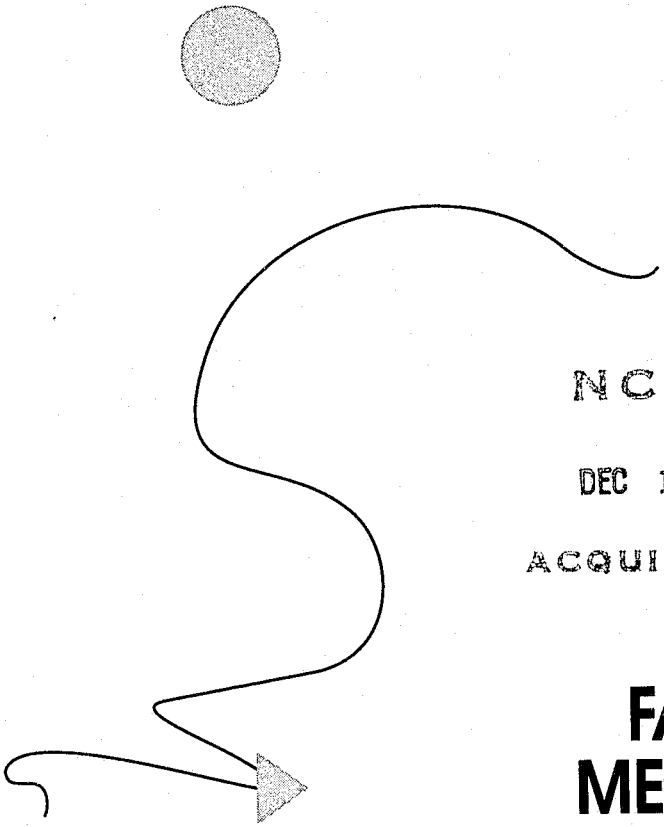
FACULTY MEMBER'S HANDBOOK



The College Series

FACULTY MEMBER'S HANDBOOK

Strategies for Preventing Alcohol and Other Drug Problems

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Public Health Service
Alcohol, Drug Abuse, and Mental Health Administration

Office for Substance Abuse Prevention
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INTRODUCTION

The *Faculty Member's Handbook* is part of the "College Series for the Prevention of Alcohol and Other Drug Problems in Higher Education." Developed by the Office for Substance Abuse Prevention (OSAP) of the Alcohol, Drug Abuse, and Mental Health Administration, Public Health Service, in the U.S. Department of Health and Human Services, with the assistance of the U.S. Departments of Education and Transportation, the American College Health Association, and representatives of higher education, the series seeks to help all segments of a campus become active in addressing a major health, safety, and educational problem facing colleges and universities today.

In addition to the *Faculty Member's Handbook*, other publications are available in the series: the *Program Administrator's Handbook* and a White Paper entitled *Alcohol Practices, Policies, and Potentials of American Colleges and Universities. A Prevention Resource Guide on College Youth* is also available from OSAP. For more information about college resources, contact the National Clearinghouse for Alcohol and Drug Information (NCADI), Department C, P.O. Box 2345, Rockville, MD 20852, 1-800-487-1447.

Overview of the *Faculty Member's Handbook*

The *Faculty Member's Handbook* is designed to involve faculty members on American college and university campuses in their campus' efforts to address alcohol and other drug (AOD) problems. This handbook is prepared to inform faculty members of the nature and extent of AOD concerns on the Nation's campuses and to enlist their involvement in responding to these concerns. Alcohol and other drug concerns are widespread, and the involvement and support of everyone in the campus community is important to addressing them.

The premise of this handbook is that *each individual can make a difference.* Whether the involved faculty member reaches numerous students through classroom activities or reaches one student who is becoming involved with alcohol and other drugs, he or she can play an influential role. Furthermore, the faculty member may help shape the campus environment so that individuals become influenced in a different way.

Why would a faculty member want to become involved in this issue more than in another social issue or cause? The answer to this may parallel the facts behind the recent declaration by the Surgeon General of U.S. Public Health Service that alcohol is the number one health problem on college campuses today; the fact is that alcohol is involved in most campus problems: property damage, attrition, academic nonperformance, physical violence, rape, human injury, and more. The AOD issue has widespread consequences and often contributes to many other problems. Furthermore, AOD use is destroying the human potential of many college students.

Why should a faculty member devote additional time and energy to the AOD issue? What are the incentives for becoming involved? In preparing this document, we recognized that the traditional collegiate reward systems may not fully recognize the additional effort involved in addressing this issue. Yet we believe that faculty members should consider becoming involved in this issue because of its inherent importance, its relationship to various other issues, and the relative ease of involvement.

Chapter 1, "The Scope of the Problem," gives the latest statistics and trends that depict what is happening on campuses today. It also describes Federal efforts to prevent AOD use. Chapter 2, "What Faculty Members Can Do," lists

eight specific actions that faculty members, regardless of their subject areas, can take to bring AOD issues into the classroom. Chapter 3, "When You Are Concerned About Someone You Know," contains information that faculty members will need to take action when a problem strikes close to their classrooms or homes. Chapter 4 summarizes key points made in this handbook, and the appendix contains information on different sources for policy statements about self-help groups and includes a series of tables and figures that reveal more about AOD problems on American campuses. This material depicts differences in use among males and females, the prevalence of binge drinking, alcohol use, cocaine use, and use of 12 other types of drugs.

Definition of Special Terms

Two terms are used throughout this handbook in a manner somewhat different from common usage. These terms are "colleges" and "students."

The term "colleges" is used to refer to all institutions of higher education to avoid excessive use of the phrase "colleges and universities." It denotes any institution that provides education to undergraduate, graduate, full-time, residential, or commuter students. The term "students" is defined in the next section.

Defining the Target Population: College Students

Faculty members and AOD prevention experts contributing to this handbook have noted that reaching college students with prevention messages is challenging. First, college students are not a homogeneous group. They comprise all racial, ethnic, and socioeconomic groups and come from all parts of the globe. They include undergraduate, graduate, full-time, part-time, residential, commuter, traditional (18 to 21 years old), and nontraditional (age 21 and older) students. These differences have implications for prevention strategies. Unless otherwise noted, traditional 18- to 21-year-old students are the targets of this handbook because of the 21 minimum age law. However, the ideas presented here apply to *all* students. The major difference is that the ultimate goal for students under age 21 is *no* use of alcohol or other drugs. For other students, the goal is low-risk consumption of alcohol and no use of illicit drugs; "low risk" means paying attention to physical issues, family background, pregnancy risk, legal considerations, safety concerns, health, and other personal issues. For example, pregnant women, alcoholics, youth under the age of 21, and people driving cars or operating other machinery should not drink alcohol.

A second challenge in targeting college students lies in the societal norms for this age group. Until recently, many college students aged 18 to 21 could legally purchase and possess alcoholic beverages. And even today there is a national social climate that views heavy drinking (and some illegal drug use) during the college years as a "rite of passage." Although lawmakers and other citizens are gradually learning the facts about the use of alcohol and other drugs by youth, it is not in time to prevent many lives from being lost. Even though the law now attempts to protect the lives and futures of students by making it illegal for them to buy or drink alcohol, freshmen can often obtain a false ID before attending orientation.

A third challenge stems from the lack of recreational activities and facilities available to students on many college campuses during the hours when they want to socialize. Students often drink and go to bars and parties because "everyone else does" or because they believe there is nothing else to do. Such drinking can have a myriad of negative consequences. Alcohol and other drug problems occur along a continuum. Alcoholism and other drug addiction are at one extreme; but long before most users become addicted, they experience one or more problems with finances, schoolwork, health, the law, emotions,

relationships, job performance, or injuries. Before a student reaches the late stage of alcoholism or other drug addiction, his or her problems may progress to the point of low grades, erratic class attendance, blackouts, chronic forgetfulness, hangovers, increasing AOD use, broken promises, damaged friendships, a dramatic change in physical appearance, a "driving while intoxicated" violation, an alcohol-related crash or fall, or a need for ever increasing sums of money. These problems may indicate that immediate attention is needed.

Even when it is too late to prevent AOD problems in a student's life and yet too early for a diagnosis of full-blown alcoholism or other drug addiction, the student needs help. If the earlier stages are recognized and confronted and the use is stopped, the student stands a better chance of leading a normal, healthy life.

Faculty members are in a powerful position to shape the lives of their students through education. Information can be presented to students in a learning atmosphere not normally available to prevention specialists. Faculty can serve as effective role models, showing students that a person can have a good time without consuming alcohol or using other drugs.

This handbook has been designed to help faculty members to make a positive difference in the lives of their students—and perhaps even save the lives of some. The AOD problem on campuses is that serious, and the influence of college faculty members can be that great.

