

# REPORT TO CONGRESS ON THE PREVENTION AND REDUCTION OF UNDERAGE DRINKING

2017



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# REPORT TO CONGRESS ON THE PREVENTION AND REDUCTION OF UNDERAGE DRINKING, 2017

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## Foreword

As U.S. Department of Health and Human Services Assistant Secretary for Mental Health and Substance Use and Chair of the Interagency Coordinating Committee on the Prevention of Underage Drinking (ICCPUD), I am pleased to present the ICCPUD's 2017 Report to Congress on the Prevention and Reduction of Underage Drinking. This Report is mandated by the Sober Truth on Preventing Underage Drinking Act, originally passed by Congress in 2006 and reauthorized in 2016. This is the ninth annual Report examining the issue of underage drinking, and it includes recent data from federal surveys, prevention activities by federal agencies, and state-specific data on prevention policies and enforcement efforts.

Among Americans under age 21, alcohol is the most frequently used substance, used more often than tobacco, marijuana, or other illicit drugs. One in five 12- to 20-year-olds reports having used alcohol in the previous month.

Underage alcohol consumption is a persistent and serious public health challenge, resulting in thousands of deaths each year through motor vehicle crashes, violence, suicide, alcohol poisoning, and other causes. Underage drinking is also implicated in sexual assault and other crimes, impaired brain function, decreased academic performance, and the increased risk of developing an alcohol use disorder later in life. Binge drinking (four drinks in a row for a female or five for a male) exacerbates underage drinking's harmful consequences and is the most common underage consumption pattern, especially among college students.

Importantly, there are evidence-based strategies for preventing or reducing underage alcohol use. Research indicates that these strategies are most effective when implemented as part of a multifaceted approach that includes parents and families, law enforcement, healthcare providers, community organizations, schools and universities, local and state governments, and the federal government. With community support, law enforcement can more effectively prevent youth from accessing alcohol. Parents, schools, and universities can provide clear, consistent education about the consequences of underage drinking. Healthcare providers can screen patients under 21 for alcohol use and provide brief intervention and referral to treatment as appropriate.

Evidence suggests that current implementation of these strategies may be having a positive effect. Since 2004, past-month alcohol use by underage drinkers has declined by 29 percent. Past-month binge drinking decreased by 30 percent between 2004 and 2014, according to the most recent available data.

The most effective way to sustain and continue these gains will be ongoing coordinated efforts at all levels of government and in our universities, schools, communities, and families to implement strategies that have proven to be effective. It is my hope that this Report will provide critical information to support such efforts.

**Elinore F. McCance-Katz, M.D., Ph.D.**

Assistant Secretary for Mental Health and Substance Use  
Department of Health and Human Services



# EXECUTIVE SUMMARY

## Introduction

The use of alcohol by persons under age 21 is a complex and challenging social problem that has defied an easy solution. Underage drinking contributes to a wide range of costly health and social problems, including motor vehicle crashes (the greatest single mortality risk for underage drinkers), suicide, interpersonal violence (e.g., homicides, assaults, rapes), unintentional injuries (e.g., burns, falls, drowning), brain impairment, alcohol dependence, risky sexual activity, academic problems, and alcohol and drug poisoning. Annually, alcohol is a factor in the deaths of approximately 4,300 youths in the United States, shortening their lives by an average of 60 years (Stahre, Roeber, Kanny, Brewer, & Zhang, 2014).<sup>1</sup>

In 2006, Congress enacted the Sober Truth on Preventing Underage Drinking Act, popularly known as the “STOP Act.” The STOP Act, which was reauthorized in 2016, requires the Secretary of Health and Human Services, on behalf of the Interagency Coordinating Committee on the Prevention of Underage Drinking (ICCPUD), to submit an annual Report to Congress. The Report to Congress includes the most current data on underage alcohol use in the United States, as well as information on federal and state prevention efforts.

## Characteristics of Underage Drinking in America

### Alcohol Is the Most Widely Misused Substance Among American Youth

Alcohol continues to be the most widely used substance among America’s youth, and a higher proportion use alcohol than use tobacco, marijuana, or other drugs. For example, according to the 2015 Monitoring the Future (MTF) study, 21.5 percent of 10th graders reported alcohol use in the past 30 days, 14.8 percent reported marijuana use in the past 30 days, and 6.3 percent reported cigarette use in the same period (Miech, Johnston, O’Malley, Bachman, & Schulenberg, 2016).<sup>2</sup>

#### Why Is Underage Drinking a Problem?

- Alcohol is used more widely than tobacco, marijuana, and other drugs by our nation’s young people (Miech et al., 2016).
- Motor vehicle crashes are the greatest mortality risk for underage drinkers. In 2015, of the 1,886 drivers ages 15–20 who were killed in motor vehicle traffic crashes, 494 (26%) had a BAC of 0.01 or higher (NCSA, 2016).
- Alcohol use contributes to brain impairment, sexual assault, and academic problems (Brown & Tapert, 2004; Abbey, 2011; White & Hingson, 2013).
- Early initiation of drinking is associated with development of an alcohol use disorder later in life (Hingson & Zha, 2009; Grant & Dawson, 1997).

### Youth Start Drinking at an Early Age

As discussed below, early initiation to alcohol use increases the risk for a variety of developmental problems during adolescence and for problems later in life. Early initiation is often an important indicator of future substance use (Buchmann et al., 2009; Grant & Dawson, 1998; Hawkins et al., 1997; Liang & Chikritzhs, 2015; Robins & Przybeck, 1985). Accordingly, delaying the onset of alcohol initiation may significantly improve later health. The peak years of

<sup>1</sup> Complete references are provided in Appendix D.

<sup>2</sup> For comparability with data from the 2015 National Survey on Drug Use and Health (NSDUH) and 2015 Youth Risk Behavior Survey (YRBS), the latest MTF data included in this report are also from 2015. The 2016 MTF data, available in December 2016, will be included in the next report.



initiation of alcohol use are 7th to 11th grades, and data from the 2015 Youth Risk Behavior Survey (YRBS) indicate almost one fifth (17.2 percent) of underage drinkers currently in high school reported use of alcohol before they were 13 years old (Kann et al., 2016). Approximately 2,052 youths ages 12 to 14 initiated alcohol use each day in 2015, according to data from the National Survey on Drug Use and Health (NSDUH; Center for Behavioral Health Statistics and Quality [CBHSQ], 2016a).

## Binge Drinking

Approximately 5.1 million (13.4 percent) of 12- to 20-year-olds reported past-month binge alcohol use<sup>3</sup> in 2015 (CBHSQ, 2016b). High blood alcohol concentrations (BACs) and impairment levels associated with binge drinking place binge drinkers and those around them at substantially elevated risk for negative consequences, such as motor vehicle crashes, injuries, unsafe sexual practices, and sexual victimization. Accordingly, reducing binge drinking has become a primary public health priority (Substance Abuse and Mental Health Services Administration [SAMHSA], 2014a).

Approximately 3.3 percent of 12- to 20-year-olds (1.3 million) could be also classified in an even higher risk drinking category: heavy drinkers (consuming five or more drinks on the same occasion on each of 5 or more days in the past 30 days). By definition, all heavy alcohol users are also binge alcohol users (CBHSQ, 2016b). Although youths, compared with adults, generally consume alcohol less frequently and consume less alcohol overall, they are much more likely to binge drink. Accordingly, most youth alcohol consumption occurs in binge-drinking episodes (NIAAA, 2017). A significant proportion of underage drinkers consume substantially more than the five-drink binge criterion. For example, averaged 2014 and 2015 data from the NSDUH show that 9.1 percent of underage drinkers had nine or more drinks during their last drinking occasion (CBHSQ, 2016a).

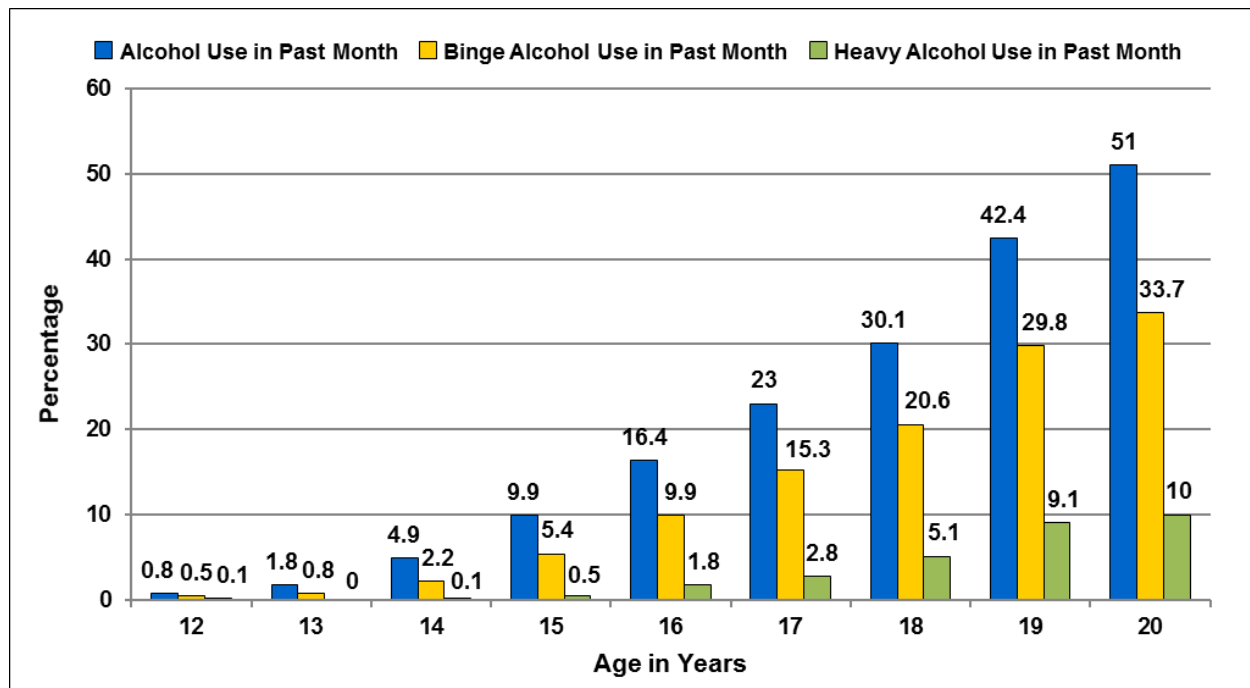
A troubling subset of binge drinking is very high-intensity binge drinking, or consumption of 10 or 15 or more drinks on a single occasion. According to MTF data for 2015, 6.1 percent of 12th graders reported consuming 10 or more drinks in a row, and 3.5 percent reported consuming 15 or more drinks in a row within the previous 2 weeks. Although these numbers have declined since 2005, the rate of decline for high-intensity binge drinking appears to be slower than for all binge drinking (Miech et al., 2016).

Binge rates increase rapidly with age (Exhibit E.1). It is important to note that very young adolescents, because of their smaller size, may reach high-risk levels of BACs with fewer drinks (three to four drinks for people ages 12 to 15) than do older adolescents (e.g., age 18 or older; Donovan, 2009). This suggests that binge and heavy drinking may be even riskier for younger adolescents than for older youth.

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<sup>3</sup> Binge drinking is generally defined as five or more drinks on a single occasion for males, and four or more drinks on a single occasion for females.

**Exhibit E.1: Current, Binge and Heavy Alcohol Use Among People Ages 12–20 by Age: 2015 (CBHSQ, 2016a)**



## Prevalence of Alcohol Abuse and Dependence Among Youth Is High

The prevalence of alcohol abuse and dependence among underage drinkers, based on the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (DSM-IV-TR)* (APA, 2000) criteria,<sup>4</sup> is quite high. According to NSDUH combined 2014–2015 data, the prevalence of alcohol abuse or dependence is about 1 in 11 (9.3 percent) among 18- to 20-year-olds. This prevalence is only slightly less than that for 21- to 24-year-olds (13.2 percent), who have the highest prevalence of alcohol use disorders. In addition, 0.7 percent of 12- to 14-year-olds and 4.5 percent of 15- to 17-year-olds are estimated to have met criteria for alcohol use disorder (CBHSQ, 2016a).

## College Drinking

Drinking and bingeing rates are higher for older underage youth, particularly 18- to 20-year-olds (see Exhibit E.1). Furthermore, rates are higher for college students<sup>5</sup> than for same-age peers not attending college. Of college students, 63.2 percent drink, compared with 51.1 percent of those of the same age and not in college (Johnston, O'Malley, Bachman, Schulenberg, & Miech, 2016). Thus, campus life and culture might encourage alcohol consumption. The problems

<sup>4</sup> The more recent *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-V)* (APA, 2013) integrates the two DSM-IV disorders, alcohol abuse and alcohol dependence, into a single disorder called alcohol use disorder (AUD). DSM-V does not specifically address adolescents. NSDUH assesses substance use disorders based on DSM-IV criteria.

<sup>5</sup> College students are defined as MTF panel participants who are full-time students enrolled in a 2- or 4-year college 1 to 4 years after high school in March during the year of the MTF survey (Johnston et al., 2016). Same-age peers are defined as individuals 1 to 4 years post high school graduation who are not enrolled in either a 2- or 4-year college at the time of survey completion.

associated with college drinking, in addition to traffic crashes and injury-related deaths, include sexual assault, other violent crime on college campuses, and reduced academic performance.

## Underage Access to Alcohol

Selling alcohol to youth under age 21 is illegal in all 50 states and the District of Columbia. Giving alcohol to youth under age 21 is also illegal, although some states make it legal to provide alcohol to youth under special circumstances, such as at religious ceremonies, in private residences, or in the presence of a parent or guardian. Despite broad restrictions, underage youth find it relatively easy to acquire alcohol, often from adults. Younger underage drinkers (ages 12 to 14) are more likely to get alcohol from a parent than from another source, according to MTF data. Older drinkers are more likely to buy alcohol themselves, give money to an adult to buy it for them, or receive alcohol from an unrelated adult.

## Prevention Efforts

Since the mid-1980s, the nation has proactively and systematically implemented underage drinking prevention efforts at the federal, state, and local levels. Key evidence-based prevention research strategies are described and called for in *Facing Addiction in America: The Surgeon General's Report on Alcohol, Drugs and Health* (HHS, 2016); the Surgeon General's *Call to Action* (Office of the Surgeon General, 2007); the Community Preventive Services Task Force *Guide to Community Preventive Services: Preventing Excessive Alcohol Consumption* (Community Preventive Services Task Force, 2016); the National Research Council and Institute of Medicine report *Reducing Underage Drinking: A Collective Responsibility* (NRC and IOM, 2004); the National Institute on Alcohol Abuse and Alcoholism's (NIAAA's) *Call to Action: Changing the Culture of Drinking at U.S. Colleges* (NIAAA, 2002), and CollegeAIM (the College Alcohol Intervention Matrix (NIAAA, n.d.)). Several of these important initiatives to encourage use of evidence-based strategies are discussed in Chapter 1 of this report.

## Framework for Success in Reducing Underage Drinking

Factors that have contributed to success are varied and complex, with one clear factor being the increased attention to this issue at all levels of society. Federal initiatives have raised underage drinking to a prominent place on the national public health agenda, created a policy climate in which significant legislation has been passed by states and localities, raised awareness of the importance of proactive and systematic law enforcement, promoted routine screening of youth in the healthcare system and brief intervention and referral to treatment where appropriate, and stimulated coordinated citizen action. Private and public efforts support the development of drug-free communities. These changes are mutually reinforcing and have provided a framework for a sustained national commitment to reducing underage drinking.

The 15 federal agencies that make up the ICCPUD (see Appendix A) contribute leadership and vision to the national effort specific to their missions and mandates. For example, NIAAA supports research on prevalence and patterns of underage alcohol use, underage drinking prevention, and treatment for youth who misuse alcohol or who have alcohol use disorder. The National Institute on Drug Abuse (NIDA) supports research on patterns and usage of drug use and alcohol use. The Centers for Disease Control and Prevention (CDC) provides research on the effectiveness of prevention strategies. SAMHSA works to reduce underage demand for alcohol, and the National Highway Traffic Safety Administration (NHTSA) provides data on

underage alcohol use and traffic crashes. SAMHSA, CDC, and the National Institutes of Health (NIH) all conduct surveys (either directly or through grants) that gather the most current data on underage alcohol use.

Each of the 15 agencies engages in programs and activities that are aimed, either directly or indirectly, at underage drinking prevention or reduction. Together, these programs and activities constitute a coordinated federal approach that has helped to support year-by-year reductions in underage alcohol use rates as reported in national surveys.

## Effective Solutions

Risk and protective factors that affect underage drinking can be influenced by programs and policies at multiple levels, including the federal, state, community, family, school, and individual levels. As noted in the 2016 Surgeon General's report, *Facing Addiction in America* (HHS, 2016):

Targeted programs implemented at the family, school, and individual levels can complement the broader population-level policy interventions, and assist in reducing specific risk factors and promoting protective factors.

A comprehensive underage drinking prevention initiative includes a balance of evidence-based prevention programs and strategies, including approaches focused on individuals and those focused on the larger environment.

Evidence-based programs focusing on individuals that are highlighted in *Facing Addiction in America* include:

- Good Behavior Game (GBG), a school-based intervention that provides teachers with a method of classroom behavior management and aims to reduce early aggressive or disruptive behavior problems. Long-term research on GBG, supported by NIDA, shows a significant reduction in drug and alcohol misuse and in substance use disorders.
- Life Skills Training (LST), a curriculum for middle school students that has delayed early use of alcohol and reduced use for up to 5 years later. NIDA funds continued research on LST.
- Strengthening Families Program: For Parents and Youth 10–14 (SFP), a seven-session skill-building program developed with NIDA funding that enhances parenting skills and adolescent substance refusal skills. Multiple studies have showed reduction in youth alcohol use through age 21.
- Screening, brief intervention, and referral to treatment (SBIRT) of adolescents and youth who are at risk of or show signs of alcohol use, can reduce risky behavior before it becomes more problematic. NIAAA has developed a screening guide titled *Alcohol Screening and Brief Intervention for Youth: A Practitioner's Guide*.

These and many other programs are supported by federal agencies and are described in more detail in Chapter 3.

Environmental-level programs include alcohol policies, enforcement practices, and public education campaigns. Evidence-based policies and practices can reduce youth access to alcohol and change the norms that support underage drinking in U.S. communities. This report describes 26 underage drinking prevention policies, all of which are evidence-based to some extent, and

many of which have been endorsed by federal sources. These are listed below in the section on State Reports.

**“Talk. They Hear You.” National Media Campaign:** The STOP Act mandated the creation of a national media campaign to prevent underage drinking. Developed by SAMHSA’s Center for Substance Abuse Prevention, the “Talk. They Hear You.” campaign is a significant environmental initiative. The campaign aims to prevent underage drinking among youth ages 9 to 15 by providing their parents and caregivers with information to address alcohol use early. The campaign, which consists of TV and print PSAs, a website, and a mobile app, has received an estimated 4.6 billion media impressions (number of times people have seen the ads or messages). The campaign is described in more detail in Chapter 3, and an evaluation of the campaign is found in Chapter 5.

## State Reports

The STOP Act requires a report on state prevention and enforcement activities. Accordingly, this report includes individual reports for each of the 50 states and the District of Columbia, including specific population and underage alcohol use data. The state reports list whether states have adopted each of the 26 policies listed below as laws or regulations.

### Laws Addressing Minors in Possession of Alcohol

1. Underage possession
2. Underage consumption
3. Internal possession by minors
4. Underage purchase and attempted purchase
5. False identification

### Laws Targeting Underage Drinking and Driving

6. Youth blood alcohol concentration limits
7. Loss of driving privileges for alcohol violations by minors
8. Graduated driver’s licenses

### Laws Targeting Alcohol Suppliers

9. Furnishing of alcohol to minors
10. Compliance check protocols
11. Penalty guidelines for sales to minors
12. Responsible beverage service
13. Minimum ages for off-premises sellers
14. Minimum ages for on-premises servers and bartenders
15. Outlet siting near schools
16. Dram shop liability
17. Social host liability
18. Hosting underage drinking parties
19. Retailer interstate shipment
20. Direct sales/shipments
21. Keg registration

- 22. Home delivery
- 23. High-proof grain alcoholic beverages

### **Laws Affecting Alcohol Pricing**

- 24. Alcohol taxes
- 25. Drink specials
- 26. Wholesale pricing

### **The STOP Act State Survey**

The STOP Act requires this report to include data from states and the District of Columbia on their underage drinking enforcement and prevention activities, including expenditures on enforcement and prevention programs. These data are collected through a survey administered to state governments annually since 2011. The survey has obtained a 100 percent response rate each year. The results are analyzed and summarized, and individual responses are included in each state's report.

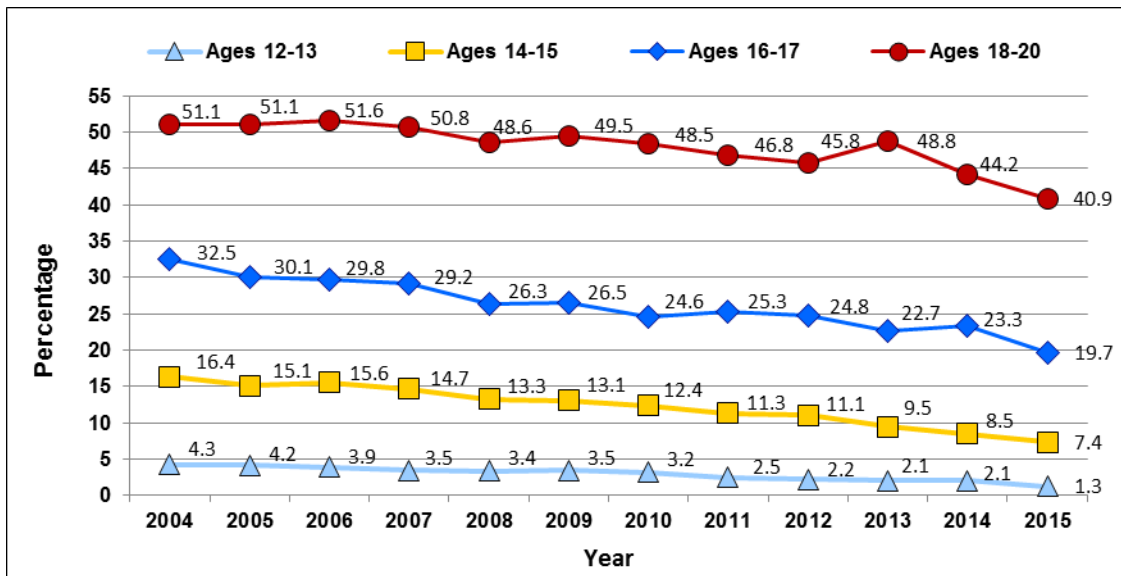
The survey gathers information on enforcement activities, including compliance checks and citations for minors in possession of alcohol. While compliance checks are fairly widely implemented, the number of checks conducted is modest: 58 percent of states that conduct checks test 20 percent or fewer of their licensees, according to the most recent survey data.

The survey also collects information on state prevention programs for youth, parents, and caregivers. States implement a wide variety of programs, the majority of which focus on individuals rather than on environmental change. Eighty-eight percent of states use best practice standards in selecting their prevention programs, and 55 percent of states evaluate their programs.

Eighty-four percent of states have created a state-level interagency committee to coordinate underage drinking prevention activities; however, only 12 percent of those include representation from the governor's office and only 12 percent from the legislature.

### **Extent of Progress in Reducing Underage Drinking**

National epidemiologic data demonstrate that national and state prevention efforts are having positive effects. Alcohol-related traffic deaths among youth ages 16 to 20 have declined 79 percent since 1982 (NHTSA, 2015). The overall prevalence of drinking for 12- to 20-year-olds has declined by 29.2 percent since 2004. College-age drinking has been more resistant to change, however, as illustrated in Exhibit E.2.

**Exhibit E.2: Past-Month Alcohol Use for 12- to 20-Year-Olds, 2004–2015 (CBHSQ, 2016a)**

### Continued Effort Is Needed

Sustained efforts on prevention programs, policies, and enforcement are needed to maintain improvements among 12- to 17-year-olds and to better address challenging patterns of alcohol consumption among 18- to 20-year-olds, particularly those in college or the military. The shifting landscape of issues and trends related to underage drinking, such as the development of powdered alcohol products; the sale of high-alcohol-content grain beverages; changes in marijuana policies and laws; and the risk to youth of adverse effects of combined drug and alcohol use must be continuously identified, monitored, and addressed. Ongoing engagement of policymakers, citizen coalitions, health professionals, educators, law enforcement, and others is essential to the implementation of effective prevention strategies.





# CHAPTER 1

## Underage Drinking: Public Health Consequences and Prevention Efforts

## Introduction

Consumption of alcohol by individuals under 21 has been recognized as a pervasive public health and safety problem for many years. Despite laws against underage drinking in all 50 states, the efforts of federal, state, and local governments spanning decades, the dedicated work of many private groups and organizations, and significant progress, alcohol is still the most widely consumed substance among America's youth, used more often than tobacco or marijuana. Alcohol use often begins at a young age and underage drinkers tend to drink more at one time than adults do and without regard for consequences.

Underage drinking has profound costs not just for underage drinkers, but also for their families, their communities, and society as a whole. In response, the federal government, together with state and local governments, has sought to develop effective approaches to reduce underage drinking and its associated costs and consequences.

This combined report is required by the Sober Truth on Preventing (STOP) Underage Drinking Act (Pub. L. 109-422), which was enacted by Congress in 2006 and reauthorized in December 2016 (Pub. L. 114-255). The STOP Act requires the Interagency Coordinating Committee on the Prevention of Underage Drinking (ICCPUD) to submit an annual report to Congress addressing underage drinking prevention programs and policies, along with data on prevalence and patterns of underage drinking. The STOP Act calls for three separate reports, published together in this document:

1. A report to Congress from the Secretary of the U.S. Department of Health and Human Services (HHS; Chapters 1 through 3) that includes:
  - A description of all federal agency programs and policies designed to prevent and reduce underage drinking
  - The extent of progress in preventing and reducing underage drinking nationally
  - Information related to patterns and consequences of underage drinking
  - Measures of the exposure of underage populations to messages regarding alcohol in advertising and the entertainment media, as reported by the Federal Trade Commission (FTC)
  - Surveillance data, including information about the initiation and prevalence of underage drinking, consumption patterns, and the means of underage access
  - Other information about underage drinking that the Secretary determines appropriate
2. A report on state underage drinking prevention and enforcement activities (Chapter 4 and the individual state reports) that includes:
  - A set of measures used in preparing the report on best practices
  - Categories of underage-drinking-prevention policies, enforcement practices, and programs (see Chapter 4 for a list of specific categories)
  - Additional information on state efforts or programs not specifically included in the Act
3. A report on the national media campaign mandated by the STOP Act (Chapter 5), including the production, broadcasting and evaluation of the campaign, and the effectiveness of the campaign

This chapter describes the harmful public health consequences of underage drinking and provides background on the ongoing national effort to prevent and reduce underage drinking.

## Adverse Consequences of Underage Drinking

Underage drinking affects the health and well-being of the individual drinker, families of drinkers, the community, and society.

The individual health and social impacts of underage drinking include, foremost, the risk of death due to motor vehicle crashes; other unintentional injuries (such as burns, falls, and drowning); alcohol and drug poisoning; and suicide.

Additional risks include brain impairment; interpersonal violence; engagement in risky sexual activity; involvement with the legal system; and academic problems. The family of the adolescent who drinks alcohol may experience a disruption of normal relationships and a family crisis. The social costs include risks to other drivers and passengers, risk of violence, and enormous economic costs. In 2010, almost \$24.3 billion (about 10 percent) of the total \$249 billion economic costs of excessive alcohol consumption were related to underage drinking (Sacks, Gonzales, Bouchery, Tomedi, & Brewer, 2015). It is estimated that 64.1 percent of underage drinking costs can be attributed to lost productivity; most of that is due to premature mortality from alcohol-attributable conditions involving underage youth (Bouchery, Harwood, Sacks, Simon, & Brewer, 2011). Underage drinking not only imposes societal costs in its own right, but also, given the increased risk that those who drink at young ages will develop alcohol use disorders later in life, contributes indirectly to the costs of excessive adult alcohol use.

### Individual Consequences

#### Mortality and Injury from Traffic Crashes

The greatest mortality risk for underage drinkers continues to be from motor vehicle crashes. In 2015, of the 1,886 drivers ages 15 to 20 who were killed in motor vehicle traffic crashes:

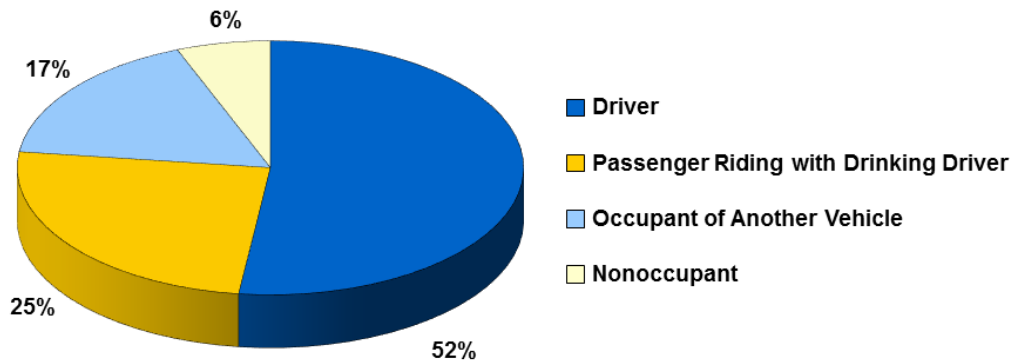
- 494 (26 percent) had a BAC of 0.01 or higher.
- 97 (5 percent) had a BAC of 0.01 to 0.07 g/dL.
- 397 (21 percent) had a BAC of 0.08 g/dL or higher (National Center for Statistics and Analysis [NCSA], 2015).

In 2015, 975 people were killed in motor vehicle traffic crashes involving a 15- to 20-year-old driver with a BAC of .01 or higher. The distribution of fatalities by person type in 2015 is shown in Exhibit 1.1.

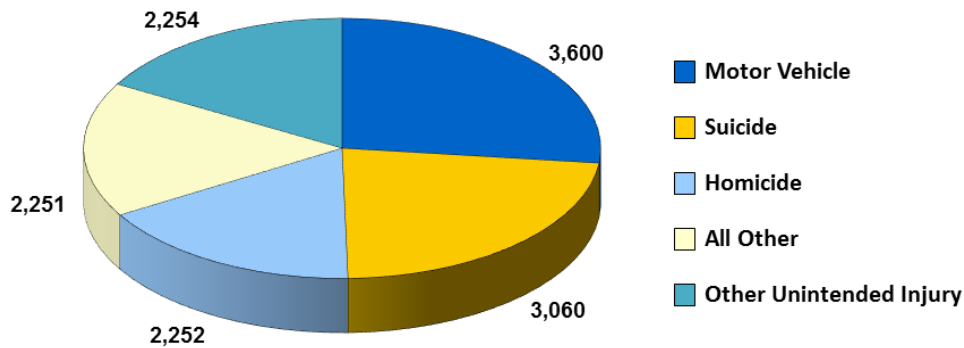
#### Other Leading Causes of Death in Youth

In addition to contributing to motor vehicle crashes, underage drinking contributes to all major causes of fatal and nonfatal injuries experienced by young people. Suicide, other unintentional injuries, and homicide, along with motor vehicle traffic crashes, are the four leading causes of death among youths ages 12 to 20 (Exhibit 1.2) (CDC, 2015a).

**Exhibit 1.1: Distribution of Fatalities in Motor Vehicle Traffic Crashes Involving a 15- to 20-Year-Old Driver with a BAC of 0.01 or Higher by Person Type in 2015**  
(NCSA, 2016)



**Exhibit 1.2: Leading Causes of Death for Youth Ages 12–20: 2015**  
(Centers for Disease Control and Prevention [CDC], 2015)



In 2015 (the latest date for which these data are available), 2,254 youths ages 12 to 20 died from unintentional injuries other than motor vehicle crashes, such as poisoning, drowning, falls, and burns (CDC, 2015). Previous research on the population suggests that about 40 percent of these deaths involved alcohol use (Smith, Branas, & Miller, 1999).

Data from 17 states show that among people who died by suicide who were ages 10 to 19 (all under the legal drinking age in the United States) and were tested, 12 percent had BACs >0.08 g/dL (Crosby, Espitia-Hardeman, Hill, Ortega, & Clavel-Arcas, 2009). Smith and colleagues (1999) estimated that, for the population as a whole, nearly one third (31.5 percent) of homicides and almost a quarter (22.7 percent) of suicides were attributable to alcohol (i.e., involved a deceased person with a BAC of 0.10 g/dL or greater). Another study focusing on youth suicide estimated that 9.1 percent of hospital-admitted suicide acts by those under age 21 involved alcohol, and of those cases, 72 percent were attributable to or caused by alcohol use (Miller, Levy, Spicer, & Taylor, 2006).

