Designing a Strategic Plan: Preventing and Reducing Alcohol and Other Drug-Related Harms on Campus

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The college student drinking prevention field has grown a great deal – let’s look at some select highlights

College student drinking hit the radar of researchers in 1945

Fry (1945)

- “These parties are often attended by faculty members, some of whom are selected to respond to the chant, ‘Old Prof. _____ is in the alcohol ward _______, Drink, Drink, Drink.’ Cheers, or moans, and laughter follow this performance according to the speed with which the professor empties his glass. These parties break up after a few hours of song and good fellowship. They do not occur often, but are part of the life of colleges and are accepted by the community as such.” (p. 244)

Fry (1945)

- “Wine is often served at fraternity dinners in the hope that members will learn to appreciate proper wines with food.” (p. 244)

- “Although milk and soft drinks are extremely popular in American colleges – the consumption of them being greater than other beverages – a special snobbism is sometimes to be associated with the appreciation and knowledge of fine wines.” (p. 244)
Fry (1945)

- Warns that a “state of intoxication” could be the primary purpose of some events.
- Discusses the opportunity for returning veterans to attend college, and speculates on the role alcohol might play related to coping when under pressure in the college setting.

Larger, even national studies, investigate the issue

Strauss & Bacon (1953)

- First widespread study of drinking at 27 colleges
Calls for effective prevention options are made, particularly as laws change

College Alcohol Study – differences from 1979 to 1985

- Task force or committee focusing on alcohol education and prevention
  - 1979: 37%
  - 1985: 64%

- Dedicated alcohol education coordinator or specialist
  - 1979: 14%
  - 1985: 48%

Gadaleto & Anderson (1986)

College Alcohol Study – differences from 1979 to 1985

- Articles in campus publications (76%)
- Films shown on campus (63%)
- Speakers (63%)
- Workshops focusing on drinking attitudes (61%)
- Poster and slogan campaigns (60%)
- Educational handouts prepared by campus groups (51%)
- Discussion groups (50%).

There was recognition of the need to address college student drinking, yet no clear guidelines on how to best do this.

Gadaleto & Anderson (1986)
Legal drinking age changes to 21 for all 50 states in 1988

- Increases to the drinking age resulted in decreased traffic crashes and decreased alcohol consumption (Wagenaar & Toomey, 2002)
- However, initial evaluations focusing on college students showed everything from shifts in where students did their drinking (George, Crowe, Abwender, & Skinner, 1989) to students’ efforts to avoid getting caught when policies were enforced, often associated with increases in risk-taking (Brittain & Roberge, 1988).

Roberts & Nowak (1986)

- “Another approach that may help during and after the transition to the minimum drinking age of 21 would be to make funds available to institutions of higher education to develop, test, and disseminate information about model alcohol education programs. Approaches to alcohol education are already in use. These approaches need to undergo rigorous evaluation and then be made available for application throughout college campuses. (p. 489)”
“A Call to Action”

NIAAA College Drinking Task Force Tier System Emphasized
Need to Use Evidence-Based Strategies, Measure Outcomes

- Tier 1: Evidence of effectiveness among college students (≥2 studies supporting efficacy)
- Tier 2: Evidence of success with other populations that could be applied to college environments
- Tier 3: Evidence of logical and theoretical promise, but require more comprehensive evaluation
- Tier 4: Evidence of ineffectiveness

www.collegedrinkingprevention.gov
Tier 1: Evidence of Effectiveness Among College Students

- Combining cognitive-behavioral skills with norms clarification and motivational enhancement interventions (ASTP only program mentioned by name as an example).
- Offering brief motivational enhancement interventions (BASICS only program mentioned by name as an example).
- Challenging alcohol expectancies.

From: “A Call to Action: Changing the Culture of Drinking at U.S. Colleges,” NIAAA Task Force

Mainstream coverage

- Estimates of morbidity and mortality in a paper by Hingson and colleagues (2002)
- Week of April 9, 2002
  - New York Times
  - CNN
  - San Francisco Chronicle
  - USA Today
  - Fox News

“What Colleges Need to Know Now: An Update on College Drinking Research” (2007)
“What Colleges Need to Know Now: An Update on College Drinking Research” (2007)

- Toomey and colleagues showed few studies available at the time of the 2002 review and evaluations of 110 environmental approaches published (of which 36 specifically targeted college students) at the time of the 2007 review.

What did this translate to on college campuses 8 years later?