Chapter One:

THE SCOPE OF THE PROBLEM

Overview

Students and other young adults in the United States are more involved with illicit drugs than are their counterparts in other industrialized nations.[1] They spend more on alcoholic beverages each year than they spend on textbooks. For the approximately 12 million college students in the United States, annual consumption of alcohol is more than 430 million gallons,[2] the equivalent of 3,500 Olympic-size pools or approximately 1 pool per campus.[3] These and other facts found in the OSAP White Paper, *Alcohol Practices, Policies, and Potentials of American Colleges and Universities*,[4] suggest that such use has serious consequences for colleges and universities:

Students dropping out of college. Over 7 percent of the Nation's freshmen will drop out of college for alcohol-related reasons,[5] and as a result, colleges will lose more than $261 million in tuition.[6]

Death. Of the college students currently enrolled in the United States, approximately the same number will eventually die from alcohol-related causes as will get master's degrees and doctorates combined.[7]

Lost productivity. College administrative staff responding to a 1988 survey estimated that approximately 34 percent of students' academic failures and 25 percent of attrition were related to alcohol use.[8] Also, a review of studies on college students' drinking showed that missing class or work was the most common indicator of problems.[9]

Decline in critical thinking. It appears that some loss of cognitive power accompanies the deleterious effects of AOD use on the central nervous system. For example, at one Missouri university, a student complained to a department head that certain questions on a midterm examination were "unfair." The student had no recollection of several lectures because she regularly smoked marijuana before going to class.[10] Researchers have found that chronic exposure to delta-9-tetrahydro-cannabinol (THC), the psychoactive ingredient in marijuana, damages and destroys nerve cells and causes other pathological changes in the brain.[11]

Injuries and other incidents. Administrators of approximately 200 colleges and universities estimated in a 1988 survey that, on the average, alcohol is involved in 68 percent of the violent behavior and 52 percent of the physical injuries on their campuses. Both numbers are significantly greater than the corresponding percentages found in responses to a 1985 survey. Moreover, some highly publicized incidents

have been cocaine induced, such as the death of college sports star Len Bias. Many other tragedies go unreported, such as the case of an alcohol-impaired Maryland student who drowned in a residence hall bathtub.[12]

A deadly tendency toward mixing two or more drugs. Alcohol often is an auxiliary drug for cocaine users who self-medicate with alcohol to relieve a psychological "crash" after a cocaine high.[13] Other polydrug users, such as a Kentucky student who succumbed to an alcohol and barbiturate combination, appear to be seeking extra sedation and not suicide, although thoughts of suicide apparently increase as drinking increases.[14]

When alcohol is the primary drug on campus, dual dependency is frequently reported by females, who are more likely than males to take a prescription drug. In a survey by Alcoholics Anonymous (AA), 45 percent of the female members of AA reported having been dependent on both alcohol and another drug, compared with 35 percent of the male members.[15]

Trends in Student Alcohol and Other Drug Use

Trend data can guide public discussion and provide a statistical basis for making critical policy decisions. The "Monitoring the Future" project, supported by the National Institute on Drug Abuse, is a systematic effort to track AOD use among American college students over a period of years.[16] The surveys included in this project are conducted by the University of Michigan's Institute for Social Research, which has been reporting AOD use among high school seniors annually since 1975. Included in this survey is a followup of a subsample of students who have graduated. Thus, data were gathered in 1990 on representative samples of the graduating classes of 1976 through 1990.

Some of the tables and a chart from the "Monitoring the Future" project are reprinted in the appendix of this handbook. A limited number of copies of the latest report, entitled *Illicit Drug Use, Drinking, and Smoking: National Survey Results from America's High School Students, College Students, and Young Adults Populations*, and a fact sheet summarizing the report are available from NCADI (P.O. Box 2345, Rockville, MD 20852).

In brief, the report shows that college students (1 to 4 years out of high school) report using drugs annually at about the same rate as their noncollege peers who are high school graduates[17] (Figures 1–4). There are some differences, however, beginning with alcohol:

- ✔ Although the purchase of alcohol is illegal for youth under 21 years of age, almost 90 percent of students have tried alcohol before entering college. Of most concern is that occasions of heavy drinking (five or more drinks in a row in the prior 2 weeks) are reported more frequently by college students (41 percent) than by high school seniors (32 percent) or their noncollege-aged peers (34 percent) (Figure 5).
- ✔ Male college students outnumber female college students in heavy drinking (56 percent versus 35 percent) (Figure 6).
- ✔ Unlike high school seniors, whose drinking indexes have declined at various rates since about 1980, college students show no real downward trend in alcohol consumption. Although daily drinking is reported to be slightly less among college students (3.8 percent in 1990) than among their noncollege peers (4.7 percent), the overall data raise questions about factors in the college environment itself that may encourage drinking, especially among males.

Trends in College Prevention Efforts

Efforts to address AOD-related problems in college settings increased in the 1980s. For alcohol alone, the contrast between 1979 and 1988 is revealed in a series of surveys of 330 college administrators, which indicated significant changes in institutional practices.[18] In 1979, for example, 54 percent of the responding colleges required that nonalcoholic beverages be provided at public functions where alcohol was served, compared with 92 percent in 1988.

A similar trend is noted concerning the presence of college prevention programs (up from 69 percent in 1979 to 97 percent in 1988), of a designated coordinator for alcohol education (up from 14 percent in 1979 to 60 percent in 1988), and of a task force or other group convened to focus on alcohol use (up from 37 percent in 1979 to 77 percent in 1988).

The results also show that 87 percent of college administrators reported prevention activities related specifically to drugs other than alcohol. Of the total number of respondents, 64 percent reported convening a task force or other group to focus on preventing other drug use.

Trends in the Federal Government

There is a definite Federal interest in preventing AOD problems on college campuses. College issues are top priorities for the Departments of Health and Human Services, Education, and Transportation. For example, OSAP convened a special "College Team" to study the needs and resources available to colleges. This team had representatives from the Departments of Education and Transportation, NCADI, and various associations and colleges.

As a result of the team's recommendations, OSAP initiated a public information and education effort entitled "Put on the Brakes: Take a Look at College Drinking." Launched in 1991 by the Surgeon General of the U.S. Public Health Service, Dr. Antonia Novello, in conjunction with spring break activities, this program calls for major national attention to be given to problems of alcohol consumption at colleges. Besides developing and distributing this publication series, OSAP has also conducted market research to learn college students' perceptions of the issues, has reviewed the literature and prevention resources available to colleges for data base input and public access, and will continue to send speakers to national conferences to call attention to the prevention needs of colleges.

OSAP also offers a service of special interest to faculty members through NCADI. OSAP's clearinghouse is the Federal resource for AOD information. It works with and through Regional Alcohol and Drug Awareness Resource (RADAR) network centers located in each State. Together, they form a national resource system containing the latest research results, popular press and scholarly journal articles, videotapes, prevention curricula, print materials, and program descriptions.

By accessing NCADI, faculty members can ask questions about any AOD-related issues, request printed materials, and order literature searches related to any aspect of the AOD field. They also can obtain the telephone number of their nearest RADAR network center. Most of the materials and services are free, giving faculty members a rich resource of teaching materials and research information.

The Department of Education operates two programs of special interest to faculty members: the Fund for the Improvement of Postsecondary Education (FIPSE) program, and the Network of Colleges and Universities Committed to the Elimination of Drug and Alcohol Abuse which has developed a set of standards which provide an outline of activities around which the campus can

develop an AOD prevention effort. (Please note, the standards of the Department of Education do not necessarily reflect the opinions or official policy of OSAP.)

The FIPSE program supports AOD education and prevention programs. To date, FIPSE has awarded 380 competitive grants, most of which have given 2 years of funding to institutional programs.[19] The Network of Colleges and Universities Committed to the Elimination of Drug and Alcohol Abuse was initiated in 1987. To date, it has enrolled 1,300 member colleges and has been endorsed by 18 related associations. For more information about it, write to Network Coordinator, Office of Educational Research and Improvement, U.S. Department of Education, Washington, DC 20208-5644, Attention: Network Information.[20]

The Department of Transportation's National Highway Traffic Safety Administration (NHTSA) has developed a resource manual entitled *A Winning Combination: An Alcohol, Other Drug, and Traffic Safety Handbook for College Campuses*. The target audience is campus AOD program coordinators. The manual has been sent to all college presidents, NHTSA regional offices, and many professionals in the field who are working at the college level. It also has been made available to participants through a workshop series entitled "Policies and Programs for the 1990s: A Team Approach to the Prevention of Alcohol, Other Drug, and Traffic Safety Problems in Higher Education." The workshop, jointly sponsored by NHTSA, OSAP, and the Department of Education, promotes planning, implementation, and evaluation of comprehensive collegiate prevention programs; a key ingredient is the bringing together of teams from various colleges to make a difference collectively.

Faculty members may write to NHTSA to receive resource publications on a variety of safety issues, including drinking and driving, safety belt use, and bicycle safety. Requests for transportation safety materials may be sent to NTS-21, NHTSA, 400 Seventh Street, SW, Washington, DC 20590. For information on the workshops, contact Health Promotion Resources, Minnesota Institute for Public Health, 509 University Avenue, St. Paul, MN 55103; 612-224-5121.

In the years ahead, it is expected that the Federal Government will increase its focus on prevention on college campuses as key issues are identified and more research is concluded. This is an encouraging time for faculty members concerned with AOD problems on their campuses. Already the college efforts and those of OSAP, the Department of Education, and NHTSA are gaining momentum and support in the public and private sectors, and additional initiatives are expected in the future.

Faculty members are in key positions to move prevention from the abstract into the concrete at the colleges where they serve. Chapter 2, "What Faculty Members Can Do," contains some suggestions for action.

Notes

1. Johnston, L.D., O'Malley, P.M., and Bachman, J.G. *Illicit Drug Use, Smoking, and Drinking by America's High School Students, College Students, and Young Adults, 1975–1987.* DHHS Pub. No. (ADM)89-1602. Rockville, MD: National Institute on Drug Abuse (NIDA), 1988. p. 14.

2. CSR, Incorporated, *Quick Facts,* Alcohol Epidemiological Data System, May 8, 1989.

3. Data are from the National Spa and Pool Institute and assume an Olympic-sized pool is 120,000 gallons, about six times the size of a residential swimming pool. The amount of alcohol consumed annually by college students would fill more than 20,000 residential swimming pools—more than the number in many States in the U.S.

4. Eigen, L.D., ed. *Alcohol Practices, Policies, and Potentials of American Colleges and Universities* for the Office for Substance Abuse Prevention, February 1991. Distributed by the National Clearinghouse for Alcohol and Drug Information, P.O. Box 2345, Rockville, MD 20852.

5. Eagle, E., and Schmidt, C. *Patterns and Trends for Dropping Out From Postsecondary Education; 1972, 1980, and 1982 High School Graduates,* National Center for Educational Statistics, January 1990.