## Brain Impairment

Adverse effects on normal brain development are a potential long-term risk of underage alcohol consumption. During adolescence, dramatic changes to the brain’s structure, neuron connectivity (“wiring”), and physiology occur (Restak, 2001). These changes affect everything from emerging sexuality to emotionality and judgment. However, not all parts of the brain mature at the same time. Differences in maturational timing across the brain can result in impulsive decisions or actions, disregard for consequences, and emotional reactions that can lead to alcohol use or otherwise put teenagers at serious risk.

Neurobiological research suggests that adolescence may be a period of unique vulnerability to the effects of alcohol. For example, research on adolescents with alcohol use disorders shows that early heavy<sup>6</sup> alcohol use may have negative effects on the actual physical development of the brain structure (Brown & Tapert, 2004) as well as on brain functioning. Negative effects indicated by neuropsychological studies include decreased ability in planning, executive functioning, memory, spatial operations, and attention, all of which play important roles in academic performance and future levels of functioning (Brown, Tapert, Granholm, & Dellis, 2000; Giancola & Mezzich, 2000; Tapert & Brown, 1999; Tapert et al., 2001; Winward, Hanson, Bekman, Tapert, & Brown, 2014).

As Brown and colleagues (2000) noted, these deficits may put alcohol-dependent adolescents at risk for falling farther behind in school, putting them at an even greater disadvantage relative to nonusers. Some of these cross-sectional findings are supported by longitudinal analyses (Squeglia, Jacobus, & Tapert, 2009). A 10-year prospective study (Hanson, Medina, Padula, Tapert, & Brown, 2011) found that having a history of heavy (defined as five or more drinks in a row) alcohol or other substance use during adolescence appears to be more important in determining cognitive deficits than whether individuals continued to have substance-related problems into their mid-twenties.

*Adverse consequences include death, injury, and brain impairment.*

The Adolescent Brain Cognitive Development (ABCD) study, launched in 2015, is expected to provide information on factors that contribute to adolescent alcohol and other substance use and its long-term effects on brain development and associated life outcomes. The ABCD study is the “largest long-term study of brain development and child health in the United States,” according to the study website (<http://abcdstudy.org>). The study will enroll about 10,000 children ages 9 and 10 at 19 research institutions across the country and follow them for 10 years, into early adulthood. Researchers will use noninvasive neuroimaging and cognitive, academic, social, emotional, and biological assessments to determine how childhood experiences interact with children’s changing biology to affect brain development and other outcomes.

An initiative of the National Institutes of Health (NIH), the Collaborative Research on Addiction at NIH (CRAN) is a partnership comprising the National Institute on Drug Abuse (NIDA), the National Institute on Alcohol Abuse and Alcoholism (NIAAA), and the National Cancer Institute (NCI). CRAN is leading the ABCD study in partnership with other NIH Institutes.

<sup>6</sup> For purposes of this study, heavy alcohol use is defined as five or more drinks in a row.

### **Risky Sexual Activity**

Underage drinking plays a significant role in risky sexual behavior, including unwanted, unintended, and unprotected sexual activity as well as sex with multiple partners. Such behavior increases the risk for unplanned pregnancy and contracting sexually transmitted diseases, including infection with HIV, the virus that causes AIDS (Cooper & Orcutt, 1997). When pregnancies occur, underage drinking may result in fetal alcohol spectrum disorders, including fetal alcohol syndrome, which remains a leading cause of intellectual disabilities (Jones, Smith, Ulleland, & Streissguth, 1973; Stratton, Howe, & Battaglia, 1996; Warren & Bast, 1988).

### **Impaired Academic Performance**

In general, cross-sectional studies have found that students who do poorly in school drink more than students whose school performance is better (Bryant, Schulenberg, O'Malley, Bachman, & Johnston, 2003). For example, students who report binge drinking are three times more likely to report earning mostly Ds and Fs on their report cards than non-binge drinkers (Miller, Naimi, Brewer, & Jones, 2007).

However, the evidence from longitudinal studies is less clear cut, and in some cases the data suggest that academic failure leads to increased drinking rather than the reverse. Using data from the Youth Development Study (Mortimer, 2003), Owens, Shippee, and Hensl (2008) tracked a panel of youth from their freshman to senior years in high school. The authors failed to find a significant link across the high school years between increased drinking and diminishing academic performance.

A 1-year longitudinal analysis of middle school and high school students using the National Longitudinal Study of Adolescent Health found that, independent of consumption levels, students who drank experienced modest declines (one tenth of a letter grade) in academic achievement (Crosnoe, Muller, & Frank, 2004). Using a similar design, Crosnoe (2006) found a stronger association between number of classes failed and later alcohol use than between alcohol use and academic performance. Academic failure appeared to lead to increased drinking through weakened bonds that traditionally control problem behavior, especially bonding to teachers. Interestingly, both Mortimer (2003) and Owens and colleagues (2008) found that increasing GPAs were associated with increasingly frequent drinking occasions. The authors speculated that good grades may bring a measure of parental freedom.

Renna (2008) tracked educational attainment and alcohol use at ages 19 and 25 among two cohorts of 18-years-olds in 1982 and 1983, using data from the National Longitudinal Survey of Youth. Binge drinking in the senior year of high school reduced the probability of receiving a high school diploma and increased the probability of graduating later in life with a general education development diploma (and hence realizing lowered earning potential). Also of interest, the study found that increases in the minimum legal drinking age (MLDA) increased the probability of people graduating by age 19 by 5.3 percentage points.

College-age drinking also has educational impacts. About 25 percent of college students report academic consequences as a result of their drinking, including missing class, falling behind, doing poorly on exams or papers, and receiving lower grades overall (White & Hingson, 2013).

## Social Costs

### Mortality and Injury

Individuals other than the drinker experience the consequences of underage alcohol use through destruction of property, unintentional injury, violence, and even death. For example, in 2015, 48 percent of all deaths in traffic crashes involving a 15- to 20-year-old driver with a blood alcohol concentration of 0.08 or higher were people other than the drinking driver (e.g., passengers, occupants of other vehicles) (NCSA, 2016).

Police and child protective services records suggest that those under age 21 commit 30 percent of murders, 31 percent of rapes, 46 percent of robberies, and 27 percent of other assaults (Miller et al., 2006). As the authors note, relying on victim reports rather than agency records would yield higher estimates. For the population as a whole, an estimated 50 percent of violent crime is related to alcohol use by the perpetrator (Harwood, Fountain, & Livermore, 1998). The degree to which violent crimes committed by those under 21 are alcohol related is yet unknown.

A review article by Nolen-Hoeksema cited a number of studies suggesting that underage drinking by both victim and assailant increases the risk of physical and sexual assault (Abbey, 2011; Nolen-Hoeksema, 2004).

### Social Costs on College Campuses

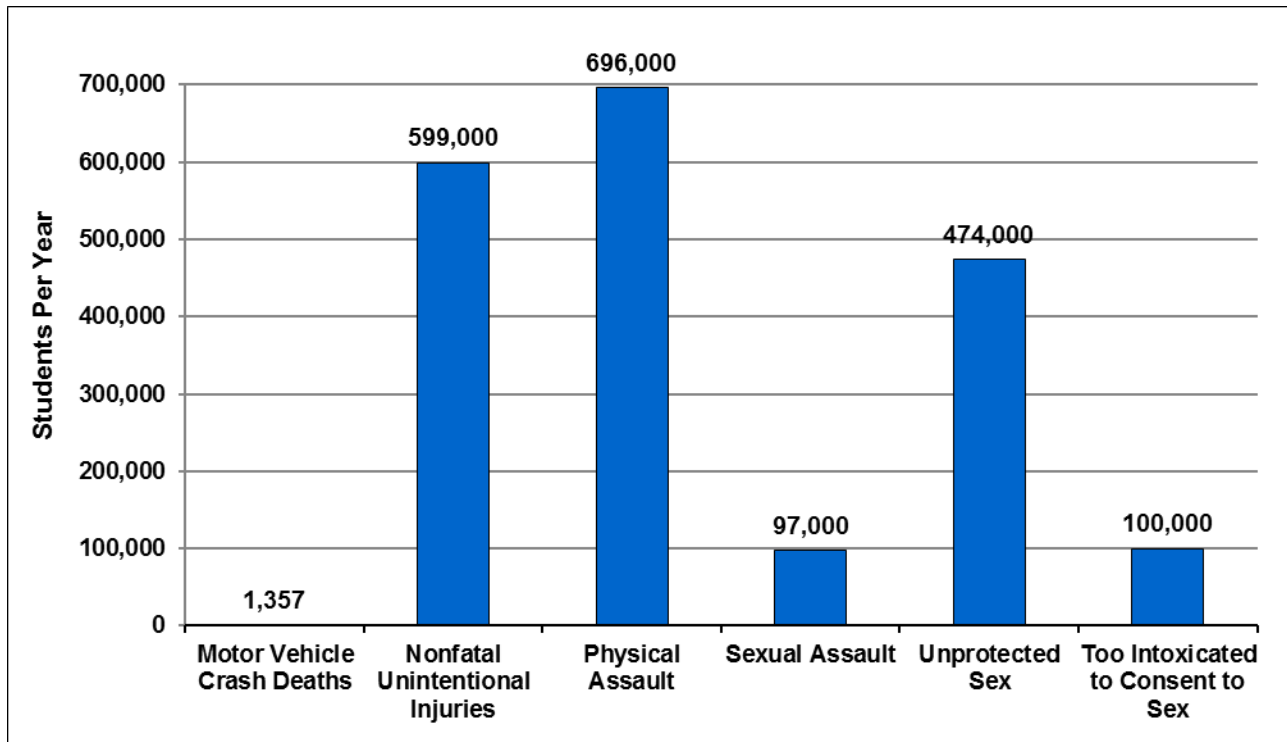
The problems associated with college drinking include sexual assault, including date rape, and other violent crime on college campuses (White & Hingson, 2013). A study of roughly 5,500 college women on two campuses revealed that nearly 20 percent experienced some form of sexual assault while at college (Krebs, Lindquist, Warner, Fisher, & Martin, 2009). One estimate based on a national survey of college students is that 97,000 students may be victims of alcohol-related sexual assault in a given year (Hingson, Heeren, Winter, & Wechsler, 2005). However, the incidence of college sexual assaults is difficult to measure and different studies report different rates (DeMatteo & Galloway, 2015).

A review by Abbey (2011) of three relevant studies concluded that approximately half of all reported and unreported sexual assaults involve alcohol consumption by the perpetrator, victim, or both (Abbey, Zawacki, Buck, Clinton, & McAuslan, 2004; Seto & Barbaree, 1995; Testa, 2002). Abbey and colleagues further reported that typically, if the victim consumes alcohol, the perpetrator does as well. Estimates of perpetrators' intoxication during the incident ranged from 30 percent to 75 percent.

Many other adverse social consequences are linked with college alcohol consumption. Hingson, Zha, and Weitzman (2009) estimated that annually, more than 696,000 college students were assaulted or hit by another student who had been drinking, and another 599,000 were unintentionally injured while under the influence of alcohol. In addition, they estimated that roughly 474,000 students ages 18 to 24 have had unprotected sex while under the influence of alcohol, and each year more than 100,000 students ages 18 to 24 report having had sexual intercourse when so intoxicated they were unable to consent (Hingson et al., 2005) (Exhibit 1.3). About 11 percent of college student drinkers report having damaged property while under the influence of alcohol (Hingson et al., 2005).



**Exhibit 1.3: Prevalence of Alcohol-Related Morbidity and Mortality Among College Students Ages 18–24** (calculated using methods of Hingson et al., 2005)



### Increased Risk of Developing an Alcohol Use Disorder Later in Life

Early-onset alcohol use, alone and in combination with increased drinking in adolescence, has been noted as a risk factor for developing alcohol-related problems in later life (Agrawal et al., 2009; Grant et al., 2005; Dawson, Goldstein, Chou, Ruan, & Grant, 2008; Hingson, Heeren & Winter, 2006; Hingson & Zha, 2009; Pitkänen, Lyyra, & Pulkkinen, 2005; York, Welte, Hirsch, Hoffman, & Barnes, 2004). Grant and Dawson (1997) found that more than 40 percent of people who initiated drinking before age 13 met DSM-IV diagnostic criteria for alcohol dependence at some time in their lives.<sup>7</sup>

The onset of alcohol consumption in childhood or early adolescence is associated with later use of drugs, drug dependence, and drug-related crash involvement (Hermos, Winter, Heeren, & Hingson, 2008; Hingson, Heeren, & Edwards, 2008). Use of both alcohol and marijuana or alcohol, marijuana, and cigarettes before age 16 is associated with a spectrum of young adult substance use problems, as well as substance use disorder diagnoses (Moss, Chena, & Yi, 2014).

Adults who started drinking at age 14 were three times more likely to report driving after drinking too much ever in their lives than were those who began drinking after age 21. Crashes were four times more likely for those who began drinking at age 14 than for those who began drinking after age 21 (Hingson, Heeren, Levenson, Jamanka, & Voas, 2001).

<sup>7</sup> Note that the criteria for alcohol-related disorders in the DSM-V (APA, 2013) do not specifically address adolescents.



## The National Effort to Reduce Underage Drinking

Over the past 30 years, a comprehensive national effort to address underage drinking has been initiated and subsequently intensified, as the multidimensional consequences associated with underage drinking have become more apparent. Substantial progress has been made through strengthening federal policy, implementing national media campaigns, increasing and supporting the involvement of communities through grants and other mechanisms, and collaborating with private agencies, such as the Robert Wood Johnson Foundation.

Development and evaluation of different approaches to prevention have been ongoing at the national level for the past three decades, with NIAAA playing a key role. Prevention efforts have focused on both the individual level, aimed at changing individual behavior, and the environmental level, aimed at limiting the availability of alcohol while increasing the safety of drinking contexts. This combined approach incorporates changes in policy and social environments along with continued education and skills training for individuals, family members, and the community (Harding et al., 2016).

Federal efforts are coordinated through the Interagency Coordinating Committee on the Prevention of Underage Drinking (ICCPUD), which includes representatives from HHS's Office of the Surgeon General (OSG), CDC, Administration for Children and Families, Office of the Assistant Secretary for Planning and Evaluation, and NIH, including NIAAA and NIDA; U.S. Department of Justice, Office of Juvenile Justice and Delinquency Prevention (OJJDP); Office of Safe and Healthy Students; Department of Transportation, NHTSA; White House Office of National Drug Control Policy (ONDCP); Department of the Treasury; U.S. Department of Defense; and FTC.

The federally sponsored research has been synthesized into several publications summarizing evidence-based prevention research strategies. The most recent is the 2016 *Facing Addiction in America, The Surgeon General's Report on Alcohol, Drugs and Health*. Other key documents include the Surgeon General's 2007 *Call to Action* (discussed in more detail below); the Community Preventive Services Task Force (*Guide to Community Preventive Services: Preventing Excessive Alcohol Consumption*, based on systematic reviews conducted between 2006 and 2012); the 2003 Institute of Medicine report entitled *Reducing Underage Drinking: A Collective Responsibility* (2004); the 2002 NIAAA report, *A Call to Action; Changing the Culture of Drinking at U.S. Colleges*; and the NIAAA CollegeAIM (the College Alcohol Intervention Matrix), also detailed below.

The national efforts aimed at the reduction of alcohol-related deaths and disability and associated healthcare costs are outlined below. Individual states have also adopted comprehensive policies and practices (detailed in Chapters 3 and 4) that can alter individual and environmental factors that contribute to underage drinking and its consequences.

### Adoption of the Minimum Legal Drinking Age

After Prohibition ended in 1933, states assumed authority for alcohol control, including enactment of laws restricting youth access to alcohol. Most states designated 21 as the MLDA for "purchase or public possession" of alcohol. But beyond setting a minimum drinking age, the nation largely ignored alcohol problems through the 1960s (NIAAA, 2005b) until, on December 31, 1970,

Congress established NIAAA to “provide leadership in the national effort to reduce alcohol problems through research.”

Between 1970 and 1976, 29 states lowered their MLDA from 21 to 18, 19, or 20 years old, in part because the voting age had been lowered (Wagenaar, 1981). However, studies conducted in the 1970s found that motor vehicle crashes increased significantly among teens, resulting in more traffic injuries and fatalities (Cucchiari, Ferreira, & Sichertman, 1974; Douglass, Filkins, & Clark, 1974; Wagenaar, 1983, 1993; Whitehead, 1977; Whitehead et al., 1975; Williams, Rich, Zador, & Robertson, 1974). As a result, 24 of the 29 states raised their MLDA between 1976 and 1984, although to different minimum ages. Some placed restrictions on the types of alcohol that could be consumed by people younger than 21. Only 22 states set an MLDA of 21. These differences across states led to youths driving across borders to buy and drink alcohol in neighboring states, with increased mortality (NHTSA, 2001). In response, Congress enacted the National Minimum Drinking Age Act of 1984, which mandated reduced federal highway funds to states that did not raise their MLDA to 21. By 1987, all remaining states had raised their MLDA to 21 in response to the federal legislation (although exceptions based on parental permission, location, and other factors exist in many states). While enforcement varies across states, the age-21 MLDA has led to significant reductions in traffic crashes among youths (NHTSA, 2014).

### **Congressional Actions Between 1992 and 2004**

In 1992, Congress created the Substance Abuse and Mental Health Services Administration (SAMHSA) to “focus attention, programs, and funding on improving the lives of people with or at risk for mental and substance abuse disorders.” In 1998, Congress mandated that the Department of Justice, through the Office of Justice Programs’ OJJDP, establish and implement the Enforcing the Underage Drinking Laws (EUDL) program, a state- and community-based initiative.

As national concern about underage drinking grew, in part because of advances in science that increasingly revealed adverse consequences, Congress appropriated funds for a study by the National Academies to examine the relevant literature to “review existing Federal, state, and nongovernmental programs, including media-based programs, designed to change the attitudes and health behaviors of youth.” The National Research Council (NRC) and the Institute of Medicine (IOM) issued the report, *Reducing Underage Drinking: A Collective Responsibility*, in 2004 (NRC and IOM, 2004).

### **Interagency Coordinating Committee on the Prevention of Underage Drinking**

The conference report accompanying H.R. 2673, the “Consolidated Appropriations Act of 2004,” directed the HHS Secretary to establish the ICCPUD (see member list, above) and to issue an annual report summarizing all federal agency activities related to the problem. The HHS Secretary directed the SAMHSA Administrator to convene ICCPUD in 2004.

ICCPUD coordinates federal efforts to reduce underage drinking and served as a resource for the development of *A Comprehensive Plan for Preventing and Reducing Underage Drinking*, for which Congress called in 2004. ICCPUD received input from experts and organizations representing a wide range of parties, including public health advocacy groups, the alcohol

industry, ICCPUD member agencies, and the U.S. Congress. The latest research available at the time was analyzed and incorporated into the plan, which HHS reported to Congress in January 2006. It included three goals, a series of federal action steps, and three measurable performance targets for evaluating national progress in preventing and reducing underage drinking.

## The STOP Act

In December 2006, Congress passed the Sober Truth on Preventing (STOP) Underage Drinking Act, Public Law 109-422, popularly known as the STOP Act. The Act states, “A multi-faceted effort is needed to more successfully address the problem of underage drinking in the United States. A coordinated approach to prevention, intervention, treatment, enforcement, and research is key to making progress. This Act recognizes the need for a focused national effort, and addresses particulars of the federal portion of that effort, as well as federal support for state activities.” The STOP Act requires the HHS Secretary, in collaboration with other federal officials enumerated in the Act, to “formally establish and enhance the efforts of the interagency coordinating committee (ICCPUD) that began operating in 2004.”

## The Surgeon General’s 2007 Call to Action

In fall 2005, ICCPUD sponsored a national meeting of the states to prevent and reduce underage alcohol use. At the meeting, the Surgeon General announced his intent to issue a Call to Action on the prevention and reduction of underage drinking. Subsequently, OSG worked closely with SAMHSA and NIAAA to develop the report. ICCPUD agencies collaborated to provide information and data for the *Surgeon General’s Call to Action to Prevent and Reduce Underage Drinking* (henceforth termed *SG’s Call to Action*). The 2006 Federal Comprehensive Plan set forth three general goals:

1. Strengthening a national commitment to address underage drinking
2. Reducing demand for, availability of, and access to alcohol by people younger than 21 years
3. Using research, evaluation, and scientific surveillance to improve the effectiveness of policies and programs designed to prevent and reduce underage drinking

In 2007, the *SG’s Call to Action* was issued (OSG, 2007). By issuing the *SG’s Call to Action*, the Surgeon General sought to raise public awareness and foster changes in American society—goals similar to those described to Congress in the Comprehensive Plan. The *SG’s Call to Action* built on the Comprehensive Plan. Based on the latest and most authoritative research, particularly on underage drinking as a developmental issue, the *SG’s Call to Action* outlined a comprehensive national effort to prevent and reduce underage alcohol consumption. The goals listed in the *SG’s Call to Action* are:

1. Foster changes in American society that facilitate healthy adolescent development and help prevent and reduce underage drinking.
2. Engage parents and other caregivers, schools, communities, all levels of government, all social systems that interface with youth, and youth themselves in a coordinated national effort to prevent and reduce underage drinking and its consequences.
3. Promote an understanding of underage alcohol consumption in the context of human development and maturation that takes into account individual adolescent characteristics as well as ethnic, cultural, and gender differences.
4. Conduct additional research on adolescent alcohol use and its relationship to development.

5. Work to improve public health surveillance on underage drinking and on population-based risk factors for this behavior.
6. Work to ensure that laws and policies at all levels are consistent with the national goal of preventing and reducing underage alcohol consumption.

The strategies for implementing these goals for parents and other caregivers, communities, schools, colleges and universities, businesses, the healthcare system, juvenile justice and law enforcement, and the alcohol and entertainment industries are included in the full *SG's Call to Action*, at <http://www.surgeongeneral.gov/topics/underagedrinking/calltoaction.pdf>.

ICCPUD agencies implemented a variety of federal programs to support the *SG's Call to Action's* goals. For example, SAMHSA and NIAAA worked with OSG to support rollouts of the *SG's Call to Action* in 13 states; SAMHSA collaborated with ICCPUD to support more than 7,000 town hall meetings, using the *SG's Call to Action's Guide to Action for Communities* (OSG, 2007) as a primary resource; and SAMHSA asked community coalitions funded under the STOP Act to implement strategies contained in the *SG's Call to Action*. These and other programs are described in more detail in Chapter 3.

## The Surgeon General's 2016 Report

In 2016, the Surgeon General released *Facing Addiction in America: The Surgeon General's Report on Alcohol, Drugs, and Health*, addressing the use and misuse of substances, including alcohol (HHS, 2016). The report is broad, covering substance use by all age groups, public health consequences, prevention, and treatment.

The report describes the extent of the substance use problem in the United States; the neurobiology of substance use, misuse, and addiction; prevention programs and policies; early intervention, treatment, and management of substance use disorders; the many services and systems that support the recovery process; the integration of healthcare systems and substance use services; and a vision for the future, including a public health approach, and concrete recommendations for reducing substance misuse and related harms.

The report provides a list of risk and protective factors for substance initiation and misuse by adolescents and young adults that operate at the individual, family, school, and community levels. The report also describes evidence-based prevention programs and policies in three different categories:

- Universal (aimed at all members of a given population, such as all children of a certain age)
- Selective (aimed at a subgroup determined to be at higher risk, such as youth involved with the justice system)
- Indicated (aimed at individuals who are already using substances but have not developed a substance use disorder)

Prevention programs and policies that have been proven effective with various groups of underage people, including the 0–10 age group, 10–18 age group, young adults, and college students, are highlighted in the report. Programs aimed at individuals and families include:

- Nurse–Family Partnership
- Raising Healthy Children/SSDP
- Good Behavior Game

- LifeSkills Training
- Keepin' it REAL
- Strengthening Families Program 10-14
- Guiding Good Choices
- Positive Family Support/Family Check-Up
- BASICS

Environmental policies that have been shown to be effective in preventing or reducing underage drinking include:

- MLDA of 21
- Compliance checks of retailers to enforce the MLDA
- Zero tolerance laws that prohibit people under age 21 from driving with any detectable blood alcohol content
- Use/lose laws that take away the driver's licenses of people under age 21 caught driving after drinking
- Laws that hold social hosts criminally liable for hosting underage drinking parties
- Laws that allow social hosts to be sued for hosting underage drinking parties
- Proposals to reduce underage people's exposure to alcohol advertising, although the evidence on effectiveness is mixed

### **NIAAA's CollegeAIM**

As described in more detail in Chapter 2, the problem of college drinking has been particularly persistent; college drinking and bingeing rates have declined more slowly than for other groups of underage drinkers. For many years, NIAAA has invested substantial resources in supporting studies on individual and environmental interventions to address college drinking. As a result, knowledge about best practices continues to grow.

In 2015, NIAAA launched a major new resource, CollegeAIM (the College Alcohol Intervention Matrix) to help college officials address harmful and underage student drinking. The centerpiece of CollegeAIM is a comprehensive, easy-to-use, matrix-based tool that helps inform college staff about potential alcohol interventions and guides them to evidence-based interventions. Although college officials have numerous options for alcohol interventions, these are not all equally effective. CollegeAIM is designed to help schools make informed choices among available strategies, thereby increasing the schools' chances for success and helping to improve student health and safety.

CollegeAIM compares and rates nearly 60 types of interventions on effectiveness, anticipated costs and barriers to implementation, public health reach, and research amount and quality. The matrix interventions are classified as either environmental-level strategies or individual-level strategies (Exhibits 1.4 and 1.5). Environmental-level strategies target the campus community and student population as a whole. Individual-level strategies focus on individual students, including those in higher risk groups such as first-year students, student-athletes, and members of Greek organizations. See <http://www.stopalcoholabuse.gov> for more detail about the strategies; go to Report to Congress, Supplemental Information [CollegeAIM Alcohol Intervention Matrix].



## Exhibit 1.4: NIAAA College Alcohol Intervention Matrix, Individual-Level Strategies

**INDIVIDUAL-LEVEL STRATEGIES:**

Estimated Relative Effectiveness, Costs, and Barriers; Public Health Reach; Research Amount; and Primary Modality<sup>1</sup>



COSTS: Combined program and staff costs for adoption/implementation and maintenance				
		Lower costs \$	Mid-range costs \$\$	Higher costs \$\$\$
<b>EFFECTIVENESS: Success in achieving targeted outcomes</b>	<b>Higher effectiveness</b> ★★★	<b>IND-3</b> Normative re-education: Electronic/mailed personalized normative feedback (PNF)—Generic/other <sup>2</sup> [#], B, ●●●, online/offsite  <b>IND-10</b> Skills training, alcohol focus: Self-monitoring/self-assessment <i>alone</i> <sup>3</sup> [#], F, ●●, online/offsite  <b>IND-21</b> Personalized feedback intervention (PFI): eCHECK UP TO GO (formerly, e-CHUG) <sup>2</sup> [#], B, ●●●, online	<b>IND-9</b> Skills training, alcohol focus: Goal/intention-setting <i>alone</i> <sup>3</sup> [#], F, ●●, IPI  <b>IND-12</b> Skills training, alcohol plus general life skills: Alcohol Skills Training Program (ASTP) <sup>2</sup> [#], F, ●●●, IPG  <b>IND-16</b> Brief motivational intervention (BMI): In-person—individual (e.g., BASICS) [#], F, ●●●●, IPI  <b>IND-22</b> Personalized feedback intervention (PFI): Generic/other <sup>2</sup> [#], B, ●●●●, online	<b>IND-17</b> Multi-component education-focused program (MCEFP): AlcoholEdu <sup>®</sup> for College <sup>2</sup> [#], B, ●●, online  <b>Interventions Delivered by Health Care Professionals</b>  Strategies in which health care professionals identify and help students whose drinking patterns put them at risk for harm, or who are already experiencing alcohol-related problems:  <b>IND-23</b> Screening and behavioral treatments <b>IND-24</b> Medications for alcohol use disorder  These approaches can reduce harmful drinking, according to studies conducted mainly in general adult populations (ages 18–65).  <i>The differences in research populations, along with wide variations in costs and barriers across campuses, precluded ratings relative to other strategies. See page 18 for more information.</i>
	<b>Moderate effectiveness</b> ★★		<b>IND-8</b> Skills training, alcohol focus: Expectancy challenge interventions (ECI)—Experiential [#], F, ●●●, IPG  <b>IND-13</b> Skills training, alcohol plus general life skills—Parent-based alcohol communication training [#], F, ●●, offsite  <b>IND-14</b> Skills training, alcohol plus general life skills or general life skills only: Generic/other <sup>2</sup> [#], F, ●●●●, IPG  <b>IND-15</b> Brief motivational intervention (BMI): In-person—Group [#], F, ●●, IPG	
	<b>Lower effectiveness</b> ★	<b>IND-2</b> Normative re-education: Electronic/mailed personalized normative feedback (PNF) Event-specific prevention (21st birthday cards) [#], B, ●●, online/offsite	<b>IND-4</b> Normative re-education: In-person norms clarification <i>alone</i> <sup>3</sup> [#], F, ●●, IPG	
	<b>Not effective</b> X	<b>IND-7</b> Skills training, alcohol focus: Expectancy challenge intervention (ECI)—By proxy/didactic/discussion <i>alone</i> <sup>3</sup> [#], F, ●●, IPG	<b>IND-1</b> Information/knowledge/education <i>alone</i> <sup>3</sup> [#], B, ●●●●, IPG <b>IND-5</b> Values clarification <i>alone</i> <sup>3</sup> [#], F, ●●, IPG	
	<b>Too few studies to rate effectiveness</b> ?	<b>IND-11</b> Skills training, alcohol plus general life skills: Alcohol 101 Plus™ <sup>2</sup> [#], B, ●, online  <b>IND-19</b> Personalized feedback intervention (PFI): CheckYourDrinking (beta 1.0 version) <sup>2</sup> [#], B, ●, online  <b>IND-20</b> Personalized feedback intervention (PFI): College Drinker's Check-up <sup>2</sup> [#], B, ●, online	<b>IND-6</b> Skills training, alcohol focus: Blood alcohol concentration feedback <i>alone</i> <sup>3</sup> [#], F, ●, IPI  <b>IND-18</b> Multi-component education-focused programs (MCEFP): Miscellaneous <sup>2</sup> [#], B, ●, online	

See brief descriptions and additional ratings for each individual-level strategy on the summary table beginning on page 13.

<sup>1</sup> **Effectiveness** ratings are based on the percentage of studies reporting any positive outcomes (see legend). Strategies with three or fewer studies were not rated for effectiveness due to the limited data on which to base a conclusion. **Cost** ratings are based on the relative program and staff costs for adoption, implementation, and maintenance of a strategy. Actual costs will vary by institution, depending on size, existing programs, and other campus and community factors. **Barriers** to implementing a strategy include cost and opposition, among other factors. **Public health reach** refers to the number of students that a strategy affects. Strategies with a broad reach affect all students or a large group of students (e.g., all underage students); strategies with a focused reach affect individuals or small groups of students (e.g., sanctioned students). **Research amount** refers to the number of randomized controlled trials (RCT) of a strategy (see legend).

<sup>2</sup> Strategies are listed by **brand name** (e.g., CheckYourDrinking) if they were evaluated by at least two RCTs; strategies labeled **generic/other** have similar components and were not identified by name in the research or were evaluated by only one RCT; strategies labeled **miscellaneous** have the same approach but very different components.

<sup>3</sup> Although this approach is a component of larger, effective programs such as BASICS and ASTP, it is evaluated here as a stand-alone intervention.

## Emerging Issues in Underage Drinking and the Government Response

Although prevention efforts have had an effect, there is a need for ongoing monitoring of trends in the marketplace and emerging public health issues. Not only are new products introduced, but youth behavior and experimentation regarding different ways to consume alcohol may change over time. Two products that have generated governmental response at the federal and/or state levels are caffeinated alcoholic beverages and powdered alcohol.

### Federal and State Actions to Address Caffeinated Alcoholic Beverages

The combination of alcohol with caffeine may pose a public health issue for young people with the increase in availability of energy drinks (which often contain large quantities of caffeine). Due to federal and state actions, premixed caffeinated alcoholic beverages (CABs) are no longer on the market, but young people may still mix these substances on their own.

