Insights and Innovations in Community Mental Health

The Erich Lindemann Memorial Lectures

organized and edited by
The Erich Lindemann Memorial Lecture Committee

hosted by William James College

Table of Contents

Foreward

The Erich Lindemann Memorial Lecture is a forum in which to address issues of community mental health, public health, and social policy. It is also a place to give a hearing to those working in these fields, and to encourage students and workers to pursue this perspective, even in times that do not emphasize the social and humane perspective. It's important that social and community psychiatry continue to be presented and encouraged to an audience increasingly unfamiliar with its origins and with Dr. Lindemann as a person. The lecturers and discussants have presented a wide range of clinical, policy, and historical topics that continue to have much to teach.

Here we make available lectures that were presented since 1988. They are still live issues that have not been solved or become less important. This teaches us the historical lesson that societal needs and problems are an existential part of the ongoing life of people, communities, and society. We adapt ways of coping with them that are more effective and more appropriate to changed circumstances—values, technology, and populations. The inisghts and suggested approaches are still appropriate and inspiring.

Another value of the Lectures is the process of addressing problems that they exemplify: A group agrees on the importance of an issue, seeks out those with experience, enthusiasm, and creativity, and brings them together to share their approaches and open themselves to cross-fertilization. This results in new ideas, approaches, and collaborations. It might be argued that this apparoach, characteristic of social psychiatry and community mental health, is more important for societal benefit than are specific new techniques.

We hope that readers will become interested, excited, and broadly educated. For a listing of all the Erich Lindemann Memorial Lectures, please visit www.williamjames.edu/lindemann.

The Erich Lindemann Memorial Lecture Committee presents

THE TWENTY-FOURTH ANNUAL
ERICH LINDEMANN MEMORIAL LECTURE

Community Ownership of Mental Health Care: The Case of Youth Substance Abuse

Mental health and health care are vulnerable to an increasingly unstable health care system. The wellbeing of citizens and clinicians and standards of mental health and professional ethics compete with organizational viability, corporate competition, and profit. How are communities of citizens, health care professionals, and responsible local leaders to obtain comprehensive, integrated, responsible health care in the midst of this clash of titans? Youth substance abuse is an issue of major community concern, and presents a model for development of community mental health programs shielded from the vagaries of distant forces by community values, creativity, and control. We examine a range of models that may suggest principles for more general use in this age of health care feudalism.

Speakers

Lisa V. Stone, MD, Vice-chairman, Wellesley Board of Health; Chair, Study Circle Planning Committee

Haner Hernandez, MEd, CADAC, Associate Director, Hispanic Office of Planning and Evaluation

Mark A. Goldstein, MD, Chief of the Student Health Service and of Pediatrics, Massachusetts Institute of Technology; Assistant Clinical Professor of Pediatrics, Harvard Medical School

Discussant

Howard K. Koh, MD, MPH, Commissioner, Massachusetts Department of Public Health

Moderator

David G. Satin, MD, LFAPA, Assistant Clinical Professor of Psychiatry, Harvard Medical School; Chairman, Erich Lindemann Memorial Lecture Committee

Friday, April 27, 2001, 2:30–5:00 pm

Massachusetts School of Professional Psychology
221 Rivermoor Street, Boston, MA 02132

Introduction by David G. Satin, MD

Let me welcome you to the 24th Annual Erich Lindemann Memorial Lecture, entitled "Community Ownership of Mental Health Care: The Case of Youth Substance Abuse." By way of a little history, the memorial lecture is given in the name of Erich Lindemann who lived from 1900 to 1974 and did seminal work in the social etiology and epidemiology of mental illness, preventive intervention and public policy as it effects incidence if mental illness and the strengthening of community resources. He was a leading figure in several key projects including the Wellesley Human Relations Service, the Community Mental Health Service of the Massachusetts General Hospital, and the National Institute of Mental Health research project, the Mental Health Effects of Forced Urban Relocation, commonly known as the West End Project.

He saw his positions as professor of psychiatry at the Harvard Medical School and Chief of the Psychiatric Service of the Massachusetts General Hospital as means of bringing the approaches of psychoanalysis, the social sciences, and public health to the attention of academic medicine and teaching them to health care professionals.

Let me go on then to today's presentation, “Community Ownership of Mental Health Care: The Case of Youth Substance Abuse.” The format of the presentation will be presentations by Lisa Stone, Haner Hernandez and Mark Goldstein, and then a discussion by Howard Koh, Commissioner of Public Health, followed by discussion with the speakers and the audience. Federal, state and local government are withdrawing from the provision of financial support of human services as part of a reduction in spending. We might want to discuss whether this is because of lack of money or a change in what society wants to spend its money on. In any case, the result is that communities must increasingly look to their own ideas and resources to meet the needs of their members.

In a way, this is a return to the concept of community mental health, as Erich Lindemann knew it: The banding together of key community individuals and agencies to improve and protect the health of their communities. In recent years, the Lindemann Memorial Lecture has sought out programs which have returned to the approach of looking to their own resources and, in the process, tailoring their goals and message to their own needs, and making a success of it. This year we look to a community mental health issue of much concern, youth substance abuse, as a focus for a small survey of community self-help efforts.

We will look to different types of community to demonstrate the variety of approaches adapted to their different needs, and also common principles of community self-help. We hear very contradictory things about alcohol and other drug abuse among young people: that it is a growing scourge that is undermining the country's youth, and

that we are panicking unnecessarily and undermining respect for those who carry the culture of our nation in the future. Recent reports from the Drug Abuse Warning Network and treatment episode data set suggest that, with the exception of marijuana, substance abuse is decreasing, at least in the 12- to 17-year-old population. But admission to drug abuse treatment programs has increased 45%. So young people are using less but worrying more. The National Longitudinal Study of Adolescent Health finds that social environment has a much greater influence on substance abuse and other destructive behavior than do ethnic, economic, or family structure factors. There is strong disagreement about what to do: punish users and distributors, make war on producers, or treat users instead of expelling them from society.

Erich Lindemann indicated his ideas of community mental health approach in a paper prepared for the Fifth Conference on Administrative Medicine, sponsored by the Josiah Macy Foundation in November 1956. ‘The term 'mental health' is of practical usefulness in delineating a broad program far beyond the confines of clinical psychiatry, dealing with rehabilitation, prevention, with the control of disease in the population, and with the promotion of positive mental health.'

Our speakers can give us both the thinking and the action in three very different communities: The Boston suburb of Wellesley, known for its thoughtful attention to problems of mental and social health; the Hispanic community, the fastest growing minority in the country and one with a high sense of identity and vigorous social activism; and the Massachusetts Institute of Technology, a world-renowned ivory tower, with both major mental health issues, including alcohol abuse and suicide, and an outstanding health and mental health program. How have these communities addressed youth substance abuse in their own terms and with their own resources? What does this teach us about how communities take ownership of their mental health?

Lisa Stone, MD

Chair, Alcohol and Our Community Steering Committee; Vice-chairman, Wellesley Board of Health; Chair, Study Circle Planning Committee

Introduction by David Satin, MD

Our first speaker is Lisa V. Stone, a graduate of Catawba College in North Carolina and George Washington School of Medicine, and a board-certified internist. In her hometown of Wellesley she was a member of the steering committee of the Drug and Alcohol Policy Advisory Coalition, founder and chair of the Wellesley Youth Charter Initiative, a town meeting member, and a member of the League of Women Voters. Last year she was elected to the Wellesley Board of Health, in which capacity she developed a conference on Understanding the Impact of Alcohol on our Community, and a community-wide ground of study and planning circles on alcohol, a population-based approach to reducing the harm of alcohol in her community. She can tell us how this has worked.

Lisa Stone, MD—Using the Study Circle Method to Address Underage Drinking: One Community's Experience

Background

Our community, like many others, has long been concerned about underage drinking. We are fortunate to have a drug and alcohol coalition that brings together the schools, police, health department, clergy, parents and elected officials. A strong police policy, good collaboration between the schools and police, and an involved parent body have also contributed to efforts to reduce the harm from underage drinking. However, in December of 1999, a series of life-threatening incidents involving underage drinking alarmed the community and the drug and alcohol coalition turned to the Board of Health for help.

The Board of Health formed a committee representing a broad spectrum of the community to evaluate the issue and recommend a response. Based on their recommendation, the Board of Health held a conference in May 2000 called, "It Takes a Town: Understanding the Impact of Alcohol on Our Community." This conference brought together eighty members of the community including teens, parents, teachers, school administrators, relevant town departments, the clergy, the police, merchants, senior citizens, and elected town officials. Invited speakers described the public health impact of alcohol on various populations, advocated for a community based prevention strategy, and introduced the Study Circle Method. Following the speakers, the attendees

participated in a one-hour study circle pilot program. Feedback from the conference indicated continued concern about underage drinking, a strong desire for the Board of Health to provide leadership in this area, and enthusiastic support for the Study Circle Method. Following the conference, the planning committee began work on a community-wide study circle program for the fall.