6. This figure is very conservative, representing tuition loss only from alcohol-related freshman dropouts from among "traditional" students. Average tuition loss per student is $2,178 per year (*Current Funds, Revenues, and Expenditures of Higher Education, Fiscal Years 1980–1988,* National Center for Educational Statistics, 1991, forthcoming). Traditional freshman dropouts are over 120,000 per year, but total freshmen dropouts are as high as 155,000 per year (*Digest for Educational Statistics, 1991 Edition,* National Center for Educational Statistics, 1992, forthcoming).

7. The average U.S. alcohol-related mortality figures are between 1.9 and 3.1 percent, based on various estimates given by P. Van Natta et al., "The Hidden Influence of Alcohol on Mortality," *Alcohol Health & Research World,* 9:56–59, 1985. The advanced degrees are given by *Statistical Abstracts of the United States,* Table No. 267, U.S. Department of Commerce, 1989.

8. Anderson, D.S., and Gadaleto, A.F. *The College Alcohol Survey 1979–1988.* (Copies may be obtained from David Anderson, Ph.D., Center for Health Promotion, George Mason University, Fairfax, VA 22030.)

9. Saltz, R., and Elandt, D. College student drinking studies 1976–1985. *Contemporary Drug Problems* 13:117–159, 1986.

10. NIDA. Marijuana update. *NIDA Capsules,* May 1989. p. 2.

11. *Ibid.* p. 14.

12. NIDA. Cocaine use in America. *Prevention Networks,* April 1986. p. 7.

13. Burglass, M.E. Use of marijuana and alcohol by regular users of cocaine. In: Milkman, H.B., and Shaffer, H.J. (eds.). *Addictions: Multidisciplinary Perspectives and Treatments.* Lexington, MA: Lexington Books, 1985.

14. Snodgrass, G., and Wright, L. Alcohol and polydrug use among college undergraduates. *NASPA Journal* 21(2):26–35, 1983.

15. Cited in National Council on Alcoholism (NCA). "NCA Policy Statement: Women, Alcohol and Other Drugs." New York and Washington: NCA, April 1988.

16. Johnston, L.D., O'Malley, P.M., and Bachman, J.G. *Illicit Drug Use, Drinking, and Smoking, National Survey Results From America's High School Students, College Students, and Young Adults Populations,* 1975–1990. Rockville, MD: NIDA, 1991 (forthcoming).

17. *Ibid.* pp. 6–14.

18. Anderson and Gadaleto. *The College Alcohol Survey 1979–1988.*

19. Personal communication from Ron Bucknam, Fund for the Improvement of Post Secondary Education, U.S. Department of Education, October 1989.

20. "Standards of the Network of Colleges and Universities Committed to the Elimination of Drug and Alcohol Abuse." Unpublished statement last revised at the meeting of the planning committee of the network, 1990.

Chapter Two:

WHAT FACULTY MEMBERS CAN DO

Overview

Faculty members have a tremendous amount of influence regarding AOD issues. Typically, one thinks of direct contact with an individual when thinking of faculty involvement; this will be addressed in the next chapter. However, much of a faculty member's involvement can be indirect and can set the stage for long-term impact. In this chapter, we examine the campus environment and ways in which faculty members can help to reshape and redirect it.

To begin to understand, it helps to step back and look at *why* students become involved in a harmful way with alcohol or other drugs. When we do this, we see several general reasons. First, they become involved because their environment fosters, or at least tolerates, this behavior. Students typically believe that others are more involved with alcohol or other drugs than is actually the case. They are in a campus environment, which typically encourages high-use behavior. Second, students become harmfully involved because little effort is made to halt or interrupt this process. They start and continue in a pattern because there is no meaningful intervention to eliminate their behavior. Third, students become involved because they lack alternatives for socializing.

Strategies for Institutional Change

In chapter 1, we outlined some facts regarding student AOD use and pointed out many problems and concerns associated with it. This handbook is based on the notion that the status quo is neither necessary nor desirable. We believe campuses can become more positive learning environments.

To achieve this goal, some change in the overall campus environment must occur. Students on college campuses across the country typically are proud of the "partying" reputation ascribed to their campus. What is the value of such a designation? Similarly, what are the negative results of such an attribution?

Much has been written about how the environment shapes individual decisions and personal behavior. In this section, we review some strategies that faculty members can institute as part of their commitment to countering the AOD problem on campus.

First, we must understand that no single strategy can magically overcome AOD problems on the college campus. Just as national, State, and regional efforts call for a comprehensive initiative involving numerous offices and individuals, so too must the college initiative. There are eight specific ways for faculty to become involved:

1. **Initiate or support the development of a multifaceted prevention program of assessment, education, policy, and enforcement.** Planning a campuswide effort may begin with baseline measures of the local situation. First comes a well-organized assessment of knowledge, attitudes, and behavior of faculty, staff, and students. For this phase, guidance from professionals with expertise in AOD issues, as well as from those in research methodology, is recommended. A simultaneous activity, which can be accomplished by interviewing law enforcement personnel and health care professionals, is taking an inventory of the availability of alcohol and other drugs on campus and in the surrounding community. The project planners can learn where and how alcohol and other drugs are obtained, and can familiarize themselves with the local regulations limiting access to these substances.

   Secondly, public information and education efforts are extremely important in a campus program. For faculty development in health promotion and AOD education, for example, project leaders might

consider developing a roster of individuals who can contribute special knowledge and skills to the training component. This has been done in some institutional programs by conducting a special survey of faculty or of department heads who, presumably, can obtain information from their faculty members.

Finally, policy and enforcement set the tone for a campus program. The appendix provides a list of several excellent sources for campus policies and other campus efforts. In planning programs, ensure that alternative recreational activities *are* available for students *when* they socialize.

2. **Use serious situations as teachable moments.** On campuses where education and other prevention efforts include free discussion of AOD problems, teachable moments seem to multiply. On one day, a student may volunteer a personal account of recovering from dependence on a drug. On another day, a different student may initiate a class discussion on legalizing drugs. The class can learn much from such moments. Daily news reports on a local, State, or national level provide fertile ground for illustrations of various issues related to virtually any academic course. These illustrations may include legislation, a report of a tragedy, and even an overheard statement.

3. **Speak out boldly about alcohol and other drug problems and foster debate about AOD-related issues.** Faculty members have many opportunities—in classes, meetings with colleagues, and conferences with administrators—to make their views known and to recruit effective support. Speaking out is part of the process of normalizing campus attitudes regarding AOD problems. Faculty also can provoke debates about the role of the alcoholic beverage industry and discussions about how college students are a prime target.

4. **Incorporate alcohol and other drug issues into courses.** Educators across the country have found that an effective way to improve students' knowledge, attitudes, and behavior regarding alcohol and other drugs is through education itself.[1] Virtually every course in the curriculum can help to achieve this goal. This natural manner of offering AOD information during classes is especially helpful to students who do not recognize themselves or their friends as having any problems. Material that is presented in third-person language can be easily understood and used.

Ideally, the first courses to be targeted should be those required for graduation. If this is done, the task of evaluating the results will be easier and more interesting.

The AOD component in the syllabus for each course can be made to fit naturally. A variety of specific prevention topics faculty members use in teaching undergraduate courses has been developed. These issues, identified later in this chapter, suggest a wide range of possibilities.

These specific issues and other curricular integrations can be developed individually or discussed in faculty workshops and departmental planning sessions, depending on institutional practices. If a coordinated plan can be agreed upon, the same examples can be featured in different courses, each requiring its own skills. For example, the intoxication curve showing the rise and fall of the blood alcohol level after drinking can become a familiar figure and a useful tool in teaching quantitative thinking. It can be put to practical use in courses ranging from business (when drug-free workplace issues or employee insurance coverage is discussed) to political science (when drug-testing issues are explored).

5. **Develop specific courses or course projects on alcohol and other drug issues.** Outstanding instructors draw large enrollments for courses based on AOD topics or on topics with an AOD component. A sociology professor included an optional question on his final examination asking which part of the course was most valuable. Three-fourths of those who answered the question identified the prevention component as the most interesting.[2]

   Students today are very career oriented; they want to know how to make their college education pay. This phenomenon, which is not unique to the United States, allows for a systematic effort to address AOD problems in terms of potential career opportunities.

   In this context, the focus is not so much on prevention in the campus environment as on building a much-needed cadre of social service professionals and a corps of scientists researching AOD problems. One reason for long waiting lists at treatment centers is the shortage of counselors and health professionals in the AOD field. In addition, there is a shortage of primary care physicians trained in the prevention and treatment of AOD problems.

6. **Develop instruction for enhancing interpersonal and intrapersonal skills.** In health education in the United States, it has become traditional to teach interpersonal skills at precollege levels. Some existing courses in the college-level curriculum probably will provide instruction in, and thoughtful consideration of, decisionmaking skills, leadership, stress management, and effective social skills. Introductory psychology is a natural place to look for these topics. However, in the usual style of such a course, the instruction will be didactic, not experiential. Course components might need some redesigning to provide active learning experiences.

7. **Monitor personal language and examples.** Faculty members serve as major role models for students. Students gain "clues" from faculty members about what is normative behavior on the campus and perhaps for the general society. Questions the faculty member raises about social issues provide an example of sensitivity, and concerns expressed about decisions internal or external to the campus illustrate critical thinking.

   Personal language used with regard to AOD issues can also help shape the norms. For example, use of the phrase "alcohol and other drugs" rather than "alcohol and drugs" communicates the message that alcohol, too, is a drug. Another example is to discuss an "alcohol-related automobile crash" rather than an "alcohol-related automobile accident" to suggest that, if alcohol was involved, it was actually avoidable (and thus not an accident).

   Finally, care must be taken not to serve alcohol to underage students and to avoid situations in which underage drinking is occurring.