Research suggests that mixing alcohol and caffeine poses public health and safety risks, because the caffeine can mask the depressant effects of alcohol without changing the alcohol's intoxicating properties (<http://www.cdc.gov/alcohol/fact-sheets/cab.htm>). This could lead

### Exhibit 1.5: NIAAA College Alcohol Intervention Matrix, Environmental-Level Strategies

ENVIRONMENTAL-LEVEL STRATEGIES:

Estimated Relative Effectiveness, Costs, and Barriers; Public Health Reach; and Research Amount/Quality<sup>1</sup>



COSTS: Combined program and staff costs for adoption/implementation and maintenance				
	Lower costs \$	Mid-range costs \$\$	Higher costs \$\$\$	
EFFECTIVENESS: Success in achieving targeted outcomes	Higher effectiveness ★★★	<b>ENV-16</b> Restrict happy hours/price promotions [###, B, ●●●] <b>ENV-21</b> Retain ban on Sunday sales (where applicable) [##, B, ●●●●] <b>ENV-22</b> Retain age-21 drinking age [##, B, ●●●●]	<b>ENV-11</b> Enforce age-21 drinking age (e.g., compliance checks) [##, B, ●●●●] <b>ENV-23</b> Increase alcohol tax [###, B, ●●●●]	
	Moderate effectiveness ★★	<b>ENV-17</b> Retain or enact restrictions on hours of alcohol sales [##, B, ●●●●] <b>ENV-34</b> Enact social host provision laws [##, B, ●●●]	<b>ENV-3</b> Prohibit alcohol use/sales at campus sporting events [##, F, ●●●●] <b>ENV-25</b> Enact dram shop (liability) laws: Sales to intoxicated [##, B, ●●●●] <b>ENV-26</b> Enact dram shop (liability) laws: Sales to underage [##, B, ●●●] <b>ENV-30</b> Limit number/density of alcohol establishments [###, B, ●●●●] <b>ENV-35</b> Retain state-run alcohol retail stores (where applicable) [###, B, ●●●●]	<b>ENV-31</b> Enact responsible beverage service training laws [##, B, ●●●]
	Lower effectiveness ★		<b>ENV-1</b> Establish an alcohol-free campus [###, B, ●●●] <b>ENV-7</b> Conduct campus-wide social norms campaign <sup>2</sup> [#, B, ●●●●]	<b>ENV-12</b> Restrict alcohol sponsorship and advertising [##, B, ●●●] <b>ENV-14</b> Implement beverage service training programs: Sales to intoxicated [C = #, S/L = ##, B, ●●●] <b>ENV-15</b> Implement beverage service training programs: Sales to underage [C = #, S/L = ##, B, ●●●●] <b>ENV-28</b> Enact keg registration laws [##, B, ●●●]
	Too few robust studies to rate effectiveness —or mixed results ?	<b>ENV-4</b> Prohibit alcohol use/service at campus social events [##, B, 0] <b>ENV-5</b> Establish amnesty policies <sup>2</sup> [#, F, ●●●] <b>ENV-8</b> Require Friday morning classes <sup>2</sup> [#, B, ●●] <b>ENV-9</b> Establish standards for alcohol service at campus social events [#, B, ●●●] <b>ENV-10</b> Establish substance-free residence halls <sup>2</sup> [#, F, ●●] <b>ENV-13</b> Prohibit beer kegs [C = #, S/L = ###, B, ●●●] <b>ENV-18</b> Establish minimum age requirements to serve/sell alcohol [##, B, ●●●●] <b>ENV-19</b> Implement party patrols [##, B, ●●●] <b>ENV-24</b> Increase cost of alcohol license [##, B, 0] <b>ENV-27</b> Prohibit home delivery of alcohol [##, B, ●●] <b>ENV-29</b> Enact noisy assembly laws [##, B, 0]	<b>ENV-6</b> Implement bystander interventions <sup>2</sup> [#, F, 0]	<b>ENV-2</b> Require alcohol-free programming <sup>2</sup> [#, F, ●●] <b>ENV-20</b> Implement safe-rides program <sup>2</sup> [##, F, ●●] <b>ENV-32</b> Conduct shoulder tap campaigns [##, B, ●●] <b>ENV-33</b> Enact social host property laws [##, B, 0] <b>ENV-36</b> Require unique design for state ID cards for age < 21 [##, B, 0]
<b>Legend</b> Barriers: ### = Higher, # = Moderate, # = Lower C = Barriers at college level, S/L = Barriers at the state/local level Public health reach: B = Broad, F = Focused Research amount/quality: ●●●● = 5 or more longitudinal studies, ●●● = 5 or more cross-sectional studies or 1 to 4 longitudinal studies, ●● = 2 to 4 studies but no longitudinal studies, ● = 1 study that is not longitudinal				

See brief descriptions and additional ratings for each environmental-level strategy on the summary table beginning on page 19.

<sup>1</sup> Effectiveness ratings are based on estimated success in achieving targeted outcomes. Cost ratings are based on a consensus among research team members of the relative program and staff costs for adoption, implementation, and maintenance of a strategy. Actual costs will vary by institution, depending on size, existing programs, and other campus and community factors. Barriers to implementing a strategy include cost and opposition, among other factors. Public health reach refers to the number of students that a strategy affects. Strategies with a broad reach affect all students or a large group of students (e.g., all underage students); strategies with a focused reach affect individuals or small groups of students (e.g., sanctioned students). Research amount/quality refers to the number and design of studies (see legend).

<sup>2</sup> Strategy does not seek to reduce alcohol availability, one of the most effective ways to decrease alcohol use and its consequences.

some to believe they are more capable of operating a vehicle, and presents other risks such as encouraging binge drinking, particularly among young drinkers.

In 2007, these health and safety risks prompted members of the National Association of Attorneys General Youth Access to Alcohol Committee to initiate investigations and negotiations with the Anheuser-Busch and MillerCoors Brewing Companies regarding their CAB products. In 2008, those companies agreed to remove caffeine and other stimulants from their products. In 2009, the U.S. Food and Drug Administration (FDA) initiated an investigation into the marketing and distribution of other CABs. In November 2010, three federal agencies—FDA, FTC, and the Alcohol and Tobacco Tax and Trade Bureau—took coordinated action to address these concerns, issuing warning letters to four manufacturers of caffeinated beverages:

- The FDA letters advised that, as used in the products at issue, caffeine was an “unsafe food additive,” rendering the products adulterated under the FDA Act; it warned that further action was possible.
- The FTC letters advised that marketing and sale of caffeinated alcohol could constitute an unfair or deceptive act in violation of the FTC Act; it urged the companies to take “swift and appropriate steps to protect consumers.”

- The Alcohol and Tobacco Tax and Trade Bureau letters warned that adulterated caffeinated malt beverages were mislabeled under the Federal Alcohol Administration Act. The letters stated that further action, including seizure and injunction, was possible.<sup>8</sup>

In response, the four companies ceased using added caffeine in their products; by summer 2011, with few (if any) exceptions, malt-based CABs were no longer available in the United States. For more references and details on health and safety risks associated with caffeinated alcoholic beverages and successful efforts to remove them from the marketplace, see the *2012 Report to Congress on the Prevention and Reduction of Underage Drinking* (SAMHSA, 2012). In parallel with the federal actions against CABs, numerous states enacted statutory or administrative bans on such beverages.

Young people continue to mix alcohol and energy drinks on their own, despite the federal government's removal of CABs from the marketplace. An NIAAA-funded research study assessed the extent of this practice and its public health and safety effects on college students (Patrick & Maggs, 2014). A sample of 508 students reported alcohol and energy drink use on 4,203 days over four consecutive semesters, starting in their freshman year. Of the sample, 30.5 percent reported combined use at least once, and respondents consumed energy drinks on 9.6 percent of the days when they reported drinking alcohol. Heavier drinking, longer times drinking, and increased negative effects occurred when alcohol was combined with energy drinks, compared with drinking occasions without energy drinks. The research suggests that continued attention to this issue is needed among policymakers and educators.

## Federal and State Actions Regarding Powdered Alcohol

On March 10, 2015, the U.S. Alcohol and Tobacco Tax and Trade Bureau (TTB), which approves alcohol labeling, issued label approvals for Palcohol, a powdered alcoholic product. A container of Palcohol contains 1 ounce of powder, which when mixed as directed with 200 milliliters of water, results in a beverage with 10 percent alcohol by volume. The company—Lipsmark, LLC—has approval to market five versions: vodka, rum, cosmopolitan, lemon drop, and powderita (margarita flavor). Public health professionals and state government officials raised concerns that because powdered alcohol is easy to conceal and transport, it would appeal to underage drinkers (Naimi & Mosher, 2015). They also argued that the product raises safety issues—drinks made from powdered alcohol could intentionally or unintentionally be made much stronger than standard drinks and could be consumed in other ways that may prove harmful (see Firger, 2014). Two recent studies suggest that underage drinkers would consume powdered alcohol if they had access to it (Stogner, Baldwin, Brown, & Chick, 2015; Vail-Smith, Chaney, Martin, & Chaney, 2016). Given this evidence, the American Medical Association (AMA) adopted a policy on June 14, 2016, calling for a ban on powdered alcohol in the United States (AMA News Release, 2016).<sup>9</sup>

The states have authority to determine which alcohol products may be sold within their borders. The sale of powdered alcohol has been illegal in Alaska since 1995. As of February 2017, 32 other states have enacted a permanent or temporary ban on the sale of powdered alcohol.

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<sup>8</sup> See <http://www.fda.gov/ForConsumers/ConsumerUpdates/ucm233987.htm#2>. The FDA investigation and warning letters involved companies that produced malt-based alcoholic beverages and did not include wine- and spirits-based products. The investigation did not address products that contain naturally brewed caffeine (e.g., coffee-based drinks).

<sup>9</sup> <https://www.ama-assn.org/new-ama-policy-calls-ban-powdered-alcohol>



Alabama, California, Connecticut, Georgia, Hawaii, Idaho, Illinois, Indiana, Kansas, Kentucky, Louisiana, Maine, Massachusetts, Michigan, Nebraska, Nevada, New Jersey, New York, North Carolina, North Dakota, Ohio, Oregon, Pennsylvania, Rhode Island, South Carolina, Tennessee, Utah, Vermont, Virginia, Washington, and West Virginia statutorily prohibit the sale of powdered alcohol. Maryland enacted a temporary 2-year statutory ban on powdered alcohol that expires on June 30, 2018. Three states—Colorado, Delaware, and New Mexico—have expanded the statutory definition of alcohol so that powdered alcohol can be regulated under their existing alcohol statutes. Prior to legislatively banning powdered alcohol, two control states—Massachusetts and Pennsylvania—stated they would not sell powdered alcohol in their state stores. Visit <http://www.stopalcoholabuse.gov> for complete legal citations; go to Report to Congress, Supplemental Information [State Report and Legal Citations].

As of February 2017, the Palcohol owner, Lipsmark, LLC, stated on its website that it is auctioning off its “secret manufacturing process” to a representative in each country rather than manufacture and distribute the powdered alcohol product itself. Currently, Palcohol is not available for purchase in the United States.



# CHAPTER 2

## The Nature and Extent of Underage Drinking in America

## Introduction

The STOP Act requires the HHS Secretary to report to Congress on the “extent of progress in preventing and reducing underage drinking nationally.” In addition, the report is to include:

- Patterns of underage consumption as described in research, including federal surveys
- Information on the onset and prevalence of underage drinking, consumption patterns, and the means of underage access
- Measures of the availability of alcohol
- Measures of the exposure of underage populations to messages regarding alcohol in advertising and the entertainment media as reported by the Federal Trade Commission (FTC)

This chapter sets out detailed updates in response to this mandate.

## Federal Surveys Used in This Report

To monitor the current status of progress on reducing underage drinking, the federal government funds three major national surveys that collect data on, among other topics, underage drinking and its consequences:

- The annual National Survey on Drug Use and Health (NSDUH), formerly called the National Household Survey on Drug Abuse
- The annual Monitoring the Future (MTF) survey (conducted pursuant to federal grants)
- The biennial Youth Risk Behavior Survey (YRBS)

Each makes a unique contribution to an understanding of the nature of alcohol use. Key findings from these data sources and other research related to underage alcohol use in the United States are described in this chapter.<sup>10</sup>

Each of these three surveys was developed for a specific purpose (see, e.g., Cowan, 2001), and direct comparison of findings across the three surveys (e.g., in the prevalence of underage drinking) is not generally appropriate, because the surveys have unique designs and different sampling frames and weighting approaches. The only overlap in the survey populations sampled is students in the 10th and 12th grades in traditional schools in 47 states (Exhibit 2.1). The surveys also use varied data collection methods (e.g., Fendrich & Johnson, 2001; Harrison, 2001). On the other hand, each survey provides a different perspective on the status of underage drinking. For consistency in reporting, detailed statistics from the survey most appropriate to address the topic of interest are provided in the main text in this report; supporting, contrasting, and supplementary data from the other surveys are then provided as appropriate.

These surveys are revised periodically to reflect the current state of the research in underage drinking. In 2015, the NSDUH definition of binge drinking was changed from five drinks on a single occasion to five drinks for males or four drinks for females. This change was made to reflect the evidence that there are differences in how alcohol is processed by males and females. Trend data for female binge drinking through 2015 are therefore not currently available.

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<sup>10</sup> Four additional surveys used by the government to obtain data on underage drinkers ages 18 and older are the Behavioral Risk Factor Surveillance System (BRFSS), National Epidemiologic Survey on Alcohol and Related Conditions, National Health Interview Survey, and Survey of Health-Related Behaviors Among Active Duty Military Personnel (formerly called the Worldwide Surveys of Substance Abuse and Health Behaviors Among Military Personnel). A more detailed description of each of these surveys and their unique contribution to research can be found in Appendix B.

**Exhibit 2.1: Summary of Major Federal Surveys Assessing Underage Drinking**

Survey/ Sponsoring Agency	Purpose	Target Population	Administration Schedule	Data Collection Method
National Survey on Drug Use and Health (NSDUH)—SAMHSA Center for Behavioral Health Statistics and Quality (CBHSQ)	Measurement of substance use, misuse, and related problems for U.S. population ages 12–65	Civilian, noninstitutionalized population ages 12–65 in the U.S. Group homes, shelters, etc., included	Annually since 1991	In-person visit to home; Audio computer-assisted self-interviews
Monitoring the Future (MTF) <sup>11</sup> —NIDA	Measurement of alcohol, tobacco, and drug use by secondary school students	Secondary school students in coterminous U.S. in grades 8, 10, and 12; a randomly selected sample from each senior class has been followed up subsequently	Annually for 12th graders since 1975 and for 8th and 10th graders since 1991; biennially for college students and adults ages 19–30; then every five years through age 55	School-based, self-administered questionnaire in classroom through 12 <sup>th</sup> grade; mail surveys for subsequent follow-up
Youth Risk Behavior Survey—CDC	Assessment of a variety of behaviors that affect adolescent health	Public, Catholic, and other private school students in grades 9–12 in the U.S. and DC (excluding most of Louisiana)	Biennially since 1991	School-based, self-administered questionnaire in classroom

## Extent of Progress

Progress in the reduction of underage drinking is assessed both by examining drinking behavior directly and by assessing changes in behaviors and outcomes that are correlated with underage drinking. An examination of trend data across the three federally sponsored surveys suggests that meaningful progress is being made in reducing the extent of underage drinking, including overall alcohol use, age of initiation, and binge drinking. (Due to natural fluctuations from year to year, examining trends over a multiyear period is more informative.) Progress is also being made in reducing driving after drinking and in increasing age of initiation.

### Extent of Progress: Alcohol Use

Exhibits 2.2, 2.3, and 2.4 provide NSDUH-based estimates of trends of past-month or past-year alcohol use in three important areas—current use, age at first use, and binge drinking—from 2004 (when the ICCPUD was first convened) through 2015.<sup>12</sup>

All age groups showed a statistically significant decline in past-month alcohol use over time. As shown in the last columns in Exhibit 2.2, for most age groups the declines have been substantial. Not unexpectedly, changes among 18- to 20-year-olds were smaller but still statistically significant. The large number of 18- to 20-year-olds using alcohol also accounts for the smaller percentage change among 12- to 20-year-olds compared with 12- to 17-year-olds (CBHSQ, 2016a).<sup>13</sup>

<sup>11</sup> For comparability with 2015 NSDUH and 2015 YRBS data (the most recent data available), the latest MTF data included in this report are also from 2015. The 2016 MTF data became available in December 2016 and will be included in the next report.

<sup>12</sup> The 2006–2010 estimates are based on data files revised in March 2012.

<sup>13</sup> CBHSQ provided special analyses of the NSDUH data for this report.

**Exhibit 2.2: Past-Month Alcohol Use for 12- to 20-Year-Olds, 2004–2015 NSDUH Data (CBHSQ, 2016a)**

Age	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	% Change 2004–2015
12–13	4.3%	4.2%	3.9%	3.5%*	3.4%*	3.5%*	3.2%*	2.5%*	2.2%*	2.1%*	2.1%*	1.3*	-69.5%
14–15	16.4%	15.1%	15.6%	14.7%*	13.3%*	13.1%*	12.4%*	11.3%*	11.1%*	9.5%*	8.5%*	7.4*	-54.8%
16–17	32.5%	30.1%*	29.8%*	29.2%*	26.3%*	26.5%*	24.6%*	25.3%*	24.8%*	22.7%*	23.3%*	19.7*	-39.4%
18–20	51.1%	51.1%	51.6%	50.8%	48.6%*	49.5%	48.5%*	46.8%*	45.8%*	43.8%*	44.2%*	40.9*	-20.1%
12–17	17.6%	16.5%*	16.7%*	16.0%*	14.7%*	14.8%*	13.6%*	13.3%*	12.9%*	11.6%*	11.5%*	9.6*	-45.4%
12–20	28.7%	28.2%	28.4%	28.0%	26.5%*	27.2%*	26.2%*	25.1%*	24.3%*	22.7%*	22.8%*	20.3*	-29.2%

\*Difference between 2004 estimate and this estimate is statistically significant at the 0.05 level.

**Exhibit 2.3: Average Age at First Use Among Past-Year Initiates of Alcohol Use Who Initiated Before Age 21, 2004–2015 NSDUH Data (CBHSQ, 2016a)**

Year	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015
Average Age at First Use	15.6	15.6	15.8*	15.8*	15.8*	15.9*	16.0*	15.9*	16.0*	16.2*	16.2*	16.3*

\*Difference between 2004 estimate and this estimate is statistically significant at the 0.05 level.

**Exhibit 2.4: Past-Month Binge Alcohol Use for 12- to 20-Year-Olds, 2004–2014 (CBHSQ, 2015)**

Age	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	% Change 2004–2014
12–13	2.0%	2.0%	1.5%	1.5%	1.5%	1.6%	1.0%*	1.1%*	0.9%*	0.8%*	0.8%*	-60.4%
14–15	9.1%	8.0%	9.0%	7.8%*	7.0%*	7.0%*	6.7%*	5.7%*	5.4%*	4.5%*	3.9%*	-57.2%
16–17	22.4%	19.7%*	20.1%*	19.5%*	17.2%*	17.1%*	15.3%*	15.0%*	15.0%*	13.1%*	13.1%*	-41.4%
18–20	36.8%	36.1%	36.2%	35.9%	33.9%*	34.9%	33.1%*	31.2%*	30.5%*	29.1%*	28.5%*	-22.4%
12–17	11.1%	9.9%*	10.3%	9.7%*	8.9%*	8.9%*	7.9%*	7.4%*	7.2%*	6.2%*	6.1%*	-45.1%
12–20	19.6%	18.8%	19.0%	18.7%	17.5%*	18.2%*	16.9%*	15.8*	15.3%*	14.2%*	13.8%*	-29.5%

\*Difference between 2004 estimate and this estimate is statistically significant at the 0.05 level.

As shown in Exhibit 2.3, among past-year initiates<sup>14</sup> of alcohol use who initiated before age 21, the overall trend in the mean age at first alcohol use went up from 15.6 in 2004 to 16.3 in 2015 with significant increases since 2006, indicating a delay in initiation of drinking (CBHSQ, 2016a). Trends in age of initiation of alcohol use are important to follow because delaying the age of first alcohol use can ameliorate some of the negative consequences of underage alcohol consumption (CBHSQ, 2016a).

Appendix B further discusses methodological issues in measuring age at first use and other indicators of alcohol initiation.

NSDUH data for binge-drinking levels, the third key area of progress in alcohol use, is shown in Exhibit 2.4.

<sup>14</sup> Past-year initiates are those who had never drunk alcohol before the previous 12 months prior to the survey interview, but had drunk alcohol for the first time in their lives in the previous 12 months.

There was a significant decline in all age groups for binge drinking in 2014 compared with 2004.<sup>15</sup>

Similarly, MTF trend data among 8th-, 10th-, and 12th-graders indicate binge drinking<sup>16</sup> increased slightly in the 1990s, leveled off in the early 2000s, and then began a gradual decline in 2002. Two recent publications provide a detailed analysis of this trend (Jang, Patrick, Keyes, Hamilton, & Schulenberg, 2017; Esser, Clayton, Demissie, Kanny, & Brewer, 2017). Declines have continued through the data recorded in 2015, which marks the lowest levels for both self-reported drunkenness and alcohol use in all three grades measured by the MTF survey (Johnston, O'Malley, Miech, Bachman, & Schulenberg, 2016b).

Analyses looking across multiple surveys through 2009 (Faden & Fay, 2004; Chen, Yi, & Faden, 2011) and then through 2013 (Chen, Yi, & Faden, 2015) confirm the patterns described above.

### Extent of Progress: Driving After Drinking

One important sign of progress in addressing underage drinking is that alcohol-related traffic deaths among youth ages 16–20 have declined 79 percent since 1982 (NHTSA, 2014, Table 18).

The 2015 NSDUH survey provided data on the percentage of youth by age who reported driving after drinking at least once in the past year (Exhibit 2.5) (CBHSQ, 2016b). As shown in the exhibit, this behavior increases steadily with age. O'Malley and Johnston (2013) reported longitudinal data for high school seniors (previous 2 weeks) on driving after drinking any alcohol and after five or more drinks and on being a passenger when the driver has had any alcohol and has had five or more drinks (Exhibit 2.6).

Exhibit 2.6 shows that all four of these behaviors have declined in the last decade, but they remain unacceptably high, especially given the risks associated with driving after even small amounts of alcohol. Males were more than twice as likely as females to report driving after five or more drinks, a finding replicated in other studies (CDC, 2014; Quinn & Fromme, 2012a). Very high percentages of high school seniors who drove after drinking five or more drinks experienced consequences. O'Malley and Johnston (2013) reported that 43.2 percent received a ticket or warning and 30.2 percent were involved in a crash.

O'Malley and Johnston (2013) note that high school seniors who drive more frequently are more likely to drive after drinking. Driving after drinking in college students is associated with living off campus (Quinn & Fromme, 2012b), spending more evenings out (O'Malley & Johnston, 2013), higher socioeconomic status, and driving someone's car without permission (Delcher, Johnson, & Maldonado-Molina, 2013).

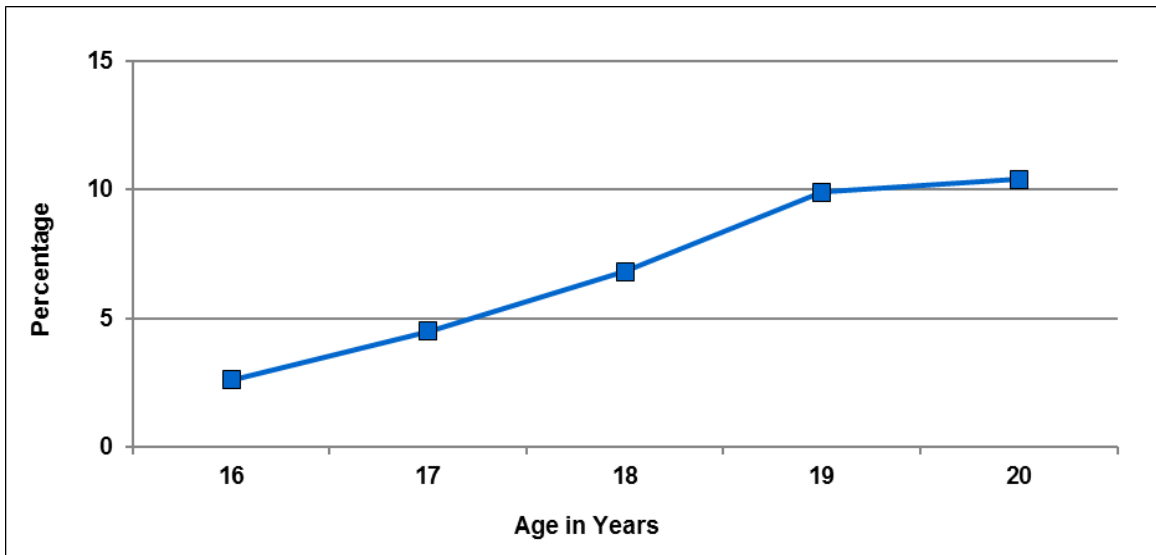
#### Supporting Data

*YRBS data indicate that, of students who drove a car or other vehicle in the 30 days prior to the 2015 survey, 7.8% drove after drinking alcohol. More males (9.5%) than females (6.0%) reported this behavior (Kann et al., 2016).*

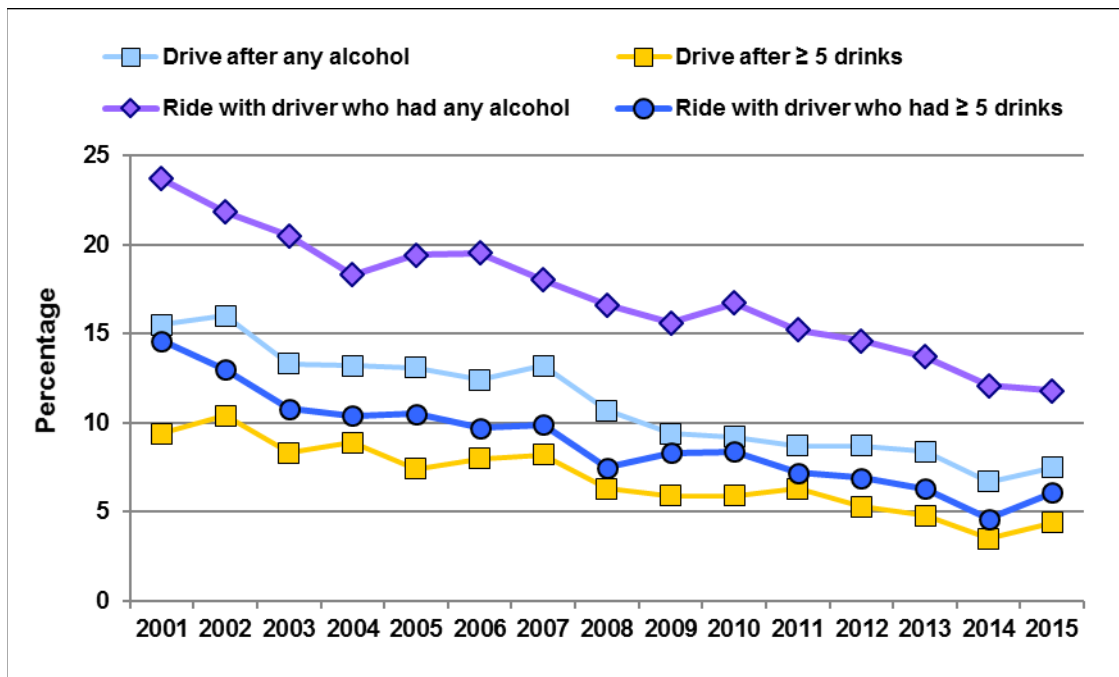
<sup>15</sup> NSDUH questionnaire changes for 2015 included a revision of the definition of binge drinking for females from five to four drinks; therefore, data for males and females combined for 2015 cannot be compared with those from previous years. Trend data will be available in 2 years. Exhibit 2.4 shows past-month binge alcohol use through 2014, the last year before the definition was changed.

<sup>16</sup> Binge drinking in the MTF survey is defined as five drinks for both males and females.

**Exhibit 2.5: Percentage of Drivers Ages 16–20 Reporting Driving After Drinking At Least Once in the Past Year by Age: 2015 NSDUH Data (CBHSQ, 2016b)**



**Exhibit 2.6: Trends in Percentage of 12th Graders Reporting Driving after Alcohol Use or Riding after Alcohol Use by the Driver: MTF Data (O'Malley & Johnston, 2013; O'Malley, 2016)<sup>17</sup>**



<sup>17</sup> Updates to 2012 report have been provided annually by Patrick O'Malley (O'Malley, 2016).



A number of policy approaches (see Chapter 4) have been shown to reduce driving after drinking and associated mortality and morbidity among youth. Chief among these is the age-21 minimum legal drinking age (MLDA). Two reviews of the research on the age-21 MLDA concluded that this policy reduces injuries and saves lives, even though the law is imperfectly enforced and widely disobeyed (DeJong & Blanchette, 2014; McCartt, Hellinga, & Kirley, 2010). Fell, Fisher, Voas, Blackman, and Tippetts (2009) found that the age-21 MLDA was associated with a 16 percent decline in the ratio of drinking to nondrinking drivers under age 21 involved in fatal crashes, after controlling for other state-level traffic safety and alcohol-related policies.

Another study examining the effects of a variety of laws designed to reduce driving after drinking found significant effects of laws related to underage purchase and consumption as well as to production and use of false identification (Fell et al., 2008).

Policies targeting young people's drinking and driving behavior may also be factors in the trend of reduction in traffic fatalities. (These policies are discussed in more detail in Chapter 4.3 and the state reports.) Graduated driver's license (GDL) policies limit the extent to which young people drive and the conditions under which they drive. "Use/lose" policies revoke driving privileges of young people convicted of an alcohol offense. Cavazos-Rehg and colleagues (2012) used 1999–2009 YRBS data to examine the impact of GDL and "use/lose" laws on drinking and driving behaviors of youth ages 16 to 17. Restrictive GDL laws and "use/lose" laws were associated with decreased driving after drinking any alcohol and decreased riding in a car with a driver who had been drinking alcohol.

## Extent of Progress: Prevalence of Alcohol Misuse and Dependence among Youth

There was a significant decline in past-year alcohol use disorder from 2004 to 2015 as defined by the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision* (DSM-IV-TR) (APA, 2000) for all age groups, and for both males and females. Trends in alcohol misuse and dependence among people ages 12–20 from 2004 to 2015 are provided in Exhibit 2.7. Nonetheless, the prevalence of alcohol misuse and dependence among underage drinkers remains quite high.

As shown in Exhibit 2.8, according to NSDUH combined 2014–2015 data, about 1 in 10 18- to 20-year-olds (9.3 percent) met criteria for DSM-IV alcohol misuse or dependence. The prevalence rate is significantly lower than for 21- to 24-year-olds (13.2 percent) and 25- to 29-year-olds (11.0 percent), but not significantly different than for 30- to 34-year-olds (8.8 percent). In addition, 0.7 percent of 12- to 14-year-olds and 4.5 percent of 15- to 17-year-olds met criteria for DSM-IV alcohol misuse or dependence (CBHSQ, 2016a). As shown in Exhibit 2.8, according to the combined 2014–2015 NSDUH data, prevalence of alcohol misuse or dependence as defined by DSM-IV-TR<sup>18</sup> is highest among those ages 21–29.

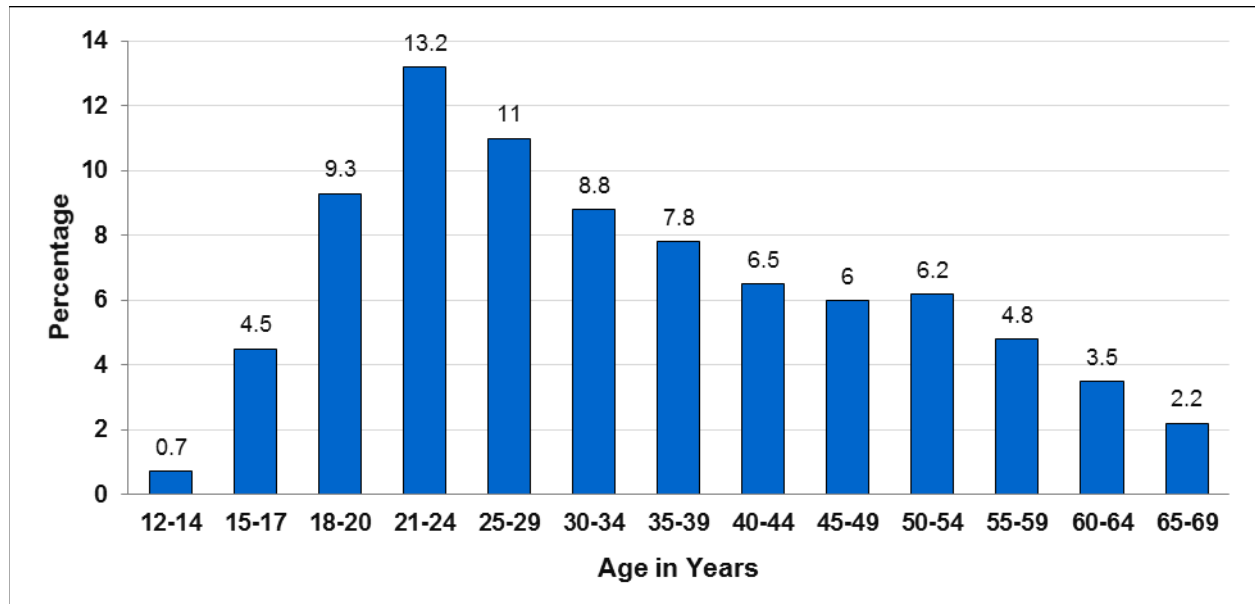
<sup>18</sup> The DSM-IV-TR (APA, 2000) criteria for abuse and dependence used in this study were originally developed for use with adults, and using them to assess abuse and dependence in adolescents may lead to inconsistencies. The more recent *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition* (DSM-V; APA, 2013) integrates the two DSM-IV disorders, alcohol abuse and alcohol dependence, into a single disorder called alcohol use disorder (AUD). DSM-V does not specifically address adolescents. Research suggests that the criteria for DSM-V and the criteria for DSM-IV would result in similar outcomes (Winters, Martin, & Chung, 2011).