NIAAA College Drinking Task Force Report Leads to Important Progress; Still Room For Improvement

- 79% of colleges aware of task force report
- Over half were implementing at least one evidence-based individual strategy
- Only 1/3 were implementing an evidence-based environmental strategy
- 98% of colleges provided some sort of education regarding alcohol (most not evidence-based)
- Larger universities with better resources more likely to implement task force recommendations
Moving beyond the Tiers of effectiveness to compiling a comprehensive strategic plan

College Alcohol Intervention Matrix (College AIM)

Overarching Goal of College AIM

Increase the likelihood that research will inform interventions to address drinking on campuses by providing a framework for schools to compare and select evidence-based intervention strategies.
Two Development Teams

<table>
<thead>
<tr>
<th>Individual Strategies</th>
<th>Environmental Strategies</th>
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</thead>
<tbody>
<tr>
<td>Mary E. Larimer</td>
<td>Traci L. Toomey</td>
</tr>
<tr>
<td>Jessica M. Cronce</td>
<td>Toben F. Nelson</td>
</tr>
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<td>Jason R. Kilmer</td>
<td>Kathleen M. Lenk</td>
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University of Washington  
University of Minnesota

Development Process

- **Phase I:** identifying interventions to be included in CollegeAIM, finalizing dimensions on which they would be evaluated, and developing coding system
- **Phase II:** Identifying, reviewing, and rating the substantial research literature on college alcohol interventions
  - Ultimately, rated nearly 60 interventions on multiple dimensions

Decision Parameters

- **Relative Effectiveness** – insufficient, not effective, limited, moderate, higher
- **Amount /Quality of Research** – 0, +, ++, ++++, ++++
- **Relative Monetary Costs for Program and Staff for Adoption and Implementation/ Maintenance** – lower, mid-range, higher
- **Relative Magnitude of Barriers** – higher, moderate, lower
- **Staffing Expertise** – policy advocate, coordinator, health professional
- **Strategy Level** – federal, state, local, college
- **Public Health Reach** – broad vs. limited
- **Targeted Population** – underage, all students, individuals, small groups
- **Research Population** – college vs. general
- **Short/Long-term Effects (individual-level only)** – short-term effects (yes/no), long-term effects (yes/no), not assessed
- **Primary Modality (individual-level only)** – individual, group, online
Phase III: Iterative review process

- 10 additional college alcohol researchers reviewed ratings, applied their knowledge and professional judgment, and provided detailed feedback

- Through multiple rounds of review and revision, consensus process distilled decades of research and hundreds of studies into a user-friendly decision tool
NIAAA’s CollegeAIM

- How can schools use CollegeAIM?
  - Review individual and environmental strategies to compare approaches
  - Find new evidence-based options to replace less effective strategies or address gaps
  - Anyone reviewing CollegeAIM can use the interactive strategy planning worksheet to select a combination of approaches based on needs and budget

Where does College AIM fit in the planning process?

- Assess behavior on campus and set priorities
- Select
- Take action
- Plan
Where does College AIM fit in the planning process?

Assess behavior on campus and set priorities

Select strategies after exploring evidence-based interventions

Select

Take action

Plan

Assess

Take action

Plan

Assess

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Assess behavior on campus and set priorities

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Assess behavior on campus and set priorities

Select strategies after exploring evidence-based interventions

Implement the chosen strategies, evaluate them, and refine the program

Select

Plan

Take action

Assess

Plan

Take action

Assess

Implement the chosen strategies, evaluate them, and refine the program
Enforce Age 21 Drinking Laws

Electronic CHECK UP TO GO (eCHECKUP)

“A mix of strategies is best” (p. 5)

Alcohol Skills Training Program (ASTP)

Brief Alcohol Screening and Intervention for College Students (BASICS)

Restrict Happy Hours & Price Promotions

Start with a compilation of what is already offered
Then, consult College AIM!

So what does the matrix look like?

There are two! One for individually-focused approaches, one for environmental-level strategies.
Select a strategy to see ratings, references, and potential resources.

www.collegedrinkingprevention.gov/CollegeAIM

www.collegedrinkingprevention.gov/CollegeAIM

Click on strategies to print for reference or discussion.

www.collegedrinkingprevention.gov/CollegeAIM

www.collegedrinkingprevention.gov/CollegeAIM
Possible Barriers to Implementing Effective Interventions on College Campuses

- Barriers can exist to dissemination, adoption, implementation, and maintenance (Rogers, 1995)

Source: Larimer, Kilmer, and Leo, 2005
Possible Barriers to Dissemination in Implementing Effective Interventions

- Published findings appear in journals not oriented to clinicians (Sobell, 1996)
  - Often little description of steps needed to apply a treatment or intervention

Source: Larimer, Kilmer, and Lee, 2005

Possible Barriers to Dissemination in Implementing Effective Interventions

- Some publications or evaluations are not “user friendly” (Backer, 2000)