8. **Work with other people on campus and in the community to prevent alcohol and other drug problems.** Individual faculty members can be involved in prevention in a variety of ways other than teaching. They can:

   - ✔ Participate in training for administrators, faculty, and staff, contributing knowledge, attitudes, and skills related to AOD problems. Depending on one's expertise, one can be a learner, a teacher, or both.
   - ✔ Help implement the prevention program by taking an appropriate role. This activity ranges from serving as program coordinator to carrying out committee duties.

- ✔ Participate in planning and evaluating the program. The level of participation (e.g., designing the evaluation plan or analyzing its results) will depend on specific faculty expertise.
- ✔ Collaborate and cooperate in student-led projects (social or educational) that support the campus AOD prevention effort.
- ✔ Coordinate and cooperate with individual citizens, professionals, business people, volunteers, religious leaders, alumni, government officials, and others in the off-campus community.

Including Alcohol and Other Drug Issues in Academic Courses

Faculty members have reported numerous ways in which AOD issues can be incorporated into existing coursework. While some of these methods simply require the inclusion of an example, others provide opportunities for more extensive treatment, elaboration, or development.

- ✔ *Psychology.* Discuss and assign papers on alcohol and other drugs as mind-altering chemicals, examining how they affect the nervous system and disrupt behavior; on theories and studies about denial and other defense mechanisms and coping behaviors in the context of AOD use; on the effects of alcohol and marijuana on learning and memory; and on the effects of cocaine, heroin, phencyclidine (PCP), and other drugs on personality and emotional stability. (These topics are usually contained in one textbook chapter, but they can also be integrated with other course units.)

- ✔ *General biology.* Examine the botanical distribution and characteristics of plants and mushrooms that are used as drugs or are used to make drugs; the anatomical and physiological sites of action of alcohol and other drugs; and the biochemical changes induced by these agents.

- ✔ *General chemistry.* Examine the molecular structures of alcohol and other drugs and how these structures can be altered to produce new and more dangerous drugs (e.g., morphine changed into heroin, cocaine changed into crack, and alcohol mixtures distilled into more potent intoxicants).

- ✔ *Mathematics.* Calculate different measurement scales of the ethanol content in different drinks. At a more advanced level, calculate intoxication rates at different dose levels. In a statistics-oriented course, analyze the epidemiology of AOD use and assign problems for graphing, correlations, and inferential tests of significance.

- ✔ *English composition.* Assign story, essay, and discussion topics (e.g., how drinking might have handicapped the writing careers of Dylan Thomas, Edgar Allan Poe, and Ernest Hemingway).

- ✔ *Western civilization.* Discuss the history and sociology of fermented beverages, from ancient mythology through contemporary practice. For the United States, concentrate on cycles of use, and on legal or economic measures to control use and prevent abuse (e.g., of narcotics, cocaine, alcohol, and marijuana).

- ✔ *Political and social sciences.* Discuss where and how to take effective action against the spread of crack cocaine; the control of street gangs and other proposed solutions to drug-related problems; and the politics of regulatory, legal, and economic approaches to preventing and reducing AOD problems.
- ✔ *Introductory philosophy.* Conduct a Socratic dialogue on changes in others' lives that are brought about by one's own drinking or drug-taking behavior.
- ✔ *Marketing research.* Develop, conduct, and analyze a survey on knowledge, attitudes, and practices of students concerning alcohol and other drugs; discuss the legal and ethical issues related to marketing legal alcohol products to underage groups.
- ✔ *Business and society.* Discuss AOD issues—including drug testing—on personal, business, and professional levels.
- ✔ *Systems analysis and design.* Conduct a small group study of AOD problems in the workplace and of the benefits of employee assistance programs (EAPs).
- ✔ *Plant science.* Assign papers on how plants are used to produce illegal drugs and on the harmful effects of these drugs.
- ✔ *Speech.* Hold debates and have presentations on alcoholism, drug addiction, self-help groups, community action groups, impaired driving, treatment, prevention, intervention, perinatal addiction, fetal alcohol syndrome, AOD-related crime, alcohol advertising, the myth of the typical alcoholic or drug addict, or what students can do to reduce AOD problems.
- ✔ *Public relations.* Design a community coalition of concerned citizens and local businesspeople who want to fight AOD-impaired driving; develop a budget, time schedule, and strategy; and prepare news releases, media kits, backgrounders, and brochures.
- ✔ *Computer science.* Develop simulation packages of alcohol's effects on the body.
- ✔ *Economics.* Assign papers on the effects of an increase in taxes on alcoholic beverages.
- ✔ *Health education.* Design a communitywide prevention program.
- ✔ *Advertising or social marketing.* Conduct focus groups of students of various ages, residential settings, majors, and fraternity and sorority affiliations to develop a report on prevention on campus.

- ✔ *Communications.* Examine the advertising and marketing of alcoholic beverages targeted at youth, racial, and ethnic groups; develop ads depicting the consequences of alcohol consumption; and develop campaigns to promote campus programs.

- ✔ *Journalism.* Analyze media coverage of AOD issues, such as how trial reporters cover related stories and the ethical issues involved.

The point of providing this variety of topics relating to AOD issues is to illustrate how these issues can be included virtually anywhere in the academic curriculum. This listing is clearly not exhaustive; a teacher's personal experience will be most helpful in expanding it. However, this listing demonstrates that AOD issues need not be limited to the health curriculum or to the course on "Alcohol and Other Drug Issues."

Chapter 3 explores actions that faculty members can take when they are concerned about the use of alcohol or other drugs by colleagues, students, friends, family members, or even themselves. No one is immune from these problems. With the prevalence of AOD problems in the United States today, we all can benefit from knowing what to do when we are concerned about someone we know.

Notes

1. U.S. Department of Education, Office of Educational Research and Improvement. *Approaches to Drug Abuse Prevention in Colleges and Universities.* Pub. No. PIP89-857. Washington, DC: U.S. Department of Education, 1988.

2. Kelley Enright, citing the course taught by Bill Bailey at Indiana University.

Chapter Three:

WHEN YOU ARE CONCERNED ABOUT SOMEONE YOU KNOW

Overview

In chapter 2, we looked at various ways in which faculty members can be involved in improving the institution's overall environment. The rationale for including this was the belief that individual behavior (of students, for example) is influenced to a large extent by the environment. Problems that individuals have concerning their use of alcohol or other drugs do not just happen, they develop over time. Further, these problems are related to the environment on the campus. It is this campus environment that faculty members have an opportunity to help shape.

In this chapter, we turn to the individual. What should a faculty member *do* when concerned about a friend, a student, or a colleague? Overall, helping students and colleagues is the same as helping relatives or close friends. It is based on a human concern about them and about how they are involved with alcohol or other drugs.

It is important that faculty members not protect their friends, students, or colleagues from the consequences of AOD problems by making excuses for unusual absences from work, school, or family events; by lending them money; by overlooking drops in performance or in class participation; or by pretending not to notice strange behavior or symptoms. Covering up for people with AOD problems may help them avoid short-term crises, but it is harmful in the long run and can keep them from addressing the real issues and seeking solutions.

The main difference in college settings as compared with other environments is that faculty members must check with their administration and operate within institutional standards/procedures to ensure that the college and the individual are protected from legal liability. While legal action in such cases is rare, faculty members should clearly understand the position of the college on AOD issues. In addition, dealing with AOD problems can be tricky because there may also be a number of health and emotional issues involved. That is why faculty members must always seek advice and support from their administration in cases involving students or colleagues.

The Faculty Member's Unique Perspective

Like students' peers, faculty members interact with students on a weekly, sometimes daily, basis. They have a clear view of the symptoms and effects of AOD problems that some students, colleagues, and administrators may deny, minimize, or rationalize. The underlying motivation for denying such problems is avoidance—of the discomfort, pain, or effort needed to deal with the problem.

With a "hidden" problem situation—that is, one in which a student or staff member with AOD problems appears on the surface to function fairly well—the possibility of denial by administration, faculty, and students may be increased. One real-life example is a history professor in a small, private college. He has at least 15 years of tenure and is respected by his students as a teacher with high standards. His students work diligently for good grades in his courses. A few days out of each month, however, he calls in sick. Everyone knows that his sick spells are associated with binges of heavy drinking. Yet there is no evidence that either the college administration or the history department chairman intends to refer him for treatment or even to discuss this problem with him. As for his students, some see his drinking problem as a dashing and somewhat amiable quirk. The college has neither an EAP nor an AOD education and prevention program. The lack of such programs conveys a subtle but clear message to everyone on campus that excessive drinking bears no consequences and will be tolerated.

Indicators of an Alcohol or Other Drug Problem

There are indicators that can alert faculty members to a hidden AOD problem. Although the pressure of a single indicator is inconclusive, proving nothing by itself, it can suggest the possibility of an AOD-related problem. The important point for the faculty member is that a pattern of behaviors is found. What the faculty member sees are some clues that a problem may exist.

A summary of indicators follows. These are classified into five general categories: usage, physical, emotional, cognitive, and social.

Usage

- ✔ Indication of major impairment
- ✔ Denial of actual usage
- ✔ Reliance on AOD and tobacco for normal life functions
- ✔ Usage to stop withdrawal symptoms

Physical

- ✔ Observed abnormalities of skin, eyes, coordination, and speech
- ✔ Pattern of frequent physical illnesses
- ✔ Sleep disturbances
- ✔ Digestive disturbances
- ✔ Evidence of withdrawal
- ✔ Decreased concern about grooming and appearance
- ✔ Passing out

Emotional

- ✔ Use of AOD and tobacco to deal with emotions
- ✔ Guilt about actions during intoxication

- ✔ Reduced emotional control
- ✔ Dramatic mood swings
- ✔ Guilt about use
- ✔ Anxious reactions
- ✔ Self-abusive behavior

Cognitive

- ✔ Decreased attention and concentration spans
- ✔ Increased forgetfulness
- ✔ Decreased problem-solving skills
- ✔ Blackouts (total memory loss for a period of time)
- ✔ Poor judgment and decisions
- ✔ Lowered academic performance

Social

- ✔ Family and other relationship difficulties
- ✔ Financial problems
- ✔ Legal problems
- ✔ Friends who are regular users of AOD and tobacco
- ✔ Decreased leisure time activities and interests
- ✔ Poor work record/performance
- ✔ Missed classes
- ✔ Fighting and/or physical aggression
- ✔ Personality change
- ✔ Offensive behavior or interference with the rights of others

Some specific behaviors that are common among college students are the following:

Ignoring or excusing behavior associated with alcohol and other drug problems. One example, traffic violations and motor vehicle crashes, frequently is related to drinking problems and is the leading cause of death and spinal cord injury among youth and young adults between 15 and 24 years of age. Without jumping to conclusions, faculty members can listen with discernment to such explanations as "I didn't see the light change" or "That car came out of a side street all of a sudden."