**Exhibit 2.7: Past-Year Alcohol Misuse or Dependence for 12- to 20-Year-Olds, 2004–2015, by Age and Sex, NSDUH Data (CBHSQ, 2016a)**

	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	% Change 2004–15	p value for the overall trend
Ages 12–20	9.6	9.4	9.1	9.0	8.9*	8.2*	8.0*	7.1*	6.6*	5.6*	5.1*	4.7*	-51.3%	<0.001
Ages 12–17	6.0	5.5	5.4*	5.4*	4.9*	4.6*	4.6*	3.8*	3.4*	2.8*	2.7*	2.5*	-58.5%	<0.001
Ages 18–20	16.8	16.9	16.5	15.8	16.4	14.7*	14.0*	13.1*	12.5*	11.0*	9.7*	8.8*	-47.4%	<0.001
Males ages 12–20	10.8	10.0	9.6*	9.8*	9.5*	8.9*	8.7*	7.2*	6.5*	5.8*	5.2*	4.5*	-58.3%	<0.001
Females ages 12–20	8.3	8.7	8.5	8.1	8.3	7.6	7.2*	6.9*	6.6*	5.4*	5.1*	4.8*	-41.7%	<0.001

\*Difference between 2004 estimate and this estimate is statistically significant at the 0.05 level.

**Exhibit 2.8: Prevalence of Past-Year DSM-IV Alcohol Abuse or Dependence by Age: 2014–2015 NSDUH Data (CBHSQ, 2016a)**



### Summary of Progress

The above data demonstrate that meaningful progress has been made in reducing underage drinking prevalence, alcohol misuse and dependence disorders, and related problems such as traffic fatalities. The factors that have contributed to this progress are varied and complex; one clear factor, however, has been increased attention to this issue at all levels of society. Federal initiatives have raised underage drinking to a prominent place on the national public health agenda, created a policy climate in which significant legislation has been passed by states and localities, raised awareness of the importance of aggressive enforcement, and stimulated

coordinated citizen action. These changes are mutually reinforcing and have provided a framework for a sustained national commitment to reducing underage drinking.

## Patterns of Consumption

Despite progress, underage alcohol use in the United States continues to be a widespread and serious problem, the consequences of which remain a substantial threat to public health. Rates of underage drinking are still unacceptably high, resulting in preventable and tragic health and safety consequences for the nation's youth, families, communities, and society as a whole. Therefore, ICCPUD remains committed to an ongoing,

*Alcohol continues to be the most widely used substance of misuse among American youth*

comprehensive approach to preventing and reducing underage drinking. This report, along with the yearly updates to state reports and survey responses, is part of that sustained effort to continue to reduce underage drinking in America.

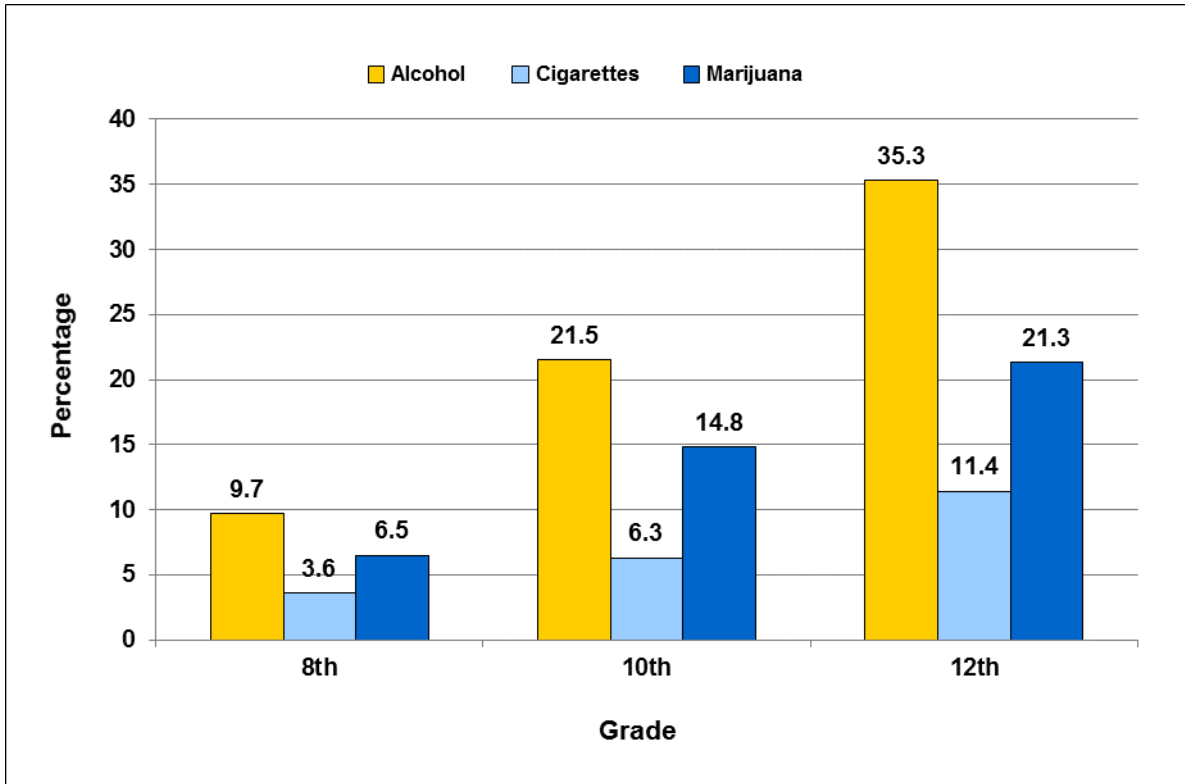
According to CBHSQ, through special analyses of NSDUH 2015 data, a higher percentage of youth who are 12 to 20 years old used alcohol in the past month (20.3 percent) than tobacco (13.7 percent) or illicit drugs (13.5 percent; CBHSQ, 2016a).

Similarly, as shown in Exhibit 2.9, a higher percentage of youth in 8th, 10th, and 12th grades used alcohol in the month prior to being surveyed than used marijuana (the illicit drug most commonly used by adolescents) or tobacco (Miech, Johnston, O'Malley, Bachman, & Schulenberg, 2016).

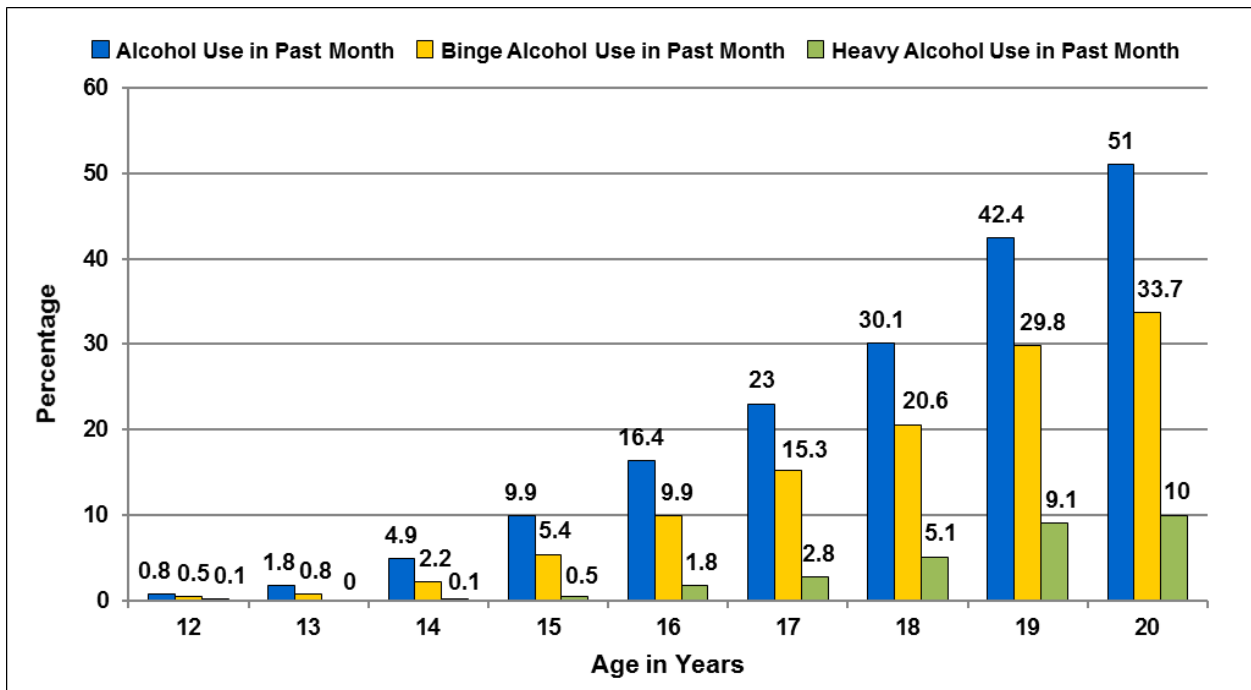
Underage alcohol consumption rates can be viewed from several perspectives, as detailed below:

- **Lifetime Use:** Data from the 2015 NSDUH indicate that 42.3 percent of those ages 12 to 20 have had alcohol (more than a sip) in their lifetime (CBHSQ, 2016b).
- **Current Use:** The 2015 NSDUH reported that approximately 20.3 percent of Americans ages 12 to 20 (about 7.7 million people) reported having at least one drink in the 30 days prior to the survey interview (CBHSQ, 2016b).
- **Binge Drinking:** Among underage drinkers (12- to 20-year-olds), 13.4 percent (5.1 million) engaged in binge drinking (five or more drinks on the same occasion, either at the same time or within a couple of hours) on at least 1 day in the past 30 days. Binge drinking was reported at all ages, with frequency increasing by age (see Exhibit 2.10) (CBHSQ, 2016b).
- **Heavy Drinking:** Approximately 3.3 percent of this age group (1.3 million) were heavy drinkers (consuming five or more drinks on the same occasion on each of 5 or more days in the past 30 days). By definition, all heavy alcohol users are also binge alcohol users (CBHSQ, 2016b). Averaged 2014 and 2015 data show that 9.1 percent of underage drinkers had nine or more drinks during their last drinking occasion (CBHSQ, 2016a).
- **Geographic Extent of Use:** Current consumption by underage individuals varies slightly by region, but occurs nationwide, with reports of consumption by those ages 12 to 20 at 26.1 percent in the Northeast, 20.5 percent in the Midwest, 18.6 percent in the South, and 18.8 percent in the West.

**Exhibit 2.9: Past-Month Adolescent Alcohol, Cigarette, and Marijuana Use by Grade: 2015 MTF Data (Miech et al., 2016)**



**Exhibit 2.10: Current, Binge, and Heavy Alcohol Use Among People Ages 12–20 by Age: 2015 NSDUH Data (CBHSQ, 2016a)**



## Onset and Prevalence

Drinking often begins at very young ages. The NSDUH survey indicates that approximately:

- 13.8 percent of lifetime alcohol users ages 12 to 20 began drinking before age 13.
- 11.5 percent of past-year alcohol users ages 12 to 20 began drinking before age 13.

Similarly, the YRBS shows that almost one fifth (17.2 percent) of underage drinkers in high schools begin drinking before age 13 (Kann et al., 2016).

The average age of first use for youths who initiated before age 21 is about 16.3 years old (CBHSQ, 2016a). However, among those who initiated alcohol use in the past year, 750,000 reported being ages 12 to 14 when they initiated. This translates to approximately 2,052 youths ages 12 to 14 who initiated alcohol use per day in 2015 (CBHSQ, 2016a). Youths who report drinking before age 15 are more likely to experience problems, including intentional and unintentional injury to self and others after drinking (Hingson & Zha, 2009; Hingson, Heeren, Jamanka, & Howland, 2000); violent behavior, including predatory violence and dating violence (Blitstein, Murray, Lytle, Birnbaum, & Perry, 2005; Ellickson, Tucker, & Klein, 2003; Ramisetty-Mikler, Caetano, Goebert, & Nishimura, 2004, 2006); criminal behavior (Eaton, Davis, Barrios, Brener, & Noonan, 2007); prescription drug misuse (Hermos, Winter, Heeren, & Hingson, 2008); unplanned and unprotected sex (Hingson, Heeren, Winter, & Wechsler, 2003); motor vehicle crashes (Hingson, Heeren, Levenson, Jamanka, & Voas, 2002); and physical fights (Hingson, Heeren, & Zakocs, 2001). Early-onset drinking is thus a marker for future problems, including heavier use of alcohol and drugs during adolescence (Hawkins et al., 1997; Robins & Przybeck, 1985; Buchmann et al., 2009; Liang & Chikritzhs, 2015) and alcohol dependence in adulthood (Grant & Dawson, 1998).

Delaying the age of first alcohol use can ameliorate some of the negative consequences of underage alcohol consumption, which means that trends in age of initiation of alcohol use are important to follow.

Appendix B further discusses methodological issues in measuring age at first use and other indicators of alcohol initiation.

## Alcohol Use and Binge Drinking Increase with Age

Drinking becomes increasingly common through the teenage years (O'Malley, Johnston, & Bachman, 1998). Frequent, heavy use by underage drinkers also increases each year from age 12 to age 20 (Flewelling, Paschall, & Ringwalt, 2004). The 2015 NSDUH reported that

### Supporting Data

#### **Ever Used Alcohol**

*MTF*: 64.0% of 12th graders, 47.1% of 10th graders, and 26.1% of 8th graders have had alcohol at some point in their lives (Miech et al., 2016; Exhibit 2.9).

*YRBS*: 63.2% of students have had at least one drink of alcohol on at least 1 day in their lives (Kann et al., 2016).

#### **Current Use of Alcohol**

*MTF*: 35.3% of 12<sup>th</sup> graders; 21.5% of 10<sup>th</sup> graders; and 9.7% of 8<sup>th</sup> graders report current use (Miech et al., 2016).

*YRBS*: 32.8% of students reported having had at least one drink in the 20 days before the survey.

#### **Binge and Heavy Use of Alcohol**

*MTF*: 46.7% of 12th graders, 28.6% of 10th graders, and 10.9% of 8th graders reported having been drunk at least once (Exhibit 2.11) (Miech et al., 2016).

*YRBS*: 17.7% of students reported five or more drinks in a row in the 30 days prior to the survey (Kann et al., 2016).

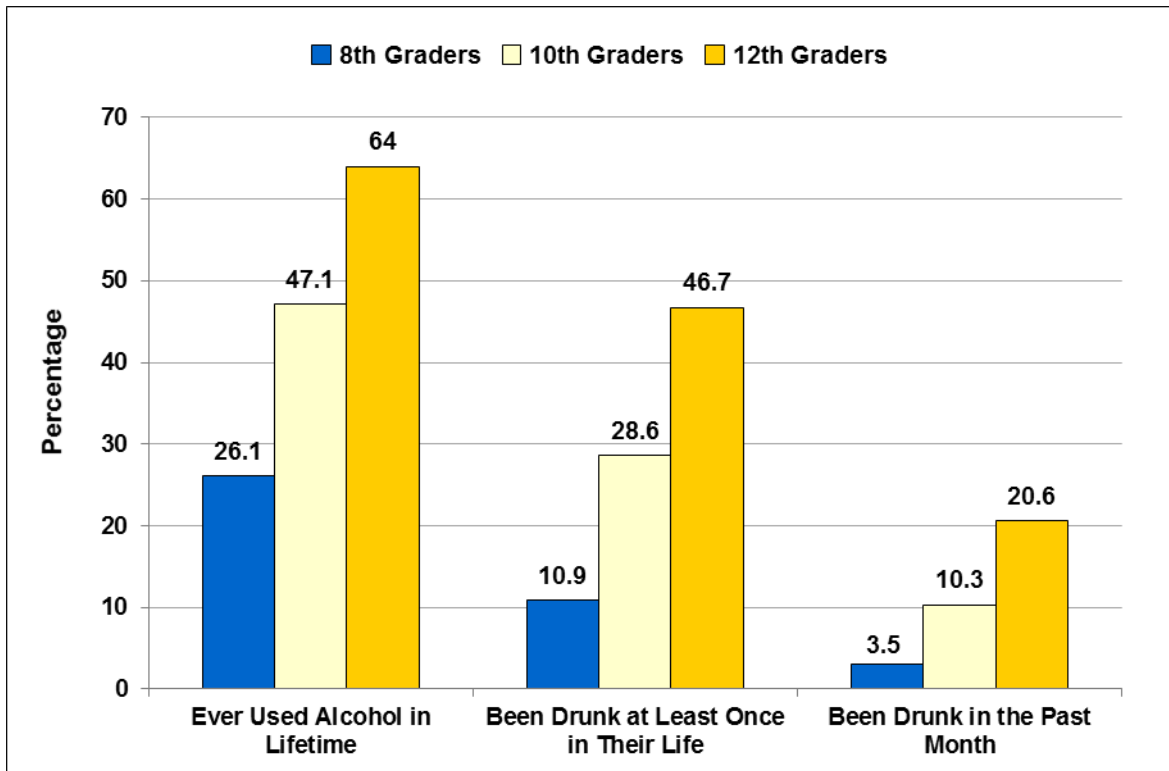
underage alcohol consumption in the past month increased with age from 0.8 percent for 12-year-olds to 51.0 percent for 20-year-olds; past-month alcohol consumption across all age groups peaked at 69.8 percent for 21-year-olds (CBHSQ, 2016b).

Binge drinking also increased steadily between ages 12 and 20 (Exhibit 2.10), peaked at age 23 (48.0 percent), and then decreased beyond young adulthood (data not shown). Approximately 5.1 million (13.4 percent) of 12- to 20-year-olds reported past-month binge alcohol use (CBHSQ, 2016b). More information about patterns of alcohol use among emerging adults (ages 18 to 24), including binge drinking, alcohol-impaired driving, and alcohol-related deaths and overdose hospitalizations, is described in a recent article (Hingson, Zha, & Smyth, 2017).

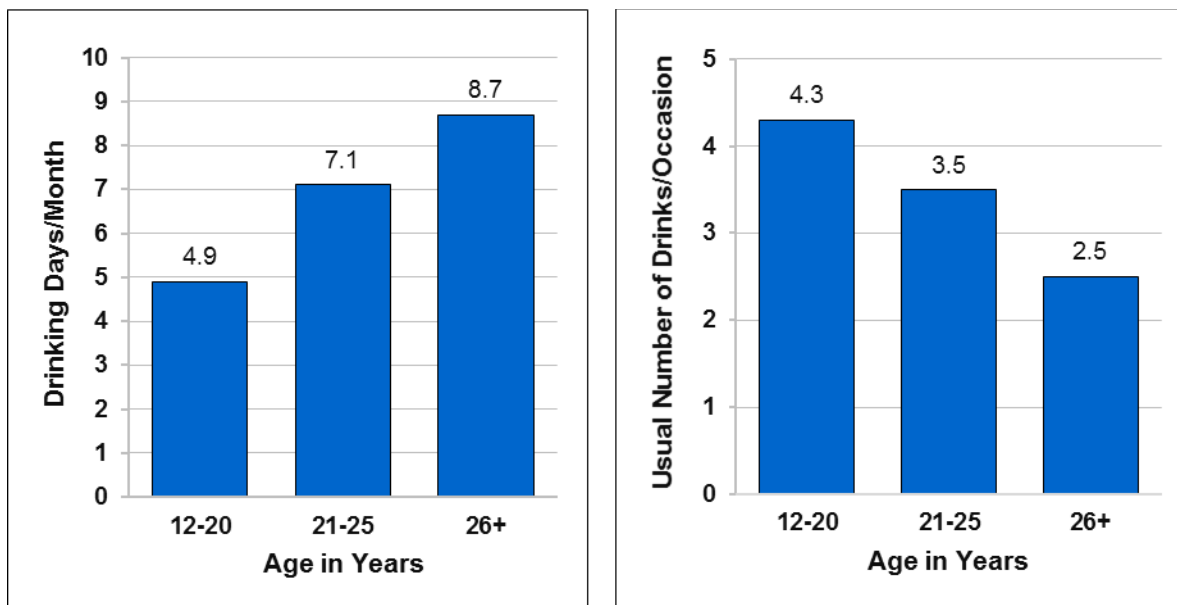
### Youth Binge More and Drink More Than Adults When They Drink

Young drinkers tend to drink less often than adults; when they do drink, however, they drink more intensely. Underage drinkers consume, on average, about four and a half drinks per occasion, five times a month, whereas adult drinkers 26 and older average two and a half drinks per occasion, nine times a month (CBHSQ, 2016a) (Exhibit 2.12). Most youth alcohol consumption occurs in binge-drinking episodes (NIAAA, 2017).

**Exhibit 2.11: Lifetime Alcohol Use, Lifetime Use to Intoxication, and Use to Intoxication Within the Past Month among 8th, 10th, and 12th Graders: 2015 MTF data (Miech et al., 2016)**



**Exhibit 2.12: Number of Drinking Days per Month and Usual Number of Drinks per Occasion for Youth (12–20), Young Adults (21–25), and Adults (≥26): 2015 NSDUH Data (CBHSQ, 2016a)**



Youths ages 12 to 15 can, according to a theoretical analysis, reach the same blood alcohol level (BAC) after consuming three to four drinks within 2 hours as adults ages 18 and older who consume four to five drinks during this same time period (Donovan, 2009).

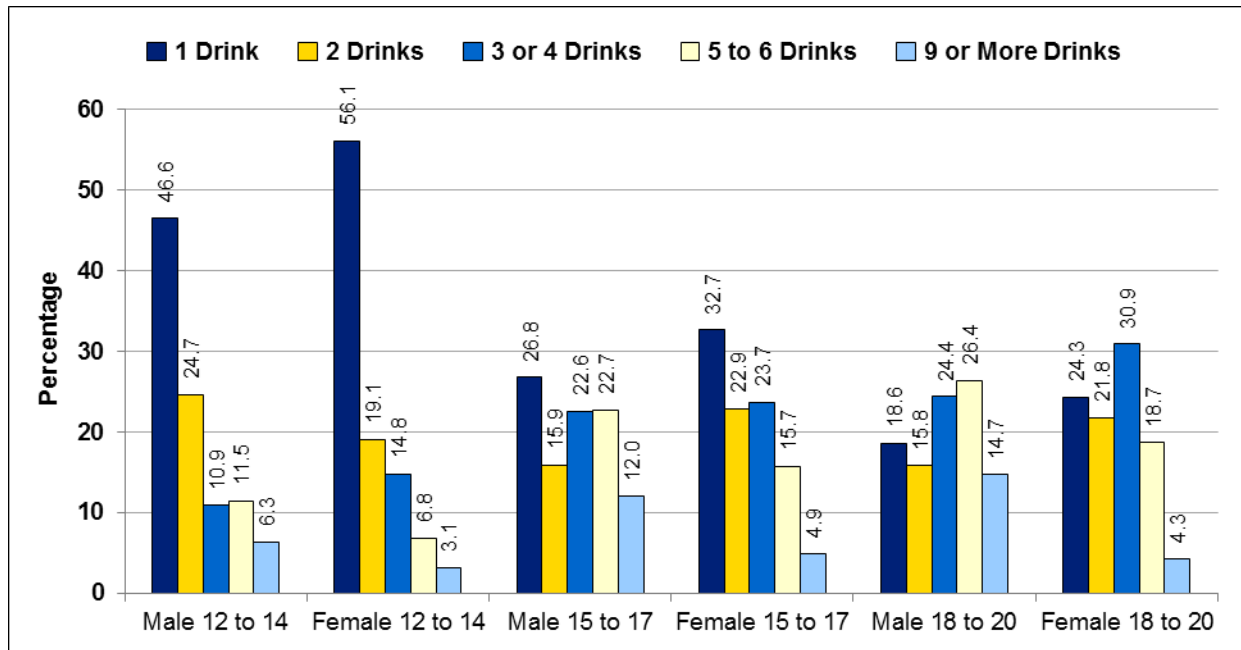
When asked about the number of drinks consumed on their last occasion of alcohol use in the past month, for 2014 and 2015 combined, 24.9 percent of underage drinkers reported one drink; 19.0 percent, two drinks; 25.8 percent, three or four drinks; 21.2 percent, five to eight drinks; and 9.1 percent, nine or more drinks (CBHSQ, 2016a). The number of drinks consumed differs by gender (Exhibit 2.13): underage females are more likely to report consuming one to four drinks, and underage males five to nine drinks or more. Among past-month alcohol users ages 12 to 20, the number of drinks reported on the last occasion tends to increase with increasing age (CBHSQ, 2016a).

Particularly worrisome among underage drinkers is the high prevalence of binge drinking, which MTF defines as five or more drinks in a row in the past 2 weeks. In 2015, 4.6 percent of 8th graders, 10.9 percent of 10th graders, and 17.2 percent of 12th graders reported binge drinking (Miech et al., 2016). In 2015, about 1.3 million youth ages 12 to 20 (3.3 percent) drank five or more drinks on a single occasion 5 or more days a month (CBHSQ, 2016b).

Faden and Fay (2004) used statistical trend analyses to examine underage drinking data from 1975 to 2002. Among 12th graders, drinking five or more drinks in a row in the past 2 weeks declined 7.6 percent, from 36.8 percent in 1975 to 29.2 percent in 2002. Analysis of the intervening years showed that the prevalence of drinking five or more drinks in a row in the past 2 weeks rose from 1975 to 1980, fell from 1980 to 1987, steeply declined from 1987 to 1993, rose from 1993 to 1997, and declined from 1997 to 2002. Subsequent statistical trend analyses showed that for 12th graders, the prevalence of drinking five or more drinks in a row in the past 2 weeks continued to fall between 2002 and 2013 (Chen et al., 2015).



**Exhibit 2.13: Number of Drinks Consumed on Last Occasion of Alcohol Use in the Past Month Among Past-Month Alcohol Users Ages 12–20, by Gender and Age Group: 2014–2015 (CBHSQ, 2016a)**



Information on the prevalence of drinking five or more drinks in a row in the past 2 weeks among 8th and 10th graders first became available from the MTF in 1991. In 1991, 10.9 percent of 8th graders and 21 percent of 10th graders reported engaging in this behavior, compared with 9.4 percent and 19.9 percent, respectively, in 2004. Rates in the intervening years oscillated heavily for 8th graders and rose steadily for 10th graders, for whom rates peaked in 2000 and have since gradually declined (Johnston, O’Malley, Bachman, & Schulenberg, 2005). Since 2002, there have been statistically significant declines in binge drinking for all three grades (Johnston, O’Malley, Bachman, & Schulenberg, 2012). For 8th, 10th, and 12th graders, 2015 marked the lowest levels for alcohol use and drunkenness ever recorded by the MTF survey (Johnston, O’Malley, Miech, Bachman, & Schulenberg, 2016b).

A troubling subset of binge drinking is “extreme” binge drinking or high-intensity binge drinking, often defined as consumption of 10 or 15 or more drinks on a single occasion (Miech et al., 2016). MTF has tracked the prevalence of consuming 10 or more and 15 or more drinks in a row since 2005. According to MTF data for 2015, 6.1 percent of 12th graders reported consuming 10 or more drinks in a row, and 3.5 percent reported consuming 15 or more drinks in a row within the previous 2 weeks. Although these numbers have declined since 2005, the rate of decline for high-intensity binge drinking appears to be slower than for binge drinking overall: a decline of 4.4 percent for 10 or more drinks in a row and 2.2 percent for 15 or more drinks in a row, compared with 9.9 percent for all binge drinking (Miech et al., 2016, p. 170). An in-depth analysis of high-intensity binge drinking (15+ drinks) suggests it may be more entrenched in some adolescent subcultures than 5+ binge drinking (Patrick et al., 2013).<sup>19</sup> In addition, analysis

<sup>19</sup> It should be noted that data estimates for 10+ and 15+ drinks for 12<sup>th</sup> graders are subject to a larger sampling error due to the limited number of cases in a single questionnaire form; data estimates on 5+ drinks are more stable.



of high school seniors in the MTF study indicates that the heaviest drinkers and marijuana users are more likely to use both substances simultaneously (Patrick, Veliz, & Terry-McElrath, 2017).

YRBS data from 2015 indicated that 4.3 percent of high schoolers (grades 9 through 12) reported drinking 10 or more drinks within 2 hours at least once in the last month. The percentage for males was 6.1 percent and for females, 2.5 percent (Kann et al., 2016).

## **Teen Binge Drinking Is Not Limited to the United States**

The most recently available data (from 2011), indicate that in many European countries, a significant proportion of young people ages 15 to 16 report binge drinking at rates higher than in the United States (Exhibit 2.14). In all countries listed in Exhibit 2.14, the MLDA is lower than in the United States. These data call into question the suggestion that having a lower MLDA results in less problem drinking by adolescents.

## **Individual, Family, and Contextual Differences in Underage Drinkers**

Adolescent alcohol consumption is a complex behavior influenced by multiple factors, including the normal maturational changes that all adolescents experience; the various social and cultural contexts in which adolescents live (e.g., family, peers, school); genetic, psychological, and social factors specific to each adolescent; and environmental factors that influence availability and appeal of alcohol (e.g., enforcement of underage alcohol policies, marketing practices, media exposure). Biological factors (such as genes and hormones) and environmental factors (such as family, peers, school, and the overall culture) interact and influence the extent to which the adolescent will use alcohol. Internal and external factors influence in reciprocal ways as the adolescent's development unfolds over time. Youths are not all at risk in the same way or to the same degree. The next sections address some of the individual, family, and contextual differences correlated with alcohol consumption.

### **Genetics**

Children whose families include individuals who misuse alcohol are at increased risk for alcohol dependence throughout their lives. Genes account for more than half the risk for alcohol dependence; environmental factors account for the rest. However, no single gene accounts for the majority of risk. Development of a complex behavioral disorder, such as alcohol dependence, likely depends on specific genetic factors interacting with one another, multiple environmental factors, and the interaction between genetic and environmental factors. Research suggests that genes have a stronger influence on the development of problematic use, whereas environment seems to play a greater role in initiation of use (Rhee et al., 2003).<sup>20</sup> The current college environment may increase the likelihood that people with genetic predispositions to alcohol use disorders will have those predispositions expressed (Timberlake et al., 2007).

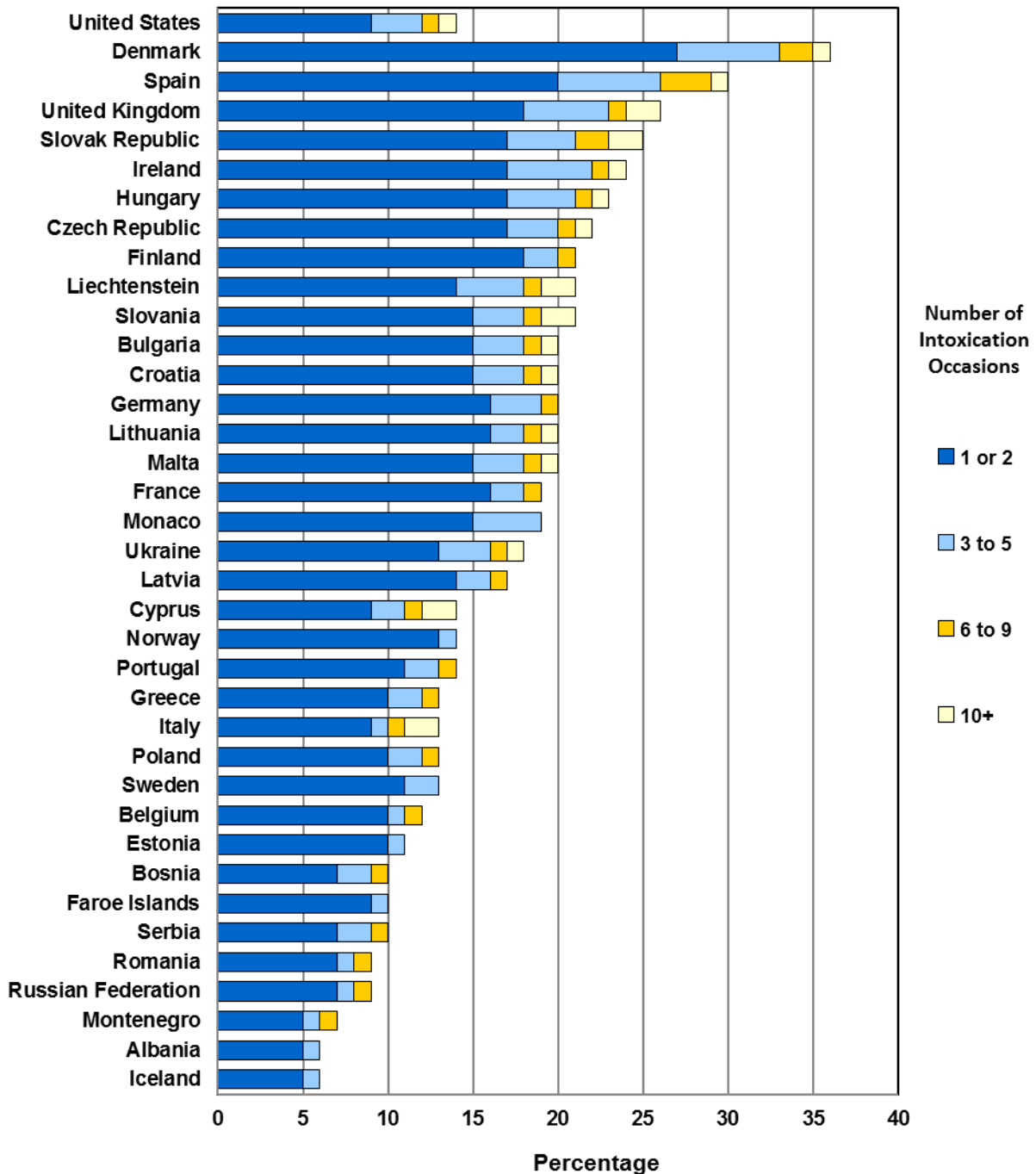
### **Gender**

Although underage males and females tend to start drinking at about the same age and have approximately the same prevalence of any past-month alcohol use, males are more likely to drink with greater frequency and to engage in binge and heavy drinking. According to the 2015

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<sup>20</sup> "Problematic use" was defined as having at least one DSM-IV abuse or dependence symptom for alcohol.

