or earlier on five days notice to the official or department in possession of the beverage, apply to the court for an order preventing the destruction or disposal of the alcoholic beverage seized and ordering the return of that beverage. The court may order the beverage returned if it is determined that return of the beverage would be in the interest of justice or that the beverage was improperly seized.

## **General Obligations Law**

*Section 11-100.* Compensation for injury or damage caused by the intoxication of a person under the age of 21

1. Any person who shall be injured in person, property, means of support, or otherwise, by reason of the intoxication or impairment of ability of any person under the age of 21, whether resulting in his death or not, shall have a right of action to recover actual damages against any person who knowingly causes such intoxication or impairment of ability by unlawfully furnishing to or unlawfully assisting in procuring alcoholic beverages for such person with knowledge or reasonable cause to believe that such person was under the age of 21.
2. In case of the death of either party, the action or right of action established by the provisions

of this section shall survive to or against his or her executor or administrator, and the amount so recovered by either a husband, wife, or child shall be his or her sole and separate property.

3. Such action may be brought in any court of competent jurisdiction.
4. In any case where parents shall be entitled to such damages, either of such parents may bring an action therefore; but that recovery by either one of such parties shall constitute a bar to suit brought by the other.

*Section 11-101.* Compensation for injury caused by the illegal sale of intoxicating liquor.

1. Any person who shall be injured in person, property, means of support, or otherwise, by any intoxicated person, or by reason of the intoxication of any person, whether resulting in his death or not, shall have a right of action against any person who shall, by unlawful selling to or unlawfully assisting in procuring liquor for such intoxicated person, have caused or contributed to such intoxication; and in any such action such person shall have a right to recover actual and exemplary damages.
2. In case of the death of either party, the action or right of action given by this section shall survive to or against his or her executor or administrator, and the amount so recovered by either a husband, wife, or child shall be his or her sole and separate property.
3. Such action may be brought in any court of competent jurisdiction.
4. In any case where parents shall be entitled to such damages, either the father or mother may sue alone therefore, but recovery by one of such parties shall be a bar to suit brought by the other.

## **Penal Law**

*Section 260-20.* Unlawfully dealing with a child in the first degree.

A person is guilty of unlawfully dealing with a child in the first degree when:

1. he knowingly permits a child less than 18 years old to enter or remain in or upon a place, premises, or establishment where sexual activity as defined by article one hundred thirty, two hundred thirty, or two hundred sixty three of this chapter or activity involving controlled substances as defined by article two hundred twenty of this chapter or involving marijuana as defined by article two hundred twenty-one of this chapter is maintained or conducted, and he knows or has reason to know that such activity is being maintained or conducted; or

2. he gives or sells or causes to be given or sold any alcoholic beverage, as defined by section three of the alcoholic beverage control law, to a person less than 21 years old; except that this subdivision does not apply to the parent or guardian of such a person or to a person who gives or causes to be given any such alcoholic beverage to a person under the age of 21, who is a student in a curriculum licensed or registered by the state education department, where the tasting or imbibing of alcoholic beverages is required in courses that are part of the required curriculum, provided such alcoholic beverages are given only for instructional purposes during classes conducted pursuant to such curriculum.

It is no defense to a prosecution pursuant to subdivision two of this section that the child acted as the agent or representative of another person or that the defendant dealt with the child as such.

Unlawfully dealing with a child in the first degree is a class A misdemeanor.

*Section 260-21.* Unlawfully dealing with a child in the second degree.

A person is guilty of unlawfully dealing with a child in the second degree when:

1. being an owner, lessee, manager, or employee of a public dance hall, public pool or billiard room, public bowling alley, theater, motion picture theater, skating rink, or of a place where alcoholic beverages are sold or given away, he permits a child less than 16 years old to enter or remain in such place unless:
  - a. the child is accompanied by his parent, guardian, or an adult authorized by a parent or guardian; or
  - b. the entertainment or activity is being conducted for the benefit or under the auspices of a nonprofit school, church, or other educational or religious institution; or
  - c. otherwise permitted by law to do so; or
  - d. the establishment is closed to the public for a specified period of time to conduct an activity or entertainment, during which the child is in or remains in such establishment, and alcoholic beverages are sold, served, given away, or consumed at such establishment during such period. The state liquor authority shall be notified in writing by the licensee or entertainment, not less than ten days prior to any such closing; or
2. he marks the body of a child less than 18 years old with indelible ink or pigments by means of tattooing; or
3. he sells or causes to be sold tobacco in any form to a child less than 18 years old.

