Alcohol, Tobacco & Other Drugs
SectionConnection
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UNDERAGE DRINKING: THE STORIES OF GORDIE AND MARK

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IN THIS ISSUE

President Barack Obama drew heavy support during his campaign from young voters for his pledge to reconsider many aspects of drug prohibition. But what about the nation's outdated drinking laws which deny the legal consumption of alcohol to anyone under 21?

No responsible-thinking person would ever support underage alcohol use or underage drinking and driving. However, most adults do not believe that young people entering college at roughly age 18 wait until they are seniors in college before they use alcohol. One may consider that, irrespective of the statistical decrease in underage drinking-and-driving fatalities nationwide, there has been an increase in underage drinking that cannot be ignored. For example, the surgeon general says more than 3,000 Americans under the age of 21 are dying every year from alcohol-related causes other than driving, including homicide, suicide, and alcohol poisoning. As an example consider the terrible tragedy of Gordie Bailey.

Gordie was an 18–year-old freshman at the University of Colorado in 2004. He had been there only one month when he underwent a Chi Psi fraternity initiation with 26 other pledges, all of whom were also underage. According to Leslie and Michael Lanahan, Gordie's mother and stepfather, the pledges were asked to drink 10 gallons of hard alcohol and wine in one half hour as part of the initiation. "You were certainly viewed as a better man if you could handle more," his mother told Leslie Stahl (2009) during a CBS Investigative Report broadcast on *60 Minutes*. Asked how much Gordie actually drank, his stepfather told Stahl, "He had had 15 to 20 shots if you had to measure it. They were not putting it into shots and drinking it. It was just guzzling out of the neck of the bottle" (Stahl, 2009). By the time the group got back to the fraternity house, Gordie was incapacitated. The police report indicated that "[h]is eyes were rolling back in his head and he couldn't walk. This isn't somebody who'd just had too much to drink. He was clearly in trauma" (Stahl, 2009).

The fraternity brothers put Gordie on the library couch and simply left him there. Alone. The chief police investigator involved in the case told Gordie's mother and stepfather that

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"Gordie lay passed out on a couch for nine hours until someone called 911 for help. …The president of the fraternity did ask several [fraternity] brothers at intervals to go in and take Gordie's pulse, as if to say, 'Tell me if he's alive or dead.'" A student told a 911 operator, "We got a guy who's passed out. He drank way too much and we found him this morning." Asked if Gordie was breathing, the student told the operator, "I don't know. He's not waking up" (Stahl, 2009).

Gordie died alone in an empty room with his friends surrounding him. Gordie died of alcohol poisoning. This preventable tragedy is simply inexcusable. A question that needs to be addressed is "If the drinking age had been 18 instead of 21, would the students have called for help when Gordie passed out?" In my clinical estimation, the answer is a resounding "Yes." The reason I believe that Gordie was allowed to die was that underage people were buying and consuming alcohol and ultimately were afraid to call the authorities for help. Because it was illegal, I believe this is the reason why they didn't call for help. The students had alcohol in the fraternity house, which was against the university's policy and against the law. They had to make a decision about what they were going to do, and, unfortunately, they made the wrong decision.

Additionally, there are other legal complications to consider. As another case in point, I cite a recent client of mine who was a 20-year-old United States Marine (I will refer to as Mark). He was referred to me for a substance abuse evaluation, secondary to being charged with underage alcohol possession. As the story goes, Mark had purchased a six-pack of beer on his base in Northern Virginia prior to leaving for a routine visit with his family in Norfolk, Virginia. En route, he was pulled over by a Virginia State Trooper for speeding; Mark had not consumed any alcohol and was not charged with driving impaired. When the officer saw a cooler on the backseat of Mark's car, the officer asked him what was in the cooler. Mark, being the honest, young man that he is, replied that he had a six-pack of beer in the cooler. He was promptly charged with underage alcohol possession. To say the least, Mark was righteously indignant and nonplussed at his legal charge. Mark opined during the interview that "they [the United States Government] allow me to vote, buy cigarettes and serve my country at 18 years old, but they don't trust me to be able to buy alcohol and drink responsibly."

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With the examples of Gordie and Mark in mind, I think that it is time that we thoughtfully consider a public reassessment of the current alcohol drinking age. The reassessment should be devoid of emotionality and, instead, be a thoughtful re-examination of the facts. Furthermore, the reassessment of the drinking age should consider the significance and potential impact of educating our youth at earlier ages so that they can learn how to drink responsibly. Other countries such as in Europe have a low level of underage drinking fatalities, and they socialize their children how to drink responsibly at relative young ages. Perhaps, our reassessment may want to consider how other counties are able to accomplish this without criminalizing our youth.