The Study Circle Method

The Study Circle Method is a process of public deliberation of complex issues. Study circles are being used by hundreds of communities across the nation on topics ranging from racism to urban sprawl. They involve large-scale citizen input in community building and problem solving and can help to break down barriers of age, race, and other characteristics that often divide people in a community. The Study Circle Resource Center (SCRC) in Pomfret, Connecticut (www.studycircles.org) has developed discussion guides on a variety of topics and assists communities in their efforts. We began work with the SCRC in June 2000 to plan our community-wide round of study circles for the fall. Because a guide did not exist on our topic, our first challenge was to write one with the assistance of the SCRC. Community relevant perspectives on the issue were identified through personal knowledge, a literature search of community and student newspapers, and interviews with selected individuals.

The Study Circle Method is process, not outcome, oriented. Groups of 8 –15 participants meet for 3-5 facilitated discussions that follow a discussion guide on the particular issue. The guide is a critical component as it ensures that the issue is thoroughly and honestly discussed, and that all perspectives on the issue are considered. Study circles use dialogue rather than debate, and citizen participation rather than experts and advocates, to deliberate complex issues. Unlike many group processes, consensus is not the goal. Instead, it seeks to identify common ground on which progress can be made.

The Program: It Takes a Town: Alcohol and Our Community, A Public Dialogue

Recruitment

Participants for the program were recruited from three target populations: teens, their parents and the community at large. A letter introducing the program and providing registration information was sent to all school families in late August 2000. It was signed by the high school principal, the superintendent of schools, the police chief, the chair of the Board of Selectmen, and the vice-chair of the Board of Health. A similar letter signed by the middle school principal was sent to eighth grade families. In addition, fliers were posted in the schools, registration forms were available in the school

office, and presentations were given at various school clubs and groups, including school committee and PTSO (parent teacher student organization) meetings as well as student congress and student community service organizations. Although we were not able to identify families whose children attend private schools, we were hopeful that our community outreach would extend to them.

Community outreach began with an article in the local newspaper in June 2000 to introduce the concept of study circles and to announce the fall program. A description of the program and registration forms were placed in the fall Recreation Department brochure. This brochure contains information on youth and adult programs, and is mailed to all residents in late August. All clergy and youth ministers/educators were contacted and provided with information to share with their congregations and youth groups. Presentations were made at various town department meetings and organizations, such as the Board of Selectmen, the Kiwanis and Rotary Clubs, and the League of Women Voters. Finally, a letter was sent to all Town Meeting members, a group with demonstrated interest in participatory democracy.

Collaboration With Study Circle Resource Center

The discussion guide was developed over the summer with assistance from SCRC. Contributions from a local hospital and college covered the printing costs. Additional planning included training facilitators and identifying sites for the study circles. Although many communities train volunteers as facilitators, because of a short timeline and summer vacation schedules we decided to use professionals from our local mental health agency. The facilitators received a training session in the Study Circle Method, provided by the SCRC. We were fortunate to be able to cover the cost of our facilitators through our Health Department community mental health budget.

Program Objectives

1. Engage the community in productive dialogue around the broader issue of the impact of alcohol and include diverse voices and perspectives in the dialogue
2. Address community concerns about underage drinking
3. Identify common ground on which positive action can be based

The Program Sessions

Kick-Off

A kick-off meeting was held in late September 2000. At this meeting, information was provided about the program and the Study Circle Method. Registration forms were

available and the discussion materials distributed. Following the kick-off the remainder of the discussion materials were sent to participants who did not attend the kick-off.

Session 1: Understanding the Impact of Alcohol

Session 1 began with group introductions, the establishment of ground rules for discussion, and personal connections with the issue. The primary goals of this session were to build group trust, to broaden the discussion of alcohol and to frame it as a public health problem. The economic, health, and social impacts of alcohol were discussed, as well as the impact on two other specific populations – the workplace and the elderly. It was hoped that by focusing on two populations other than teens, the youth would feel less targeted and become more engaged in the discussion. The concept of direct and second-hand effects was also presented.

Session 2: Exploring Attitudes and Behavior

Previously, attempts in the community to address the issue of underage drinking were stalled by a polarized debate – with one side believing that underage drinking is illegal and should not be tolerated in any form, and the other side acknowledging the illegality but understanding that some teens choose to drink and that they and their families need relevant information. At public forums, the illegal argument generally was supported and those holding other views either did not attend or were excluded from the discussion. The goal of this session was to move the participants beyond the polarized debate.

Using specific examples of drinking behavior provided in the reading material, participants were asked to characterize them as legal/illegal, appropriate/inappropriate, high risk/low risk and responsible/irresponsible. The examples covered all age groups, and sought to provoke thoughtful exploration of previously held assumptions. By recognizing some adult behavior as legal but irresponsible or high risk, and some underage behavior as illegal but low risk or appropriate, it was hoped that the community could begin to move beyond the divisive and stalled debate about underage drinking. The difference between low and high risk drinking and the concept of healthy drinking were also presented and deliberated.

Session 3: Underage Drinking

One of the limiting factors in previous attempts to create dialogue on this issue had been the presence of dominant voices representing one viewpoint, or the inclusion of only some of the perspectives held on the issue. A fundamental aspect of the Study Circle Method is to include all perspectives, and to discuss them thoughtfully and thoroughly. Rather than leave the discussion to the perspectives held by those around the table, the study circle discussion guide puts all perspectives on the table and explores the

advantages and disadvantages of each. The facilitator ensures a level playing field for discussion, and a thoughtful and broad deliberation. The perspectives included in our guide were 'zero tolerance,' 'drinking as a rite of passage,' 'the harm reduction approach,' and a 'risk/resiliency framework.' Zero tolerance is the view that all underage drinking is illegal and advocates for strict enforcement of policies and laws.

Harm reduction agrees that abstinence is best, but acknowledges that not all adolescents choose abstinence. Drinking as a rite of passage is a perspective that is often tacitly held by members of a community and that contributes to general ambivalence around this issue. Many parents recall their own youthful experimentation with alcohol, and expect/want their children to have similar experiences. A risk/resiliency framework seeks to identify both the risk factors and protective factors that an individual, family or community possesses that either increase or decrease an adolescent risk behavior. It often focuses on the root causes of risk behaviors, rather than on a single behavior.

Session 4: Turning Ideas Into Action

An important component of the Study Circle Method is the identification of common ground on which progress can be made, followed by the development of action ideas, and a plan to implement the action ideas. Participants are encouraged to brainstorm ideas for action at all levels - individual, small group, community and societal levels. In the last session, participants reflected on the previous discussions and were provided with some examples of action other communities had taken, including the social norm marketing approach. Each facilitator submitted a list of action ideas to the Steering Committee.

The Action Forum

Held in late November 2000, this meeting brought together all the participants, the facilitators, and the community. A standing room only crowd listened attentively while program participants presented the action ideas. The action ideas had been categorized into large clusters of ideas to prevent redundant reporting, and one or two participants presented each category. For example, one issue identified by many study circles was the need to address police-teen relations. The Deputy Chief of Police and a high school student, both program participants, presented the ideas relating to this broad category. Following the presentations, those attending the action forum voted on the ideas they felt it was most important to move forward while being entertained by a high school jazz band and enjoying refreshments. At the conclusion of the meeting, a date was set in January 2001 to reconvene and to establish task forces to implement the action ideas.

Results

Participants filled out anonymous evaluation forms that provided information on participant demographics and the effectiveness of the program sessions, the facilitators, and the discussion guide. Participants were asked about changes in their own understanding of the issues, understanding of other's attitudes, and ability to communicate with others on this issue.

Program Objective 1: Engage the community, including diverse voices and perspectives

Ten study circles were held, involving 104 participants. The participants ranged in age from 15 to 88 years old. Among them were high school students, police officers, representatives from various town boards and departments, a youth minister, members of the Council on Aging, community clubs and organizations, the high school principal, and members of the middle and high school faulty, inclosing members of the guidance fitness and health departments, as well as classroom teachers. The demographics of the participants are summarized in table 1. Although most participants were white, middle-aged females, over ¼ of participants were male, and 12 % were teens. Not surprisingly, most were well educated, with over half possessing a graduate degree. Of interest is that more than half described themselves as liberal, suggesting a changing demographic of a once very conservative community. Because of the demographic distribution, some study circles were more diverse than others. Not all study circles had teens or elders represented, and some were all female. This variety of experience is portrayed in participants' answers to the question; *"What did you like most/least about the program?"*

> "Having a chance to discuss and listen to one another. We weren't expected to change people's minds, but to work hard at hearing all perspectives."
>
> "The diversity of age and sex helped others to get a better understanding of others"
>
> Because our group included teenagers and adults I feel we all gained greatly. I think it felt good to talk about a sensitive topic in harmony, with humor and understanding."
>
> "Although there was some diversity in opinions, for the most part the attendants seemed to be those already active in the community – particularly on this subject, and it makes me think a broader spectrum was not reached."

"I got so much out of my participation. I hope to arrange for two of the teens to speak at a Kiwanis meeting. I really fell these kinds of connections are so important and they remind me of how hard it is for teens to grow up. You forget about that age over time – thank God."