Acting irresponsibly. Less dramatic indicators include skipping class frequently, staying away from discussions, and being consistently late in handing in assignments.

Maintaining that there is no problem. This attitude usually comes as a response to a perceived challenge. A direct challenge, because it virtually invites denial, is an inept way to learn about problems with alcohol and other drugs. Even without confrontation, people may call attention to their symptoms, attributing them to a "bug," the weather, or an allergy. In this way, they deny the real cause (alcohol or other drugs) and, at the same time, seem to be offering a clue that a problem exists.

Making light of problems. This approach is somewhat different from ignoring or excusing problems because AOD use is partially acknowledged. But through the use of humor, such use is treated as temporary or as having no significance.

These indicators provide some guidance for the faculty member who is concerned about someone. With awareness of some of these indicators, the faculty member can then decide what action to take. Again, these indicators provide some guidance that something may be causing a problem with the individual. It *may* be the developing harmful involvement with alcohol or other drugs, or it *may* be some other issue or problem. In any event, the faculty member then considers *what to do* and *how to do it.*

Responding to an Alcohol or Other Drug Problem

At this point, the faculty member has decided that something needs to be done. The faculty member also knows that the earlier the individual of concern is dealt with, the better off she or he is.

What we are talking about here is the faculty member making a response to the individual—having a conversation with him or her to express both awareness of the individual's behavior and the faculty member's concern about it.

Some basic steps guide this discussion:

1. Choose a time and a place when the individual is most receptive. This includes when the individual is not under the influence of alcohol or other drugs. It should be in a private setting.

2. Tell the person why you are talking with him or her. This is a statement of concern and caring. Let the person know how you feel about him or her overall and that you care.

3. Describe the behavior you have seen; be specific as to the time and place and the behavior you saw.

4. Express your concern with this behavior. What consequences, if any, will occur if it continues?

5. Outline what you would like to see done. What change in behavior would you like to see?

During this discussion, do not expect an immediate admission and a genuine resolution to change. If such a statement is voiced, it may be simply to end the conversation. If an individual is becoming involved in a problematic way, denial will be high.

Also, do not assume that you make an immediate difference. Many times, it takes a variety of people responding to the problematic behavior of others on a continuous, repetitive basis. Most of the time, those intervening lay the foundation for a later person to have the ultimate impact.

Think about what you want as a result. Ultimately, this is the halting of the problematic behavior of concern, the reduction of the harmful involvement with alcohol or other drugs.

One additional way in which the faculty member can be involved is to empower other people to intervene. A faculty member who is concerned does not need to make the actual contact. The concern can be expressed through another person. The faculty member may realize that she or he may not be the best person to talk with the student of concern; in this case, someone else may be contacted to intervene with this student.

Finally, it helps to consider some other resources and personnel who would be helpful. These follow in the next section.

Resources for Help

Some potential allies in devising the most effective strategy are listed below.

Professional counselors. Such expertise is not always available, but a hospital, a clinic, or a community agency would show where to find the appropriate facilities and personnel. Also, the campus health service or the student counseling center could provide a counselor. If the institution has an EAP, as many do, this is a logical place to begin.

If an EAP is not available, the local telephone directory should provide names of hospital centers or community agencies that work with individuals who have AOD problems. If all else fails, the listings under "Alcohol" or "Drugs" in the Yellow Pages should describe services that will help suggest the next step to take.

Religious leaders. A minister, priest, or rabbi can be a source of information and referral regarding treatment and individual or family counseling. Many religious leaders are skilled and experienced counselors. Several religious organizations sponsor and operate treatment facilities as well.

Support groups. Almost every community has a wide range of treatment and counseling programs, and some have special programs for adult children of alcoholics. People close to those with AOD problems can benefit from outside help, whether or not the person addicted to alcohol or other drugs agrees to seek treatment. Also, people who have experienced similar problems can be among the best sources for referrals, advice, and moral support. Alcoholics Anonymous (AA), the pioneer support group in this field, created the basic model used by other groups; AA and other major support groups may be available locally. A full description of these groups is located in the appendix of this handbook.

Support groups are usually an adjunct to formal treatment, and millions of recovering people who are enjoying their lives free of alcohol and other drugs are these groups' best advertisements. Almost every community has support groups, which are free of charge, existing on donations alone. These groups are a valuable resource for faculty members.

Chapter Four:

SUMMARY

The AOD problem on campuses is tremendous, with U.S. students more involved with illicit drugs than their counterparts in other industrialized nations. Besides the ramifications for health, safety, and learning, there are serious legal implications for colleges, some of which have been held responsible for AOD-related injuries in lawsuits. Alcohol and cocaine currently appear to be the most serious threats on campuses. Because other drugs also are prevalent, however, faculty should address a wide array of drugs in their educational efforts.

Alcohol and other drug problems are threatening to destroy generations of students—the same students who sit in college classrooms around the country. These students are confronted by the following problems:

- ✔ alcoholism;
- ✔ drug addiction or related problems, including death;
- ✔ increased risk of acquired immunodeficiency syndrome or other sexually transmitted diseases due to possible AOD-impaired judgment that may lead to poor sexual choices or intravenous drug use with shared needles;
- ✔ impaired-driving crashes that often result in injury or death;
- ✔ untreated emotional damage from AOD problems of family members;
- ✔ AOD-related birth defects;
- ✔ date and acquaintance rape or assault;
- ✔ trauma, including falls, fires, and drowning;
- ✔ violence or other crimes;
- ✔ fatal overdoses occurring from illegal drug use, drinking games, club initiations involving heavy ingestion of alcohol, or mixing alcohol and other drugs; and
- ✔ lost potential as an individual and as a contributing member of society.

Faculty members across the country have successfully undertaken eight courses of preventive action:

1. Initiate or support the development of a multifaceted campus program of assessment, education, policy, and enforcement.

2. Use serious situations as teachable moments.

3. Speak out boldly about AOD problems and foster debate about AOD-related issues.

4. Incorporate AOD information into courses.

5. Develop specific courses or course projects on AOD issues.

6. Develop instruction for enhancing interpersonal and intrapersonal skills.

7. Monitor personal language and examples.

8. Work with other people on the campus and in the community to prevent AOD problems.

Alcohol and other drug problems are widespread on U.S. campuses. These problems may seem intimidating, especially to faculty members who work on a campus whose administration is not ready to address the problems fully. *However, one faculty member can make a tremendous difference.* This is the major point of this handbook. Each faculty member can become involved in helping shape the campus environment and in responding to individuals who are becoming harmfully involved with alcohol or other drugs. Whether the faculty member is the one who makes the noticeable impact or the one who lays the groundwork for others to have the noticeable impact, the value of becoming involved is important.

Below is an allegorical example illustrating how one faculty member can make a difference.

The Starfish Man

One morning at dawn, a young boy went for a walk on the beach. Up ahead, he noticed an old man stooping down to pick up starfish and fling them into the sea. Finally, catching up with the old man, the boy asked him what he was doing. The old man answered that the stranded starfish would die unless they were returned to the water. "But the beach goes on for miles, and there are millions of starfish," protested the boy. "How can what you're doing make any difference?" The old man looked at the starfish in his hand and then threw it to safety in the waves. "It makes a difference to this one," he said.

Faculty members are respected authority figures whose voices are heard by their students, colleagues, and administrators and by the surrounding community. Their prevention efforts can empower students burdened with AOD problems to find safety and freedom.

Appendix

Sources of Policy Statements

Alcohol and Other Drugs in the College or University Setting

The Network of Colleges and Universities Committed to the Elimination of Drug and Alcohol Abuse

The Network has developed a set of standards which provide an outline of activities around which the campuswide effort may develop. Colleges and universities may become members of the Network by stating that they are attempting to meet these standards. Specific initiatives and activities are incorporated within the four areas of Policy, Education, Enforcement, and Assessment.

Contact: Network Coordinator
Office of Educational Research and Improvement
U.S. Department of Education
444 New Jersey Avenue, NW
Washington, DC 20208
202-219-2106

American College Personnel Association

The American College Personnel Association (ACPA) sponsored a taskforce on alcohol and other drug issues. This group prepared a document of *Guidelines for a Comprehensive Institutional Response to Alcohol and Other Drug Problems.* Included in this document are four elements: (a) Developing a Comprehensive Program; (b) What Individuals, Groups/Departments, and Institutions Can Do To Help Prevent and Reduce Alcohol and Other Drug Problems; (c) Planning Constituencies; (d) Examples of Efforts. Specific efforts include education, curriculum, policy, prevention, intervention, treatment, referral, role model, networking, needs assessment, evaluation and research, community cooperation, alternative activities, and law enforcement.

Contact: Chairperson, ACPA Commission on Alcohol and
Other Drugs Counseling Center
Central Michigan University
Mt. Pleasant, MI 48859
517-774-3381

American Council on Education

The American Council on Education convened an ad hoc advisory committee on alcohol and other drugs and prepared a resource document *Alcohol and Other Substance Abuse: Resources for Institutional Action.* This document contains the Network standards, a synopsis of liability issues, resources, and a conceptual framework for collegiate efforts. This framework includes (a) Assessing and Managing the Environment; (b) Comprehensive Policies and Procedures; (c) Education and Training Programs; and (d) Rehabilitation and Treatment Programs.