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UNDERAGE DRINKING: THE DEBATE BEGINS

Maurice Fisher, Sr., PhD, MSW, LCSW

Along with the war on terrorism evolves a new conflictual front in the United States. However, instead of focusing on bombs and bullets, this battle involves alcohol and voting ballots. With thousands of Americans under the age of 21 deployed in Iraq, Afghanistan, and other military hot spots around the world, several states are taking a second look at laws that bar these same service members from being able to legally take a drink of alcohol once they return from combat. This article attempts to highlight both sides of the debate on lowering the nation's drinking age from 21 to 18 years old.

Background

Prohibition–with the ratification of the 18th Amendment in 1919 and the passage of the Volstead Act in 1920, both of which made the manufacture, sale, and transportation of alcohol illegal–was designed to decrease alcohol consumption and crime, but historic studies show that both alcohol consumption and crime increased during the 1920s and early 1930s. In 1984, the Federal Uniform Drinking Age Act, under the Federal Aid Highway Act, created a national drinking age of 21 by allowing the federal government to withhold 10 percent of highway funds from states with lower drinking ages. The 1984 legislation also intended to curb underage binge drinking. Therefore, to obtain federal funding, all states were forced to raise their drinking age to 21. It is important to note here that while there is no "official," federally-mandated, alcohol drinking-age law, per se, by placing federal sanctions on states to raise the drinking age from 18 to 21 years old or forfeit federal highway funding, those states not in compliance obviously acquiesced.

Prior to the passage of the Federal Uniform Drinking Age Act, 30 states allowed 18-year-olds to drink some form of alcohol. Some states set the drinking age limit at 18 for beer and wine and the drinking age limit at 21 for all other alcohol; some authorized 18-year-olds to drink [an allowance of up to] 3.2% of beer, and some simply lowered the drinking age for all alcohol [consumption] to 18 (Johnson, 2007). Within four years of the enactment of the Federal Uniform Drinking Age Act, though, all 50 states had officially established "21 years old" as the minimum "legal" drinking age. Wyoming became the final state to move the drinking age to 21.

The effort to raise the drinking age resulted in the United States having one of the most age-restrictive alcohol policies among all countries where alcohol is not banned for religious reasons. The majority of nations (including the U.S.'s closest neighbors, Mexico and Canada) allow citizens to drink at age 18, with many European countries (such as France, Germany, Italy, and Spain) granting at least some alcohol-consumption rights to 16-year-olds.

As we all know from United States history, prohibition was a failed social policy that simply drove those who drank alcohol underground and into illegal activities such as manufacturing, selling, and/or buying homemade alcohol brews. Perhaps this same social phenomenon has occurred with raising the alcohol drinking age to 21.

Rationale for Maintaining the Current Drinking Age

Opponents against changing the current drinking age typically cite two main sources: Mothers Against Drunk Driving (MADD) and the

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National Highway Transportation Safety Administration (NHTSA). According to a fact sheet posted on NHTSA's Web site (as cited in the Department of Transportation's (DOT) 2001 study, *Community How To Guide On...PUBLIC POLICY: Underage Drinking Prevention),* "The National Highway Transportation Safety Administration (NHTSA) estimates that minimum drinking age laws have saved 18,220 lives (of all ages) since 1975. ...These laws have had greater impact over the years as the drinking ages in the states have increased, affecting more drivers age 18 to 20" (p. viii).

The DOT and NHTSA released a report, prepared by Hedlund, Ulmer, and Preusser entitled *Determine Why There Are Fewer Young Alcohol-Impaired Drivers*. Statistics cited in the report include the following:

- In the United States in 1982, there were 10,270 drivers under the age of 21 involved in fatal crashes. Forty-three percent (4,393) of these drivers were deemed to have been drinking prior to their crashes.
- In 1998, the number of under 21-year-old drivers in fatal crashes was 8,128 with 21 percent (1,714) of these determined to have been drinking.
- Comparing 1998 with 1982, the number of youthful drivers involved in fatal crashes declined by 21 percent, and the number who had been drinking declined by 61 percent.

  (DOT & NHTSA, 2001)

These same opponents cite MADD to defend their position. According to MADD's Web site (2007), lowering the drinking age to 18 would increase alcohol-related fatalities. MADD indicates that approximately nine hundred families a year would have to bury a teenager if the drinking age was lowered to 18, and since the enactment of the 21 Minimum Legal Drinking Age (MLDA) law in 1984, "the number of young people killed annually in crashes involving drunk drivers under 21 has been cut in half" (MADD, n.d.). Hence, lowering the drink age to 18 is based mostly on driving incidences but does not consider other underage-related drinking deaths.