**Exhibit 2.14: Percentage of European Students Ages 15–16 Who Reported Being Drunk in the Past 30 Days Compared with American 10th Graders (Hibell et al., 2012; data from the 2011 European School Survey Project on Alcohol and Drugs)**



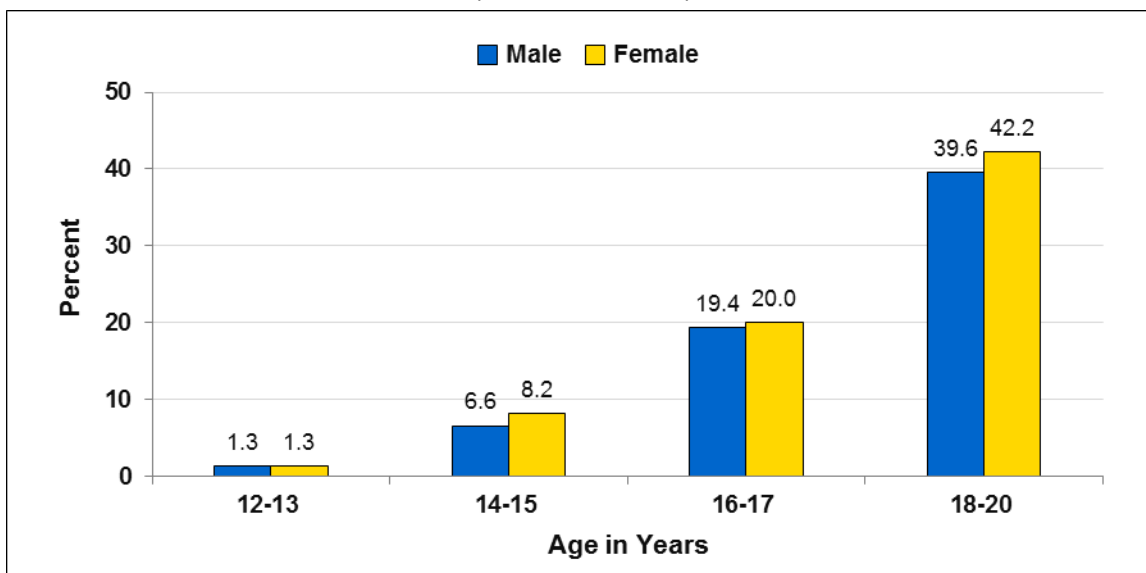
**Note:** The 2011 European School Survey Project on Alcohol and Drugs (ESPAD) question is: “On how many occasions (if any) have you been intoxicated from drinking alcoholic beverages (staggered when walking, not able to speak properly, throwing up or not remembering what happened)?” Information on ESPAD data collection is available at [www.espad.org](http://www.espad.org).

NSDUH data, 19.8 percent of males ages 12 to 20 were current drinkers compared with 20.8 percent of females in that age group (CBHSQ, 2016b). Among underage drinkers, the prevalence of past-month alcohol use was similar between girls and boys for each examined age group (CBHSQ, 2016a) (Exhibit 2.15).

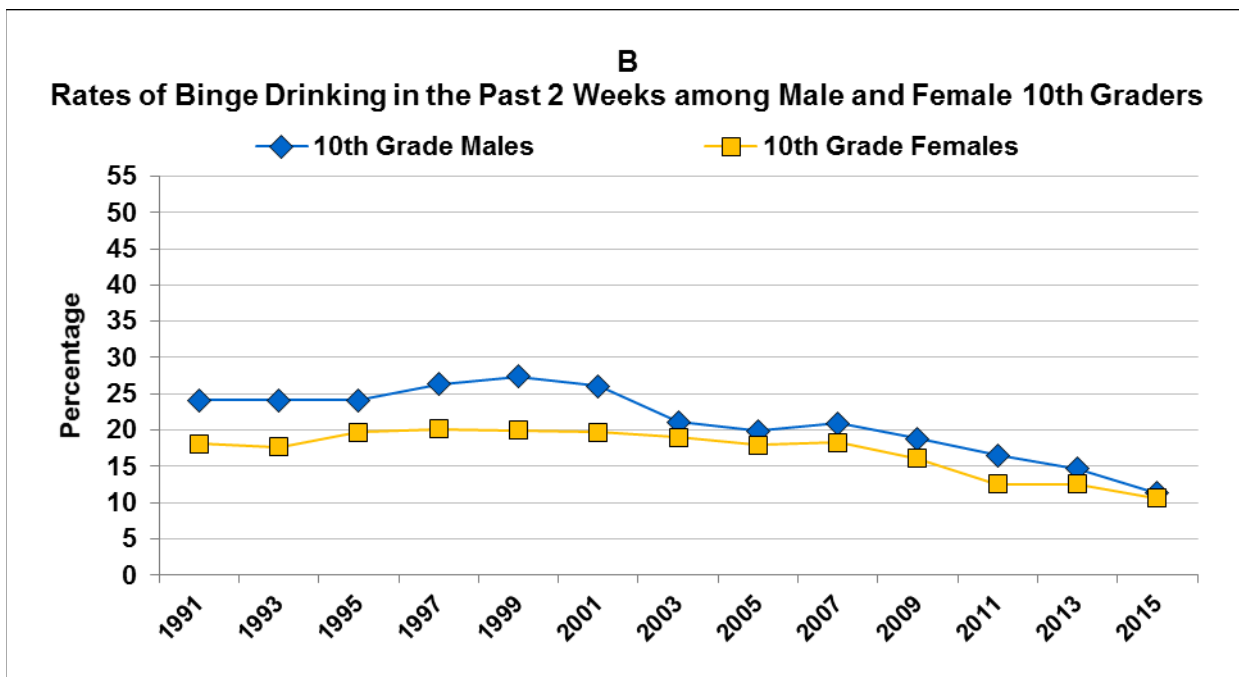
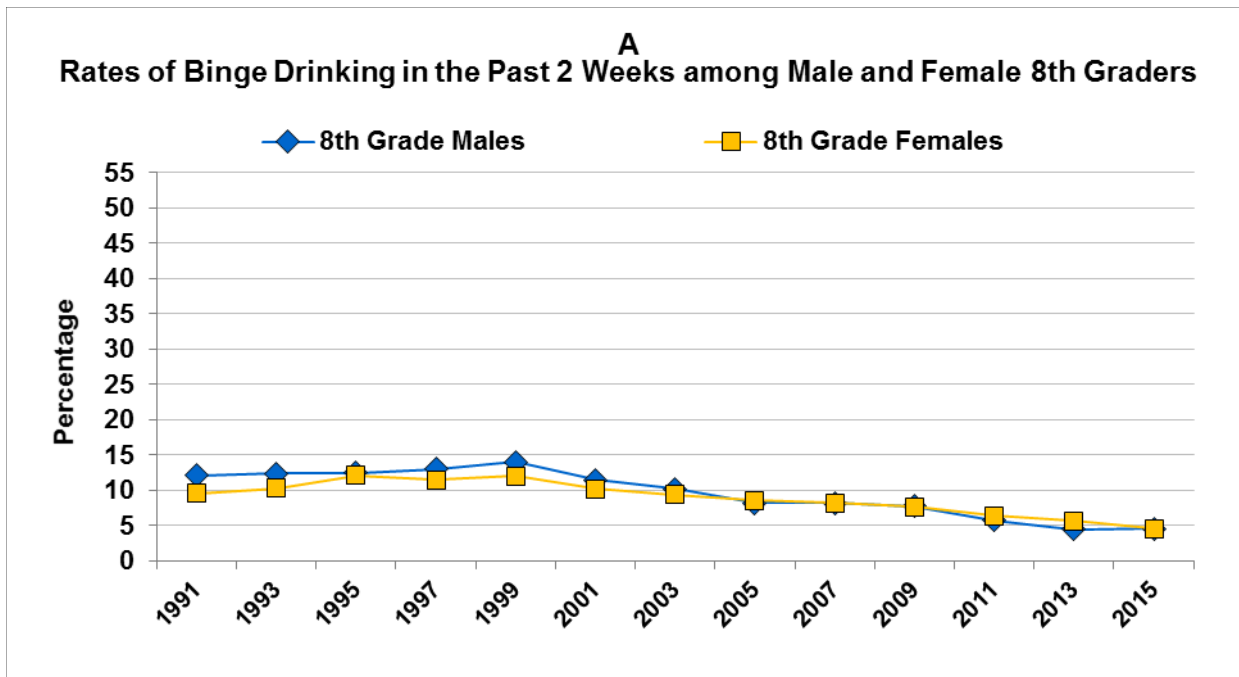
MTF data demonstrate that since 1991, rates of binge drinking have generally been *decreasing* for college-age (approximately 19- to 22-year-olds), and 12th-, 10th-, and 8th-grade males and females (although not as steeply for college students). Across all grade groups, rates for males have been decreasing faster than for females; the gap between male and female bingeing rates has been steadily closing since 1991 (Johnston, O'Malley, Bachman, & Schulenberg, 2009, 2012; Johnston, O'Malley, Bachman, Schulenberg, & Miech, 2014; 2015b) (Exhibit 2.16). For example, in 1991, among 12th graders there was a 16.6 percentage point spread between the rates of males and females; in 2015, it was 4.4 points.

Any discussion of gender differences in underage drinking should include considerations of the biological factors that may underlie or contribute to differences in drinking behavior and its consequences. Although females report less alcohol consumption than males, differences in body composition (e.g., increased body fat, decreased muscle mass, and subsequently less body water, in females) result in a greater BAC in females compared with males consuming the same amount of alcohol. These physiological differences suggest that females will experience alcohol-related problems at lower doses of alcohol. On the other hand, males tend to have lower reactivity (perceived effects of alcohol as a function of amount consumed), putting them at greater risk for binge and heavy drinking (Schulte, Ramo, & Brown, 2009).

**Exhibit 2.15: Past-Month Alcohol Use by Age and Gender, 2015 NSDUH Data**  
(CBHSQ, 2016a)

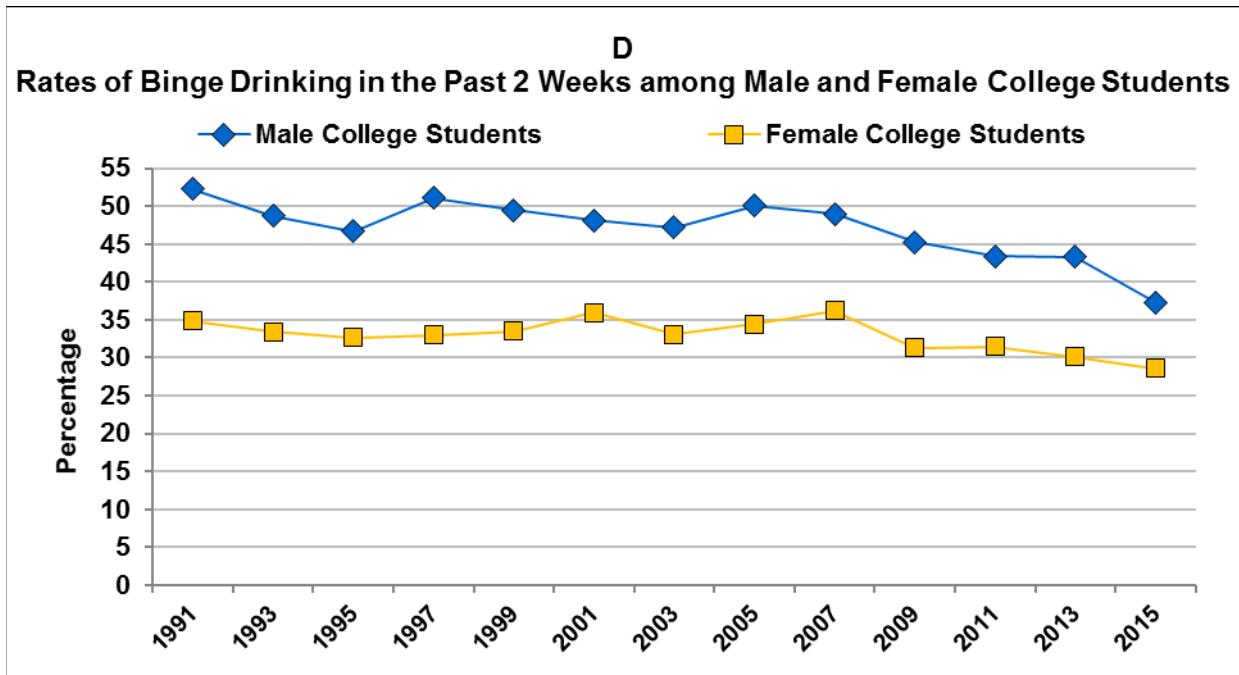
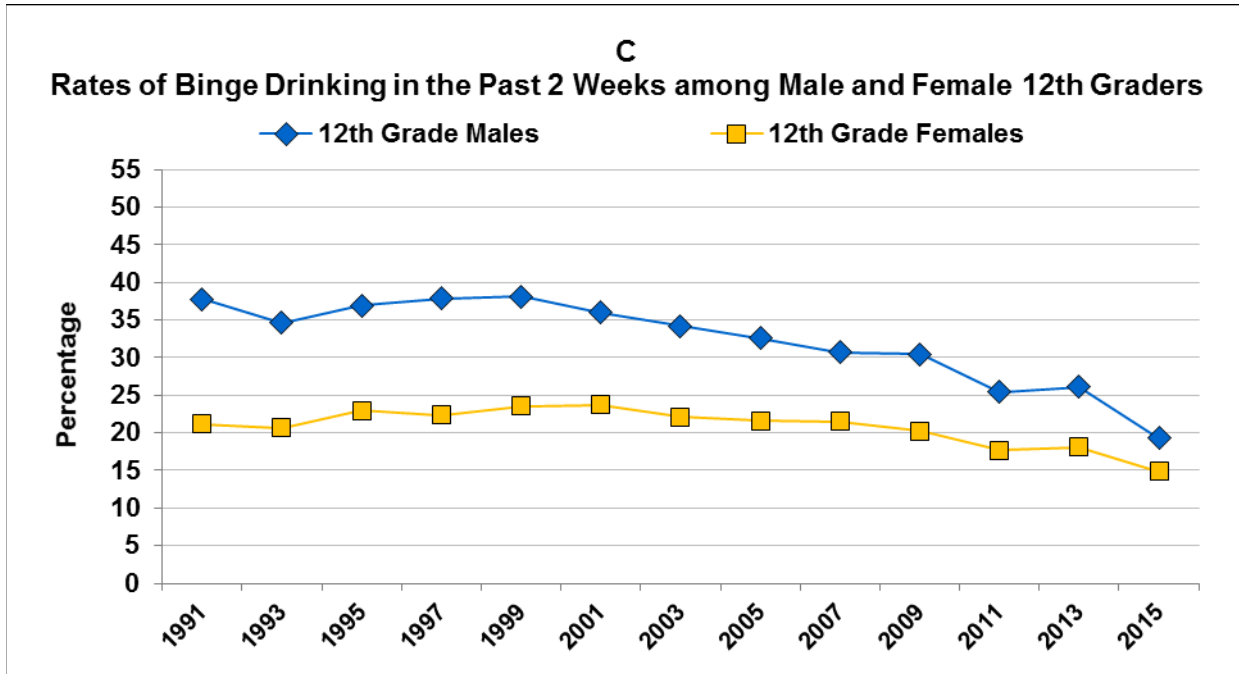


**Exhibit 2.16: Rates of Binge Drinking in the Past 2 Weeks Among Male and Female 8th, 10th, and 12th Graders and College Students,<sup>21</sup> MTF Data 1991–2015**  
 (Johnston et al., 2016; Miech et al., 2016)



<sup>21</sup> MTF Volume 2 defines college students as follow-up respondents (i.e., high school graduates) 1 to 4 years past high school who report that they were taking courses as full-time students in a 2- or 4-year undergraduate college at the beginning of March in the year in question. Non-college students are those 1–4 years past high school, not enrolled in college. Note some of these respondents may be age 21 or over.

Exhibit 2.16 (continued)



## Race and Ethnicity

According to 2002–2015 NSDUH data,<sup>22</sup> Whites ages 12 to 20 were more likely to report current alcohol use than any other race or ethnic group. The detailed prevalence of past-month alcohol use by gender and race/ethnicity was White males (30.4 percent), White females (29.3 percent), Native Hawaiian or Other Pacific Islander males (26.0 percent), American Indian or Alaska Native females (25.5 percent), Native Hawaiian or Other Pacific Islander females (25.5 percent), Hispanic or Latino males (24.6 percent), females of multiple races (24.1 percent), males of multiple races (23.7 percent), American Indian or Alaska Native males (22.4 percent), Hispanic or Latina females (22.2 percent), Black or African American males (19.0 percent), Black or African American females (18.0 percent), Asian males (16.8 percent), and Asian females (15.2 percent). Among most races/ethnic groups, males and females reported similar rates of current alcohol use except that among Whites, Blacks, and Hispanics, males ages 12 to 20 were more likely to report current use than were females (CBHSQ, 2016a).

Multiyear NSDUH data (2002–2014) for males and females ages 12 to 20 on binge alcohol use indicate that an estimated 23.1 percent of White males reported having five or more drinks on the same occasion on at least 1 day within the past 30 days, followed closely by Native Hawaiian or Other Pacific Islander males (21.7 percent) (CBHSQ, 2015). The remaining race/ethnicity and gender groups are American Indian or Alaska Native males (19.7 percent), Hispanic males (18.2 percent), White females (18.2 percent), American Indian or Alaska Native females (17.0 percent), males of multiple races (16.8 percent), Native Hawaiian or Other Pacific Islander females (14.7 percent), females of multiple races (14.2 percent), Hispanic females (13.1 percent), Black males (10.3 percent), Asian males (9.9 percent), Black females (7.9 percent), and Asian females (7.2 percent) (see Exhibit 2.17).

These ethnic and racial differences must be viewed with some caution. As Caetano, Clark, and Tam (1998) noted, there are important differences in alcohol use and related problems among ethnic and racial subgroups of Blacks, Hispanics, Asians, and Native Americans/Alaska Natives. Moreover, the patterns of consumption for any group or subgroup represent a complex interaction of psychological, historical, cultural, and social factors inadequately captured by a limited set of labels. With these cautions in mind, however, the data discussed thus far highlight the importance of considering race and ethnicity in underage drinking prevention measures.

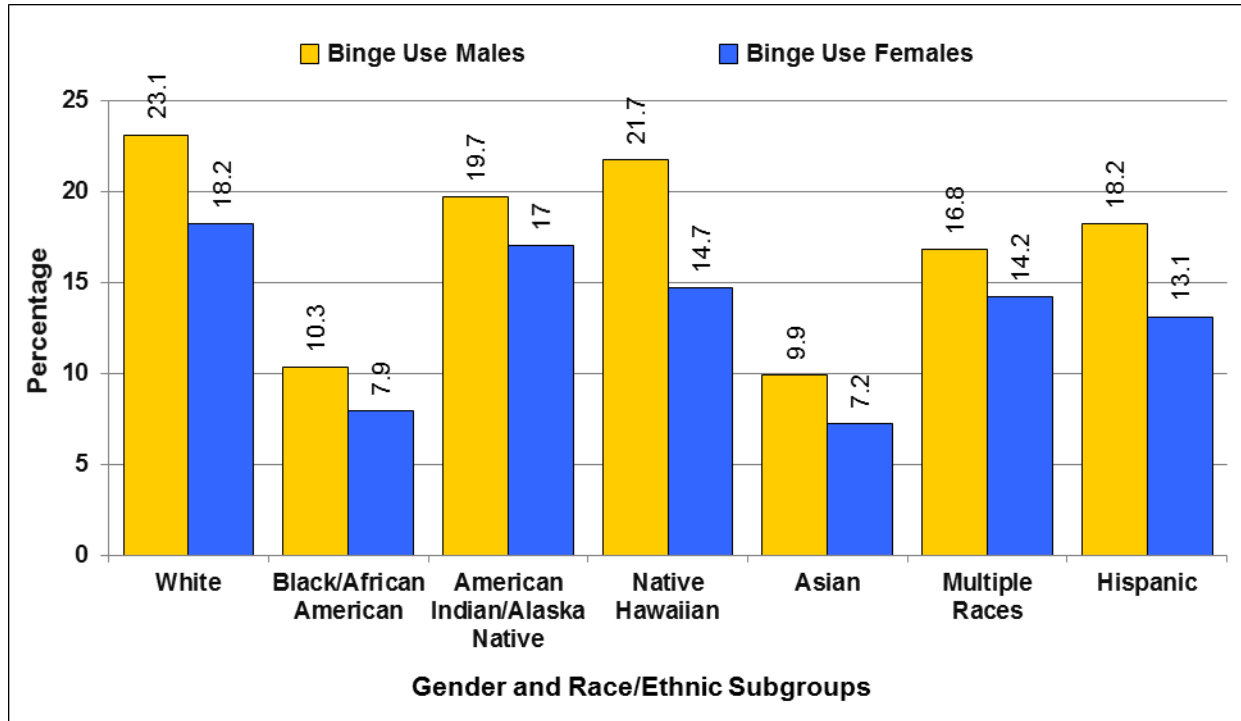
## Parental Attitudes and Behaviors

Parental monitoring and parental attitudes and perceptions about drinking (such as seeing underage drinking as a rite of passage) have been shown to be very important influences on underage drinking. Studies have found that some parenting practices have proven beneficial in reducing adolescent alcohol use (Beck, Boyle, & Boekeloo, 2003; Ennett, Bauman, Foshee, Pemberton, & Hicks, 2001; Resnick et al., 1997; Watkins, Howard-Barr, Moore, & Werch, 2006). Parental monitoring, communication, and emotional support have a positive effect on

*Youth drinking is correlated with adult drinking behaviors*

<sup>22</sup> To provide sample sizes sufficient to produce reliable estimates for each race/ethnic group, multiyear estimates of past-month alcohol use and binge drinking by race/ethnicity were calculated.

**Exhibit 2.17: Binge Drinking in the Past Month Among People Ages 12–20 by Race/Ethnicity and Gender, Annual Averages Based on 2002–2014 NSDUH Data (CBHSQ, 2015)**



**Note:** Because the NSDUH definition of binge drinking for females changed in 2015, it is not currently possible to provide trend data for combined male and female binge drinking through 2015. This exhibit provides data through 2014. Trend data will be available in 2 years (CBHSQ, 2016c).

adolescent alcohol use and are predictive of reduced adolescent alcohol problems (Ennett et al., 2001; Wood, Read, Mitchell, & Brand, 2004). At least one study suggests that parental disapproval of any alcohol use during high school is correlated with reduced alcohol use in college (Abar, Abar, & Turrisi, 2009). Some parents believe that providing alcohol to their children at home under supervision will lead to more moderate drinking practices. However, a meta-analysis of 22 studies found that parental provision of alcohol was associated with increased adolescent alcohol use, heavy episodic drinking, and higher rates of alcohol problems (Kaynak, Winters, Cacciola, Kirby, & Arria, 2014). The data were equivocal that parental provision is protective in the face of other risks.

## Combined Factors

Generational transmission has been widely hypothesized as one factor shaping the alcohol consumption patterns of young people. Whether through genetics, social learning, or cultural values and community norms, researchers have repeatedly found a correlation between youth drinking behaviors and those of their adult relatives and other community adults at the household and community levels. Nelson, Naimi, Brewer, and Nelson (2009) demonstrated this relationship at the population level as well, using YRBS state-based estimates. State estimates of youth and adult current drinking and binge drinking from 1993 through 2005 were significantly correlated when pooled across years. Xuan and colleagues (2013), analyzing YRBS data from 1999 to 2009, found a positive correlation between state-level adult binge drinking and youth binge drinking. A 5 percentage point increase in binge-drinking prevalence



among adults was associated with a 12 percent relative increase in the odds of alcohol use among youth.

Paschall, Lipperman-Kreda, and Grube (2014) examined relationships between characteristics of the local alcohol environment and adolescent alcohol use and beliefs in 50 California cities. A greater increase in past-year alcohol use and heavy drinking over a 3-year period was observed among adolescents living in cities with higher levels of adult drinking (measured at baseline), compared with adolescents not living in such cities. Stronger state alcohol policies directed to the general population (e.g., alcohol taxes and regulations on alcohol outlet density) are independently associated with less youth drinking, and the effect of these policies on youth drinking is mediated, in part, through their effects on adults (Xuan et al., 2015). Similarly, a study found that, while more than one fourth of traffic crash deaths among young people are alcohol related, stronger alcohol policy environments are associated with lower mortality rates from alcohol-related motor vehicle crashes (Hadland et al., 2017).

### **Number of People Present at Drinking Event**

Underage alcohol use is strongly affected by the context in which drinking occurs. Of particular concern is underage drinking at large parties.

Most (76.0 percent) people ages 12 to 20 who had consumed alcohol in the past month were with two or more people the last time they drank, 17.5 percent were with one other person the last time they drank, and 6.5 percent were alone.<sup>23</sup> Underage people who drank with two or more other people on the last occasion in the past month had more drinks on the last occasion on average (4.3 drinks) than did those who drank with one other person (2.9 drinks) or drank alone (2.6 drinks; Pemberton, Colliver, Robbins, & Gfroerer, 2008) (CBHSQ, 2016a).

The number of people present at the last drinking event appears to differ across age groups. Among current drinkers, youths ages 12 to 14 were more likely to have been alone (12.6 percent) or with one other person (23.6 percent) the last time they drank, compared with youths ages 15 to 17 (7.7 percent alone and 15.8 percent with one other person) or ages 18 to 20 (5.7 percent alone and 17.8 percent with one other person) (CBHSQ, 2016a). In the 15–17 and 18–20 age groups, underage current drinkers who drank with two or more other people averaged more drinks on the last occasion than those who drank with one other person or alone (Exhibit 2.18).

Most male and female underage drinkers were with two or more other people on their last drinking occasion (75.5 percent and 76.6 percent, respectively). However, male drinkers were more likely to drink alone (7.3 percent) than were female drinkers (5.8 percent).

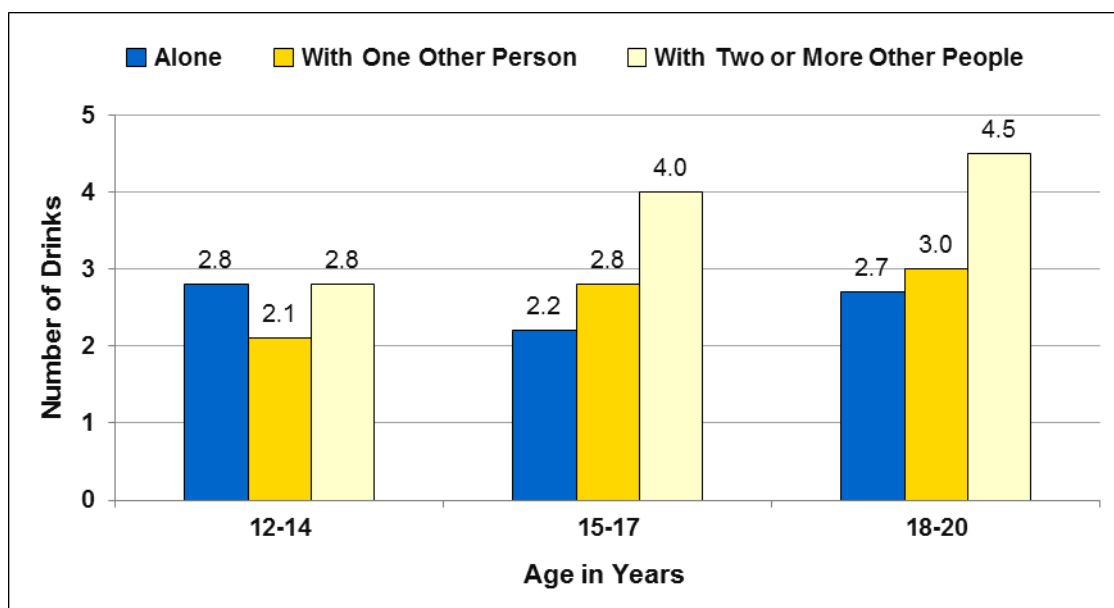
Overall, underage people who drank with others were likely to consume a greater number of drinks on average than those who drank alone. Those who drank with two or more other people consumed more drinks on average (4.3 drinks) than did those who drank with one other person (2.9 drinks) or drank alone (2.6 drinks). Males consumed more drinks than did females for two of the three situations (drinking with one other person or drinking with two or more people). For example, when the last drinking occasion was with two or more other people, males averaged 5.1 drinks, whereas females averaged 3.5 drinks (CBHSQ, 2016a).

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<sup>23</sup> The discussion in this section combines data for 2014 and 2015.



**Exhibit 2.18: Average Number of Drinks Consumed on Last Occasion of Alcohol Use in the Past Month Among Past-Month Alcohol Users Ages 12–20, by Social Context and Age Group: Annual Averages Based on 2014–2015 NSDUH Data (CBHSQ, 2016a)**



### Location of Alcohol Use

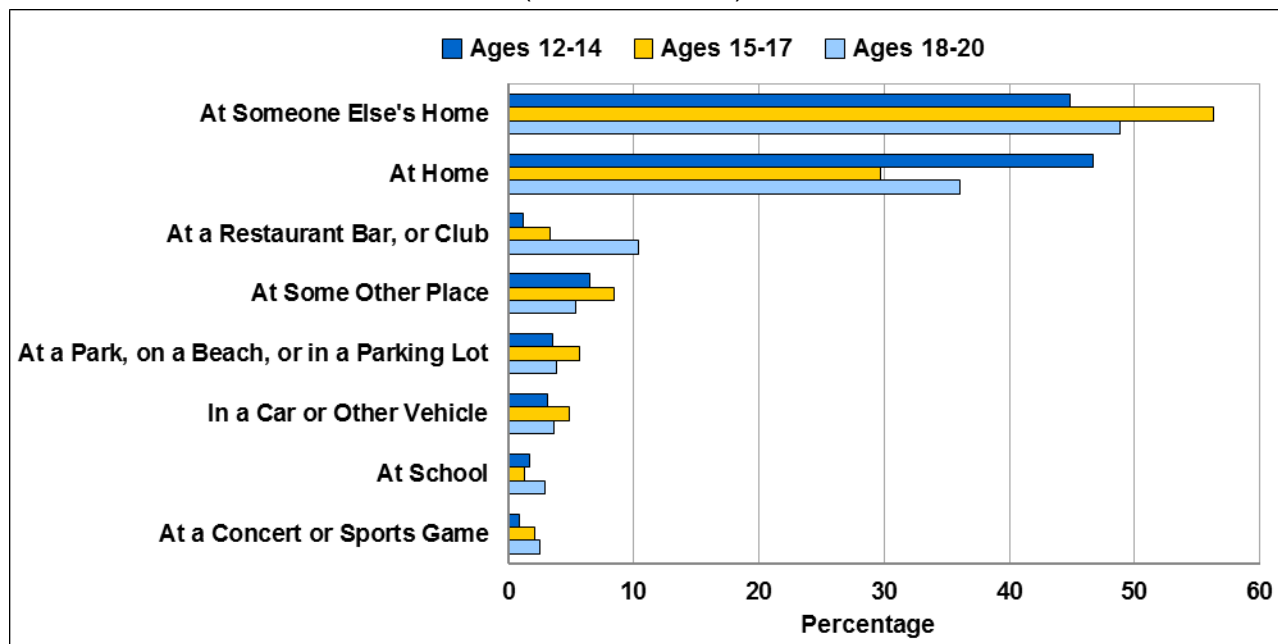
Most underage drinkers reported last using alcohol in someone else’s home (50.7 percent, averaging 4.5 drinks) or in their own home (34.7 percent, averaging 3.5 drinks).<sup>24</sup> The next most popular drinking locations were at a restaurant, bar, or club (8.1 percent, averaging 4.4 drinks); at a park, on a beach, or in a parking lot (4.3 percent, averaging 4.9 drinks); or in a car or other vehicle (3.9 percent, averaging 5.2 drinks). Current drinkers ages 12 to 20 who last drank at a concert or sports game (2.3 percent of all underage drinkers) consumed an average of 6.2 drinks (CBHSQ, 2016a). Thus, most young people drink in social contexts that appear to promote heavy consumption and where people other than the drinker may be harmed by the drinker’s behavior.