Program Objective 2: Address community concerns

Tables 2 – 5 summarize the responses from the questionnaire. 95% of the participants rated the program as good or very good. Most felt the program had increased their ability to understand their own, and others', attitudes and beliefs. In addition, written feedback is represented by the following responses to the question: *"What did you like most/least about the program?"*

"Always felt we were truly getting to the 'meat' of the discussion and would have loved to have talked more but not enough time!!!"

"Safe environment for expressing a wide range of beliefs, opinions and concerns. Encouraged dialogue."

"Adults actively working to understand the problem and each other."

'Not as much focus on adult alcohol use as I would have liked."

"Having younger children, this allowed me a time to question my own attitudes and practices BEFORE I've been directly confronted with problems in my own family."

"I feel that this type of process is not effective, except in a general 'feel good' sort of way."

"For me the study circles were of great value. It created the opportunity to meet people who are involved with the town. I naively have always believed that if a family takes care of its own, all will be well – but I now know that it not only takes a family to love and protect – but a community." (from a parent who lost a daughter to drug and alcohol abuse)

Program Objective 3: Identify common ground on which action can be based

Due to the large number of action ideas put forward by the study circle participants, ideas were grouped into eleven categories to avoid redundant reporting. Following the action forum, those ideas that had the most interest were developed into task forces to move them forward. For specific action outcomes, see the section: Follow Up: Alcohol and Our Community, Phase 2, below. Sample responses to: *"What did you like most/least about the program?"*

> "I guess in some ways I feel even more helpless and the problem seems worse than I originally thought. There are so many variables that it is quite frustrating to come up with reasonable and effective solutions for an issue of such a large scope."

> "It was the first time I left a meeting and really felt very positive about the community."

> "Not sure where the effort lead."

> "I found it helpful to hear different viewpoints from people with different experiences and different aged children. Mostly, I feel like this program is a real start to take some action on the issue."

Follow Up: Alcohol and Our Community, Phase 2

A Steering Committee and four task forces were established in January 2001. We were very fortunate to receive funding for this phase from a local community health care foundation. The funding provides compensation for a coordinator, administrative support, professional representation on our Steering Committee, and programmatic expenses. The Steering Committee meets monthly and is comprised of a chair (member, Board of Health), a representative from our community mental health agency, the Director of Youth Services, two members of the Health Department staff who provide administrative and coordinating responsibilities, the moderator of the community drug and alcohol coalition, and two student representatives. The task forces established were:

- Saturday Night Program – to address the need for more youth social opportunities.
- Study Circle Program – to develop a Police-Teen-Community pilot program, and to coordinate all study circle programs.
- Resource library – to develop a lending library for the community on alcohol.

- Social Norms Research Group – to research this approach and make recommendations to the Steering Committee

Challenges

Recruitment

The major challenges were recruiting a sufficient number of participants, and including diversity in demographics and perspectives on the issue. The recruitment of teens was particularly difficult, as the teens were appropriately skeptical of the intent of the program, believing it to be another attempt of the adult community to tell them what to think and do. In addition, those that did participate tended to be those with limited experience with alcohol, particularly its harmful effects. It is hoped that the positive experience of those who did participate, and articles about the program that appeared in the student newspaper (written by students), will help to spread confidence and interest in the program. Fortunately, some time has passed since the series of incidents that prompted the development of the program, and no major event involving alcohol has transpired since. Therefore, recruitment may be more difficult in the future. Again, the presence of positive media and participant reaction should help to counter the less prominent concern about the issue.

Cost

Although a community wide study circle does not have to be a costly program to run, we choose to use professional facilitators who we were able to pay through our own budget. This may be an unusual circumstance for many communities. In that case, more time will be needed in the planning stage to recruit community volunteers as facilitators and train them. The development of the discussion guide was a time consuming effort, but of no cost. Other communities interested in alcohol could use our guide and tailor it to make it relevant to them with little time and effort. The other costs of printing and postage were covered by local contributions. A grant has been obtained to cover the cost of Phase 2. The Health Department is an appropriate body in many communities to apply for grant funding.

Sustainability

Community work is often difficult to sustain. Community volunteers, and their particular concerns at any point in time, wax and wane. Programs are frequently abandoned before they have a chance to succeed. It is recommended that a commitment to three years of the program be made to provide sufficient participation to result in a successful program. It is also recommended that when possible, a paid coordinator be

put in place. Reports to the community demonstrating small successes along the way can also help to maintain community interest, participation, and support.

Discussion

The issue of alcohol is a complex one that is often divisive within families, communities, and nationally. It is an issue that affects us all, but there is no clear consensus on it. There are widely divergent perspectives about both alcohol use itself and the role of the individual, the community, and the government. The negative social, health, and economic impacts are weighed against the enjoyable aspects, the traditional and religious uses of alcohol, and the potentially beneficial health effects. The visible devastating consequences of high risk drinking among youth and the illegal nature of underage drinking are contrasted with a societal ambivalence evidenced by poor adult role modeling and omnipresent media messages promoting underage use. This ambivalence leads to the delivery of mixed messages and general confusion among both adults and teens. While consensus within a community is an unrealistic goal, this program demonstrated the ability of a community to come together for productive dialogue on a complicated and sensitive issue. Through public deliberation, common ground was identified on which progress is being made. Numerous other beneficial effects have also been noted – new relationships, new collaborations, and a renewed sense of hope.

Two unique components were largely responsible for the success of this program- the use of the Study Circle Method and the leadership provided by the local Board of Health. The Study Circle Method of democratic deliberation provided our community with a positive and productive approach to this complicated issue. In addition, leadership from the Board of Health helped to frame the issue as a public health problem and to place it in the community where it belongs. Together, they brought back into the dialogue those who had been frustrated or excluded by previous attempts, and enlarged the discussion to involve all sectors of the community, rather than focusing exclusively on the school community. Typically, the onus has been put on the schools to address the problem of underage drinking. Although schools clearly need to educate students and their parents about the dangers of underage drinking, and they need to develop and enforce policies around it, it is unfair, and inappropriate, for a community to rely on their public schools to respond to this issue. The origin of, as well as the response to, the harm related to high risk and underage drinking is located in the environment in which it occurs. It is important to consider the total environment in both understanding and addressing the issue. A community-based program also allows for community specific and relevant discussion and action. By involving a diverse spectrum of the community,

and by involving community leaders as well as those impacted by the issue, common ground can be identified, and appropriate action formulated. This program, combined with efforts around policy, access, and enforcement, can be incorporated into an environmental management approach.

We recommend that communities concerned with the harmful impact of alcohol among their populations in general, or in a discrete segment of their population (adolescents, elderly, workplace, etc.) consider using the Study Circle Method of complex problem solving. Where possible, a community-based effort is most appropriate and a local Board of Health should be considered as a possible resource and/or leader of the initiative. Copies of our discussion guide are available from the Wellesley Health Department. The discussion guide may be used as a template and adapted to your community's needs. Contact Cheryl Lefman, Coordinator, Alcohol and our Community Steering Committee, 79 Oak Street, Wellesley, MA 02482 (Tel: 781 235-0135, clefman@yahoo.com) or visit our website at www.wellesley.ci.ma.us/hth.

Table 1: Demographics

	n	%		GENDER	n	%
RACE				Female	66	72%
White	89	96%		Male	26	28%
*Non-white	4	4%		TOTAL	92	100%
TOTAL	93	100%				
				EDUCATION		
AGE				High school	10	11%
10-19	11	12%		High school graduate	1	1%
20-29	1	1%		College	6	6%
30-39	7	8%		College graduate	22	24%
40-49	31	35%		Graduate degree	54	58%
50-59	35	38%		TOTAL	93	100%
60-69	3	3%				
70-79	2	2%		POLITICS		
80-89	1	1%		Conservative	12	15%
TOTAL	91	100%		Moderate	20	24%
				Liberal	45	54%
				Don't know	6	7%
				TOTAL	83	100%

*1 African-American, 1 Hispanic, 1 Asian, I other

Table 2: What effect, if any, has the study circles had upon the following? (n=67)

	Increased	No Change	Decreased
Your ability to discuss issues openly and frankly…	54%	42%	3%

Your understanding of your own attitudes and beliefs…	70%	27%	2%
Your understanding of others' attitudes and beliefs…	91%	9%	None
Your ability to communicate with people who may have different beliefs…	48%	52%	None

Table 3: Overall Experience *(n=69)*

The length of each meeting was…	2% said too long	10% said too short	87% said just right
The number of meetings was…	1.5% said too many	17% said too few	81% said just right
The number of people in my circle was…	8% said too many	12% said too few	80% said just right
Overall, I would rate the program as…	2% said poor None said very poor	4% were neutral	19% said good 75% said very good

Table 4: Facilitation (n=69)

	Agree	Neutral	Disagree
The facilitators made everyone feel welcome…	100%	None	None
The facilitator did not try to influence the group with his/her own view…	100%	None	None
The facilitator intervened when someone monopolized the conversation…	78%	16%	6%
The facilitator explained the study circle principals and the difference between dialogue and debate…	85%	12%	3%

Table 5: Discussion materials (n=69)

	Agree	Neutral	Disagree
The guide included different points of view without advocating any one point of view…	99%	1%	None
The guide could be used by all kinds of people, across all walks of life…	88%	6%	6%
The guide stimulated meaningful discussion…	92%	3%	5%
The guide presented the right amount of material…	75%	16%	9%

Haner Hernandez, MEd, CADAC

Associate Director, Hispanic Office of Planning and Evaluation

Introduction by David Satin, MD

Thank you, Dr. Stone. We should be very clear and it's hard to believe that something so complicated can end up being so clearly understood, and to me it's remarkable that you can get such a busy and varied community together to share in a project like this and to see the point of it, see the use of it, and have something come out of it that is going to be inspiring to other people. It says something about that community, that type of community.