Rationale for Lowering the Current Drinking Age to 18

Seven states are currently considering proposals to lower the legal drinking age from 21 to 18:

- If enacted, bills currently in the Kentucky, Wisconsin, and South Carolina legislatures would lower the legal age only for military personnel.
- Missouri citizens are working on a ballot initiative that would apply to all individuals age 18 and above.
- A lawyer in South Dakota is working on a campaign to allow 19- and 20-year-olds to buy "low alcohol" beer (containing no more than 3.2% alcohol by weight).
- Minnesota is considering a bill that would allow bars and restaurants to sell alcohol to anyone age 18 or older, but would limit liquor store sales to customers age 21 and up.
- In February 2008, the Vermont legislature authorized a task force to explore the potential ramifications of lowering the state's legal drinking age to 18.

  (McBride, 2008)

The push to repeal the state statutes began simple enough. The former president of Middleburg College, John M. McCardell, Jr., espoused the most resent notion in 2007 to lower the drinking age through his newly formed nonprofit organization, Choose Responsibility. Choose Responsibility has proposed changes to existing state laws and college policies utilizing a multi-faceted approach that combines education, certification, and provisional driving licensing for 18- to 20-year-old high school graduates who choose to use alcohol (McBride, 2008). Called the Amethyst Initiative, McCardell and his colleagues have been propounding this notion for

the past year. Several college presidents across the United States have joined the effort (MADD, n.d.).

Additionally, the National Youth Rights Organization (NYRO) has supported the effort to reduce the drinking age. NYRO argues on its Web site that 21-and-over drinking laws are inconsistent with the nation's standard policy of granting adult rights at age 18. "When you are 18 you are judged mature enough to vote, hold public office, serve on juries, serve in the military, fly airplanes, sign contracts and so on," the group writes. "Why is drinking a beer an act of greater responsibility and maturity than flying an airplane or serving your country at war?" (NYRO, 2008).

Choose Responsibility and NYRO argue that when the drinking age was raised to 21, this merely led to those younger than 21 to drink covertly and illegally. Furthermore, NYRO argues that NHTSA statistics are flawed inasmuch as while overall alcohol-related deaths from drinking impaired has decreased in the 18 to 20 age bracket, the number of lost lives has merely been transferred to the 21 to 24 age group (McBride, 2008). Moreover, both groups underscore the fact that although vehicular accidents due to drunk driving are down, owing to the 21-year-old drinking-age limit, myriad other medically maladies and deaths (e.g., suicides, homicides, and alcohol poisoning) have risen in the 18 to 21 age range.

Conclusion

To date, no state has repealed its alcohol age restriction of 21 years old. Advocates from both sides of this issue can be sure that revising the existing drinking age will be a slow-moving, albeit deliberate, process. Both sides make cogent and passionate arguments related to their position. Given the passion and zeal that both sides of this issue generate, it is amazing there has been no empirical research to date conducted relative to lowering the drinking age. In my estimation, this would be a good first step in generating data upon which cogent policies can be developed.

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DEAFNESS: UNDERSTANDING THE BASICS IN ORDER TO PROVIDE EFFECTIVE TREATMENT

Jessica Holton, MSW, LCSW, LCAS

Internationally, one week is dedicated to deafness and deaf awareness annually during the last full week of September. The 2009 Deaf Awareness Week was held from September 21 through September 27. It is estimated that seven to ten percent of the general population is considered to be hard of hearing (Guthmann & Graham, 2004), and two million Americans are considered profoundly deaf (National Child Traumatic Stress Network, 2004). Another study estimates that almost one percent of the U.S. population is deaf (Western Interstate Commission for Higher Education (WICHE) Mental Health Program, 2006). In correlation to these statistics, approximately ten percent of the general population has a substance use disorder, and through their research findings, Guthmann and Graham maintain that individuals with a disability, such as deafness, appear to be at a higher risk for substance abuse than the general population (2004).

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Deaf individuals are regularly cut off from, and not included in, the majority population's mode of communication. Thus, this has led to many deaf individuals receiving minimal information regarding the dangers from excessive drug and alcohol use. This lack of information may result in resorting to abusing alcohol and other illegal substances in order to reduce stress or to fit in with both deaf and hearing peers. Few studies have been conducted to identify the variables that predict drinking and substance abuse among deaf individuals. Information regarding substance abuse and treatment options is often haphazard and incomplete.