It is no defense to a prosecution pursuant to subdivision three of this section that the child acted as the agent or representative of another person or that the defendant dealt with the child as such.

Unlawfully dealing with a child in the second degree is a class B misdemeanor.

## **Mental Hygiene Law**

### *Section 19.25. Alcohol Awareness Program*

- a. The Office shall establish an alcohol awareness program within the Office, which shall focus upon, but not be limited to, the health effects and social costs of alcoholism and alcohol abuse.
- b. The form, content, and method of presentation of various aspects of such program shall be developed by the Commissioner, provided that such program shall not exceed two hours per week over a period not to exceed eight weeks.
- c. The Commissioner shall establish a schedule of fees to be paid by each participant and may, from time to time, modify same. Such fees may be waived, reduced, or otherwise adjusted by the court upon application for re-sentence in accordance with the provisions of paragraph (a) of subdivision five of section 420.10 of the criminal procedure law. For the purposes of this section the term "fee" shall also mean "payment" as referred to in paragraph (a) of subdivision five of section 420.10 of the criminal procedure law. Such fees shall not exceed amounts necessary to pay the ongoing expenses of the program. Provided, however, that pursuant to an agreement with the Office, a municipality, a department, or part thereof, or other not-for-profit corporation may conduct such a course in such program with all or part of the expense of such course being borne by such municipality, department, or part thereof, or other not-for-profit corporation. Ten percent of all fees received for such courses shall be paid to the Office for administrative costs of program implementation.
- d. A certificate of completion shall be sent to the court by the Office upon completion of the program by all participants.
- e. The Commissioner shall, on or before September first, nineteen hundred ninety-two and on or before each September first thereafter, submit to the governor and the legislature a report on the operation and accomplishments of the program.

## **Vehicle and Traffic Law**

*Section 1192-a. Operating a vehicle after having consumed alcohol; under the age of 21; per se.*  
[Effective November 1, 1996, S5960, Chapter 196 of the laws of 1996]

No person under the age of 21 shall operate a motor vehicle after having consumed alcohol as defined in this section. For purposes of this section, a person under the age of 21 is deemed to have consumed alcohol only if such person has .02 of one per centum or more but not more than

.07 of one per centum by weight of alcohol in the person's blood, as shown by chemical analysis of such person's blood, breath, urine, or saliva, made pursuant to the provisions of section 1194 of this article.

*Section 1193. Suspensions.*

- a. Except as otherwise provided in this subdivision, a license shall be suspended and a registration may be suspended for:
  1. six months, where the holder has been found to have operated a motor vehicle after having consumed alcohol in violation of section 1192-a of this article where such person was under the age of 21 at the time of commission of such violation.
  2. one year or until the holder reaches the age of 21, whichever is the greater period of time, where the holder has been found to have operated a motor vehicle after having consumed alcohol in violation of section 1192-a of this article, and has previously been found to have operated a motor vehicle after having consumed alcohol in violation of section 1192-a of this article.

*Section 1194-a. Driving after having consumed alcohol; under the age of 21; procedure*

Every person under the age of 21 who is alleged to have operated a motor vehicle after having consumed alcohol as set forth in section 1192-a of this article, and who is not charged with violating any subdivision of section 1192 of this article arising out of the same incident, is entitled to a hearing before a hearing officer in accordance with the provisions of this section. Unless otherwise provided by law, the license or permit to drive or any nonresident operating privilege of such person shall not be suspended or revoked prior to the scheduled date for such hearing.

The hearing shall be limited to the following issues:

1. Did such person operate the motor vehicle?
2. Was a valid request to submit to a chemical test made by the police officer in accordance with the provisions of section 1194 of this article?
3. Was such person less than 21 years old at the time of operation of the motor vehicle?
4. Was the chemical test properly administered in accordance with the provisions of section 1194 of this article?
5. Did the test find that such person had driven after having consumed alcohol as defined in section 1192-a of this article?
6. Did the police officer make a lawful stop of such person?

The burden of proof shall be on the police officer to prove each of these issues by clear and convincing evidence.