Contact: Office on Self-Regulation Initiatives
American Council on Education
One Dupont Circle, NW
Washington, DC 20036
202-939-9355

American College Health Association

The American College Health Association prepared a document entitled *Recommended Standards: Alcohol and Other Drug Use, Misuse and Dependency.* This addresses the roles that collegiate student services and the student health service should play. Included in this document are discussions of General Approach, Mission of College Health Program, Professional Competence, Administrative/Professional Standards, Organization and Administration, and Human Resources. Specific recommendations for alcohol and other drug programs include (a) Primary Prevention—preventing the occurrence of a problem; (b) Secondary Prevention—reversing, halting, or retarding a problem; and (c) Tertiary Prevention—minimizing the effects of disease on disability.

Contact: Task Force on Alcohol and Other Drugs
American College Health Association
1300 Piccard Drive, #200
Rockville, MD 20850
301-963-1100

Description of Self-Help Groups

Families Anonymous (FA)
P.O. Box 528
Van Nuys, CA 91408
818-989-7841
Founded: 1971
Local groups: 475
For: Parents, relatives, and friends concerned about drug problems

FA is a self-supportive, self-help group patterned after Al-Anon Family Group Headquarters and Alcoholics Anonymous World Services programs. Assists families in overcoming overprotectiveness of drug abusers and in developing a better understanding of their problems, thereby improving interfamily relationships. Aids in establishing community meetings; makes referrals to other agencies. Telecommunications services: Hotline.

Women for Sobriety
P.O. Box 618
Quakertown, PA 18951
215-536-8026
Founded: 1975
Members: 5,000
Local groups: 450
For: Women alcoholics

This program is "based on abstinence, comprised of 13 acceptance statements that, when accepted and used, will provide each woman with a new way of life through a new way of thinking, starts with coping first but then moves on to overcoming and a whole change in the approach to each day." Recognizes differences between male and female alcoholics in the method of successful recovery. Small groups organize and meet independently. Maintains speakers' bureau; conducts seminars and workshops.

Cocaine Anonymous World Services
3740 Overland Ave., Ste. G
Los Angeles, CA 90034
213-559-5833
Founded: 1982
For: Cocaine users

Fellowship of men and women who share their experience, strength, and hope with one another so that they may solve their common problem, help others recover from addiction, and remain free from cocaine and all other mind-altering drugs. Applies the Alcoholics Anonymous World Services' 12-step approach to persons addicted to cocaine.

Narcotics Anonymous
P.O. Box 9999
Van Nuys, CA 91409
818-780-3951
Founded: 1953
Local groups: 14,000
For: Recovering drug addicts

Recovering addicts throughout the world who offer help to others seeking recovery. Members meet regularly to facilitate and stabilize their recovery. Uses the 12-step program of Alcoholics Anonymous World Services to aid in rehabilitation.

Alcoholics Anonymous World Services
P.O. Box 459, Grand Central Station
New York, NY 10163
212-686-1100
Founded: 1935
Members: 1,735,000
Local groups: 85,270
For: Alcoholics

International fellowship of men and women who share their experience, strength, and hope with one another so that they may solve their common problem and help others recover from alcoholism and achieve sobriety. Alcoholics Anonymous is not allied with any sect, denomination, political organization, or institution; does not engage in any controversy; and neither endorses nor opposes any causes. Is self-supported through members' contributions. Telecommunications services: FAX (212) 576-8497.

Al-Anon Family Group Headquarters
P.O. Box 182, Madison Square Station
New York, NY 10159
212-302-7240
For: Parents, relatives, and friends of an alcoholic

A fellowship of men and women who are making an effort to achieve a comfortable way of living by sharing their experience, strength, and hope with one another. Members meet informally to discuss how their attitudes and reactions to the disease of alcoholism may be aggravating their situations. The Al-Anon program is based on the 12 steps of Alcoholics Anonymous and offers both men and women a way to find serenity and build self-confidence.

Adult Children Anonymous (ACA)
P.O. Box 182, Madison Square Station
New York, NY 10159
800-344-2666
For: Adults whose parents or grandparents are/were alcoholics

A fellowship of men and women who wish to heal themselves and become aware of self-destructive patterns through sharing their experience, strength, and hope with one another. ACA does not wish to blame but rather wishes to understand the family disease concept. Participants become free to grow and accept responsibility for their own lives. ACA is not allied with any sect, denomination, political organization, or institution; does not engage in any controversy; and neither endorses nor opposes any cause. ACA's primary purpose is to help others heal themselves through the process of self-discovery. The 12 steps and 12 traditions of ACA enable participants to come out of denial, free themselves from the shame and pain of the past, and learn to live full lives.

Tables and Figures

Table 1. Trends in Lifetime[a] Prevalence of 14 Types of Drugs Among College Students 1–4 Years Beyond High School

	Percent who used in lifetime										
	1980	1981	1982	1983	1984	1985	1986	1987	1988	1989	1990
Approx. Wtd. N =	(1040)	(1130)	(1150)	(1170)	(1110)	(1080)	(1190)	(1220)	(1310)	(1300)	(1400)
Alcohol	94.3	95.2	95.2	95.0	94.2	95.3	94.9	94.1	94.9	93.7	93.1
Any illicit drug[b]	69.4	66.8	64.6	66.9	62.7	65.2	61.8	60.0	58.4	55.6	54.0
Any illicit drug[b] other than marijuana	42.2	41.3	39.6	41.7	38.6	40.0	37.5	35.7	33.4	30.5	28.4
Marijuana	65.0	63.3	60.5	63.1	59.0	60.6	57.9	55.8	54.3	51.3	49.1
Inhalants[c]	10.2	8.8	10.6	11.0	10.4	10.6	11.0	13.2	12.6	15.0	13.9
Hallucinogens	15.0	12.0	15.0	12.2	12.9	11.4	11.2	10.9	10.2	10.7	11.2
LSD	10.3	8.5	11.5	8.8	9.4	7.4	7.7	8.0	7.5	7.8	9.1
Cocaine	22.0	21.5	22.4	23.1	21.7	22.9	23.3	20.6	15.8	14.6	11.4
Crack[d]	NA	NA	NA	NA	NA	NA	NA	3.3	3.4	2.4	1.4
MDMA ("Ecstasy")[e]	NA	NA	NA	NA	NA	NA	NA	NA	NA	3.8	3.9
Heroin	0.9	0.6	0.5	0.3	0.5	0.4	0.4	0.6	0.3	0.7	0.3
Other opiates[f]	8.9	8.3	8.1	8.4	8.9	6.3	8.8	7.6	6.3	7.6	6.8
Stimulants[f]	29.5	29.4	NA	NA	NA	NA	NA	NA	NA	NA	NA
Stimulants, adjusted[f,g]	NA	NA	30.1	27.8	27.8	25.4	22.3	19.8	17.7	14.6	13.2
Crystal methamphetamine[h]	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	1.0
Sedatives[f]	13.7	14.2	14.1	12.2	10.8	9.3	8.0	6.1	4.7	4.1	NA
Barbiturates[f]	8.1	7.8	8.2	6.6	6.4	4.9	5.4	3.5	3.6	3.2	3.8
Methaqualone[f]	10.3	10.4	11.1	9.2	9.0	7.2	5.8	4.1	2.2	2.4	NA
Tranquilizers[f]	15.2	11.4	11.7	10.8	10.8	9.8	10.7	8.7	8.0	8.0	7.1

Source: Johnston, L.D. "Illicit Drug Use, Drinking and Smoking: National Survey Results from America's High School Students, College Students and Young Adults Populations, 1975–1991," Rockville, MD: NIDA, 1991, forthcoming.

NOTES: Level of significance of difference between the two most recent years: s = .05, ss = .01, sss = .001.
NA indicates data not available.

[a] Data are uncorrected for cross-time inconsistencies in the answers.

[b] Use of "any illicit drug" includes any use of marijuana, hallucinogens, cocaine, and heroin, or any use of other opiates, stimulants, barbiturates, methaqualone (until 1990), or tranquilizers not under a doctor's orders.

[c] This drug was asked about in four of the five questionnaire forms in 1980–89, and in five of the six questionnaire forms in 1990.

[d] This drug was asked about in two of the five questionnaire forms in 1987–89, and in all six questionnaire forms in 1990.

[e] This drug was asked about in two of the five questionnaire forms in 1989, and in two of the six questionnaire forms in 1990.

[f] Only drug use that was not under a doctor's orders is included here.

[g] Based on the data from the revised question, which attempts to exclude the inappropriate reporting of nonprescription stimulants.

[h] This drug was asked about in two of the six questionnaire forms. N is two-sixths of N indicated.