There seems to be a significant lack of psychologists, therapists, clinical social workers, and other mental health professionals who can appropriately and effectively communicate with deaf and hard of hearing individuals. Misdiagnosing a deaf individual as mentally ill or mentally retarded has often resulted in improper placement, misguided treatment and/or case management, unjustified exclusion of the individual from hospital programs and activities, and inappropriate aftercare referrals. Such acts frequently result in deaf individuals being isolated as well as experiencing feelings of bewilderment, rage, mistrust, frustration, depression, and the like–all of which agencies and providers should be assisting in lessening rather than contributing to. Currently, there is minimal data available that describes the degree of substance abuse among deaf individuals. Likewise, there is minimal literature that demonstrates the risk factors that lead to substance abuse among the deaf, as well as interventions that lessen their recidivism rate.

About two percent of deaf individuals receive appropriate treatment for mental illness. It is estimated that the deaf population is three to five times more likely than the hearing population to have serious mental illnesses. Given that deaf individuals represent approximately one percent of the population, there should be approximately 8,000 deaf people in drug or alcohol treatment on any given day (WICHE Mental Health Program, 2006). Unfortunately, there is no evidence of even a fraction of that estimate accessing treatment. There is a notable lack of detailed research dealing with the experiences of deaf individuals within the mental health services environment. It is hypothesized that there are more cultural differences and stressors among deaf individuals than hearing individuals. And as previously stated, deaf individuals are frequently cut off from, and not included in, the majority population's mode of communication (Guthmann & Graham, 2004). Communication barriers within the family, isolation from others, fear of being stigmatized, and concerns dealing with confidentiality within treatment are risk factors many deaf individuals experience.

At least ninety percent of deaf children are born to hearing parents (Guthmann & Graham, 2004). It has been widely documented that most hearing parents do not learn sign language in order to communicate with their deaf or hard of hearing children. Often times, parents of deaf and hard of hearing children are not informed of the communication and educational options available to their children. This leads to the preferences of the parents' mode of communication with the children not being considered. A large number of

deaf individuals are raised in families and attend schools in which their mode of communication isolates them from the information flow experienced by hearing individuals. Graduates of deaf education programs in the United States have an average reading level of third grade. Many deaf individuals, despite being intelligent, do not demonstrate proper English regarding reading or writing skills. This is often due to American Sign Language being the primary language of deaf and hard of hearing individuals and English being the secondary language (Guthmann & Graham, 2004).

Because of the differences in language, a misconception that the hearing population has about deaf individuals is that they are not as bright or as educated and themselves. This assumption is often made secondary to deaf individuals never learning how to speak or the struggle with utilizing proper English grammar. Most deaf and hard of hearing people attempt to learn English usage and have speech training, but naturally enough they may find it easier to use their primary sign language in order to communicate more often than not. Another myth about deaf people shared by many in the hearing population is that a deaf person's unusual sounding speech means that the person is mentally retarded. Speech development depends greatly on one's ability to hear his or her own voice. For the deaf person, that foundation for learning speech is not there. Hearing people often take this foundation for granted since they have only experienced the ability to hear. The ability to hear or speak clearly does not correlate with intelligence. Another misconception is that deaf individuals are mute. This assumption by many is incorrect. Some deaf people may choose not to use their voices if they think they will be difficult to understand or have inappropriate pitch or volume.

In order to be culturally aware, it is essential for people to understand that terms like "deaf-and-dumb" or "deaf-mute" are outdated and considered offensive today. Deaf-and-dumb is a relic from the medieval English era. Greek philosopher Aristotle pronounced that deaf individuals were "deaf-and-dumb," because he felt that deaf people were incapable of being taught, of learning, and of reasoned thinking. Historically, "deaf-mute" stems from the 18th or 19th century and was a term used by hearing people to identify a person who was not only deaf but was one who could not speak either. "Mute" means silent and without voice. This label is inaccurate since deaf and hard of hearing individuals typically have functional vocal chords. The descriptor "hearing-impaired" could also be considered offensive by some. This term is often preferred by hearing people, largely because they view it as politically correct. In the mainstream society, to boldly state one's disability (e.g., deaf, blind, etc.) is typically considered somewhat rude and impolite. "Hearing-

impaired" is a well-meaning phrase; however, it could be resented by deaf and hard of hearing people. Deaf and hard of hearing people feel that the words "D/deaf" and "hard of hearing" are not negative at all. Overall, deaf and hard of hearing people believe that there is nothing wrong with either word and that their culture, language, and community are just as fulfilling as those experienced by the mainstream society.