Drinking location varies by age. For example, drinkers ages 12 to 14 were more likely to have been in their own homes the last time they drank (46.7 percent) than were 15- to 17-year-olds (29.7 percent) or 18- to 20-year-olds (36.1 percent). By contrast, 12- to 14-year-olds were less likely to report being in someone else’s home the last time they drank (44.9 percent) than the 15- to 17-year-olds (56.3 percent).

Drinkers ages 18 to 20 were more likely than those in younger age groups to have been in a restaurant, bar, or club on their last drinking occasion (10.4 percent for those ages 18 to 20 versus 1.2 percent for those ages 12 to 14 and 3.3 percent for those ages 15 to 17 (Exhibit 2.19). Female current alcohol users ages 12 to 20 were more likely than males to have had their last drink at a restaurant, bar, or club (9.9 percent versus 6.3 percent) (CBHSQ, 2016a).

<sup>24</sup> For the analyses in this section, 2014 and 2015 NSDUH data are combined to provide sufficient sample sizes.

**Exhibit 2.19: Drinking Location of Last Alcohol Use Among Past-Month Alcohol Users Ages 12–20 by Age Group: Annual Averages Based on 2014–2015 NSDUH Data (CBHSQ, 2016a)**



## Underage Drinking Parties

The data cited above suggest that underage drinking occurs primarily in a social context (three or more drinkers) at private residences. Such drinking occasions include parties at which large numbers of youth are present. Drinking parties attract those 21 and over as well as significant numbers of underage drinkers (Wells, Graham, Speechley, & Koval, 2005). For this reason, parties are a common environment in which young drinkers are introduced to heavy drinking by older and more experienced drinkers (Wagoner et al., 2012).

Parties are settings for binge drinking and other patterns of consumption leading to high BACs (Clapp, Reed, Holmes, Lange, & Voas, 2006; Clapp, Min, Shillington, Reed, & Croff, 2008; Demers et al., 2002; Paschall & Saltz, 2007; Usdan, Moore, Schumacher, & Talbott, 2005; Wagoner et al., 2012). Factors that increase the risk of high BACs include the size of party and the number of people drinking (Wagoner et al., 2012), drinking games (Clapp et al., 2006, 2008), “bring your own booze” policies (Clapp et al., 2006), parties sponsored by fraternities (Paschall & Saltz, 2007), and parties where illicit drugs are available (Clapp et al., 2006).

Demers and colleagues (2002) suggested that large parties have a greater facilitative effect on men’s drinking than on women’s. Drinking parties are also often settings for aggression, including serious arguments, pushing, fights, and sexual assault (Wagoner et al., 2012). Because large numbers of youth are drinking outside their own homes, drinking parties may significantly increase the risk of driving after drinking (PIRE, 2000; Gonzales, Largo, Miller, Kanny, & Brewer, 2015).

Drinking parties pose serious problems for law enforcement officers. These include breaking up parties without allowing drinkers to flee to their cars (PIRE, 2000), processing large numbers of underage offenders (PIRE, 2000), and identifying the individuals who have furnished alcohol to

minors (Wagoner et al., 2012). Paschall, Lipperman-Kreda, Grube, and Thomas (2014) rated social host policies for comprehensiveness and stringency. They found a small but significant negative relationship between the strength of the policies and underage drinking at parties among past-year drinkers. For information on party-related enforcement practices that states are implementing, see Chapter 4. For information on relevant state legal policies see “Hosting Underage Drinking Parties” and “Keg Registration” in Chapter 4.

## College Environment

In its landmark 2002 report, *A Call to Action: Changing the Culture of Drinking at U.S. Colleges* (henceforth referred to as the *NIAAA Call to Action*), NIAAA noted the following:

The tradition of drinking has developed into a kind of culture—beliefs and customs—entrenched in every level of college students’ environments. Customs handed down through generations of college drinkers reinforce students’ expectation that alcohol is a necessary ingredient for social success. These beliefs and the expectations they engender exert a powerful influence over students’ behavior toward alcohol.<sup>25</sup>

Campus drinking culture persists 13 years later (Johnston, O’Malley, Bachman, Schulenberg, & Miech, 2015a). Although college-bound 12th graders are consistently less likely than non-college-bound counterparts to report heavy drinking, individuals in college<sup>26</sup> report higher rates of binge drinking than do same-age youth who are not attending college (Exhibit 2.20) (Johnston, O’Malley, Bachman, et al., 2016). Colleges and universities vary widely in their student-drinking and binge-drinking rates; however, overall rates of college student drinking and binge drinking exceed those of same-age peers who do not attend college (Johnston, O’Malley, Bachman, et al., 2016). Of college students, 63.2 percent drink, compared with 51.1 percent of those of the same age and not in college; 38.4 percent report having been drunk in the past month, compared with 24.9 percent of others.

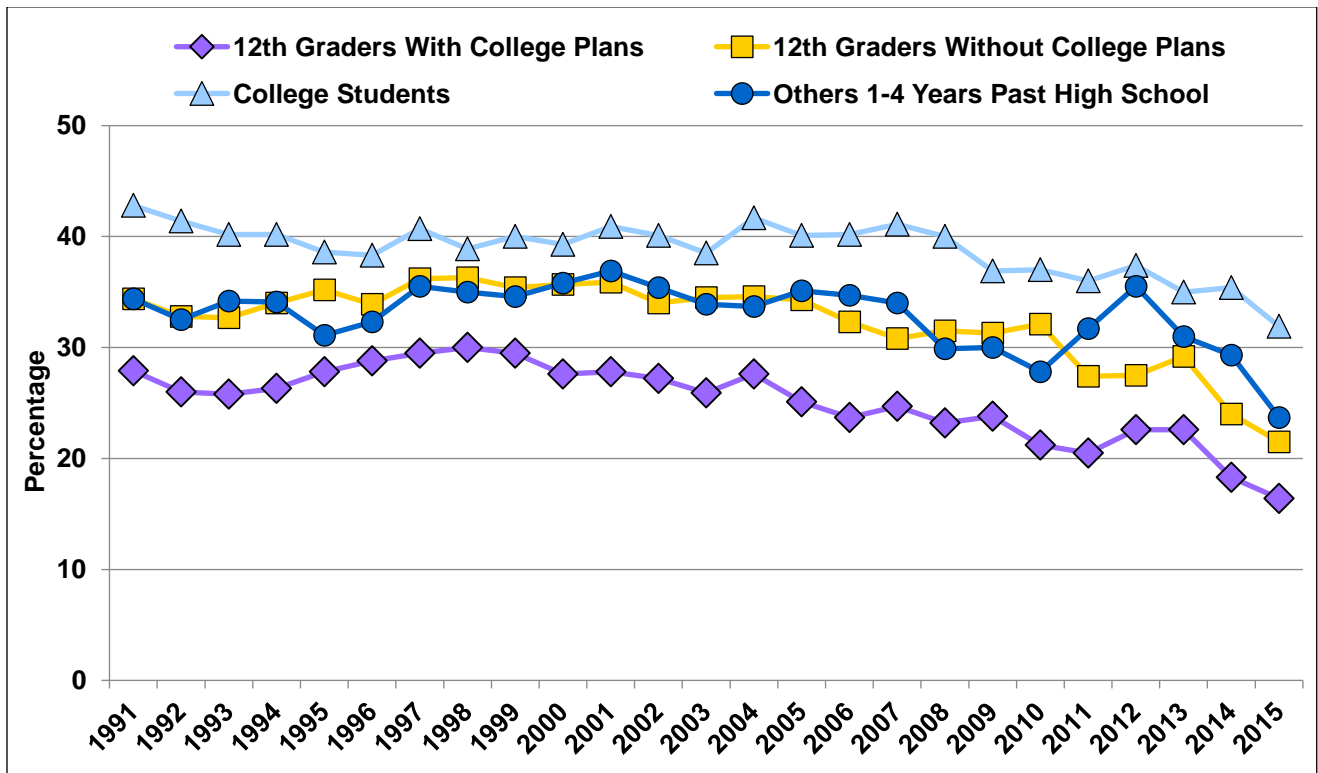
Binge-drinking rates among college students have declined from 40.2 percent in 1993 to a current rate of 32 percent; however, drinking patterns remain a concern (Miech et al., 2016). Some college students far exceed the binge criterion of five drinks per occasion (Wechsler, Molnar, Davenport, & Baer, 1999; Wechsler & Nelson, 2008). In 2015, 11.2 percent of college students reported consuming 10 or more drinks in a row in the past 2 weeks. College males were more likely to report extreme binge drinking (18.3 percent) than were females (6.8 percent) (Johnston, O’Malley, Bachman, et al., 2016).

These findings suggest that college environments influence drinking behaviors (Hingson, Heeren, Levenson et al., 2002; Kuo, Wechsler, Greenberg, & Lee, 2003; see also LaBrie, Grant, & Hummer, 2011).

<sup>25</sup> For many students, alcohol use is not a tradition. Students who drink the least attend 2-year institutions, religious schools, commuter schools, and historically Black colleges and universities (Meilman, Presley, & Lyster, 1994; Meilman, Presley, & Cashin, 1995; Meilman, Leichter, & Presley, 1999; Presley, Meilman, & Cashin, 1996; Presley, Meilman, Cashin, & Lyster, 1996).

<sup>26</sup> College students are defined as those follow-up MTF respondents *1 to 4 years past high school* who report that they were taking courses as *full-time students* in a *2- or 4-year undergraduate college* at the *beginning of March* of the year in question. Non-college same-age peers are follow-up MTF respondents *1 to 4 years past high school* who do not report taking courses. Both groups include a percentage of individuals who have reached the legal drinking age. Underage college students drink about 48 percent of the alcohol consumed by students at 4-year colleges (Wechsler, Lee, Nelson, & Kuo, 2002).

**Exhibit 2.20: Prevalence of Binge Drinking in the Past 2 Weeks by 12<sup>th</sup> Graders With and Without College Plans, College Students, and Others 1 to 4 Years Past High School: 1991–2015 (Miech et al., 2016)**



### Availability and Access to Alcohol

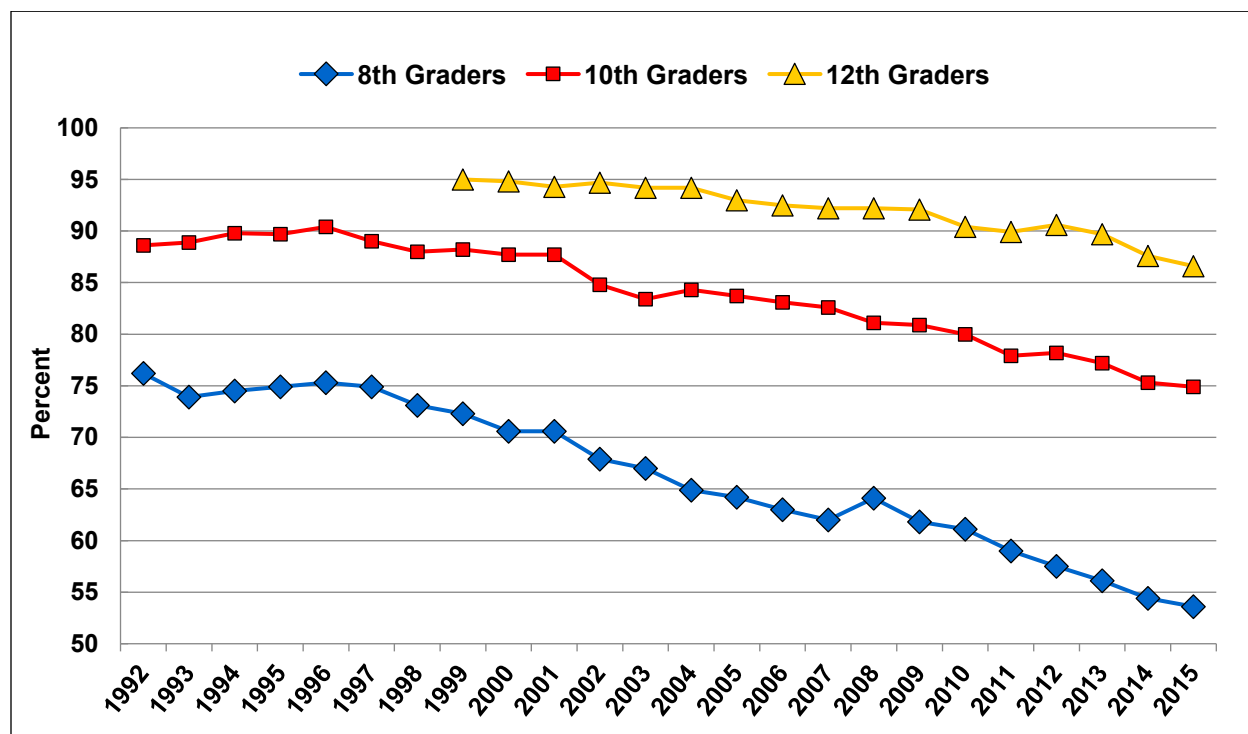
Ease of concealment, palatability, alcohol content, marketing strategies, media portrayals, parent modeling, and economic and physical availability may all contribute to the quantity of and settings for consumption. Beverage preferences may also affect the policies and enforcement strategies most effective in reducing underage drinking (CDC, 2007).

### Alcohol is Perceived as Readily Available by the Underage Population

The relationship among alcohol availability, levels of consumption, and occurrence of alcohol-related problems is well documented in the *Surgeon General’s (SG’s) Call to Action* (OSG, 2007). As shown in Exhibit 2.21, most teens see alcohol as readily available. In 2015, 53.6 percent of 8th graders, 74.9 percent of 10th graders, and 86.6 percent of 12th graders said alcohol would be “fairly easy” or “very easy” to get (Miech et al., 2016). Perceived availability, however, has declined (Exhibit 2.21).

These reductions in perceived availability may be attributable in part to the policies and enforcement practices described in Chapter 4.2 (see “Laws Addressing Minors in Possession of Alcohol,” “Laws Targeting Alcohol Suppliers,” and “Alcohol Pricing Policies”). Continued attention to these policies and practices may lead to further reductions.

**Exhibit 2.21: Changes Over Time in Percentage of 8<sup>th</sup>, 10<sup>th</sup>, and 12<sup>th</sup> Graders Who Say Alcohol Is Fairly Easy or Very Easy to Get, MTF Data (Miech et al., 2016)**



### Alcohol Is Available From a Variety of Sources

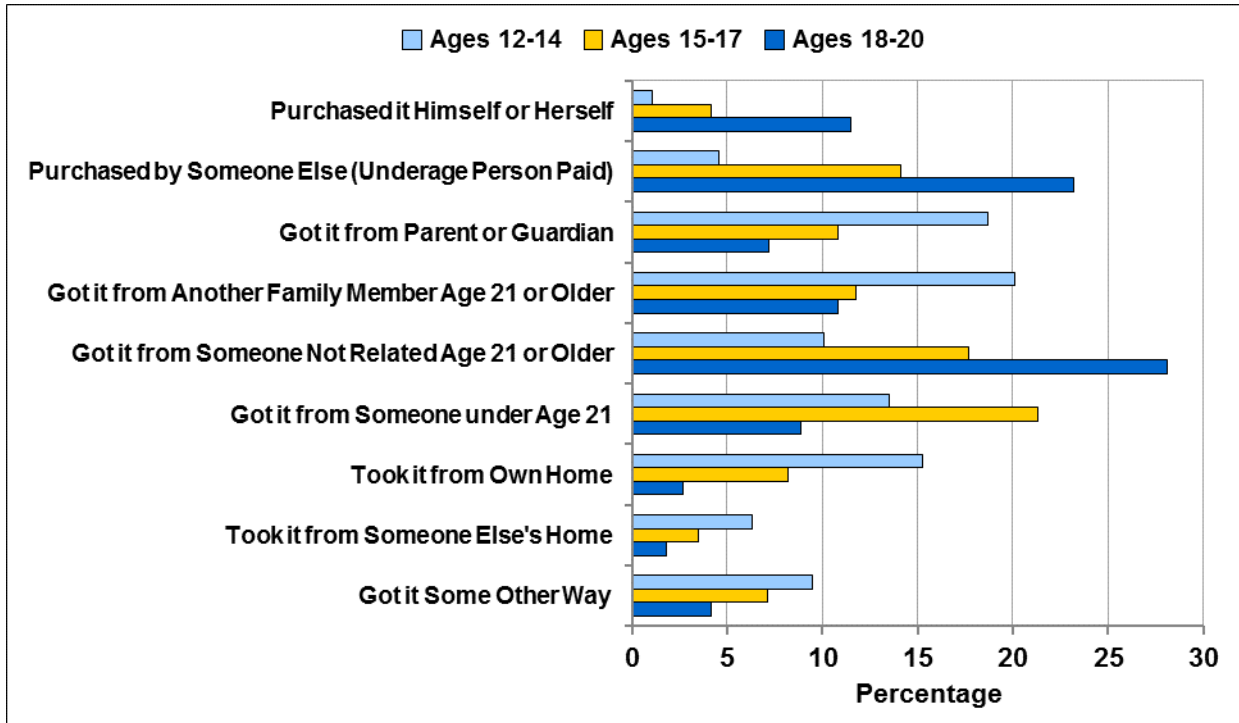
NSDUH divides sources of last alcohol use into two categories: the underage drinker paid (he or she purchased it or gave someone else money to do so) or did not pay (he or she received it for free from someone or took it from his or her own home or someone else's home). Combined data from 2014 and 2015 show that among all underage current drinkers, 29.3 percent paid for alcohol the last time they drank, either purchasing the alcohol themselves or giving money to someone else to do so.

Those who paid for alcohol themselves consumed more drinks on their last drinking occasion (average of 5.2 drinks) than those who did not (average of 3.4 drinks). This difference is at least partially explained by the fact that older underage drinkers are more likely to pay for alcohol and to drink more (CBHSQ, 2016a).

Among all underage drinkers, 70.7 percent did not pay for the alcohol the last time they drank. A total of 24.6 percent were given alcohol for free by an unrelated person age 21 or older, 8.6 percent got the alcohol from a parent or guardian, 11.4 percent got it from another family member age 21 or older, and 4.6 percent took it from their own homes (CBHSQ, 2016a).

The most common sources of alcohol varied substantially by age as shown in Exhibit 2.22. For youths ages 12 to 14, the most common sources were receiving it free from another family member age 21 or older (20.1 percent) or from a parent or guardian (18.7 percent). For youths ages 15 to 17, the most common sources were receiving it free from someone under age 21 (21.3 percent) or from an unrelated person age 21 or older (17.7 percent) and giving somebody else money to purchase the alcohol (14.1 percent) (CBHSQ, 2016a).

**Exhibit 2.22: Source of Last Alcohol Used among Past-Month Alcohol Users Ages 12–20, by Age Group: NSDUH Data 2014–2015 (CBHSQ, 2016a)**



Among 18- to 20-year-olds, most current drinkers either received alcohol for free from an unrelated person age 21 or older (28.1 percent) or gave someone else money to purchase the alcohol (23.2 percent). Older underage people were more likely to have paid for alcohol themselves (either purchasing it themselves or paying someone else to purchase it) on their last drinking occasion: 34.9 percent of 18- to 20-year-olds did so, compared with 18.6 percent of 15- to 17-year-olds and 5.8 percent of 12- to 14-year-olds. Male underage drinkers were more likely to have paid for alcohol themselves on their last drinking occasion (34.2 percent) than their female counterparts (24.3 percent; CBHSQ, 2016a).<sup>27</sup>

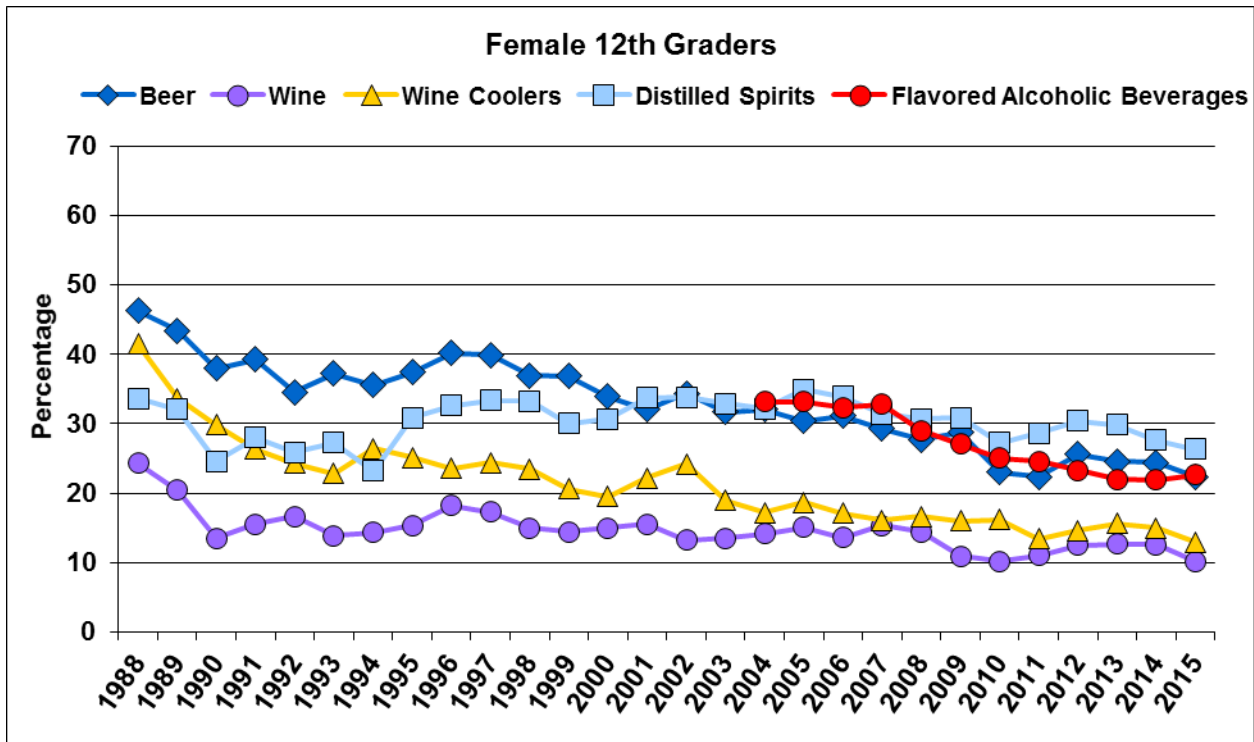
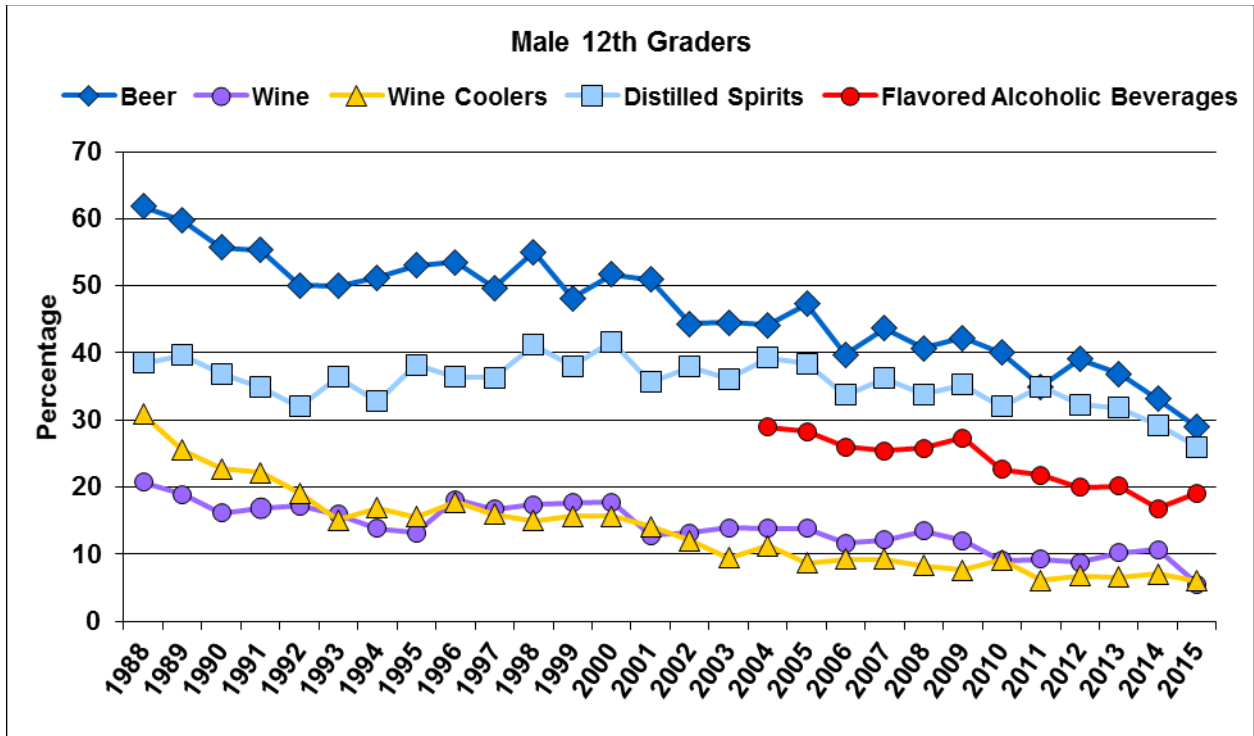
Enforcement of furnishing laws (see Chapter 4) is one key to reducing youth access to alcohol. A 2013 multicomunity study found significant associations between the level of underage drinking law enforcement in the intervention communities and reductions in both 30-day use of alcohol and binge drinking (Flewelling et al., 2013).

### Alcohol Use by Beverage Type

Different alcohol beverage types are likely associated with different patterns of underage consumption. Tracking young people’s beverage preferences is thus an important aspect of prevention policy. Since 1988, MTF data indicate beverage choices have shifted markedly for both male and female 12th graders (Exhibit 2.23). Wine is now consumed by 13 percent or fewer of underage drinkers and is therefore not discussed here. In 1988, beer was the beverage of choice for both sexes by a large margin. By 2011, however, for males consumption of beer had declined and consumption of distilled spirits had increased, such that the two were equally

<sup>27</sup> More detailed information can be found in the special report by Pemberton et al. (2008).

**Exhibit 2.23: Trends in the Percentage of Male and Female 12th Graders Using Specific Types of Alcoholic Beverages in the Past 30 Days, MTF Data 1988–2015**  
 (Johnston, O'Malley, Miech, Bachman, & Schulenberg, 2016a)





reported that year; in subsequent years, choice of beer slightly exceeded choice of spirits. For females, a similar change occurred earlier (in 2005); females continue to choose distilled spirits over beer by a slight margin.

In 2004 (the first year flavored alcoholic beverages were included in the survey), female choice of beer, distilled spirits, and flavored alcoholic beverages was about the same. Female consumption of flavored alcoholic beverages has declined steadily since then. Male consumption of flavored alcoholic beverages, which has not been as high as female consumption, also declined during this period.

Data from eight states (a subset of YRBS data) indicate that, among students in 9th to 12th grades who reported binge drinking, distilled spirits were the most prevalent beverage type (Siegel, Naimi, Cremeens, & Nelson, 2011). In a study of a nationally representative sample of youth ages 13 to 20 who had consumed at least one alcoholic drink in the past 30 days, distilled spirits accounted for 43.8 percent of binge-drinking prevalence, the highest percentage for any beverage type (Naimi, Siegel, DeJong, O'Doherty, & Jernigan, 2015).

Several studies (Albers et al., 2015; Naimi, Siegel, et al., 2015; Fortunato et al., 2014; Siegel et al., 2013) focused on underage drinkers' brand preferences, consistently finding that underage drinkers prefer a limited number of brands. Naimi and colleagues (2015), using a nationally representative internet panel, found that the 25 brands consumed most frequently during binge drinking account for 46.2 percent of all binge drinking reports. Siegel and colleagues (2013) found that the top 25 brands account for about half of all alcohol consumption by volume.

Although high-potency grain alcohol products have a reported market share among youth of 0.7 percent, their retail availability is of considerable concern (Siegel et al., 2013). These products are cheap, and given that they are twice as strong (151 to 190 proof) as standard spirits products (80 to 101 proof), underage consumers may find it very difficult to gauge their alcohol consumption, increasing the likelihood of injury. Epidemiologic data on the use of high-potency grain alcohol is currently limited. Siegel and colleagues (2013), utilizing an internet panel of youth ages 13 to 20, found that 5.8 percent reported consuming high-alcohol-content grain alcoholic beverages in the past 30 days. Naimi and colleagues (2015) reported that when underage drinkers consume grain alcohol, they are significantly more likely to binge.

Given the dangers of high-potency grain alcohol, some states have banned its sale.<sup>28</sup> Improved data on these products, including underage use and related injury, would help policymakers evaluate appropriate responses.

## **Exposure of Underage Populations to Messages Regarding Alcohol in Advertising and Entertainment Media**

The STOP Act requires the Report to Congress to include measures of the exposure of underage populations to messages regarding alcohol in advertising and the entertainment media, as reported by FTC. To date, FTC has conducted four formal studies of the exposure of those under 21 to alcohol advertising. In each case, FTC issued compulsory process orders to companies representing 70 percent or more of alcohol marketing dollars, and required them to

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<sup>28</sup> Maryland (MD Code, Art. 2B, § 16-505.2), California (West's Ann.Cal.Bus. & Prof.Code § 23403), and Florida (West's F.S.A. § 565.07) have all enacted such laws.



provide demographic data about the audience for each individual ad disseminated during the study period.

These studies have resulted in significant improvements in industry self-regulation over time. For example, FTC's 1999 Alcohol Report revealed that industry self-regulatory codes permitted as much as half of the audience for individual ads to consist of persons under 21. Even then, only half of the companies were able to demonstrate compliance with this weak standard (FTC, 1999). The agency recommended that the industry raise its placement standard. In 2003, FTC reported that industry had come into substantial compliance with the prior 50 percent adult standard. More significantly, the agency announced that the alcohol industry had agreed to modify its voluntary codes to require that adults (21+) constitute at least 70 percent of the audience for each individual alcohol ad, based on reliable data. To facilitate compliance, the revised codes of the beer and spirits industries required members to conduct periodic post-placement audits and promptly remedy any identified problems (FTC, 2003).

In its 2008 Report, the FTC data showed that 92.5 percent of advertising placements in magazines, newspapers, radio, and television placed during the study period (the first half of 2005) complied with the 70 percent standard; furthermore, because placements that missed the target were concentrated in smaller media, more than 97 percent of total alcohol advertising "impressions" (individual exposures to advertising) were due to placements that complied with the standard. In total, 86.2 percent of the alcohol advertising audience consisted of legal-age adults (FTC, 2008).

The FTC's 2014 Alcohol Report evaluated industry compliance with the 70 percent standard, as well as marketing on the internet and social media. The data for the study period (the first half of 2011) showed that 93.1 percent of the companies' placements in measured media met the 70 percent standard. (Measured media refers to TV, radio, magazine, newspaper, and internet websites whose audience characteristics, including age, are measured by demographic services.) When data were aggregated across companies and media, 85.4 percent of alcohol advertising impressions (individual ad exposures) were seen by adults (21+), and 14.6 percent were seen by underage persons. The overall audiences for major social media (Facebook, Twitter, and YouTube) exceed 70 percent age 21+; Facebook further limits alcohol ad viewing to people who previously registered as 21+, and Twitter and YouTube offer age-gating technologies. The report also announced that in mid-2011, pursuant to an earlier FTC recommendation, the industry had adopted a 71.6 percent adult audience composition standard for future ad placements (reflecting 2010 U.S. Census data on the percentage of the population age 21+).

As previously noted, many factors influence youth drinking decisions. Although evidence of a causal relationship is lacking, some research indicates that youth exposure to alcohol advertising is associated with initiation of alcohol consumption by youth and with increased alcohol consumption by youth who drink. A systematic review showed that of 13 longitudinal research studies examined, 12 studies demonstrated an association between youth exposure to alcohol advertising and the initiation of alcohol consumption by youth as well as increased alcohol consumption by youth who had already initiated alcohol use (Anderson, Bruijn, Angus, Gordon, & Hastings, 2009). A more recent review examined 12 different longitudinal studies published since 2008 and found significant associations between youth exposure and alcohol consumption in all 12 studies (Jernigan, Noel, Landon, Thornton, & Lobstein, 2017).