Our next speaker is Haner Hernandez Bonilla, a certified drug and alcohol counselor, Associate Director for Statewide Training and Technical Assistance at the Hispanic Office of Planning and Evaluation. He has his M.Ed. from Cambridge College, is a certified drug and alcohol counselor and graduate of the AIDS and Substance Abuse Certificate Program at Boston University. He is the director of the Latino Addictions Counselor Training Program; former Director of Implementation and Operation for HOPE, in which capacity he managed government contracts related to health promotion, disease prevention, education and leadership development. He is the Director of the Center for Health Promotion at HOPE, youth project manager, developing training materials and training in AIDS, HIV, self esteem, violence prevention, substance use and abuse, Latino cultural and history, sexuality and peer pressure. His volunteer and cultural work includes counseling of Latino males in the Gandara Addiction Recovery Program, and co-founder and member of Casa Don Pedro Albizuo Campos Graduates Association, providing leadership, advocacy, support and planning for substance abuse and HIV/AIDS education, prevention and treatment and other social, economic and political issues affecting the Latino community. He and one of the people he works with will tell us about a different kind of community, an ethnic community, and how they address youth substance abuse.

Haner Hernandez, MEd, CADAC—Substance Abuse in the Latino Community

I want to say good afternoon. I want to first thank Dr. Satin for inviting us to be a part of this lecture. Again, my name is Haner Hernandez and I am Associate Director at HOPE, the Hispanic Office of Planning and Evaluation, Massachusetts. We have an office in Jamaica Plain, an office in Lawrence and an office in western Massachusetts, out of Springfield, Massachusetts, and I am joined with an esteemed colleague, Victor

Ortiz, and a personal friend who has taught me a great deal about what it means to work in this field, and what it means to give back to community.

I will talk briefly about the Latino community, similar stuff that we're facing in terms of substance abuse, Latino youth in particular, and Victor will share some personal reflections in terms of his experience in Massachusetts, both with substance abuse and treatment. First let me say that I will be using the term 'Latino', and some people prefer to be called 'Hispanic', some people prefer to be called 'Latino'.' I prefer to say 'Latino' and I respect if someone wants to be called Latino, Puerto Rican, Dominican, Hispanic, whatever it is that want to be called, that's what I respect and that's what I say to people, but for the purpose of my talk, I will mention the word 'Latino.'

We're now seeing a lot of the census data, and I will talk mostly in numbers for Massachusetts and try not to bore you with a bunch of numbers. According to the 2000 census, Latinos make up 6.8% of the population in Massachusetts. We're the largest so-called minority in the state, with 420,729 people counted by the census. Of course I hope that we're all familiar with the undercount. A lot of people are undocumented and choose not to fill out the forms and send them back, so experts in this area estimate that Latinos are if not 7% a little bit more than 7% of the Massachusetts population.

We increased by almost 50% from 1990 to the 2000 census. In 1990 we were 287,549, and again I will give you the number for 2000: 420,729 people counted in Massachusetts. Latinos are a very young population. That total number that I gave you, the census counted 271,000 people who were over the age of 18, so Latinos are relatively very young. If you look at the population in the Northeast, specifically Massachusetts, it won't give you exact numbers or statistics. But the majority are Puerto Rican, there's a very large Dominican community, and depending on what areas of the state you move around in, you will see large pockets of people from Central and South America.

This presents special challenges when we talk about health, when we talk about substance abuse treatment and prevention issues. I say that because for the most part we're taught to think a certain way. If that person speaks Spanish, automatically he or she is Hispanic, and we are lumped into one category, and that is a disservice when we're trying to provide services, in terms of understanding people where they come from. Because we are very diverse: not all of us speak Spanish, not all of us speak the same type of Spanish, and cultures are very different. Even in neighbor countries- I am to me, and to folks who hear me who know where I'm from- I'm from the Caribbean, I'm from Puerto Rico. People from the Dominican Republic, right next door, we do things a little bit different.

Let me give you an example of something. In the early '80s when we were addressing issues related to HIV/AIDS there was a slogan that was developed by the Department of Public Health in Massachusetts- ‘AIDS: You don't have to get it.’ Basically

it was a public media campaign. Simple enough, and so, somebody said, 'We need to translate it. We have a Latino population, we need to do some translation.' The translation when something 'El CIDA: No lo tienes que cojer.' I'm from the Caribbean, sounds good to me, means to me that somebody from the Caribbean did the translation. People from Central America, particularly people from Mexico, 'cojer' has a sexual connotation that has to do with anal sex, so if you're trying to deliver a message that is around sexuality preventing HIV/AIDS and you use a word that can be offensive, counter-productive, and it's of that nature, and complicated that we're talking about certain issues.

So we need to be very careful in terms of how we tailor messages, treatment, prevention, and everything else in terms of communities. I work closely with people from the Bureau of Substance Abuse Services of the Department of Public Health, and they facilitated some data to me in terms of lifetime use to residential programs for youth in Massachusetts. And I selected that one, there were many other data but I think that this is important to know: 99.7% reported using alcohol, 98.7, marijuana, 59.6% cocaine, and 25.7% heroin. That speaks volumes in terms of what we're confronting and having to deal with at a community level. In terms of Latinos and what we're confronting at community-based level and in community-based organizations, and what we hear from people by way of study circles, by way of just working with the community and community organizing, prevention and education programs, and I think it's very commonly known is availability in our communities is astonishing.

You can walk in any direction in any one of our communities for five minutes and purchase anything from crack cocaine to heroin to an automatic weapon to sex to whatever it is that you want to purchase. You have money in your pocket, then you can purchase that. We hear a lot of that. That's in terms of the legal aspects of substance abuse and crime. But also in our communities you see these major billboards that lace our community with alcohol messages, major drug selling, alcohol but with sexual messages behind it. So there's very beautiful woman, a very beautiful, attractive man, and they're promoting alcohol with very mixed messages: If you take this and you'll end up with somebody like this. We all know that doesn't happen but our communities are inundated with that on a daily basis, and in many of our communities on every street or every other street corner, there are liquor stores with all of this advertisement as well being promoted. This is all done legally.

The people who work in tobacco have done a very good job in educating folks around cancer and tobacco and that sort of thing and changing some of the laws, lobbying to change some of the laws related to advertising and minors and youth and that sort of thing. And we have a lot that we can learn from there, and some people are doing some very good work, but availability is a major issue for us in our communities.

Drugs and crime for the most part are glamorized, something that you should get into because it's cool. Being in school is not cool, being smart, having answers, that is not seen as cool, but having a brand-new car, having hundred-dollar sneakers, having $50 sweater, that is seen very popular, and it's sad to say but we live in a society that puts profit before people, and this should come as no surprise.

I talk about all these things because they're directly related to substance abuse, and directly related to treatment and prevention programs, if we truly want to understand and address these issues. For example, in our communities, in terms of crack and heroin, in the early '80s I remember a bag of heroin used to costs anywhere from $30 to $40. Today that same bag costs $8 to $10. Why is that? In the '80s crack cocaine was introduced very cheap drug. Still is very cheap. Competition between two deadly substances drives one price down and also purity up--something like 98% pure in terms of heroin. So you can imagine what that does to communities. On the other side, speaking about Latinos specifically, very high drop-out rates. We push constantly in terms of these sneakers, these clothes, all this material stuff that we have to have on the outside, and then the alternatives are what?

In terms of employment, there are very high unemployment rates, so a young person who is in the community and has all these ideas about consuming, all these things cost a lot of money. Are you going to flip burgers at McDonald's for the minimum wage or are you going to make $300 or $400 in one evening on the street corner? And it's very easy to see how some young people can go in that direction and we are, as a community, devastated in this sense. The drop-out rate in Massachusetts for Latinos is the highest in this state, it's 8.2% in some communities. It is very high.

That is very unfortunate, and when we think about these programs again I talk about many different things because they're all related, and many times we focus on one thing or on one cause or one effect and we don't have the clear picture, clear understanding in terms of what communities are confronting and dealing with. Again, alternatives are very few and far between. Let me speak a little bit about treatment before I speak about some other things. According to the Department of Public Health there are a total of 81 residential programs in Massachusetts, and this comes directly out of the Treatment Service Directory, published by the Department, by the Bureau, and 62 of these programs provide services to males.