Table 2. Trends in Annual Prevalence of 14 Types of Drugs Among College Students 1–4 Years Beyond High School

	Percent who used in last 12 months										
	1980	1981	1982	1983	1984	1985	1986	1987	1988	1989	1990
Approx. Wtd. N =	(1040)	(1130)	(1150)	(1170)	(1110)	(1080)	(1190)	(1220)	(1310)	(1300)	(1400)
Alcohol	90.5	92.5	92.2	91.6	90.0	92.0	91.5	90.9	89.6	89.6	89.0
Cigarettes	36.2	37.6	34.3	36.1	33.2	35.0	35.3	38.0	36.6	34.2	35.5
Any illicit drug[a]	56.2	55.0	49.5	49.8	45.1	46.3	45.0	40.1	37.4	36.7	33.3
Any illicit drug[a] other than marijuana	32.3	31.7	29.9	29.9	27.2	26.7	25.0	21.3	19.2	16.4	15.2
Marijuana	51.2	51.3	44.7	45.2	40.7	41.7	40.9	37.0	34.6	33.6	29.4
Inhalants[b]	3.0	2.5	2.5	2.8	2.4	3.1	3.9	3.7	4.1	3.7	3.9
Hallucinogens	8.5	7.0	8.7	6.5	6.2	5.0	6.0	5.9	5.3	5.1	5.4
LSD	6.0	4.6	6.3	4.3	3.7	2.2	3.9	4.0	3.6	3.4	4.3
Cocaine	16.8	16.0	17.2	17.3	16.3	17.3	17.1	13.7	10.0	8.2	5.6
Crack[c]	NA	NA	NA	NA	NA	NA	1.3	2.0	1.4	1.5	0.6
MDMA ("Ecstasy")[d]	NA	NA	NA	NA	NA	NA	NA	NA	NA	2.3	2.3
Heroin	0.4	0.2	0.1	0.0	0.1	0.2	0.1	0.2	0.2	0.1	0.1
Other opiates[e]	5.1	4.3	3.8	3.8	3.8	2.4	4.0	3.1	3.1	3.2	2.9
Stimulants[e]	22.4	22.2	NA	NA	NA	NA	NA	NA	NA	NA	NA
Stimulants, adjusted[e,f]	NA	NA	21.1	17.3	15.7	11.9	10.3	7.2	6.2	4.6	4.5
Crystal methamphetamine[g]	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	0.1
Sedatives[e]	8.3	8.0	8.0	4.5	3.5	2.5	2.6	1.7	1.5	1.0	NA
Barbiturates[e]	2.9	2.8	3.2	2.2	1.9	1.3	2.0	1.2	1.1	1.0	1.4
Methaqualone[e]	7.2	6.5	6.6	3.1	2.5	1.4	1.2	0.8	0.5	0.2	NA
Tranquilizers[e]	6.9	4.8	4.7	4.6	3.5	3.6	4.4	3.8	3.1	2.6	3.0

Source: Johnston, L.D. "Illicit Drug Use, Drinking and Smoking: National Survey Results from America's High School Students, College Students and Young Adults Populations, 1975–1991," Rockville, MD: NIDA, 1991, forthcoming.

NOTES: Level of significance of difference between the two most recent years: s = .05, ss = .01, sss = .001.
NA indicates data not available.

[a] Use of "any illicit drug" includes any use of marijuana, hallucinogens, cocaine, and heroin, or any use of other opiates, stimulants, barbiturates, methaqualone (until 1990), or tranquilizers not under a doctor's orders.

[b] This drug was asked about in four of the five questionnaire forms in 1980–89, and in five of the six questionnaire forms in 1990.

[c] This drug was asked about in one of the five questionnaire forms in 1986, in two of the five questionnaire forms in 1987–89, and in all six questionnaire forms in 1990.

[d] This drug was asked about in two of the five questionnaire forms in 1989, and in two of the six questionnaire forms in 1990.

[e] Only drug use that was not under a doctor's orders is included here.

[f] Based on the data from the revised question, which attempts to exclude the inappropriate reporting of nonprescription stimulants.

[g] This drug was asked about in two of the six questionnaire forms. N is two-sixths of N indicated.

Table 3. Trends in 30-Day Prevalence of 14 Types of Drugs Among College Students 1–4 Years Beyond High School

	Percent who used in last 30 days										
	1980	1981	1982	1983	1984	1985	1986	1987	1988	1989	1990
Approx. Wtd. N =	(1040)	(1130)	(1150)	(1170)	(1110)	(1080)	(1190)	(1220)	(1310)	(1300)	(1400)
Alcohol	81.8	81.9	82.8	80.3	79.1	80.3	79.7	78.4	77.0	76.2	74.5
Any illicit drug[a]	38.4	37.6	31.3	29.3	27.0	26.1	25.9	22.4	18.5	18.2	15.2
Any illicit drug[a] other than marijuana	20.7	18.6	17.1	13.9	13.8	11.8	11.6	8.8	8.5	6.9	4.4
Marijuana	34.0	33.2	26.8	26.2	23.0	23.6	22.3	20.3	16.8	16.3	14.0
Inhalants[b]	1.5	0.9	0.8	0.7	0.7	1.0	1.1	0.9	1.3	0.8	1.0
Hallucinogens	2.7	2.3	2.6	1.8	1.8	1.3	2.2	2.0	1.7	2.3	1.4
LSD	1.4	1.4	1.7	0.9	0.8	0.7	1.4	1.4	1.1	1.4	1.1
Cocaine	6.9	7.3	7.9	6.5	7.8	6.9	7.0	4.6	4.2	2.8	1.2
Crack[c]	NA	NA	NA	NA	NA	NA	NA	0.4	0.5	0.2	0.1
MDMA ("Ecstasy")[d]	NA	NA	NA	NA	NA	NA	NA	NA	NA	0.3	0.6
Heroin	0.3	0.0	0.0	0.0	0.0	0.0	0.0	0.1	0.1	0.1	0.0
Other opiates[e]	1.8	1.1	0.9	1.1	1.4	0.7	0.6	0.8	0.8	0.7	0.5
Stimulants[e]	13.4	12.3	NA	NA	NA	NA	NA	NA	NA	NA	NA
Stimulants, adjusted[e,f]	NA	NA	9.9	7.0	5.5	4.2	3.7	2.3	1.8	1.3	1.4
Crystal methamphetamine[g]	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	0.0
Sedatives[e]	3.8	3.4	2.5	1.1	1.0	0.7	0.6	0.6	0.6	0.2	NA
Barbiturates[e]	0.9	0.8	1.0	0.5	0.7	0.4	0.6	0.6	0.5	0.2	0.2
Methaqualone[e]	3.1	3.0	1.9	0.7	0.5	0.3	0.1	0.2	0.1	0.0	NA
Tranquilizers[e]	2.0	1.4	1.4	1.2	1.1	1.4	1.9	1.0	1.1	0.8	0.5
Cigarettes	25.8	25.9	24.4	24.7	21.5	22.4	22.4	24.0	22.6	21.1	21.5

Source: Johnston, L.D. "Illicit Drug Use, Drinking and Smoking: National Survey Results from America's High School Students, College Students and Young Adults Populations, 1975–1991," Rockville, MD: NIDA, 1991, forthcoming.

NOTES: Level of significance of difference between the two most recent years: s = .05, ss = .01, sss = .001.
NA indicates data not available.

[a] Use of "any illicit drug" includes any use of marijuana, hallucinogens, cocaine, and heroin, or any use of other opiates, stimulants, barbiturates, methaqualone (until 1990), or tranquilizers not under a doctor's orders.

[b] This question was asked in four of the five questionnaire forms in 1980–89, and in five of the six questionnaire forms in 1990.

[c] This question was asked in two of the five questionnaire forms in 1987–89, and in all six questionnaire forms in 1990.

[d] This drug was asked about in two of the five questionnaire forms in 1989, and in two of the six questionnaire forms in 1990.

[e] Only drug use that was not under a doctor's orders is included here.

[f] Based on the data from the revised question, which attempts to exclude the inappropriate reporting of nonprescription stimulants.

[g] This drug was asked about in two of the six questionnaire forms. N is two-sixths of N indicated.

Table 4. Trends in 30-Day Prevalence of *Daily* Use for Marijuana, Cocaine, Stimulants, Alcohol, and Cigarettes Among College Students 1–4 Years Beyond High School

Percent who used daily in last 30 days

	1980	1981	1982	1983	1984	1985	1986	1987	1988	1989	1990
Approx. Wtd. N =	(1040)	(1130)	(1150)	(1170)	(1110)	(1080)	(1190)	(1220)	(1310)	(1300)	(1400)
Alcohol											
Daily	6.5	5.5	6.1	6.1	6.6	5.0	4.6	6.0	4.9	4.0	3.8
5+ drinks in a row in last 2 weeks	43.9	43.6	44.0	43.1	45.4	44.6	45.0	42.8	43.2	41.7	41.0
Marijuana	7.2	5.6	4.2	3.8	3.6	3.1	2.1	2.3	1.8	2.6	1.7
Cocaine	0.2	0.0	0.3	0.1	0.4	0.1	0.1	0.1	0.1	0.0	0.0
Stimulants[a]	0.5	0.4	NA	NA	NA	NA	NA	NA	NA	NA	NA
Stimulants adjusted[a,b]	NA	NA	0.3	0.2	0.2	0.0	0.1	0.1	0.0	0.0	0.0
Cigarettes											
Daily	18.3	17.1	16.2	15.3	14.7	14.2	12.7	13.9	12.4	12.2	12.1
Half-pack or more per day	12.7	11.9	10.5	9.6	10.2	9.4	8.3	8.2	7.3	6.7	8.2

Source: Johnston, L.D. "Illicit Drug Use, Drinking and Smoking: National Survey Results from America's High School Students, College Students and Young Adults Populations, 1975–1991," Rockville, MD: NIDA, 1991, forthcoming.

NOTES: Level of significance of difference between the two most recent years: s = .05, ss = .01, sss = .001.
NA indicates data not available.

[a] Only drug use that was not under a doctor's orders is included here.

[b] Based on the data from the revised question, which attempts to exclude the inappropriate reporting of nonprescription stimulants.