Source: Larimer, Kilmer, and Lee, 2005

Possible Barriers to Adoption in Implementing Effective Interventions

- Reactions from key individuals involved in the process (DeJong and Langenbahn, 1996)
  - Diversity of opinion around how to proceed
    - Could lead to difficulty in committing

Source: Larimer, Kilmer, and Lee, 2005
### Possible Barriers to Adoption in Implementing Effective Interventions

- Unreasonable expectations (Liddle, et al., 2002)
- Insufficient “buy-in” (Liddle, et al., 2002)
- Not enough time working with directors, administrators, staff, or students

Source: Larimer, Kilmer, and Lee, 2005

### Possible Barriers to Implementation in Implementing Effective Interventions

- Proper training of those delivering a program
- A tendency to “reinvent” innovations (Rohrbach, D’Onofrio, Backer, & Montgomery, 1996)

Source: Larimer, Kilmer, and Lee, 2005

### Possible Barriers to Implementation in Implementing Effective Interventions

- Organizational factors (Simpson, 2002)
  - Resources, issues impacting effective delivery, attitudes among leaders, etc.
- Resistance among staff familiar and comfortable with a prior approach (Liddle, et al., 2002)

Source: Larimer, Kilmer, and Lee, 2005
Possible Barriers to Maintenance in Implementing Effective Interventions

- Therapist drift (i.e., issues of fidelity)
- Need for ongoing assessment and continued training

Source: Larimer, Kilmer, and Lee, 2005

Possible Administrative Barriers in Implementing Effective Interventions

- Tendency to move toward “next best thing”
  - One approach being pursued at the expense of another
- Concern that directing attention or funds toward a behavior indicates that “problem” exists

Source: Larimer, Kilmer, and Lee, 2005

Suggestion: Compile a team from across campus that can represent multiple insights and needs
Suggestion: Individually-focused approaches must be packaged with environmentally-focused approaches, and vice-versa.

Suggestion: Make sure brief interventions are a component of what is offered, and consider importance of harm reduction approaches.

**Spectrum of Intervention Response**
**What is Harm Reduction?**

- The most harm-free or risk-free outcome following a harm reduction intervention is abstinence.
- Any steps toward reduced risk are steps in the right direction.

**How are these principles implemented in an intervention with college students?**

- Legal issues are acknowledged.
- Skills and strategies for abstinence are offered.
- However, if one makes the choice to drink, skills are described on ways to do so in a less dangerous and less risky way.
- A clinician, facilitator, student affairs professional, or program provider must elicit personally relevant reasons for changing.
  - This is done using the Stages of Change model and Motivational Interviewing.

**The Stages of Change Model**


<table>
<thead>
<tr>
<th>Stages and Interventions</th>
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<tbody>
<tr>
<td>Pre-contemplation</td>
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<td>Contemplation</td>
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<td>Preparation</td>
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<td>Action</td>
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<td>Maintenance</td>
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Motivational Enhancement

Assessment Skills Training

Relapse Prevention
Motivational Interviewing


Brief Interventions and Motivational Interviewing

- Non-judgmental
- Non-confrontational
- Meet people where they are
- Elicit personally relevant reasons to change
- Explore and resolve ambivalence
- Discuss behavioral change strategies when relevant

What is resistance?

- Resistance is verbal behaviors
- It is expected and normal
- It is a function of interpersonal communication
- Continued resistance is predictive of (non) change
- Resistance is highly responsive to our style
Goals of a Brief Intervention

- When there are signs of potential risks and/or existing harms, provide early intervention.
- If ultimately in line with what motivates the individual, prompt contemplation of change.
- If ultimately in line with what motivates the individual, prompt commitment to change or even initial action.
- Reduce resistance/defensiveness.
- Explore behavior change strategies and discuss skills to reduce harms.

What does it mean to “do” BASICS?

- The “AS” is the alcohol screening
  - Originally a separate in-person session
  - Subsequently achieved online, but BASICS does require a screening

- The “I” is the intervention
  - Originally a second in-person session guided by personalized graphic feedback
  - Personalized graphic feedback delivered online/in-print without interaction with a facilitator (PFI) is not BASICS
  - Intervention must be delivered with fidelity (meaning adherence to MI spirit, style, and strategies)
**Suggestion: Consider SBIRT where appropriate**

**Screening:** Universal screening for quickly assessing use/severity/risks

**Brief Intervention:** Motivational/awareness-raising intervention to prompt contemplation of or commitment to change

**Referral to Treatment:** Referral to specialty care or follow-ups

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They may not seek help for these issues, but they do go to:

- Health Center
- Counseling Center
- Academic Advising
- Meetings with coaches or trainers
- Wellness Center
- Meetings with RAs
- Conduct
- Other Student Life offices
Each of these settings provides the opportunity to…

- Formally screen
- Informally screen
- Provide brief intervention (where ethical and applicable)
- Point students in the direction of other support services