Others have noted that during 2001–2009, youth exposure to alcohol advertising on television in the United States, as measured by gross rating points, increased 71 percent. During the same period, adult (ages 21 to 49) exposure to alcohol advertising on television increased by 64 percent. This is largely attributable to increased alcohol advertising on cable television programs, particularly by distilled spirits companies (Jernigan, Ross, Ostroff, McKnight-Eily, & Brewer, 2013). In 2009, 13 percent of youth exposure on television came from advertising that was noncompliant with the industry’s voluntary placement standards (Center on Alcohol Marketing and Youth [CAMY], 2010) (Jernigan et al., 2013).

This had led some advocates to propose additional limits on alcohol marketing. However, as noted by the Surgeon General, studies evaluating the relationship between alcohol advertising and youth consumption typically have not controlled for other factors known to influence underage drinking, such as parental attitudes and drinking by peers. Furthermore, studies have yet to determine whether reducing alcohol marketing leads to reductions in youth drinking. One study estimated that a 28 percent decrease in alcohol marketing in the United States could lead to a decrease in the monthly prevalence of adolescent drinking by 1 to 4 percent (i.e., from 25 percent to between 21 and 24 percent) (Saffer & Dave, 2006). A separate study of alcohol advertising bans concluded that “there is a lack of robust evidence for or against recommending the implementation of alcohol advertising restrictions” (Siegfried et al., 2014).

### **Healthcare Provider Screening for Underage Drinking**

Many young people are neither asked by medical providers about their drinking nor advised to reduce or stop drinking. A nationally representative study of 10th graders (the NEXT Generation Health Study) sponsored by the National Institute of Child Health and Human Development found that in the past month, 36 percent reported drinking, 28 percent reported binge drinking, and 23 percent reported drunkenness. Of those who saw a physician in the past year (82 percent), 54 percent were asked about drinking, 40 percent were advised about related harms, and 17 percent were advised to reduce or stop. Frequent drinkers, binge drinkers, and those who reported having been drunk were more often advised to reduce or stop. Nonetheless, only 25 percent of them received that advice from physicians. In comparison, 36 percent of frequent smokers, 27 percent of frequent marijuana users, and 42 percent of frequent other drug users were advised to reduce or quit those behaviors (Hingson, Zha, Iannotti, & Simons-Morton, 2013).

Considerable literature has been published indicating that brief alcohol interventions with a provider such as a physician, nurse, psychologist, or counselor are effective in reducing adolescent drinking and related problems. Many reviews have been published on this topic (Tanner-Smith & Lipsey, 2015; Scott-Sheldon, Carey, Elliott, Garey, & Carey, 2014).

# CHAPTER 3

## A Coordinated Federal Approach to Preventing and Reducing Underage Drinking

The 2006 Sober Truth on Preventing Underage Drinking (STOP) Act records the sense of Congress that “a multi-faceted effort is needed to more successfully address the problem of underage drinking in the United States. A coordinated approach to prevention, intervention, treatment, enforcement, and research is key to making progress. This Act recognizes the need for a focused national effort, and addresses particulars of the federal portion of that effort as well as federal support for state activities.”

## A Coordinated Approach

The congressional mandate to develop a coordinated approach to prevent and reduce underage drinking and its adverse consequences recognizes that alcohol consumption by those under 21 is a serious, complex, and persistent societal problem with significant financial, social, and personal costs. Congress also recognizes that a long-term solution will require a broad, deep, and sustained national commitment to reducing the demand for, and access to, alcohol among young people. That solution must address not only the youth themselves but also the larger society that provides a context for that drinking and in which images of alcohol use are pervasive and drinking is seen as normative.

The national responsibility for preventing and reducing underage drinking involves government at every level; institutions and organizations in the private sector; colleges and universities; public health and consumer groups; the alcohol and entertainment industries; schools; businesses; parents and other caregivers; other adults; and adolescents themselves. This section of the present report focuses on the activities of the federal government and its unique role in preventing and reducing underage drinking. Through leadership and financial support, the federal government can influence public opinion and increase public knowledge about underage drinking; enact and enforce relevant laws; fund programs and research that increase understanding of the causes and consequences of underage alcohol use; monitor trends in underage drinking and the effectiveness of efforts designed to reduce demand, availability, and consumption; and lead the national effort.

All Interagency Coordinating Committee on the Prevention of Underage Drinking (ICCPUD) agencies and certain other federal partners continue to contribute their leadership and vision to the national effort to prevent and reduce underage alcohol use. Each participating agency plays a role specific to its mission and mandate. For example, the National Institute on Alcohol Abuse and Alcoholism (NIAAA), part of the National Institutes of Health (NIH), supports biomedical and behavioral research on the prevalence and patterns of alcohol use and misuse across the lifespan and of alcohol-related consequences—including alcohol use disorder (AUD); injuries; and effects on prenatal, child, and adolescent development. This body of research includes studies on alcohol epidemiology, metabolism and health effects, genetics, neuroscience, prevention, and treatment. NIAAA and the Centers for Disease Control and Prevention (CDC) provide the research to promote an understanding of the serious nature of underage drinking and its consequences.

In general, the Substance Abuse and Mental Health Services Administration (SAMHSA), the National Highway Traffic Safety Administration (NHTSA), and the U.S. Department of Education (ED) conduct programs to reduce underage demand for alcohol, and the U.S. Department of Justice (DoJ), through its Office of Juvenile Justice and Delinquency Prevention (OJJDP), works to reduce underage consumption of and access to alcohol, as well as the

availability of alcohol itself. SAMHSA, CDC, and NIAAA conduct surveillance that gathers the latest data on underage alcohol use and the effectiveness of programs designed to prevent and reduce it. NHTSA, CDC, SAMHSA, NIAAA, and the National Institute on Drug Abuse (NIDA) gather data on adverse consequences. As these agencies interact with one another, the activities and expertise of each inform and complement the others, creating a synergistic, integrated federal program for addressing underage drinking in all its complexity.

## Federal Agencies Involved in Preventing and Reducing Underage Drinking

Multiple federal agencies are involved in preventing and reducing underage drinking. Each sponsors programs that address or relate to underage alcohol consumption, and each is a member of ICCPUD. The agencies and their primary roles related to underage drinking are as follows:

1. **U.S. Department of Health and Human Services (HHS)/Administration for Children and Families (ACF):** ACF is responsible for federal programs that promote the economic and social well-being of families, children, individuals, and communities. Many of these programs strengthen protective factors and reduce risk factors associated with underage drinking. Website: <http://www.acf.hhs.gov>
2. **HHS/Office of the Assistant Secretary for Planning and Evaluation (ASPE):** ASPE is the principal advisor to the HHS Secretary on policy development and is responsible for major activities in policy coordination, legislation development, strategic planning, policy research, evaluation, and economic analysis. The Division of Behavioral Health and Intellectual Disabilities Policy (BHIDP) focuses on financing, access/delivery, organization, and quality of services and supports for individuals with severe and persistent mental illnesses or severe addictions and individuals with intellectual disabilities. Topics of interest include coverage and payment issues in Medicaid, Medicare, and private insurance; quality and consumer protection issues; programs and policies of the Centers for Medicare and Medicaid Services (CMS), SAMHSA, and the Health Resources and Services Administration (HRSA) as they affect individuals with mental and substance use disorders; and prevention of mental health conditions and substance misuse, including prevention of underage drinking. Website: <http://www.aspe.hhs.gov>
3. **HHS/Centers for Disease Control and Prevention (CDC):** CDC's mission is to promote health and quality of life by preventing and controlling disease, injury, and disability. Consistent with that mission, CDC is involved in strengthening the scientific foundation for the prevention of underage and binge drinking. This includes assessing the problem through public health surveillance and epidemiological studies of underage drinking and its consequences. CDC also evaluates the effectiveness of prevention policies and programs and examines underage drinking as a risk factor through programs that address health problems such as injury and violence, sexually transmitted diseases, and fetal alcohol spectrum disorders (FASDs). CDC trains new researchers in alcohol epidemiology and builds state public health system capacity. CDC also conducts systematic reviews of what works to prevent alcohol-related injuries and harms. Website: <http://www.cdc.gov>
4. **HHS/Indian Health Service (IHS):** IHS is responsible for providing federal health services to American Indians and Alaska Natives. IHS is the principal federal healthcare provider and health advocate for American Indians and Alaska Natives, and its goal is to raise their health status to the highest possible level. IHS provides a comprehensive health service delivery

system for approximately 2 million American Indians and Alaska Natives who belong to 566 federally recognized tribes in 36 states. Website: <http://www.ihs.gov>

5. **HHS/National Institutes of Health (NIH)/National Institute on Alcohol Abuse and Alcoholism (NIAAA):** The NIAAA mission is to generate and disseminate fundamental knowledge about the effects of alcohol on health and well-being, and apply that knowledge to improve diagnosis, prevention, and treatment of alcohol-related problems, including alcohol use disorder, across the lifespan. Website: <http://www.niaaa.nih.gov>
6. **HHS/NIH/National Institute on Drug Abuse (NIDA):** NIDA’s mission is to “advance science on the causes and consequences of drug use and addiction and to apply that knowledge to improve individual and public health.” NIDA supports most of the world’s research on the health aspects of drug abuse and addiction and carries out programs that ensure rapid dissemination of research to inform policy and improve practice. Website: <http://www.drugabuse.gov>
7. **HHS/Office of the Assistant Secretary for Health (OASH) – Office of Disease Prevention and Health Promotion (ODPHP), Office of the Surgeon General (OSG), and Office of Adolescent Health (OAH):** Several ODPHP-led initiatives address underage drinking. The Substance Abuse Topic Area of Healthy People 2020 initiative monitors measures for underage alcohol consumption, including binge drinking and riding with drivers who consumed alcohol. [Healthfinder.gov](http://healthfinder.gov) offers reliable guidance for consumers on how parents can talk with their kids about the dangers of alcohol. Additionally, the *Dietary Guidelines for Americans* provide guidance on alcohol consumption, including policies from other agencies on who should not drink. Websites: <http://www.healthypeople.gov>, <http://www.health.gov>, <http://health.gov/dietaryguidelines>  
  
The Surgeon General (SG), the nation’s chief health educator, provides Americans with the best available scientific information on how to improve their health and reduce the risk of illness and injury. The OSG oversees the approximately 6,000-member Commissioned Corps of the U.S. Public Health Service and assists the SG with other duties. Website: <http://www.surgeongeneral.gov>  
  
OAH supports and evaluates the evidence-based Teen Pregnancy Prevention program, implements the Pregnancy Assistance Fund, coordinates HHS efforts related to adolescent health, and communicates adolescent health information to health professionals and groups. OAH is also the convener and catalyst for the development of a national adolescent health agenda. Website: <http://www.hhs.gov/ash/oah>
8. **HHS/Substance Abuse and Mental Health Services Administration (SAMHSA):** SAMHSA’s mission is to reduce the impact of substance misuse and mental illness on America’s communities. SAMHSA works toward underage drinking prevention by supporting state and community efforts, promoting the use of evidence-based practices (EBPs), educating the public, and collaborating with other agencies and interested parties. Website: <http://www.samhsa.gov>
9. **Department of Defense (DoD):** DoD coordinates and oversees government activities relating directly to national security and military affairs. Its alcohol-specific role involves preventing and reducing alcohol consumption by underage military personnel and improving the health of service members’ families by strengthening protective factors and reducing risk factors in underage alcohol consumption. Website: <http://www.defense.gov>



10. **Department of Education (ED)/Office of Safe and Healthy Students (OSHS):** OSHS administers, coordinates, and recommends policy to improve the effectiveness of programs providing financial assistance for drug and violence prevention activities and for activities that promote student health and well-being in elementary and secondary schools and institutions of higher education. Activities may be carried out by state and local educational agencies or other public or private nonprofit organizations. OSHS supports programs that prevent violence in and around schools; prevent illegal use of alcohol, tobacco, and drugs; engage parents and communities; and coordinate with related federal, state, school, and community efforts to foster safe learning environments that support student academic achievement. Website: <http://www2.ed.gov/about/offices/list/oese/oshs/aboutus.html>
11. **U.S. Department of Justice (DoJ), Office of Juvenile Justice and Delinquency Prevention (OJJDP):** OJJDP provides national leadership, coordination, and resources to prevent and respond to juvenile delinquency and victimization. OJJDP supports states and communities in their efforts to develop and implement effective, coordinated prevention and intervention programs and to improve the juvenile justice system's ability to protect public safety, hold offenders accountable, and provide treatment and rehabilitation services tailored to the needs of juveniles and their families. OJJDP's central underage drinking prevention initiative, Enforcing Underage Drinking Laws (EUDL), was a nationwide state- and community-based multidisciplinary effort that sought to prevent access to and consumption of alcohol by those under age 21, with a special emphasis on enforcement of underage drinking laws and implementation programs that use best and most promising practices. The breadth of focus changed significantly in Fiscal Year (FY) 2014 because of a reduction in funding for the EUDL initiative. FY 2014 EUDL funding supported underage drinking prevention activity led by Healing to Wellness Courts in five selected tribes. By FY 2015, all funding to support EUDL efforts was discontinued.
12. **Department of the Treasury/Alcohol and Tobacco Tax and Trade Bureau (TTB):** TTB's mission is to collect the taxes on alcohol, tobacco, firearms, and ammunition; protect the consumer by ensuring the integrity of alcohol products; and prevent unfair and unlawful market activity for alcohol and tobacco products. Website: <http://www.ttb.gov>
13. **Department of Transportation (DOT)/ National Highway Traffic Safety Administration (NHTSA):** NHTSA's mission is to save lives, prevent injuries, and reduce traffic-related healthcare and other economic costs. NHTSA develops, promotes, and implements effective educational, engineering, and enforcement programs to reduce traffic crashes and resulting injuries and fatalities and reduce economic costs associated with traffic crashes, including underage drinking and driving crashes. Website: <http://www.nhtsa.gov>
14. **Federal Trade Commission (FTC):** FTC is the only federal agency with both consumer protection and competition jurisdiction in broad sectors of the economy; in total, it has enforcement or administrative responsibilities under 70 laws. As the enforcer of federal truth-in-advertising laws, the agency monitors alcohol advertising for deceptive or unfair practices, brings law enforcement actions in appropriate cases, and conducts studies of alcohol industry compliance with self-regulatory commitments. Website: <http://www.ftc.gov>
15. **Office of National Drug Control Policy (ONDCP):** The principal purpose of ONDCP is to establish policies, priorities, and objectives for the nation's drug control program. The goals of the program are to reduce illicit drug use, manufacturing, and trafficking; drug-related

crime and violence; and drug-related health consequences. Part of ONDCP's efforts relate to underage alcohol use. Website: <http://www.whitehouse.gov/ondcp>

The following section highlights current initiatives to prevent and reduce underage drinking and its consequences. Further details about departmental and agency programs to prevent and reduce underage drinking appear later in this chapter under "Inventory of Federal Programs for Underage Drinking by Agency."

## How Federal Agencies and Programs Work Together

The STOP Act requires the HHS Secretary, on behalf of ICCPUD, to submit an annual Report to Congress summarizing "all programs and policies of federal agencies designed to prevent and reduce underage drinking." ICCPUD aims to increase coordination and collaboration in program development among member agencies so that the resulting programs and interventions are complementary and synergistic. For example, ICCPUD-sponsored town hall meetings, now called "Communities Talk: Town Hall Meetings to Prevent Underage Drinking," have been held every other year since 2006, in every state, the District of Columbia, and most of the territories. They are an effective way to raise public awareness of underage drinking as a public health problem and mobilize communities to take action. At these meetings, communities used CDC, NHTSA, NIAAA, and NIDA statistics, videos, and other resources produced by SAMHSA and training materials developed by OJJDP through the EUDL program. ICCPUD agency members recommend grantees and other community-based organizations as event hosts and encourage them to make use of ICCPUD agency resources to create comprehensive action plans for community change.

In addition, NIAAA, CDC, SAMHSA, and other federal agencies collaborate with private groups, such as CADCA (Community Anti-Drug Coalitions of America) and Mothers Against Drunk Driving (MADD), in efforts to reduce underage drinking.

## A Commitment to Evidence-Based Practices

At the heart of any effective national effort to prevent and reduce underage drinking are reliable data on the effectiveness of specific prevention and reduction efforts. With limited resources available and human lives at stake, it is critical that professionals use the most time- and cost-effective evidence-based approaches known to the field. Traditionally, efficacy has been ensured through practices that research has shown to be effective instead of those based on convention, tradition, folklore, personal experience, belief, intuition, or anecdotal evidence. The term for practices validated by documented scientific evidence is evidence-based practices, or EBPs.

Despite broad agreement regarding the need for EBPs, there is currently no consensus on the precise definition of an EBP. Disagreement arises not from the need for evidence, but from the kind and amount of evidence required for validation. The gold standard of scientific evidence is the randomized controlled trial, but it is not always possible to conduct such trials. Many strong, widely used, quasi-experimental designs have produced and will continue to produce credible, valid, and reliable evidence—these should be relied on when randomized controlled trials are not possible. Practitioner input is a crucial part of this process and should be carefully considered as evidence is compiled, summarized, and disseminated to the field for implementation.



The Institute of Medicine (now the Health and Medicine Division of the National Academies), for example, defined an EBP as one that combines the following three factors: best research evidence, best clinical experience, and consistency with patient values (IOM, 2001). The American Psychological Association adopted a slight variation of this definition for the field of psychology, as follows: EBP is “the integration of the best available research with clinical expertise in the context of patient characteristics, culture, and preferences” (APA Presidential Task Force on Evidence-Based Practice, 2006).

The federal government does not provide a single, authoritative definition of EBPs, yet the general concept of an EBP is clear: some form of scientific evidence must support the proposed practice, the practice itself must be practical and appropriate given the circumstances under which it will be implemented and the population to which it will be applied, and the practice must have a significant effect on the outcome(s) to be measured. For example, OSHA requires that its grantees use EBPs in the programs they fund, and NHTSA has produced a publication titled “Countermeasures That Work” for use by State Highway Safety Offices (SHSOs) and encourages SHSOs to select countermeasure strategies that have either proven effective or shown promise.

### **National Registry of Evidence-Based Programs and Practices**

SAMHSA developed the National Registry of Evidence-Based Programs and Practices (NREPP) (<http://www.nrepp.samhsa.gov>), a searchable database of interventions for the prevention and treatment of mental and substance use disorders that are rated by independent reviewers. The purpose of the registry is to assist the public in identifying approaches to preventing and treating mental and substance use disorders that are scientifically tested and can be readily disseminated to the field. NREPP is one way by which SAMHSA works to improve access to information on tested interventions, thereby reducing the lag time between the creation of scientific knowledge and its practical application in the field.

In addition to helping the public find evidence-based interventions, SAMHSA and other federal agencies use NREPP to inform grantees about EBPs and to encourage their use. The NREPP database is not an authoritative list, but a registry; SAMHSA does not approve, recommend, or endorse the specific interventions listed therein. Policymakers in particular should avoid relying solely on NREPP ratings as a basis for funding or approving interventions. NREPP provides useful information and ratings of interventions to assist individuals and organizations in identifying practices that may address their particular needs and match their specific capacities and resources. As such, NREPP is best viewed as a starting point for further investigation regarding interventions that might work well and produce positive outcomes for a variety of stakeholders. As of fall 2016, nearly 100 programs were evaluated by NREPP using a new, more rigorous system, and posted on the NREPP website. See the NREPP section under SAMHSA, “Activities Related to Underage Drinking” later in this chapter for further information.

### **The Guide to Community Preventive Services (The Community Guide)**

CDC supports the use of an evidence-informed approach for its broad range of recommendations, guidelines, and communications. This approach calls for transparency in reporting the evidence that was considered and requires that the path leading from the evidence to the recommendations

or guidelines be clear and well described, regardless of the strength of the underlying evidence or the processes used in their development. The Guide to Community Preventive Services (The Community Guide) provides the model for CDC's evidence-informed approach (<http://www.thecommunityguide.org>).

Under the auspices of the independent, nonpartisan, nonfederal, unpaid Community Preventive Services Task Force, the reviews found on The Community Guide website systematically assess all available scientific evidence to determine the effectiveness of population-based public health interventions and the economic benefit of all effective interventions. The Task Force reviews the combined evidence; makes recommendations for practice and policy; and identifies gaps in existing research to ensure that practice, policy, and research funding decisions are informed by the highest quality evidence.

CDC's Alcohol Program works with The Community Guide, SAMHSA, NIAAA, and other partner organizations on systematic reviews of population-based interventions to prevent excessive alcohol consumption, including underage and binge drinking and related harms. To date, the Community Preventive Services Task Force has reviewed the effectiveness of various community-based strategies for preventing underage and binge drinking, including limiting alcohol outlet density, increasing alcohol excise taxes, dram shop liability, limiting days and hours of alcohol sales, electronic screening and brief intervention (e-SBI) for alcohol misuse, enhancing enforcement of minimum legal drinking age (MLDA) laws, lowering blood alcohol concentration (BAC) laws for younger drivers, and offering school-based instructional programs for preventing drinking and driving and for preventing riding with drunk drivers.

Strategies recommended by the Community Preventive Services Task Force for preventing excessive alcohol consumption include:

- **Promoting dram shop liability**, which allows the owner or server of a retail alcohol establishment where a customer recently consumed alcoholic beverages to be held legally responsible for the harms inflicted by that customer.
- **Increasing alcohol taxes**, which, by increasing the price of alcohol, is intended to reduce alcohol-related harms, raise revenue, or both. Alcohol taxes are implemented at the state and federal levels and are beverage-specific (i.e., they differ for beer, wine, and spirits).
- **Maintaining limits on days of sale**, which is intended to prevent excessive alcohol consumption and related harms by regulating access to alcohol. Most policies limiting days of sale target weekend days (usually Sundays).
- **Maintaining limits on hours of sale**, which prevents excessive alcohol consumption and related harms by limiting the hours of the day during which alcohol can legally be sold.
- **Regulating alcohol outlet density** to limit the number of alcohol outlets in a given area.
- **Using e-SBI** to reduce excessive alcohol consumption and related harms, by means of electronic devices such as computers, telephones, and mobile devices, to facilitate delivery of key elements, including (1) screening individuals for excessive drinking and (2) delivering a brief intervention, which provides personalized feedback about the risks and consequences of excessive drinking.
- **Recommending against privatization of retail alcohol sales**, because privatization results in increased per capita alcohol consumption, a well-established proxy for excessive alcohol consumption. Further privatization of alcohol sales in settings with current government control of retail sales is recommended against.

- **Enhancing enforcement of laws prohibiting sales to minors** by initiating or increasing the frequency of retailer compliance checks for laws against the sale of alcohol to minors in a community.

The Community Preventive Services Task Force also recommends the following interventions for preventing alcohol-impaired driving:

- **0.08 percent BAC and above laws**, making it illegal for a driver's BAC to equal or exceed 0.08 percent.
- **Lower BAC laws for young or inexperienced drivers**, which apply to all drivers under age 21. Among states, the illegal BAC level for young drivers ranges from any detectable BAC to 0.02 percent.
- **Maintain current MLDA laws**, which specify an age below which the purchase or public consumption of alcoholic beverages is illegal. In the United States, the age in all states is 21.
- **Publicized sobriety checkpoint programs**, where law enforcement officers stop drivers to assess their level of alcohol impairment, which are publicized in advance.
- **Mass media campaigns** intended to reduce alcohol-impaired driving and designed to persuade individuals to either avoid drinking and driving or prevent others from doing so.
- **Multicomponent interventions with community mobilization**, in which communities implement multiple programs and policies in multiple settings to influence the community environment to reduce alcohol-impaired driving.
- **Ignition interlocks**, devices that can be installed in motor vehicles to prevent operation of the vehicle by a driver who has a BAC above a specified level (usually 0.02 to 0.04 percent).
- **School-based instructional programs** to reduce alcohol-impaired driving and riding with alcohol-impaired drivers.

More information on these recommended interventions for preventing alcohol-impaired driving can be found at <http://www.thecommunityguide.org>.

## Underage Drinking–Related Goals

The HHS Healthy People 2020 program provides science-based, national, 10-year objectives for improving health. It was developed by the Federal Interagency Workgroup, which includes representatives from numerous federal departments and agencies. SAMHSA and NIH served as co-leaders in developing Healthy People 2020 objectives for substance misuse, including underage drinking.<sup>29</sup>

A number of the programs listed below in “Inventory of Federal Programs for Underage Drinking by Agency” will advance the following Healthy People 2020 objectives related to underage drinking:

- Increase the number of adolescents who have never tried alcohol
- Increase the proportion of adolescents who disapprove of having one or two alcoholic drinks nearly every day and who perceive great risk in binge drinking
- Reduce the number of underage drinkers who engage in binge drinking
- Reduce the proportion of adolescents reporting use of alcohol or any illicit drugs during the past 30 days

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<sup>29</sup> For details regarding these substance use-related objectives, go to: <http://www.healthypeople.gov/2020/topicsobjectives2020/objectiveslist.aspx?topicId=40>

- Reduce the proportion of adolescents who report that they rode, during the previous 30 days, with a driver who had been drinking alcohol

A smaller set of Healthy People 2020 objectives called Leading Health Indicators has been selected to communicate high-priority health issues and actions that can be taken to address them. These include the following indicator for underage drinking: “Adolescents using alcohol or any illicit drugs during the past 30 days.” For more information on Healthy People 2020, please go to <http://www.healthypeople.gov/2020/topicsobjectives2020>.

## **Inventory of Federal Programs for Underage Drinking by Agency**

As required by the STOP Act, this section of the report summarizes major initiatives under way throughout the federal government to prevent and reduce underage alcohol use in America.

### **Interagency Coordinating Committee on the Prevention of Underage Drinking (ICCPUD)**

#### **Activities Specific to Underage Drinking**

ICCPUD, established in 2004 at the request of the HHS Secretary and made permanent in 2006 by the STOP Act, guides policy and program development across the federal government with respect to underage drinking. ICCPUD is composed of representatives from DoD, ED/OSHS, FTC, HHS/ACF, HHS/ASPE, HHS/CDC, HHS/IHS, HHS/NIH/NIAAA, HHS/NIH/NIDA, HHS/OASH/OSG, HHS/SAMHSA, DoJ/OJJDP, DOT/NHTSA, ONDCP, and Treasury/TTB. (See Appendix A for a list of ICCPUD members.)

**Town Hall Meetings:** Beginning in 2006 and every 2 years since, ICCPUD—with SAMHSA as the lead agency—has supported almost 10,000 Town Hall Meetings to prevent underage drinking in communities in every state, the District of Columbia, and most U.S. territories. To place a renewed emphasis on the initiative’s focus, while raising awareness of underage drinking as a public health problem and mobilizing communities around its evidence-based prevention, the initiative was renamed in 2016 to Communities Talk: Town Hall Meetings to Prevent Underage Drinking. Due to SAMHSA’s expanded outreach and partnership development, more than 1,500 Communities Talk events were held nationwide in 2016, with over 1,420 communities registering to hold one or more events. Additionally, more than 200 institutions of higher education (IHEs) registered as primary Communities Talk event organizers, doubling the number of IHE events from 2014 to 2016.

Feedback from host organizations, via a survey approved by the Office of Management and Budget, indicates that these events are an effective approach for raising public awareness of underage drinking as a public health problem and mobilizing communities around its evidence-based prevention. Most of the 2016 events focused on ways to reduce underage access to alcohol, such as through environmental prevention (e.g., compliance checks) and parental involvement. In addition, these events launched or strengthened collaboration among underage drinking prevention stakeholders. In planning Communities Talk meetings, most of the event organizers reported collaborating with other organizations, and more than two thirds of them plan to collaborate with other agencies and programs in follow-up efforts to prevent and reduce underage drinking. SAMHSA is developing a summary report on the 2016 events.

SAMHSA supports event organizers with a growing portfolio of online resources for planning, promoting, hosting, and evaluating their events. For the 2016 initiative, SAMHSA held a training webcast, “Communities Talk: Planning a Successful 2016 Town Hall Meeting,” and a webinar training, “Youth Engagement in Underage Drinking Prevention.” Both are posted as on-demand trainings on the ICCPUD website.

During 2014, SAMHSA incorporated responsive design technology into the Communities Talk: Town Hall Meetings web section. Responsive design technology enables users of any device with an internet connection to easily access content and have it automatically reformat to the screen of the device being used.

**Messages:** To strengthen the national commitment to prevent and reduce underage drinking, it is important that federal agencies convey the same messages at the same time. Therefore, the leadership of the ICCPUD agencies will continue to:

- Increase efforts to highlight in speeches and meetings across the country the need to prevent underage drinking and its negative consequences.
- Ensure that members of the Administration are speaking with a common voice on the issue.
- Reinforce the messages that ICCPUD has developed.
- Use a coordinated marketing plan to publicize programs, events, research results, and other activities and efforts that address underage drinking.

**Support the Minimum Drinking Age:** Agency leadership will continue to develop and use messaging that supports a 21-year-old drinking age and will promote this in speeches and message points.

**Materials and Technical Assistance:** ICCPUD has collected information on underage drinking prevention materials developed by participating agencies. This inventory is being used to strengthen each agency’s efforts to provide high-quality and timely information and to help avoid unnecessary duplication of effort. In addition, ICCPUD has collected information on each agency’s technical assistance activities, facilitating coordination of effort when possible.

**ICCPUD Web Portal:** SAMHSA, on behalf of ICCPUD, maintains a web portal dedicated to the issue of underage drinking (<http://www.stopalcoholabuse.gov>) that consolidates comprehensive research and resources developed by the federal ICCPUD agencies. The portal includes information on underage drinking statistics (i.e., prevalence, trends, and consequences), evidence-based approaches, and other resources and materials that support prevention efforts. Direct links are provided to federally supported websites designed to prevent substance misuse, including alcohol. Information is intended to serve all stakeholders (e.g., community-based organizations involved in prevention, policymakers, parents, youth, and educators). The portal also includes a section for the Communities Talk initiative and its supporting resources.

During 2016, SAMHSA added 158 news and research summaries to the ICCPUD web portal reflecting the broad range of programs, products, services, initiatives, and research introduced or advanced by ICCPUD agencies throughout the year. SAMHSA also enhanced the Communities Talk section of the ICCPUD web portal to improve the relevancy and accessibility of resources by performing a content audit of highly viewed sections and enhancing the layout to increase visual interest. In 2016, the web portal received a monthly average of 1,269 visits per day, and the average time spent on the site was 11 minutes and 46 seconds.



## Department of Defense (DoD)

### Activities Specific to Underage Drinking

**Youth Program:** Building health and life skills increases young people’s capacity to engage in positive behaviors. Through affiliation with the Boys & Girls Clubs of America, programs such as SMART Moves® (Skills Mastery and Resistance Training) help young people resist alcohol, tobacco, drugs, and premature sexual activity. This year-round program, provided in Military Youth Programs worldwide, encourages collaboration among staff, youth, parents, and representatives from community organizations.

### **DoD Education Activity (DoDEA):**

- *Health Education Curriculum:* Health education develops health literacy skills along with health promotion and disease prevention concepts including the impact of underage drinking.
- *Red Ribbon Week:* Sponsored by the National Family Partnership, Red Ribbon Week provides DoDEA schools and families an opportunity to discuss the dangers of drug abuse and the benefits of living a healthful and drug-free lifestyle.
- *Substance Abuse and Violence Prevention:* Health education includes the application of specific skills to increase personal and community health; safety and injury prevention; nutrition and physical activity; mental health; and prevention of alcohol, tobacco, and drug use.

**Law Enforcement:** DoD ensures enforcement of underage drinking laws on all federal installations.

### Activities Related to Underage Drinking

DoD has a series of substance use disorder prevention efforts, including universal, selective, and indicated prevention strategies. The placement of behavioral health personnel in primary care medical settings is intended to combat stigma associated with receiving behavioral health care and provides an opportunity to improve early screening, identification, and intervention of many behavioral health conditions.

**Active Duty and Reserve Component Health-Related Behaviors (HRB) Survey:** DoD conducts the HRB survey every 1 to 3 years to measure more than 17 health-related behaviors for Active-Duty and Reserve Component military personnel. Substance use data are collected on age of first substance use, binge drinking, and prevalence and frequency of substance use.

**Alcohol Abuse Countermarketing Campaign:** DoD’s Defense Health Agency launched “That Guy” in 2006 as an integrated marketing campaign targeting military enlisted personnel ages 18 to 24 across all service branches. Based on research and behavior change marketing concepts, the campaign uses a multimedia, peer-to-peer approach to raise awareness of the negative short-term social consequences of excessive drinking. “That Guy” is credited with contributing to reductions in binge drinking, and is now actively deployed around the world. Select achievements to date include:

- An average time of 9:15 minutes per user on the “That Guy” website
- More than 60,000 “Likes” on Facebook
- More than 30,000 downloads of the “That Guy” Buzzed mobile game

- More than 5.2 million branded materials disseminated to all services
- More than 7,400 points of contact (POCs) engaged across the globe
- Millions reached pro bono through video and radio PSAs broadcast around the world through Armed Forces Radio and Television Service, Army and Air Force Exchange Service, and community stations

“That Guy” ([www.thatguy.com](http://www.thatguy.com)) has received 39 awards for excellence in categories that include poster and web design, animation, gaming, marketing, and research. Previous analyses of DoD service member surveys, such as the Status of Forces Survey (SOFS) performed by the Defense Manpower Data Center and the Health Related Behaviors Survey (HRBS), indicate that binge-drinking rates are lower at locations actively implementing the “That Guy” campaign. The 2014 SOFS (the most recent survey released that measured awareness of the campaign) reveals the “That Guy” campaign has achieved a 59 percent awareness rate among the target audience.