Figure 1. Alcohol: Trends in Annual Prevalence Among College Students vs. Others 1–4 Years Beyond High School

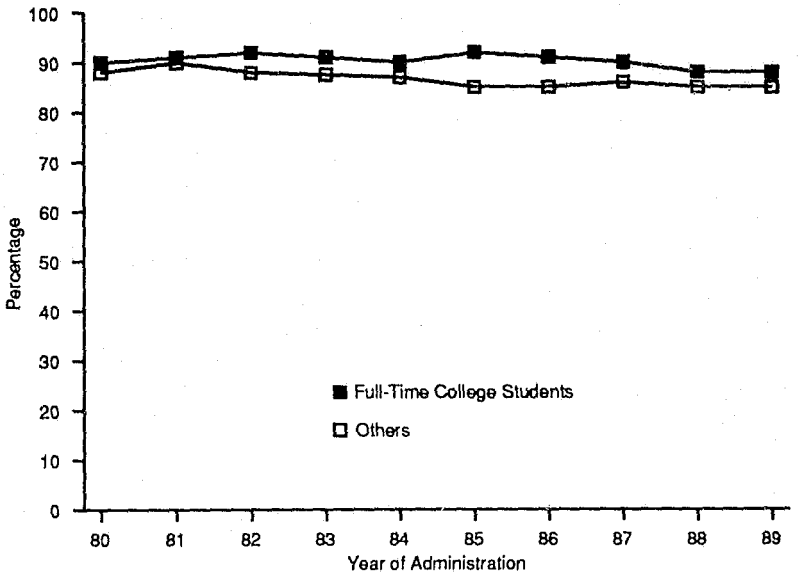
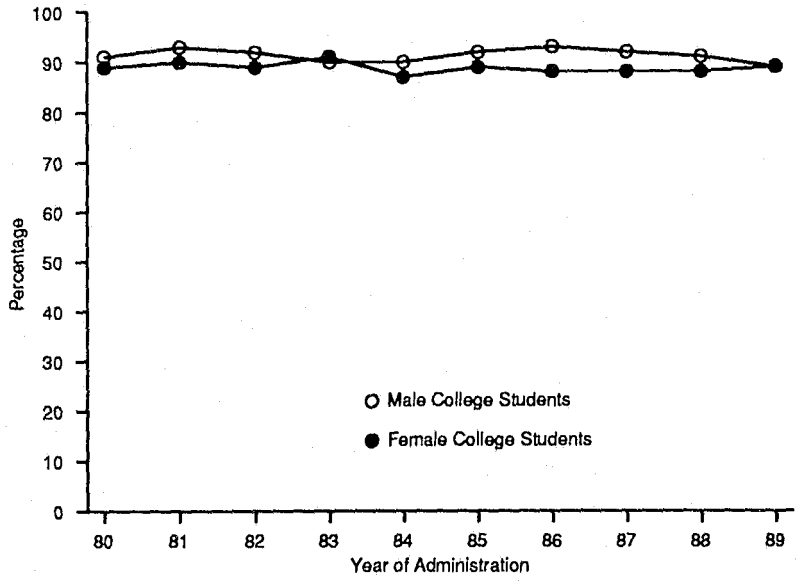


Figure 2. Alcohol: Trends in Annual Prevalence Among Male and Female College Students



Source: Johnston L.D. "Drug Use, Smoking and Drinking by America's High School Students, College Students, and Young Adults, 1975–1987," DHHS Pub. No. (ADM) 89-1602, Rockville, MD: NIDA, 1988.

Figure 3. Alcohol: Trends in 30-Day Prevalence of *Daily* Use Among College Students vs. Others 1–4 Years Beyond High School

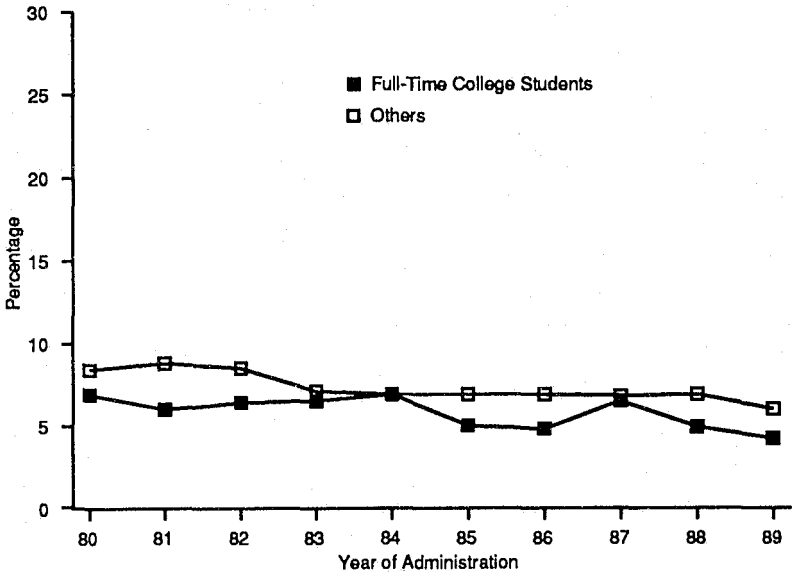
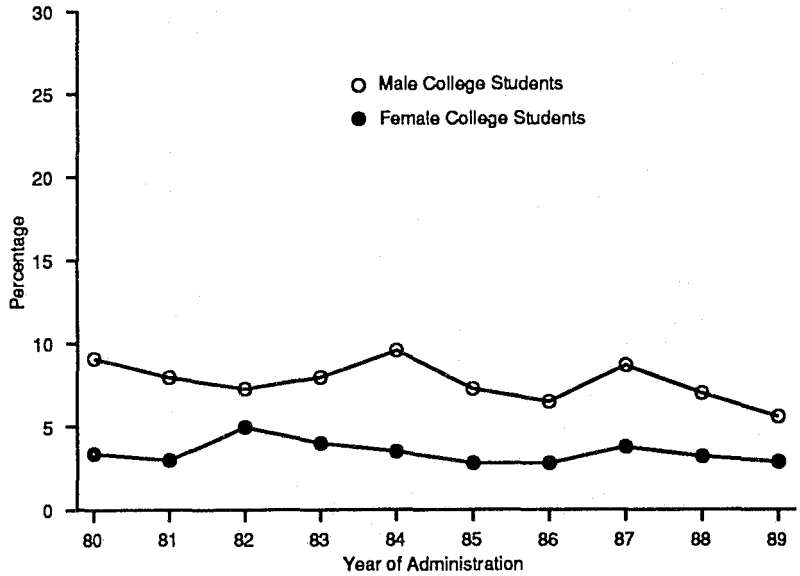


Figure 4. Alcohol: Trends in 30-Day Prevalence of *Daily* Use Among Male and Female College Students



Source: Johnston L.D. "Drug Use, Smoking and Drinking by America's High School Students, College Students, and Young Adults, 1975–1987," DHHS Pub. No. (ADM) 89-1602, Rockville, MD: NIDA, 1988.

Figure 5. Alcohol: Trends in 2-Week Prevalence of Use of 5 or More Drinks in a Row Among College Students vs. Others 1–4 Years Beyond High School

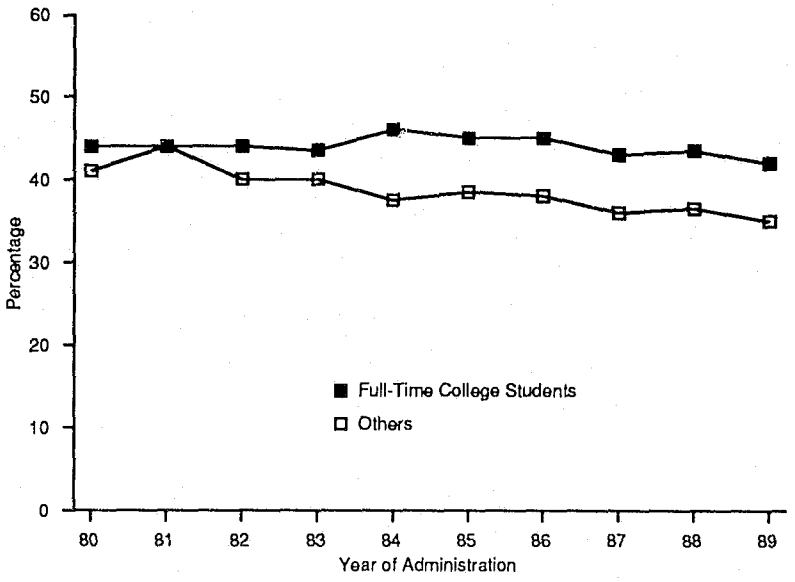
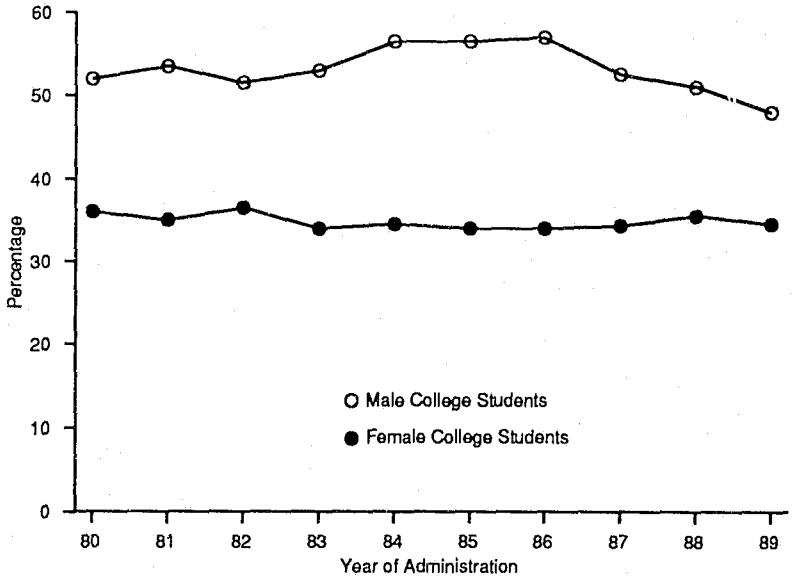


Figure 6. Alcohol: Trends in 2-Week Prevalence of 5 or More Drinks in a Row Among Male and Female College Students



Source: Johnston, L.D. "Drug Use, Smoking and Drinking by America's High School Students, College Students and Young Adults, 1975–1987," DHHS Pub. No. (ADM) 89-1602, Rockville, MD: NIDA, 1988.

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