If, after such hearing, the hearing officer, acting on behalf of the commissioner, finds all of the issues set forth in this subdivision in the affirmative, the hearing officer shall suspend or revoke the license or permit to drive or nonresident operating privilege of such person in accordance with the time periods set forth in subdivision two of Section 1193 of this article.

If, after such hearing, the hearing officer, acting on behalf of the commissioner, finds any of said issues in the negative, the hearing officer must find that the operator did not drive after having consumed alcohol.

## Appendix 4 ♦ CONFRONTATION GUIDELINES

### Conditions That Help The Confronter

- ♦ Care about the person
- ♦ Be nonjudgmental
- ♦ Be well-informed
- ♦ Be consistent
- ♦ Develop support
- ♦ Be positive
- ♦ Be confident
- ♦ Be a clear communicator
- ♦ Be open to further involvement with the person

### When confronting, you should:

- ♦ Be simple and direct, proceeding openly and smoothly. Rushed interpersonal encounters of any type usually are not conducive to increased awareness.
- ♦ Know the facts regarding the behavior you are confronting.
  - What conditions surround the observed behavior?
  - What relationship do you have with the person you are confronting?
  - How does that person see you?
- ♦ Be specific and clear in your confrontation.
- ♦ Confront behavior, not values. Selling your values as the appropriate way to behave probably will not work. Specify what behaviors are causing others a problem, such as damage, rowdiness, messiness, etc. Specify the behaviors you observe that *may* be contributing to issues at hand, such as personal isolation, disciplinary action, etc.
- ♦ At every available opportunity, communicate your interest in the person and ask him or her clarifying questions.
  - How do you view your current behavior?
  - How does this behavior help you?
  - How does this make things better/worse for you?
- ♦ Be aware and stay in control of your feelings. If you are angry, check to see if your anger is directed at the behavior or the person, and communicate the distinction. Identify feelings as feelings, rumors as rumors, and facts as facts.
- ♦ Focus on the person's strengths, but do not engage in an on-the-spot counseling session or personality buildup period.

- ◆ Confront behavior in a positive and constructive manner. Show the individual you are concerned with the positive elements of the situation. Collective responsibility is such an element and includes consideration of others.
- ◆ Make the confrontation objective about the specific observed behavior and subjective about your interest in the person.
- ◆ End the confrontation with an open invitation to talk.

*Remember:* Education, practice, and staff development all contribute to the effectiveness of the confronter.

## Appendix 5 ♦ EDITORIAL GUIDELINES

Presented here is the latest version of the Center for Substance Abuse Prevention's (CSAP) *Internal Editorial Guidelines*, which were revised to reflect the ever-changing field of substance abuse prevention. The rationale for each specific guideline is included. While CSAP is not suggesting that this terminology be utilized by the field as a whole when developing substance abuse materials, CSAP is pleased to share these *Guidelines* with anyone who may find them of interest.

CSAP welcomes comments at any time - please write to Director, Division of Public Information and Dissemination, Center for Substance Abuse Prevention, 5600 Fishers Lane, Rockwell II Building - Suite 800, Rockville, MD 20857.

CSAP has adopted the following editorial style when referring to those substances, both licit and illicit, within the scope of CSAP's mandate. Please note the limited exceptions to the general rules.

- ♦ "Substance abuse" is the *preferred term* to previously used terms such as "alcohol and other drugs" and "alcohol, tobacco, and other drugs." The rationale is that the term substance abuse is broadly understood to be inclusive of all substances of use/misuse/abuse with CSAP's mandate (e.g., alcohol, tobacco, marijuana, cocaine, heroin, PCP, steroids, designer drugs, inhalants, and psychoactive prescription and over-the-counter medications).

When there is a need to distinguish among the terms use, misuse, and abuse, the following definitions may be helpful: *use* is a nonjudgmental, descriptive term of consumption; *misuse* means harmful use of legal substances by persons of legal age; and *abuse* is any consumption of illicit drugs or underage use of legal substances such as tobacco and alcohol.