Referral to treatment/services

- Richter, et al. (2016) followed 1,054 participants in one of two conditions related to tobacco cessation
  - “Warm handoff” – staff called the Quitline, notified the Quitline that a person was on the line, then transferred the call to the patient
  - Fax referral – staff fax referred patients to the Quitline on the day they were discharged
- Percentage enrolled in Quitline services:
  - Warm handoff participants: 99.6%
  - Fax participants: 59.6%
- No difference proportion of those who had quit at follow-up

Referral to treatment/services

- Boudreaux, et al. (2015) looked at 5 models among emergency department patients who received a referral for alcohol use
  - (1) Warm Handoff – clinician-facilitated phone call
  - (2) Patient Direct – patient-initiated call made during visit
  - (3) Electronic referral
  - (4) Patient choice
  - (5) Modified patient choice between 1 & 2, offered 3 if 1 & 2 were declined
- 90% consultation completion when referral was made in session vs. 10% consultation completion when referral was made after the session
Suggestion: Consider role of parents

Launched February 2017

Source: Healthy Youth Survey, 2014

GOT IT FROM PARENTS WITH THEIR PERMISSION

Source: Washington Young Adult Health Survey (Kilmer: PI)
Examining role of parents and peers

- Fairlie, Wood, & Laird (2012) collected data during summer before starting college, 10 month follow-up (spring semester of first year), and 22 month follow-up (spring semester of second year).
- Looked at social modeling (e.g., # of close friends who drink heavily, perceived friend approval of drinking and getting drunk) and parental permissiveness

Heavy episodic drinking as a function of high or low social modeling + high or low parental permissiveness
Suggestion: Consider opportunities to emphasize positive community norms

Suggestion: Consider consistency of enforcement and effectiveness of policies
Increased enforcement of minimum drinking age laws.
- Studies show that increased enforcement, particularly with compliance checks on retail outlets, cuts rates of sales to minors by at least 50 percent.

NIAAA (2002); NIAAA (2015)

Environmental strategies/factors

Implementation, increased publicity, and enforcement of other laws to reduce alcohol-impaired driving.
- Lowering legal limits to .08%
- Using sobriety check points
- Providing server training intervention
- Instituting administrative license revocation laws
- Seat belt laws

NIAAA (2002); NIAAA (2015)

Restrictions on alcohol retail outlet density.
- Higher density of alcohol outlets is associated with higher rates of consumption, violence, other crime, and health problems.
- Higher level of drinking rates associated with larger number of businesses selling alcohol within one mile of campus

NIAAA (2002); NIAAA (2015)
Rubington’s R.A. Research  
Rubington (1993, 1996)

- Suggests that sanction data change because residents and R.A.’s negotiate what will and will not be sanctioned.
  - If there is a decrease in violations...
    - Is the policy working?
    - Are students “wising up” as to where and when to do their drinking?
    - Are R.A.’s getting less strict in their enforcement?

Rubington’s R.A. Research  
Rubington (1993, 1996)

- Different R.A. styles (“by the book,” “laid back,” or “in between”), and there is variability in styles of enforcement depending on the site of the offense
  - Too laid back can cause loss of control on one’s floor
  - Too strict can result in efforts to circumvent the policy

Support for policies and enforcement is there!

- A small group students may be quite vocal on campus to the point administrators withhold policy changes assumed to be unsupported by the student body (Lavigne, et al., 2008)

- Among students, Saltz (2007) found a “universal tendency” to underestimate student support for policies
Saltz (2007) conclusions (p. 459)

- “...camps would actually have more incipient support for a variety of alcohol prevention policies than is likely to be perceived by the students themselves, and, by extension, administrators and others belonging to the campus community. “
- “...Unless students are persuaded that such support is not limited to a fringe element, new policies are likely to be met with at least passive, if not active, resistance.”
- “...This then, suggests that today’s campus prevention interventions, which now often comprise campaigns to correct students’ perception of peer alcohol consumption, may want to incorporate a parallel effort to correct their perception of peer support for policies as well.”
- “This information may prove revelatory to some, and critical to the chances of having a significant impact on alcohol-related problems on campus, which is the ultimate target.”

Our Work Is Not Done

- More research needed on...
  - Retention of students (and examining impact of substance use on this)
  - Strategies in College AIM with insufficient research
  - Best packaging of approaches
  - Cultural adaptations
  - Continued evaluation of texts/technology as component of prevention
  - Overlap of substance use and other health issues
  - Simultaneous/occurring substance use
  - Effective prevention and intervention for marijuana
  - Effective prevention and intervention for non-medical use of prescription substances
Final Suggestion:
Remember, every one thing you do is part of an overall puzzle

GO HUSKIES!!!!!

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