I was working on an initiative to expand, and still am, residential services for Latino males in Massachusetts. So I called all of the residential programs and I asked two questions: Number one: Do you accept Latino males? Of course every one is going to say 'yes'--It would be illegal to say 'no.' Number two: Do you accept Latino males who are monolingual, Spanish-speaking only? Of the 62 programs, seven said 'yes.' Of those seven, three provide services exclusively to Latino males. The other three said 'yes' based

on having a part-time Spanish-speaking person. So if you only speak Spanish and you want to get into one of these residential programs, you can see how the language barrier is there, and we are working to change that. In 1987 there were no programs for Latino women and their children in Massachusetts. To date we have three, and we have three form Latino males funded by the Massachusetts Department of Public Health.

There are other faith-based programs as well in Massachusetts. I know of no residential programs for Latino youth exclusively and we can talk about that a little bit. There are several programs that provide services to youth in terms of substance abuse in Massachusetts. The Child in Need of Services programs, ages 11 through 17, there are five of those programs in the state, and 31.3% of the clients that received services there in the last fiscal year were Latino. Youth intervention programs, ages 10 through 19, there are two, and 88.9% were Latinos. Youth residential programs, there are five, ages 14 through 18, and 8% of the population serviced in FY 2000, last year were Latino. In criminal justice programs there are 6- 17.9% of those serviced were Latino in the last fiscal year. So there is work happening in terms of substance abuse and Latinos in Massachusetts, and I'll talk a little bit about what HOPE is doing but I'll also talk about what are some of the challenges, which I think I've done some of that piece today.

We do a lot of work with the system funded by the Department of Public Health, with the residential programs as well as the outpatient programs, so I get to listen to providers as well as consumers very consistently in terms of what's happening, what the needs are of the system and that sort of thing. A lot of what I hear, both from Latino providers as well as non-Latino providers- there are many who provide services to the Latino community, so there's a need for respect and understanding of culture, whatever culture that is because we all have one. But specifically, I'm talking about the Latino culture. There's been need for that in terms of understanding and sensitivity.

I stay away from the term 'cultural competency' because I don't think that anyone is ever culturally competent and I don't think there's such a thing. I think that we work in that direction consistently but I don't think that there's such a thing. There's a need for bilingual as well as bicultural counselors, and to that end we run a Latino addictions counselor training program in Massachusetts funded by the Bureau to train Latino substance abuse counselors to become certified and/or licensed in the state of Massachusetts. To me, I can speak English, I think, very well, but the issue of language is very important because I want to talk about difficult things, and when we're trying to heal from substance abuse or any other difficult issue in our lives, we want to speak in our native language even though we can understand and speak other languages. That happens with me automatically that is not something that I do because I choose to do it.

It happens innately, so language is very important for people -- their surroundings, where they go, what they see on the walls, how they're treated, how they're greeted, our

service of family and culture and values are sometimes very different than other cultures. And we need to understand that and incorporate that into what we do, as well as food and other issues facing community. I want to stop here and have Victor speak briefly in terms of his personal reflections, but this is a topic that we can do hours and hours and hours of training on. I just tried to touch on some of the pieces that we've dealt with, that we've confronted and that we're currently working with other providers to improve, and, I hope that I can answer people's questions and turn to more dialogue when we get to that part of the discussion.

Victor Ortiz, (Accompanying Haner Hernandez)

Thank you, Haner, for a very good presentation. I want to thank everyone that's here this afternoon for being here and listening to what I think is a very, very important subject. Thank you, Stone, for a wonderful presentation. I enjoyed your presentation. I'm here to give a personal account to what Haner has presented this afternoon. As an individual I work and am affiliated with many community-based organizations that deal specifically with substance abuse issues, violence prevention, HIV/AIDS, STVs, peer pressure, and I've done numerous workshops and presentations around those issues.

Haner and I have presented on many occasions and I've always enjoyed doing this type of work because I think it's important for us to get the message out and give people a realistic and clear perspective on what the issues are. As an individual, my parents were born and raised in Puerto Rico. They came here, like many others who came here, in search of a better opportunity. They spoke very little English at all and very little understanding of this society, and they struggled very much to establish themselves in Boston. I am the oldest of four, the only boy, and I have three younger sisters, and we grew up in a neighborhood, as Haner describes so eloquently, a very tough neighborhood. A neighborhood that was the majority of the people that lived in the neighborhood were Latino, in this case, Puerto Rican, and it was a close community, but a community that was filled with a huge population of drug abuse.

At that time the issues were majority of the time was heroin. There was a huge, huge explosion of heroin use at that time. I can recall many times living on the first floor where I could open my window and actually touch the people early in the morning that were hanging on the street corners, I mean on the actual street on the sidewalk, that were using heroin. But my recollection enables me to understand that although I saw this as a young person there was still a sense of respect, there was still a sense of having respect for people that were older than you because that is something within the culture that is really, really enforced, although the individuals that were out there were under these conditions.

I got first introduced to heroin, first, let me back up a little bit, first to alcohol, as a rite of passage. You know, within our culture we always say that if you want to be a man, you've got to smell like a man, so here's a beer. And so to me, as a young person I didn't see any difficulty with that. I didn't think that I was doing anything wrong. I even remember seeing a picture, once I was older, in our family photo album of myself sitting at this family bar that we had, me in diapers with a Schlitz in my hand. So in my growth and development I understand that my addiction of drugs began at that time.

At a later age, at the age of 12, I started consuming heroin. I started using heroin as a way to be accepted among my peer group. To me it was very important for myself as a young person to be accepted, and I understood later on as an older person that for young people in general it's important to be accepted. It's very difficult to be rejected. You want to be part of a group, you want to be part of what's happening, and a lot of times you're willing to do whatever it takes in order to be accepted. In my case, in order for me to be accepted among my peers I started using heroin. My ignorance at that time, of course being young, I would look at older individuals that, as I stated, were out there on the street when I was a little boy, that were much older, and were consuming heroin from the vantage point of intravenously. I was using it by nasal, by sniffing heroin, and I would think that they were different than I because they developed a certain habit that you would see them on the streets. They would different, they were extremely addicted to drugs, where I was living with my mother so things were a little bit different. Although I was on occasion consuming heroin.

I never in my wildest dreams, ever, ever, ever thought that one day later on in life that I would end up like the ones that I criticized. You know, I went to school and had great opportunities to go to school, and as I tell young people all over wherever I go that as young people, we go to school with dreams and goals, we never go to school thinking about, maybe one day I'll want to be a heroin addict, or this is not our goal but it happens. And it happened to me to a point where I lost all sight of any kind of educational envisions, because the addiction was just too much to bear. I don't want to stand here and give you guys a long story, but I just want to give you the Monarch notes and get you right to the specifics.

Luckily, I was able to interact with people who were doing some positive work in the community and offered me the opportunity to receive help, and I must say that I am extremely lucky because very few people go into detoxes or residential programs for the very first time and develop a long-term success rate as far as recovery is concerned. Many people have to go in and out many times before more or less to a certain degree they get it. And I was very lucky to go into my first residential program, which is at the Casa Don Pedro Albizuo Campos, which is a Hispanic facility. But my whole transition of coming off the streets and coming into this facility was an adventure, because I didn't

want to go. Not because I didn't want the help, but because I was born and raised in Boston. I went to school, I was taught English, I read English, I cannot read in Spanish, could not speak in Spanish, not very well at all, so I didn't want to go to a Latino program. I wanted to go to the other facility where it was just English-speaking.

There a man convinced me after a long conversation, that I should go there, that this is where I needed to be. And he told me why, but I was just not at my state of mind where I could think properly and understand, but I went anyway. There I really started developing a really good sense of self and understanding my culture, my history, beliefs, values, customs, things of that nature that really started to build me from inside, that allowed me to grow as a person, and allowed me to see the issue of drugs from a wider perspective. That experience and experience alone of being able to receive group therapy, individual therapy, and being able to have to speak the language.

So not only was I receiving the treatment as far as my issue of drug abuse, but at the same time I was reconnecting myself to what is mine. This was something that I didn't have, not because I didn't get it at home, but because I was born and raised in Boston, and my educational experience only allowed me to deal with one side of the reality, not my other side of my reality. That opportunity allowed me to grow. From that vantage point I was introduced, and this is how I met Haner, introduced to a different program, which is still part of the Hispanic Office of Planning and Evaluation, called Poder Latino, which is translated, 'Latino Power.' This is a youth group, peer-leadership group that teaches and trains us around the issues of substance abuse, HIV and AIDS.

This was my first experience as a young man of developing positive relationships with other peers of my age and understanding and sharing with them the issues of substance abuse, HIV and AIDS and violence. There it took me to a different level, and it made me understand the importance and the value of not only trying to be a productive individual but being able to go on and educate others around this issue of substance abuse and HIV and AIDS. These programs, the facility of Casa Don Pedro Albizuo Campos and the youth program of Hispanic Office of Planning and Evaluation, I always say this wherever I go, made me a whole person. Because that part of my life was missing, and because that part of my life was missing, I as an individual, developed a low sense of self. I had no sense of who I was because I didn't that in school, I definitely didn’t get that in the community, I didn't get that in our society, where, as Haner described, all the mixed messages.