- ♦ To avoid redundancy, a *useful alternative* to "substance abuse" is "alcohol and drug abuse" or "drug abuse" (as applicable). However, where appropriate, the specific drug should be named, such as marijuana in CSAP's "Reality Check" campaign, or tobacco in the Synar Regulations. This may be especially important when referring to the consequences and/or correlates of substance abuse, such as violence, where, for example, tobacco use is not generally viewed as a risk factor for being a perpetrator or victim of violence.
- ♦ Where an organization's program is being cited, the actual name of the program should be used even if it appears inconsistent with these *Guidelines*. For example, an evaluation report on a program entitled "Mudville's Alcohol and Other Drugs Prevention Project" should use that title rather than modify it to "substance abuse." The same holds true for citations, references, and quotations. Nor should existing CSAP program titles, such as the National Clearinghouse for Alcohol and Drug Information, be changed. Further, these

*Editorial Guidelines* should not be used as a factor in judging the appropriateness of another organization's materials or to modify reference documents such as a thesaurus.

- ◆ Avoid using the terms “hard” or “soft” drugs because these terms imply that some drugs, such as marijuana, are not harmful. Or instance all illicit drugs are harmful, as are some prescription and over-the-counter drugs when misused.
- ◆ Because drug use should not be trivialized, avoid the term “recreational” use of drugs, which implies that drug-taking behavior is a harmless leisure-time activity. Further, the term “responsible use” should be avoided because there is some risk (health, social, and/or legal) associated with virtually all drug use, and wrongly suggests that individuals can control their use of addictive or dependency-producing substances.
- ◆ Use “injected drugs” or “injectable drugs” rather than “IV drugs” or “IV use.” The term “IV” has a distinctly medical connotation, so its use in this context may create confusion with medically-appropriate procedures. Further, “IV” excludes other (non-IV) injectable use.
- ◆ Avoid using derogatory terms such as “drunks,” “potheads,” “dope fiends,” or “drug addicts.” These expressions show a lack of respect and understanding for individuals with alcohol and drug problems, and may alienate policy-makers from the very people toward whom prevention and treatment efforts are aimed.
- ◆ Because many people do not associate beer and wine with having significant alcohol content, use the inclusive term “beer, wine, and/or other alcohol beverage” where appropriate to clarify the point. Whenever possible, attempt to be specific regarding the alcoholic beverage under discussion rather than using the terms “liquor” or “spirits” (which technically refer only to distilled spirits, not wine or beer) or derogatory terms such as “booze.”

## **Appendix 6 ♦ SUGGESTED GUIDELINES FOR TALKING TO STUDENTS ABOUT TRAUMATIC EVENTS**

The Steering Committee has found these guidelines helpful in the post 911 era.

1. If possible, engage students in a discussion of their reactions, pointing out some of the common experiences that they may mention. It is often helpful for people to just be with one another during times of crises. Saying the “right” words isn't the most important thing; feeling connected to people close to you is more important.
2. Realize that people may have intense or surprising emotional reactions, whether they personally know those involved or not. These reactions may include:
  - a. Numbing responses: shock, disbelief, a feeling of unreality, feeling nothing.
  - b. Intense emotional responses: crying, sadness, anxiety, fear, missing loved ones.
  - c. Physical needs being upset: loss of appetite, increase in appetite, feeling nauseous, insomnia, and inability to concentrate.
  - d. Irrational thoughts: fearing that the same event will happen to them, startling easily, worrying about safety of themselves or others, feeling haunted by media images.
3. Again, these responses are normal and to be expected. We can help by allowing people to identify and discharge all the questions, fears, and uncertainties going through their heads. It is important to recognize concerns rather than talk people out of them.
4. Encourage them to understand that they must take good care of themselves at this time.
  - a. Most importantly, talk to others. Call family, talk to friends, and talk to other university personnel.
  - b. Take care of basic needs. Eat, sleep, and try to stay in normal routines.
  - c. Do whatever healthy strategy they think of to make themselves comfortable.
5. Remember University resources.
  - a. Talk to professors, advisors, hall directors, hall ministers, administrators, and members of the University Ministry staff and the Jesuit community and so forth.
  - b. Seek professional help from the Counseling Center if symptoms persist and are interfering in normal functioning.
  - c. University Ministry staff, resident ministers and members of the Jesuit community are available for support and pastoral counseling during this difficult time.
  - d. Counseling Center and University Ministry staff are available to attend classes to speak with students. Please contact them through the Counseling Center and University Ministry.

Author unknown