Deafness is typically viewed from two different perspectives: the pathological (or medical) model and the cultural model (Guthmann & Graham, 2004). The pathological model focuses on deafness being a disability and that somehow deafness needs to be fixed or cured. The cultural model focuses on deafness being a difference rather than a disability. The latter model also focuses on having pride in being deaf and being a part of the deaf culture and the deaf community. Individuals that have pride in deafness are referred to as "Big D" Deaf. Individuals who consider their hearing loss as a medical diagnosis are typically referred to as "little d" deaf or hard of hearing. As with any cultural diversity or difference, it is necessary to research the various attributes in order to provide the most effective treatment for the individual.

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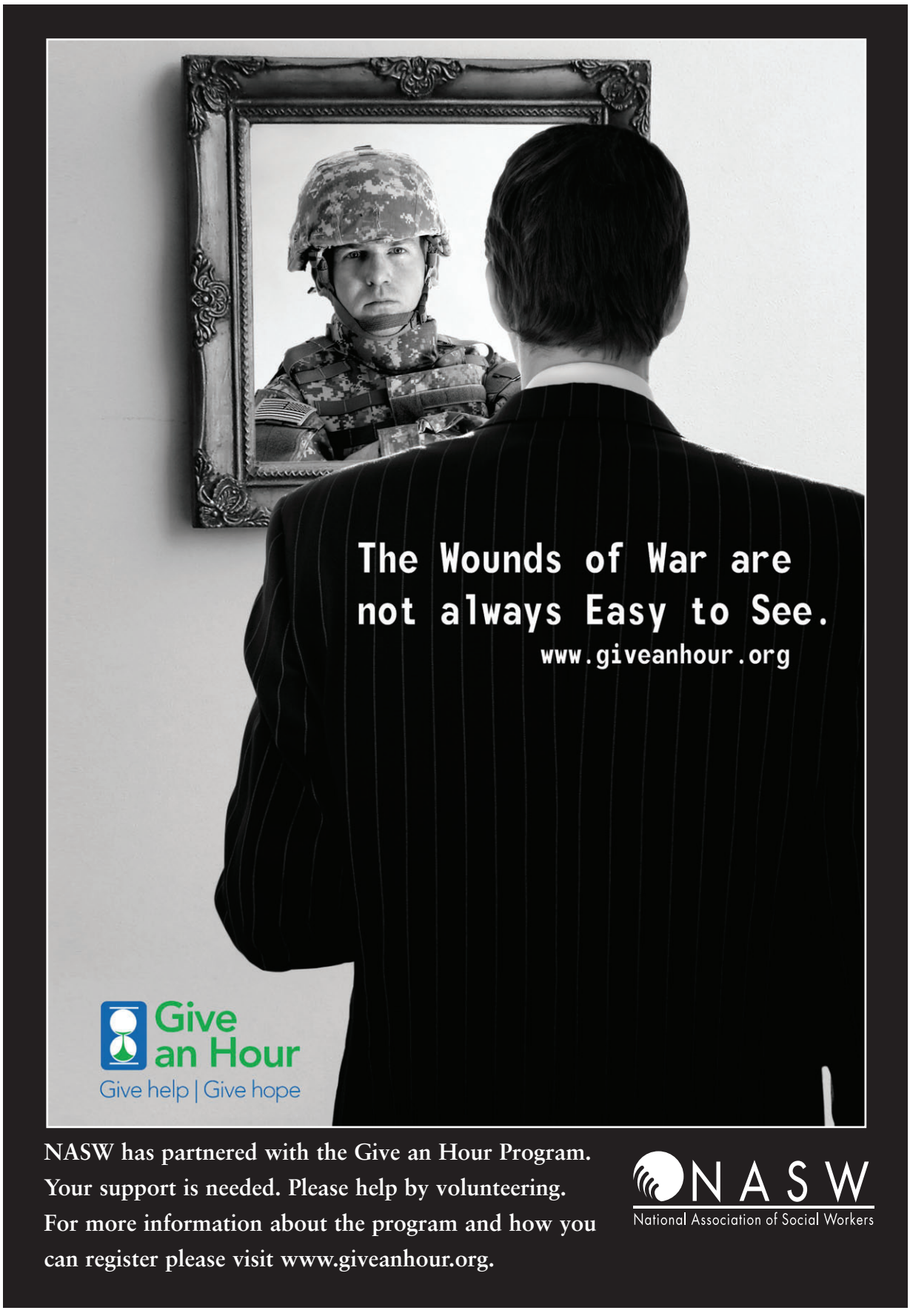

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