What I received as a young man was mixed messages, a false sense of what a man is supposed to be, so it took a long time, it took a process, for me to put me back on the road to becoming a young man and into a man but it was these programs that allowed it and put me on that road. And so I am forever grateful for the Hispanic Office of Planning and Evaluation, for their youth program, and I'm grateful for Casa Don Pedro Albizuo

Campos for their residential treatment program. I think Haner, when he gives a description of all the different issues and talks about all the problems, we can just sit there and imagine, and I'm sitting there, thinking about my personal, how I was involved in that and it affected me, and you look at the end result and you look at the fact that there are very few programs that service this I think we can really add it up and see that there is a need for these types of services, and I know that as an individual I have benefited extremely from these services. Thank you.

Mark Goldstein, MD

Chief of the Student Health Service and of Pediatrics, Massachusetts Institute of Technology; Assistant Clinical Professor of Pediatrics, Harvard Medical School

Introduction by David Satin, MD

How different are two communities, Wellesley and a Hispanic community? How they both respond to the demands, the horror, the wish for self-improvement, but with such different contexts. A context of an organized community, which is surprised at something, alcoholism and substance abuse, occurring among the youth, and a community which is inundated with alcoholism and other substance abuse in the context of trying to develop structure and identity and a format within which young people develop. Let us turn then to yet a third community.

Mark Goldstein is a graduate of the University of Maryland and Georgetown University School of Medicine, and a board-certified pediatrician, and assistant clinical professor of pediatrics at the Harvard Medical School. He is Chief of Pediatrics at the Student Health Services at the Massachusetts Institute of Technology as well as a member of the Division of Adolescent Medicine at the Children's Hospital Medical Center, and Chair of the Committee on Student Health and Sports Medicine of the Massachusetts Medical Society. Among his publications are the books, "Boys into Men: Staying Healthy Through the Teen Years" and "Guide to Adolescent Health." How much use would this be to the people in the Hispanic community or are you talking about a different world than they are talking about? Of interest are his 1998 presentation, "Death from Alcohol Poisoning: An Institutional Response" at the New England Health Association and the 1999 presentation, "Alcohol and the College Student" at the Children's Hospital. Here we can hear about an institutional community.

Mark Goldstein, MD—The University Community and Substance Abuse

Animal House, a 1970's movie classic, takes place in the Delta fraternity at a New England college. A spoof of college fraternity life in the 1960's, Bluto Blutarsky, played by John Belushi is a hard drinking, guitar smashing, garbage eating undergraduate. This film depicts the adventures of young college men whose sole purpose in attending college seems to be drinking, having sex and leading a hedonistic existence. Fast forward to September 1997: an MIT fraternity. Newly entered freshman Scott Krueger is comatose from a lethal ingestion of alcohol. He is rushed to the Beth Israel Hospital in Boston where he is connected to life support. After three days, no brain function is noted, and he is disconnected from his ventilator.

September 2000. MIT president Charles Vest travels to a suburb of Buffalo, NY, spends the day with the Krueger's, apologizes and agrees to a six million dollar settlement to avoid litigation in regard to the death of Scott Kreuger. As portrayed in Animal House, excessive drinking is not new to undergraduate students. The 1995 Youth Risk Behavior Surveillance Data by the Centers for Disease Control shed light on the prevalence of drinking in high school students. Depending on the state of residence between 16-48% of high school males surveyed and between 13-39% of high school females surveyed had a recent history of episodic heaving drinking. In Boston, the overall rate was 18%, and for the Commonwealth of Massachusetts, the overall rate was 33%.

In the same year, the National College Health Risk Behavior Survey, which was also conducted by the Centers for Disease Control, showed that the prevalence of episodic heavy drinking in white students was 39.5%, black students 12.5%, and Hispanic students 30.2%. The same survey also demonstrated that the 18-24 year old group had a 41.5% prevalence of heavy drinking, but the rate declined to 22.0% in the 25-year and older group. And Dr. Henry Wechsler from the Harvard School of Public Health, in his seminal studies of college drinking has repeatedly demonstrated an overall binge-drinking rate in the U.S. of 44%, and this prevalence rate has not changed, despite all of the programming, discussions, policy changes and treatments offered to our students.

Before we discuss how a university community can take ownership and responsibility for the alcohol abuse of its students, it is important to understand some of the risk factors for drinking in youth. According to Bill Polk, headmaster of the Groton School, 'The maze of life often looks most dismaying to adolescents. During a period of rapid emotional, intellectual and physical change, adolescents are faced with a confusing array of paths, each offering inducements, some highly risky. Our people must navigate them in a culture of deregulation in which the old sign posts, passed along from one generation to the next have collapsed.'

In the transition from high school to college, researchers have looked at predictors for heavy drinking in college students. In one study of 366 heavy drinkers in high school, four risk factors were evaluated as predictors of heavy drinking: gender, family history of drinking problems, prior conduct problems and college residence. Positive correlation with heavy college drinking was noted for males, students who resided either in a fraternity or sorority and a past history of conduct problems. In Baer's study, which was published in 1995, a family history of alcohol problems was not consistently associated with alcohol dependence symptoms in the students. Wechsler noted in the American Journal of Public Health 1995, these correlates for undergraduate binge drinking:

- Age less than 24 years

- Never married
- White
- Male
- Binge drinking in high school
- Parent not an abstainer and family approves of alcohol use
- Residence in a fraternity or sorority
- Parties are important to the student
- Religion is not very important
- Athletics are important
- Academic work is not very important

Other risk factors include a genetic predisposition: according to Wechsler, children of alcoholics are more likely to initiate drinking during adolescence compared to children of non-alcoholics. And certain psychiatric disorders are risk factors for alcohol abuse in college students. Alcohol abuse is two times as likely in students with anxiety disorder compared to those without it, and college students diagnosed with alcohol abuse were almost four times as likely to have a major depressive disorder compared to students who did not abuse alcohol. Students whose parents' have favorable attitudes about drinking have a positive correlation with a student's initiation and continuation of drinking alcohol. Lack of parental support, monitoring and communication is significantly related to alcohol abuse in teens.

Peer drinking, acceptance, and pressure are associated with adolescent drinking. Positive expectancies about alcohol are risk factors for adolescent drinking. Researchers have shown that positive expectancies increase with age and predict problem drinking. Werner, in the Archives of Pediatrics and Adolescent Medicine showed that students who became high-risk drinkers at Vanderbilt had stronger positive outcome expectancies for drinking at entrance to that university. Students who were initial high-risk drinkers and then moderated during college had increasing concerns for negative outcome expectancies. Risk factors for college drinking also include environmental pressures such as academic pressures, competition and workloads. Institutional bonding, drinking traditions, and the social milieu are other risk factors. The college culture- this is what we do for fun, we drink to relieve stress, and these are the games we play- all contribute to the risk for drinking on a campus. And if a college is in the midst of other colleges where heavy drinking is a social norm, than that is a risk factor.

Even the physical properties of a university may be risk factors for undergraduate drinking. Building design may facilitate or inhibit social interactions. Students feel more secure and satisfied in environments that emphasize support and involvement not unlike a village. The greater the number of students in a residence hall, the more

disconnected they can be and this can lead to increasing amount of drinking or other substance abuse. The organization of a college may be a risk factor for student drinking. Where fraternities and sororities are important to college life, there is a higher binge-drinking rate. Students who live in coeducational housing tend to be more independent and more moderate drinking norms emerge.

At the Massachusetts Institute of Technology, before September 1997, undergraduate drinking did occur frequently even though policies from the Dean's Office defined who could drink, where, when and the penalties were elucidated. At social events, underage students were not always carded; alcohol was served to all comers at certain events. In fact, the youngest students were given the dubious honor of mixing drinkers at social mixers. With the release of Henry Wechsler's studies, concern about drinking at MIT escalated, at least in certain areas of the university community. Core surveys of MIT undergraduates revealed our binge-drinking rate at 26%, which was well below the national level. However, secondary effects from binge drinking were noted in our students including insults, serious arguments, unwanted sexual advances and injuries.

Scott Krueger's death in 1997 was the catalyst for change at MIT. The climate at MIT in the ensuring weeks and months after his death was somber, depressed and reactionary. The administration became engaged at once with the alcohol problem on campus since MIT suddenly was catapulted in repeated assaults from the media in local and national news. Something had to be done. The village was in chaos. The initial responses to the problem were probably an over reaction. But the reaction seemed appropriate at the time. Parents, press and local governments were enraged that a brilliant, promising and handsome young man at a prestigious university lost his life due to excessive drinking. His photograph flashed repeatedly in the media, the Boston district attorney initiated a criminal investigation and a grand jury examined numerous witnesses and an investigation of the death ensued for a year. Students and administrators were worried about indictments. Parties with alcohol were banned, under age students who were drinking and transported to the Medical Department risked disciplinary reports and several fraternities were eventually closed down. A number of Deans left, were replaced or assigned new work roles, a chancellor position was created and the Working Group on Dangerous drinking was established co chaired by biology Nobel laureate Phillip Sharp and myself.

In establishing a community response to an alcohol problem, it is necessary to engage all members of that community. At MIT, through the working group, discussions were initiated with students, faculty, staff and clinicians. Parents of students were difficult to engage. Shortly after Scott Krueger died, MIT held a previously scheduled freshman parents weekend. At a session led by the President that I attended with parents

and administration, to say the least, the atmosphere was hostile and heated. The deliberations of the working group included discussions with national experts on alcohol abuse in youth, a review of the relevant literature and site visits to college residences. The Working Group established the following points:

- Dangerous drinking is prevalent at most universities and it is seen as a "rite of passage," a celebration from parental supervision and a product of peer pressures
- Poor academic performance, incomplete coursework and inappropriate behaviors are due to dangerous drinking and these problems were existent at MIT
- Drinking allowed students to be comfortable with social experiences especially since many MIT students seemed to be stressed in certain social situations
- Although the perception seemed that Scott's fraternity brothers did not give care for him when he needed care, the MIT community cared about its members and the members of the community cared about one another

Social norms are changed by reiterative processes of forming new understandings about appropriate behavior. These processes require education of the university community and leadership in articulating a new consensus. A highly visible new senior administrative position reporting to the president or chancellor was recommended by the working group. Duties were to include developing, coordinating and implementing educational programs about dangerous drinking, developing overall alcohol policies, establishing programs to change the acceptability of dangerous drinking, increasing the likelihood that students with drinking problems receive care and taking the leadership in communicating with the various constituencies.

An exhaustive national search for such a leader yielded no one. A retired MIT professor of linguistics took the helm for several years on a temporary basis. A search continues, almost three years after issuance of the Working Group's report, for an Associate Dean for Alcohol Education and Community Development. After the death of Scott Krueger, the Working Group felt that students had become increasingly reluctant to call for medical help for their dangerously intoxicated colleagues. Some of the reluctance was caused by the dual role of the Campus Police who provide EMT service in addition to playing a law-enforcement role on campus. Intoxicated underage students, transported to the MIT Medical Department for care, would be cited and reported to the Dean's office for possible disciplinary action. Although the Working Group recommended immunity to students and their living groups when students were

transported in an intoxicated state to the Medical Department, this granting of immunity has not occurred.

The culture of a community such as MIT is quickly communicated to freshmen. In fact, the culture is often conveyed before an accepted student accepts MIT as may occur in a spring revisit. Community cultural change occurs only when educational outreach is performed in a proactive, not a reactive manner. The working group suggested that information about dangerous drinking issues be communicated expeditiously to incoming students. Parents were asked to talk about alcohol to their rising freshman during the summer before matriculation, and MIT forwarded educational materials to all parents of pre frosh.

MIT has previously considered its students as adults; after all they were intellectually capable of adult thinking. But developmentally all need to go through the steps and processes of adolescence. And in my view, this has been a major issue in community understanding. Students are adolescents and they need the support, guidance and wisdom from the village. The tasks and risks and conflicts of adolescence need to be passed through by all including our best and brightest. Faculty have felt if students are capable of winning an acceptance to MIT, then these students are capable of managing their own affairs. The working group recommended adult supervision in fraternities as well as during fraternity rush.

Criticism was aimed at the MIT administration because the university did not have sufficient housing for all freshmen. As a result, it was perceived that the university encouraged freshmen to live off campus in fraternities or the so-called independent living groups. In these groups, devoid of adult supervision, risky and dangerous behaviors were more likely to occur. And if MIT did not have a housing problem, some say Scott would be alive today. Realizing and reacting to this criticism, MIT administration promised to have a new dormitory built for 2001 so all freshmen could be housed on campus. And the working group felt strongly that requiring freshmen to live on campus would reduce their risk of being involved in dangerous drinking activities. When the new dormitory opens a year later than scheduled, all freshmen will be required to live on campus and under the supervision of faculty housemasters and graduate student tutors.

What else can a university community do to decrease dangerous drinking? Social marketing was considered. Students may drink excessively due to the perception that everyone else is drinking. Social marketing attempts to correct that perception by advertising that a community has a lower drinking rate among its students than is generally thought by the student body. Some research studies indicate that social marketing may lower the overall drinking rate. However, close analysis of the research

showed flawed methodology. The Medical Department held many educational sessions with students regarding the metabolism of alcohol and dangerous drinking.

The university may identify potential alcohol abusers early in their college career. The literature supports the effectiveness of brief interventions in the treatment of alcohol problems. Orford in 1976 found that a brief contact with a medical professional was as effective as a two-week inpatient hospitalization for alcoholism especially for those individuals with less severe dependence. At the University of Washington, alcohol-screening questions were embedded within a broader screening of health behaviors, and the questionnaire was administered to some of the undergraduate students. High-risk alcohol use included but was not limited to binge drinkers.

High-risk drinkers were identified and two 50-minute sessions were scheduled with a counselor. The first session was devoted to assessing use, negative consequences and associated risks from alcohol. At this session the therapist sought to build rapport with the student, orient the student to the purpose and structure of the meeting and gain commitment from the student to participate in the intervention. A second appointment was scheduled preferably two weeks later. The second session was devoted to providing personalized feedback and advice about the student's pattern of alcohol use and the risks associated with the use. Individual risk factors including positive expectancies, family use of alcohol and undesirable consequences of alcohol were reviewed. There are many published studies, which find that brief interventions by trained therapists with problem drinkers are more effective than no counseling and as effective as more interventional treatment.

MIT is planning a pilot program on alcohol abuse, which would begin with a web-based questionnaire to be completed by undergraduates. Each student would be paid to return a questionnaire. The responses would be screened and a pilot class selected to be followed. They would be interviewed later in the year after their patterns of behavior had been established. Each high-risk student would be interviewed by counselors and followed up. Program costs for the pilot may approach $80,000 for one year. More than 3 ½ years after the death of Scott Krueger, cultural change has occurred at MIT but at a slow pace and with many problems. The university community, the surrounding cities and towns, colleges as well as alumni mediate culture. The alcohol culture is promoted externally to the campus community by mass media including films, newspapers and magazines, websites, television as well as the behavior of adults, which includes parents, Hollywood, sports figures and leaders in the government. Internally, the "work hard, play hard" ethic at MIT persists and will remain so. While there are suggestions that there are fewer students seen for drinking problems at MIT, this may be artifactual and may be related to the transportation problem. In fact, underage drinking may have been

driven underground. There is no solid evidence, however, that other substances have been substituted for alcohol.

Changes have occurred at MIT since Scott Krueger's death.

- The administration including the President, Chancellor and Deans are engaged and concerned about the drinking problem
- Energy is devoted to programming
- Budget is devoted to alcohol issues
- Housing is being built for Freshmen
- The concept that freshmen need to pass through all of the stages of adolescence is becoming more credible
- Effective September 1, 2001, students who buy the MIT hospitalization plan may have unlimited outpatient mental visits each year with no co pay

Scott Krueger's class will graduate from MIT this June and with their departure the students who knew MIT before his death will be alumni. The members of a university community pass the culture of that community and as the classes come and go, inevitably the culture around alcohol use will slowly change.

In Animal House, a fraternity brother's girlfriend drinks herself to a stupor, performs a strip tease and falls into an alcohol induced sleep. Her boyfriend debates whether or not to have sex with her and the viewer does not know what actually transpires. Except we do know that the inebriated coed is transported to her parents' house in a shopping cart, the fraternity brother rings the doorbell and flees away into the darkness of the night shirking his responsibilities.

More than 30 years after Animal House, we still deal with the same issues. As Kara Loewentheil, a Yale sophomore, wrote in the *Yale Alumni Magazine,* 'It's hard to be anywhere at Yale without your brain engaging in high gear. It's perfectly understandable that Yale students need a way to escape a bit. We don't do yoga. We don't sit around and stare at the walls. Instead, we go drinking…'

A lesson learned is that behavior around alcohol use cannot be legislated. Community change will occur if there is vision and leadership at the top as well as at the grassroots level. While change must occur at the individual level, one cannot lose sight of that individual's placement in the university community, the extended community and society. Dangerous drinking in our students is not necessarily the fault of bad parenting, risky peers, uncaring college administrators, reckless media or our rapid paced highly wired society: it is the result of many factors including a broken village. The questions remain: do we want to change, should we start to change, where do we begin change and how do we change? Is now the time to rebuild the village?

Howard Koh, MD, MPH

Commissioner, Massachusetts Department of Public Health

Introduction by David Satin, MD

I don't know how to generalize that. In thinking about the issue of not drug abuse, substance abuse among young people but to each reaction to substance abuse among people, the three different communities seem to offer three different responses. Wellesley, communities that tried to bring as many as possible of these participants together to address the issue. The Hispanic community is one that seems to rely on activists within the community, and resources, organizations within the community, to provide services to the community as a whole, to offer them some kind of foundation, some kind of solid place from which to address the substance abuse issue. And the administration with authorities who've thought about the problem of the community and decided what should be an appropriate way of handling the residents in the community, but also the institution, the institutions' interests, the institutions' willingness to allocate resources.

Three very different ways of reacting. We looked for someone who could give us an overview on this public health issue. Remember, Erich Lindemann was somebody who more or less introduced the idea of mental health as a public health issue that could be dealt with in terms of epidemiology, causation, public health preventive measures. We're fortunate to have Howard Koh who is commissioner of the Massachusetts Department of Public Health since 1997. He's a graduate of Yale College and Yale University School of Medicine, and nationally known in the area of cancer prevention, tobacco control and Asian American health issues. He was, perhaps still is, Professor of Dermatology, Medicine and Public Health at the Boston University Schools of Medicine and Public Health. At the Department of Public Health he has exercised the power of prevention and strengthened its commitment to diversity and eliminating health disparities in multicultural and minority populations.

Howard Koh, MD, MPH—A Public Health Policy on Substance Abuse

Thank you Dr. Satin, thank you to the audience and to my colleagues on the panel. Tremendous presentations this afternoon, so it's my honor to try to wrap this up and to give you some unifying themes as commissioner of public health, and to hopefully chart some suggestions for the future. I couldn't help but thinking as I heard these presentations that there's a wonderful line in the document, "Healthy People 2010"--and that's the public health blueprint for the community for the next nine, 10 years. There's a

line that was ringing through my head and that is, 'The health of the individual is inextricably linked to the health of the community,' and that's actually what public health is all about.

I'm a physician, as some of my colleagues are here on the panel, and I was trained as a medical student to think that if you're the best doctor in the world, which I try to be, as all the doctors try to be, and you took care of your patients very well that your community would be healthier, but I have evolved into public health because I realize that to truly have a healthy society you need the total community involved. That's what today is truly all about. So we've heard about some communities and their responses to this tremendous public health challenge of substance abuse. I've also come to learn as commissioner of substance abuse is not simply a health problem.

When you think of how it affects young people, older people, its effects crime, on violence, on sexual assaults, on drunk driving, on mental health, on criminal justice, this is a societal problem from top to bottom. Everybody is affected by the problem, everybody has to be part of the solution. That's what we've just heard this afternoon. I'm often asked, 'What are the biggest challenges in public health and what are the most important issues?' and some people would say it's understanding emerging technology, some would say it's cracking the human genome, which has just been cracked, some would say it's health care. These are all important issues, but I always contend that the major public health challenge that's facing us today is and will always be understanding and changing human behavior. This is incredibly important and incredibly hard. And the theme you kept hearing this afternoon is relevant to that theme because we have a culture of substance abuse that affects all of us.

All human beings are susceptible to addiction, whether we like to realize that or not, and we have glamorized substance abuse, or we have allowed it to be glamorized. I was struck when multiple presenters that this was a rite of passage, that's true. That's a rite of passage for our kids and as a father of three teenage kids I wrestle with this in my other hat as a dad. I am very touched by the story of Scott Krueger because that tragedy occurred within days of me starting my job as commissioner in September, 1997. In some ways that was not only a watershed for MIT and for Massachusetts but for me personally. I was struck by Dr. Goldstein's comments on Animal House, because that's the culture that normalizes and glamorizes substance abuse, so changing human behavior is our biggest challenge and we've heard some comments about how we might do that.

I think the challenge for all of us is that we get everybody involved to deglamorize and denormalize what is destructive and potentially addictive behavior, and try to do this in every conceivable fashion and weave in a theme of health into the process, and you've heard many examples of how we've tried to do that on a college campus, in a town and in

a particular ethnic culture. That's what we're trying to do in public health as we tackle this particular issue. Tobacco has been raised multiple times as an area where we're making a huge difference, and we are. We have probably the best anti-tobacco programs in the world here in Massachusetts and I'm very proud of that. And if I point to tobacco, which is, obviously, the major form of substance abuse, this is an area where we're changing the norm. we're deglamorizing that addiction, in actually a pretty rapid way.

In tobacco we have focused on treatment but also prevention, mostly because we have a tobacco tax that funds prevention efforts, and our anti-tobacco media is trying to change the norm in every conceivable way and we're making a difference because of the drop in cigarette consumption. I'm hoping we can do the same for substance abuse. It's much harder in some ways because whereas tobacco is, I call myself, slow-motion suicide, alcohol and other drugs devastates lives more acutely, so most of the funding in our state is in treatments. We have a continuum of services that's been alluded to, with detoxification centers, recovery homes, outpatient centers. What I'm hoping that we can do even more with respect to prevention, because ultimately that's how we're going to solve this problem, and I really respect the efforts of all my colleagues on the panel for promoting the power of prevention, we have a mission statement at the Department of Public Health.

Our mission is to help people lead healthy lives in healthy communities, and the next line reads 'We believe in the power of prevention,' and I often tell my audiences that I moved into public health because as a physician I saw too much suffering that I knew could be prevented. It frustrated me, as I'm sure it frustrates all physicians. The public health community-wide approach is a way of maximizing the power of prevention. In Dr. Stone's excellent presentation I was very much struck about her comments on behavior change, and most people who are not experts in this area think about behavior change in very black and white terms. I'm actually referring legal use or illegal use, or use versus abstinence, sort of on-off, black-white, but Dr. Stone mentioned, I thought very appropriately, that there's a continuum in reduction and we have to keep educating ourselves about this, that changing behavior takes multiple steps.

I also liked Dr. Stone's comments on moving from higher-risk behavior to lower-risk behavior, again stressing that continuum. I believe these are all things that we're trying to promote at the Department of Public Health through many areas: Substance abuse, tobacco control, cancer screening, HIV, cardiovascular disease, prevention--these are all areas where we try to change the health of the individual by focusing on the health of the community. Let me close by saying that the whole area of youth and substance abuse is one that has now really grabbed my own passion. I'm convinced that as a public health commissioner I can only do so much governance. I was particularly struck as I got involved in homelessness issues how substance abuse plays a role in that societal issue

too. About a year ago I helped convene what I'm told is one of the fist interagency substance abuse task forces in government. So we have been meeting every several months attended by the commissioner of mental health, a very close colleague; Department of Youth Services Commissioner of Social Services; Commissioner of Transitional Services, used to be called welfare; Massachusetts Behavioral Partnership and the Commissioner of Medical Assistance. And we are also inviting members of the Criminal Justice System, the juvenile court, our chief justice.

I have the honor of chairing this group and we are putting a lot of these issues that you've heard on the table at the highest levels of state government and the message that I'm trying to promote as the chairman founder of this group is to say this is a societal issue, we need to address it together with every resource that is at our disposal, and we need to engage everybody in the community, not just certain segments because the impact is felt by all of us. So I hope in the future I can come back and tell you we are making progress. At the very least we're increasing communication amongst parts of government we are expanding substance abuse education and training for colleagues in other parts of government, and in public forums like this that I see how communities are empowering themselves. That's very, very inspiring and very encouraging.

Ultimately this is for the next generation, and if we have to leave a legacy for the next generation I can't think of a more important legacy than the legacy of changing social norms regarding substance abuse. If we can do that in our lifetimes we will have done something very important that should have a very long-lasting effect. That's why we're all here today. Let me end and also apologize by saying that family commitments are going to force me to leave a little earlier than I would have liked, but I do want to thank again Dr. Satin and the committee and especially my co-presenters. These were some really very thoughtful presentations and as one who is charged with making sure that six million people in Massachusetts are as healthy as possible I am very happy to see colleagues like those on this panel who are really making a difference. Thank you very much.

Discussion

David Satin:

Thank you, Commissioner. I wonder how to start off the discussion. We're here to hear about different communities and how they address their own mental health problems, in this case, youth substance abuse. The commissioner has made clear that the Department of Public Health responds to the needs of the communities and responds to the input of the communities, so maybe we can do two things to start off and people can join in from the audience with observation, experiences and suggestions. What can we teach one another about how to deal with this problem of youth substance abuse? What can we learn from one another and what we know advise one another more about how to deal with this issue, and how can all three of these communities advise the commissioner about what is a good way the community responds to address, hopefully to prevent, youth substance abuse?

Lisa Stone:

I'll volunteer. I think one of the things that struck me the most that growing realization for me personally that this issue belongs in the gray zone, but the other thing that I've learned and what I was struck with today is that whenever we do something, it's sort of the laws of fitness: for every action there's a reaction. We've also found in our community that can lead to drive the behavior underground and what we found when we investigated the episodes, that we had of seven teenagers dying nearly all of them were related to the fact that the students had made a decision to, and had planned it out in advance, but had very little time outside the eyes and the ears to accomplish them all. And it put them at very high risk. But in the Latino community, where there's so much, and my community was so frightened by seven near-tragedies, and you have real tragedies all the time, and so, I mean, maybe it's the dilemma of needing to get into the gray zone of not too much surveillance that could increase the risk, but yet enough surveillance to decrease the risk, particularly in youth. So it just strikes me that there is always this tension.

Howard Koh:

I agree with that. I find that one of the biggest problems in my work is convincing others it's from the university community, and it's hard to convince them that alcohol issues seriously hit students. And for years for alcohol use there was very little budgetary money available for that in until the tragedy changed attitudes, but attitudes still can burn slowly and as I mentioned plans to change with time and culture may change but administrators don't necessarily change, and adults are also influenced by all the mass

media. A number of these people are drinking when they come to college. We inherit it. Some start drinking in college, but many have started in middle school and even more so in high school and so in a sense we're trying to deal with that, but knowing that the problem is conceived before they come to college.