**Screening, Brief Intervention, and Referral to Treatment (SBIRT):** This Implementation Pilot was initiated by the Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury (DCoE) in order to adapt the SBIRT approach for the military patient-centered medical home (PCMH). The Pilot used an implementation science approach via the VA/DoD Practice-Based Implementation Network (PBI Network) model. SBIRT appears to be a feasible approach for military health primary care settings to further enhance efforts to assist service members and their families to receive interventions for alcohol misuse.

### Service-Level Prevention Programs

**Marine Corps Substance Abuse Program (SAP):** The U.S. Marine Corps (USMC) SAP provides plans, policies, and resources to prevent consequences of substance misuse. Specific program efforts are based on the Health and Medicine Division of the National Academy of Sciences prevention continuum and focus on the common risk and protective factors framework. The USMC SAP’s efforts include:

- *Establishment of a Coordinated Continuum of Care:* The Navy Bureau of Medicine and Surgery and the USMC Marine and Family Programs have a Memorandum of Understanding (MOU) establishing a formal continuum of coordinated mental illness and substance abuse prevention and care services.
- *Universal Training:* Unit Marine Awareness and Prevention Integrated Training (UMAPIT) educates all Marines about behavioral health risk factors and warning signs, including alcohol use and misuse. UMAPIT incorporates protective factors and skill-building techniques to ensure that Marines understand their responsibility to intervene when a fellow Marine shows signs/symptoms of alcohol misuse and other behavioral health concerns.
- *Selected Training:* The Marine Corps adopted the evidence-based motivational intervention called “PRIME for Life” (PFL) as the USMC’s educational program for substance misuse education, which teaches Marines to self-assess high-risk behaviors and influence changes in attitudes, beliefs, and behaviors around alcohol consumption. It is designed to target high-risk populations such as the 17- to 25-year-old Marine at risk for substance misuse.
- *Indicated Training:* PFL 16 hours (PFL 16.0) is an evidence-based, indicated prevention intervention course designed to teach Marines who have been involved in an alcohol-related incident about the dangers and risks involved with alcohol misuse. PFL is facilitated by Substance Abuse Counseling Center (SACC) certified prevention specialists who provide



Marines with increased substance use awareness and with new skills for making lower risk decisions.

- *Deterrence*: The Alcohol Screening Program (ASP) initiated in 2013 supports the 21st Century Marine and Sailor Initiative, and seeks to identify alcohol misuse and direct appropriate intervention before a career- or life-altering incident occurs. The ASP uses random Breathalyzer testing of Marines and Sailors to screen for underage drinking and alcohol use while in a duty status.
- *Case Identification and Treatment*: The USMC model supports an integrated approach while maintaining adherence to the scope of practice delineated in the aforementioned MOU. This model includes standardized screening instruments, employs warm hand-offs for referrals, and emphasizes ease of access.
- *Substance Abuse Counseling Centers (SACCs)*: USMC SACCs are fully accredited by the Commission on Accreditation of Rehabilitation Facilities (CARF) and provide multiple levels of evidence-based services including education, care coordination, group therapy, and individual and family support.
- *Collaboration with Sexual Assault Prevention and Response (SAPR)*: SAP collaborates with SAPR to create effective prevention messaging in response to the correlation between alcohol and sexual assault. SAP and SAPR work together using social media messaging and awareness campaigns to increase knowledge about the risks associated with alcohol misuse and sexual assault.
- *Installation-Specific Prevention Planning*: SAP provides quarterly training to SACC staff. SAP utilizes the Strategic Prevention Framework (SPF) developed by SAMHSA to support the development of annual installation integrated prevention plans.

***Navy Alcohol and Drug Abuse Prevention (NADAP)***: The Navy's comprehensive substance abuse prevention program supports fleet readiness by combating alcohol and drug abuse. NADAP's efforts include marketing responsible use, education and training, early intervention, substance abuse rehabilitation, and accountability.

- *Keep What You've Earned*: A campaign that encourages responsible drinking among sailors by celebrating the achievements in their Navy careers. Through recognition of their hard work and dedication, sailors are reminded of their accomplishments and how much they have to lose if they make poor choices regarding alcohol.
- *Domino Strategy on How to Drink Responsibly*: A social marketing campaign that encourages sailors to pay attention to the size, content, and amount of alcohol they consume in each sitting, using responsible drinking guidelines defined by HHS.
- *Shot of Reality*: This 90-minute improvised show focuses on alcohol awareness and the pitfalls of alcohol and drug abuse to help sailors make better decisions and take care of shipmates.
- *Street Smart*: This 90-minute interactive presentation by firefighters and paramedics reminds sailors of the dangers of drinking, drunk driving, illegal drug use, and not wearing seat belts.
- *Myth vs. Truth*: This program provides Sailors with facts about career and administrative implications of alcohol-related incidents, including policy and procedures addressing Sailors who incur multiple DUI/DWI charges.
- *Comedy Is the Cure*: This 60-minute stand-up comedy show highlights the dangers and risks of alcohol and drug abuse and sexual assault and harassment.

- *Initial Entry:* All new Navy entrants receive education on alcohol and drug abuse awareness and prevention, Navy policies, resources for help, and disciplinary consequences associated with misuse of alcohol.
- *Command Indoctrination:* All newly reporting personnel are briefed thoroughly on resources for help, command policy, and punitive consequences for failure to obey policies on alcohol and drug misuse, with emphasis on deglamorization, responsible use, treatment of driving under the influence (DUI) offenses, prohibitions against drinking during normal working hours, and illicit use of substances.
- *Periodic Awareness through General Military Training (GMT):* Alcohol and drug abuse awareness education is scheduled periodically through the Naval Education and Training Command GMT program.
- *Alcohol Aware Program:* This program is a command-level alcohol abuse prevention and responsible use course designed for all hands. Each participant is asked to anonymously evaluate his or her own pattern of drinking to determine whether it is appropriate and, where necessary, make adjustments.
- *Alcohol Impact Program:* Alcohol Impact is the first intervention step in the treatment of alcohol abuse. It is an intensive, interactive educational experience designed for personnel who have challenges with alcohol. The course is primarily an educational tool; however, objectives within the course could identify the need for a higher level of treatment.
- *Alcohol and Drug Abuse Managers/Supervisors (ADAMS) for Leaders:* Commanding Officers, Officers in Charge, Executive Officers, Command Master Chiefs, Chiefs of the Boat, and as applicable, other senior command personnel complete ADAMS for Leaders.
- *Drug and Alcohol Program Advisor (DAPA):* Members assigned as DAPAs and assistant DAPAs complete the command DAPA course within 90 days of appointment. DAPAs are the command's primary trainers of AWARE (Alcohol/Drug), and develop command policies and prevention plans that discourage substance use disorders and support mission readiness.
- *Alcohol Server Training for Morale, Welfare, and Recreation Personnel:* Personnel employed in Navy recreation facilities who are responsible for selling or serving alcoholic beverages complete appropriate training to ensure compliance with Navy and local regulations and statutes, enforcement of policies related to underage drinking, knowledge of alternatives, and a full understanding of designated driver programs.
- *Personal Readiness (PR) Summits:* PR Summits are conducted throughout the year in fleet-concentrated areas. A PR Summit may also offer some or all of the following topics often associated with alcohol abuse: Sexual Assault Prevention and Response (SAPR), domestic violence prevention, equal opportunity, substance abuse prevention, nutrition and physical readiness, suicide prevention, and behavioral health.
- *Navy Alcohol and Drug Abuse Prevention (NADAP) E-Gram:* Provides quarterly updates on substance abuse policy, news, and prevention tools.
- *Alcohol Detection Devices (ADD):* ADD is an education and awareness tool to assist a command in promoting responsible use of alcohol. This tool helps identify members who may not be fit and ready for duty as a result of their alcohol use decisions, and may be useful in referral decisions regarding a substance abuse rehabilitation program.
- *Alcohol and Drug Management Information Tracking System (ADMITS):* ADMITS is the Navy repository for alcohol incidents, screening, treatment, and training information. It provides statistical reporting and longitudinal assessment of the effectiveness of Navy

substance abuse prevention programs, and historical data to field activities that evaluate and recommend the disposition of members who have an alcohol incident.

- *Navy Alcohol and Drug Abuse Prevention (NADAP) Facebook*: This is a Facebook fan page sponsored by NADAP that provides updated information and discussions on substance abuse prevention issues, strategies, and policy.
- *Drug Education for Youth Program (DEFY)*: DEFY is a comprehensive, year-long, phased program designed to reduce risk factors linked to adolescent alcohol and drug abuse, school failure, delinquency, and violence in youth ages 9–12.

***Army Substance Abuse Programs (ASAP)***: ASAP establishes, administers, and evaluates substance abuse prevention training, evaluation of education certification, and professional training programs for all Army personnel worldwide within the Active Component, National Guard, and Army Reserve. The goal of ASAP is to provide soldiers, command, Department of Army civilians, contractors, and family members with the education and training necessary to make informed decisions about alcohol and drugs. The following programs are currently provided by ASAP to meet the needs of soldiers seen by the Army:

- *Alcohol and Drug Abuse Prevention Training (ADAPT)*: ADAPT is an educational/motivational intervention that focuses on the adverse effects and consequences of alcohol and other drug abuse. Its curriculum consists of a minimum of 12 hours of course material. As its ADAPT curriculum, the Army utilizes Prime for Life (PFL), a motivational intervention used in group settings to provide early intervention and prevent alcohol and drug problems. PFL is an evidence-based program that provides measurable outcomes and effectiveness as recognized by its inclusion within the SAMHSA NREPP. It provides soldiers with the ability to self-assess their own high-risk behaviors and influence change in attitude, belief, and behavior.
- *Adolescent Support and Counseling Services (ASACS)*: ASACS is a school-based program that provides alcohol/drug abuse counseling services, as well as alcohol/drug abuse and deployment support prevention services to eligible adolescent family members at 17 locations outside the contiguous United States. ASACS employs evidence-based Feedback Informed Therapy (FIT) to keep adolescents engaged in treatment. The ASACS-Army provided over 22,839 counseling hours and over 7,618 prevention contact hours in FY 2016 for military families Outside of the Continental US (OCONUS) with 25 counselors on hand, reducing the early return of families from overseas for these issues.

***Army Campaigns***: The Army campaign division of ASAP recognizes and endorses campaigns that go beyond alcohol or other drug abuse problems. Installations are required to conduct two campaigns a year. Headquarters, Installation Management Command, collects after-action reports and shares best practices regarding the campaigns across the enterprise.

- *Red Ribbon Campaign*: Red Ribbon Week is the oldest and largest drug prevention campaign in the country. The mission of the Red Ribbon Campaign is to present a unified and visible commitment to the creation of a drug-free America.
- *Summer Safety Impaired Driving Prevention Campaign*: The 101 Critical Days of Summer (Memorial Day through Labor Day) safety campaign is intended to remind the Army that it cannot afford to lose focus on safety either on- or off-duty.

- *National Drunk and Drugged Driving (3D) Prevention Month/Campaign:* December is annually designated as 3D Prevention Month to recognize the risks and reduce the prevalence of driving under the influence of alcohol and other drugs.
- *Drive Sober or Get Pulled Over* is a nationwide impaired-driving prevention campaign.

***Air Force Innovative Prevention Program:*** The U.S. Air Force (USAF) Alcohol Abuse Prevention Program (AAPP) encourages healthy, controlled alcohol use (and nonuse for underage people) as the normative lifestyle choice for young USAF personnel. The USAF takes a collaborative approach, working with other prevention and resiliency programs, to address underage drinking, alcohol misuse, and illegal drug use. The USAF uses a comprehensive community-based approach with four levels: strong leadership support, individual-level interventions, base-level interventions, and community-level interventions. The USAF's Alcohol Brief Counseling (ABC) Program is an indicated prevention program that follows a brief counseling, and a brief education, intervention format. The goal of the ABC Program is to go beyond educating individuals about alcohol-related facts, to increase their interest in critically examining their drinking patterns to ultimately implement risk reduction skills.

In 2006, the Office of Juvenile Justice and Delinquency Prevention (OJJDP) initiated an Enforcing Underage Drinking Laws (EUDL) military discretionary grant program to reduce drinking among underage active-duty Air Force members, to support implementation of a set of interventions using an environmental strategies approach to reduce drinking and associated alcohol-related misconduct among active-duty Air Force members ages 18–25 with a specific focus on the underage population. The initiative resulted in decreased problem drinking, increased awareness of the dangers associated with underage drinking, and an association between a particular mix of coalition activities and improved drinking outcomes.

***Department of Homeland Security/U.S. Coast Guard (USCG) Substance Abuse Program:*** The USCG's global mission is to protect the public, the environment, and U.S. economic interests—in the nation's ports and waterways, along the coast, in international waters, or in any maritime region as required—supporting national security (<http://www.uscg.mil>).

After careful consideration of alcohol's negative influence on readiness and proficiency of the force as well as the direct correlation between age of onset of drinking and negative consequences related to alcohol, in 2014 the USCG established age 21 as the minimum drinking age, regardless of the service member's duty location. The USCG is restructuring its policies to reflect this and many other changes related to alcohol use and the delivery of treatment services. Prevention- and treatment-seeking behaviors are being strengthened and encouraged. The USCG's Health Promotion policy was officially promulgated on July 9, 2015, reflecting the before-mentioned changes. The USCG implemented an Addiction Orientation for Healthcare Providers course, a 1-week course that trains all Medical Officers on how to conduct, screen, and refer patients with substance abuse disorders to the appropriate level of treatment. More than 85 percent of Medical Officers have been trained.

## Department of Education (ED)

### Activities Specific to Underage Drinking

***National Center on Safe Supportive Learning Environments (NCCSLE):*** NCCSLE is funded by ED to help schools and communities address issues that affect conditions for learning, such as bullying, harassment, violence, and substance abuse. In 2013, NCCSLE offered a series of webinar events that provided constructive information and strategies that colleges and surrounding communities could use to strengthen their learning environments and address problems of violence, mental health, and substance use. This series included *Community Coalitions Working Collaboratively across Secondary and Postsecondary Education to Address Underage Drinking*, a webinar hosted by ED as a part of the underage drinking series sponsored by ICCPUD, available at <https://safesupportivelearning.ed.gov/events/webinar/community-coalitions-working-collaboratively-across-secondary-and-postsecondary>. Publications and other resources hosted on this site can be used to assist administrators and other prevention professionals at colleges and universities to help prevent violence and substance abuse on their campuses and in the surrounding communities.

### Activities Related to Underage Drinking

***ED’s School Climate Transformation Grant – Local Educational Agency Grants Program:*** In FY 2014, ED awarded the first round of grants under the School Climate Transformation Grant – Local Education Agency Grants program. These FY 2014 grant awards provided more than \$35.8 million to 71 school districts in 23 states, Washington, D.C., and the U.S. Virgin Islands. The funds are being used to develop, enhance, or expand systems of support for implementing evidence-based, multitiered behavioral frameworks for improving behavioral outcomes and learning conditions for students. ED has developed a variety of measures to assess the performance of the School Climate Transformation Grants, including measures related to the decrease in suspensions and expulsions of students for possession or use of drugs or alcohol.

***ED’s Safe and Supportive Schools News Bulletin:*** The *Safe and Supportive News Bulletin* is used by the ED OSHS to provide weekly email updates to grantees and other stakeholders in the education community on work related to OSHS and on topics related to school safety, school climate, substance abuse, violence prevention in education, and promotion of student health and well-being. The bulletin also highlights other federal funding opportunities related to these topics (including underage drinking prevention).

## Federal Trade Commission (FTC)

### Activities Specific to Underage Drinking

***Consumer Education:*** In 2015, FTC continued its “We Don’t Serve Teens” (WDST) program, promoting compliance with the legal drinking age of 21 (see [www.DontServeTeens.gov](http://www.DontServeTeens.gov)). Recognizing that most youth ages 12–20 who drink obtain access to alcohol for free (from family or friends, or by taking it without permission from their home or someone else’s), this program urges parents and other adults to stop teens’ easy access to alcohol, and lets them know why this is an important goal. Available in English and Spanish, the program provides information about the risks of underage drinking, tips for fighting easy teen access to alcohol, and talking points to rebut common myths about the legal drinking age. The site includes free



downloadable radio PSAs, radio announcer text, and artwork for posters, billboards, and transit ads. FTC has leveraged this program by working with private partners that use these materials to promote the WDST message around the country at no cost to the government.

### **Activities Related to Underage Drinking**

***Alcohol Advertising Program:*** In 2014, FTC published its fourth major report on alcohol advertising and youth, including industry compliance with self-regulatory commitments to reduce youth exposure to marketing (FTC, 2014). The report provided data on youth drinking rates and risks; alcohol marketing expenditures in 22 categories; industry compliance with the then-current commitment to ensure that at least 70 percent of the audience for each ad consists of adults 21+; and product placement in entertainment media. The report also made recommendations for improvement. In 2014 and 2015, FTC staff made presentations to industry members, regulators, and others about the report, its recommendations for improvement, and the importance of continued progress in self-regulatory efforts. In 2016, FTC staff continued to promote compliance with, and improvements to, alcohol industry self-regulatory practices.

## **Administration for Children and Families (ACF)/HHS**

### **Activities Related to Underage Drinking**

***Runaway and Homeless Youth (RHY) Program:*** The Family and Youth Services Bureau (FYSB) provides funding to local communities to support young people, particularly runaway and homeless youth and their families. Basic Center Program grants offer assistance to at-risk youth (under age 18) in need of immediate temporary shelter. Shelters provide family and youth counseling and referrals to services such as substance use disorder treatment. Through the Street Outreach Program, FYSB awards grants to public and private nonprofit agencies to conduct outreach that builds relationships between grantee staff and street youth to help them leave the streets. The Transitional Living and Maternity Group Home Program (TLP) supports projects that use trauma-informed services and the positive youth development approach to provide longer term residential services to homeless youth, including pregnant and parenting youth, ages 16 to under 22 for up to 21 months. These services help to successfully transition young people to independent living. TLPs enhance youths' abilities to make positive life choices through education, awareness programs, and support. They include evidence-driven services such as substance use education, life skills training (LST), recovery, and counseling. Grantee sites are all expected to be alcohol free. All participants are expected to participate in program activities that would prepare them to make healthy choices regarding alcohol and drug use. All RHY programs are mandated to provide substance use education as needed (and treatment services as needed) either directly or indirectly. FYSB has several RHY programs that have extensive experience in this area. For more information, visit <http://www.acf.hhs.gov/programs/fysb>.

***Family Violence Prevention and Services:*** The Family Violence Prevention and Services Act (FVPSA) provides the primary federal funding stream dedicated to the support of emergency shelter and supportive services for victims of domestic violence and their dependents. FVPSA is located in FYSB, a division of the Administration on Children, Youth and Families in ACF. FYSB administers FVPSA formula grants to states, territories, and tribes; state domestic violence coalitions; and national and special-issue resource centers. First authorized as part of the Child Abuse Amendments of 1984 (P.L. 98-457), FVPSA has been amended eight times. It was most recently reauthorized in December 2011 for 5 years by the CAPTA Reauthorization Act of 2010

(P.L. 111-320 42 U.S.C. 36 10401, et seq.). The statute specifies how most of the appropriated funds will be allocated, including three formula grants and competitive national resource center grants. The remaining discretionary funds are used for competitive grants, technical assistance, and special projects that respond to critical or otherwise unaddressed issues. In 2017, the appropriation level was \$158,741,181. The FVPSA program also administers the National Domestic Violence Hotline.

FVPSA formula grants are awarded to every state and territory and more than 250 tribes. These funds reach 1,500 domestic violence shelters and 257 nonresidential programs, providing both a safe haven and an array of supportive services to intervene in and prevent abuse. Each year, FVPSA-funded programs serve 1.2 million survivors and their children and respond to 2.6 million crisis calls. FVPSA-funded programs do not just serve survivors but also reach their communities; in 2016, programs provided more than 183,000 presentations reaching 4.8 million people, of which almost half were youth.

Of the \$150.5 million appropriated to FVPSA in 2017, \$14.5 million in FVPSA formula grants were distributed based on population to 260 different tribes in 28 states. Award amounts ranged from \$17,691 to \$1,592,236. In FY 2016, approximately 28,226 adult victims and their dependents accessed supportive services through their domestic violence program such as victim advocacy, crisis counseling, safety planning, culturally-specific support groups, information and referrals to other community-based services. FVPSA funded tribes and tribal organizations also provided 198,262 bed nights to approximately 8,455 victims and their children. There were 1,781 unmet requests for shelter services due to the shortage of shelter and housing options and shelters being at capacity.

For more information, visit <http://www.acf.hhs.gov/programs/fysb/programs/family-violence-prevention-services>.

***Abstinence Education Program:*** FYSB administers the Title V State Abstinence Education Program. This program focuses on educating young people and creating an environment within communities that supports teen decisions to postpone sexual activity until marriage. Grantees use evidence-based, medically accurate interventions to promote abstinence from risky behaviors that lead to poor health outcomes, including substance misuse and underage drinking, unplanned pregnancy, and sexually transmitted infections. Grantees are encouraged to use trauma-informed practices and positive youth development as they serve youths. For more information, visit <http://www.acf.hhs.gov/programs/fysb>.

***Personal Responsibility Education Programs (PREP):*** FYSB supports healthy decision making through projects funded to states, tribes, and community organizations to implement pregnancy prevention programs. As part of the Patient Protection and Affordable Care Act, Congress passed and the President signed the PREP into law. In FY2016, APP received 21 applications in response to the Tribal PREP funding opportunity announcement. Eight of the 21 were funded for 5-year grants. The Year 1 funding totaled \$3.436 million. In Year 2, the non-competing continuation awards were reduced by 5.8% as a result of sequestration to a total of \$3.271 million. There are currently only eight Tribal PREP grantees. PREP funds formula and discretionary grants to educate adolescents on both abstinence and contraception to prevent pregnancy and sexually transmitted infections and at least three of six congressionally mandated “adulthood preparation subjects” (APS). Several APS topics—adolescent development, healthy



life skills, and healthy relationships—address healthy decision-making skills, which encompass substance and alcohol prevention messaging. For example, in North Carolina, PREP funded school-based clubs that collect pledges from their peers in schools and the community promising to not engage in underage drinking as part of community service learning projects during prom season. The South Broward Hospital District, another PREP grantee, supported “Alcohol Literacy,” which features sessions designed to specifically target and address alcohol education and refusal skills for youth in the 5th through 8th grades. In addition, abstinence programs promote positive youth development programming that promotes healthy decision-making related to alcohol or drug use. In 2014, a Competitive Personal Responsibility Education Program (CPREP) grantee, Ambassadors for Christ Youth Ministries in Houston, Texas, established the goal to reduce incidence of drug/alcohol use by 15 percent each year for 3 years. The grantee added evidence-based programs, including adult preparation subjects that focus on healthy decision-making.

***Sexual Risk Avoidance Education (SRAE) Program:*** FYSB administers projects that implement sexual risk avoidance education which teaches youth and young adults how to voluntarily refrain from non-marital sexual activity and other youth risk behaviors. Funded projects teach targeted youth the benefits associated with self-regulation, success sequencing for poverty prevention, healthy relationships, goal setting, and resisting sexual coercion, dating violence, and other youth risk behaviors such as underage drinking or illicit drug use without normalizing teen sexual activity. The services are targeted to participants that reside in areas with high rates of teen births and/or are at greatest risk of contracting sexually transmitted infections (STI). The SRAE Program is designed to empower youth to make healthy decisions and to provide tools and resources to prevent pregnancy and youth engagement in other risky behaviors. For more information, visit <http://www.acf.hhs.gov/programs/fysb>.

***Evaluation and Data Collection:*** Since 2011, FYSB has engaged in a 7-year, multisite evaluation effort of PREP programs. FYSB is currently concluding a federal-level evaluation of four sites, with a significant investment in piloting new evidence-based approaches to serving vulnerable populations, which include youth in foster care, pregnant and parenting teens, rural youth, and youth in alternative educational settings. In FY2017, FYSB initiated the second cohort of evaluation of PREP Innovative Strategies and Tribal PREP through a research project entitled Promising Youth Programs. For more information on PREP evaluation efforts, visit <https://www.acf.hhs.gov/fysb/programs/adolescent-pregnancy-prevention/evaluation>.

## Centers for Disease Control and Prevention (CDC)/HHS

### Activities Specific to Underage Drinking

***Reducing Youth Exposure to Alcohol Marketing:*** The CDC Alcohol Program within the National Center for Chronic Disease Prevention and Health Promotion funds the Center on Alcohol Marketing and Youth (CAMY) at the Johns Hopkins Bloomberg School of Public Health to conduct public health surveillance of youth exposure to alcohol marketing and improve adherence to voluntary industry standards on the placement of alcohol advertising, with the ultimate goal of decreasing youth exposure to alcohol marketing and decreasing excessive alcohol consumption, including underage drinking. For more information on CAMY, see <http://www.camy.org>.

## Activities Related to Underage Drinking

**Alcohol-Related Disease Impact (ARDI):** ARDI is an online application that provides national and state estimates of average annual deaths and years of potential life lost (YPLL) due to excessive alcohol use. The application allows users to create custom data sets and generate local reports on these measures as well. Users can obtain estimates of deaths and YPLL among people under age 21 attributed to excessive alcohol use.

**Behavioral Risk Factor Surveillance System (BRFSS):** BRFSS is an annual random-digit-dial telephone survey of U.S. adults ages 18 years and older in all 50 states, the District of Columbia, Guam, Puerto Rico, the U.S. Virgin Islands, American Samoa, Palau, and the Federated States of Micronesia. It includes questions on current drinking, number of drinking days, average number of drinks per day, frequency of binge drinking ( $\geq 4$  drinks per occasion for women;  $\geq 5$  per occasion for men), and the largest number of drinks consumed on a drinking occasion. CDC's Alcohol Program has also developed an optional, seven-question binge drinking module that can be used by states to obtain more detailed information on binge drinkers, including beverage-specific alcohol consumption and driving after binge drinking. CDC also worked with national and international experts to develop an optional module to assess the delivery of screening and brief intervention (SBI) for excessive alcohol use in clinical settings. This optional module was implemented in 22 states for the 2014 BRFSS. In 2011, BRFSS introduced changes to address the growing effects of cellphone-only households, resulting in higher estimates in many states for certain chronic disease indicators and risk behaviors, including binge drinking. For more information, see <http://www.cdc.gov/brfss>.

**Youth Risk Behavior Surveillance System (YRBSS):** The YRBSS monitors priority health risk behaviors among youth and young adults. It includes a biennial, national school-based survey of 9th- through 12th-grade students that is conducted by CDC, and state and local surveys of 9th- through 12th-grade students conducted by education and health agencies. These surveys include questions about the frequency of alcohol use, frequency of binge drinking, age of first drink of alcohol, and usual source of alcohol. States and cities that conduct their own surveys have the option to include additional alcohol questions, such as type of beverage usually consumed and usual location of alcohol consumption. The YRBSS also assesses other health risk behaviors (including sexual activity and interpersonal violence) that can be examined in relation to alcohol consumption. Additional information on the YRBSS is available at <http://www.cdc.gov/yrbss>.

**School Health Policies and Practices Study (SHPPS):** SHPPS is a national survey periodically conducted to assess school health policies and practices at the district, school, and classroom levels. It includes information about school health education on alcohol and drug use prevention, school health and mental health services related to alcohol and drug use prevention and treatment, and school policies prohibiting alcohol use. Additional information is available at <http://www.cdc.gov/SHPPS>.

**Pregnancy Risk Assessment Monitoring System (PRAMS):** PRAMS is a population-based mail and telephone survey of women who have recently delivered a live-born infant. It collects state-specific data on maternal attitudes and experiences before, during, and shortly after pregnancy. It also includes questions on alcohol consumption, including binge drinking during the preconception period and during pregnancy, along with other factors related to maternal and child health. For more information, see <http://www.cdc.gov/prams>.

**National Violent Death Reporting System (NVDRS):** NVDRS is a state-based active surveillance system in 40 states, the District of Columbia, and Puerto Rico that collects risk factor data on all violence-related deaths, including homicides, suicides, and legal intervention deaths (i.e., deaths caused by police and other people with legal authority to use deadly force, excluding legal executions), as well as unintentional firearm deaths and deaths of undetermined intent. Alcohol-related information collected includes (1) alcohol dependence or problem (whether the victim was perceived by self or others to have a problem with, or to be addicted to, alcohol); (2) alcohol use suspected (whether alcohol use by the victim in the hours preceding the incident was suspected, based on witness or investigator reports or circumstantial evidence, such as empty alcohol containers around the victim); (3) alcohol crisis (whether the victim had a crisis related to their alcohol problem within 2 weeks of the incident or an impending crisis within 2 weeks of the incident); (4) tested for alcohol (i.e., whether the victim's blood was tested for the presence of alcohol); (5) alcohol test results (recorded as present, not present, not applicable [i.e., not tested], or unknown); and (6) BAC measured in mg/dL. For more information, see <http://www.cdc.gov/ViolencePrevention/NVDRS>.

**The Guide to Community Preventive Services:** The Community Preventive Services Task Force (Task Force) and CDC's Community Guide Branch work with CDC programs and other partners to systematically review the scientific evidence on the effectiveness of population-based strategies for (1) preventing alcohol-impaired driving and (2) preventing excessive alcohol consumption and related harms (see "The Guide to Community Preventive Services" earlier in this chapter). In 2012, the Task Force and the Community Guide Branch, in collaboration with the National Center for Injury Prevention and Control, updated the 2001 publicized sobriety checkpoints systematic review and, in collaboration with the CDC Alcohol Program, conducted a review of electronic delivery of SBI for excessive alcohol use. The results of these reviews are summarized on The Community Guide website: <http://www.thecommunityguide.org>.

**Preventing Alcohol-Exposed Pregnancies:** CDC's National Center on Birth Defects and Developmental Disabilities (NCBDDD) has a number of activities supporting the prevention of fetal alcohol spectrum disorders (FASDs) among women of childbearing age (18–44 years). NCBDDD continues to monitor alcohol consumption (any use and binge drinking) among women of childbearing age (18–44 years) in the United States, using the BRFSS. These data help identify groups of women at risk for an alcohol-exposed pregnancy and guide the development of prevention programs aimed at reducing risk behaviors and improving pregnancy outcomes. Recent BRFSS data reveal that 1 in 10 pregnant women ages 18 to 44 report drinking any alcohol and 1 in 33 report binge drinking (defined as consuming 4 or more drinks on an occasion) in the past 30 days. NCBDDD, in collaboration with the National Center for Health Statistics (NCHS), added four additional alcohol questions to the National Survey of Family Growth (NSFG). The NSFG data provide population-based estimates on alcohol consumption among women of reproductive age and their risk for alcohol-exposed pregnancy. A recent CDC Vital Signs report on Alcohol and Pregnancy reports that three in four women who want to get pregnant as soon as possible report drinking alcohol.

NCBDDD funds six FASD Practice and Implementation Centers and five national partner groups to prevent FASDs and risky drinking. Through strategic collaborations with national organizations, medical societies, academic centers, and a variety of practitioners from six health disciplines (family medicine, medical assistance, nursing, obstetrics and gynecology,

pediatrics, and social work), partners work to impact healthcare practice at the systems level and enhance FASD prevention opportunities nationally for women of reproductive age and their support networks.

CHOICES, an evidence-based intervention for nonpregnant women of reproductive age, aims to reduce the risk for an alcohol-exposed pregnancy by reducing risky drinking, using effective contraception, or changing both behaviors. CHOICES has been implemented in multiple settings, including sexually transmitted disease clinics, family planning clinics, community health centers, and American Indian communities. A CHOICES curriculum training package is available for order at <http://www.cdc.gov/ncbddd/fasd.freematerials.html>. The curriculum is being converted into a web-based training that will also include remote “live” modules to enhance skills-building activities. Also, two training and technical assistance centers are working to increase the capacity to implement alcohol screening and brief intervention and CHOICES in primary care settings serving American Indian and Alaska Native (AI/AN) populations. Resources based on lessons learned from these efforts are in development, including a tailored version of CDC’s *Planning and Implementing Screening and Brief Intervention for Risky Alcohol Use* specifically for tribal communities (<http://www.cdc.gov/ncbddd/fasd/documents/alcoholsbiimplementationguide.pdf>).

In addition, CDC and ACF are working together to improve the health and developmental outcomes for children with prenatal exposure(s) to alcohol and other drugs within the child welfare system. This project seeks practice change and improvement to facilitate appropriate identification, referral, interventions, and family education that can reduce the risk of poor developmental outcomes and potential cycles of abuse/neglect.

***Alcohol Screening and Brief Intervention (SBI) in Primary Care:*** NCBDDD continues to promote use of alcohol SBI in primary care settings. NCBDDD worked with the American Academy of Pediatrics to assess pediatricians’ use of alcohol SBI with adolescent patients, which informed the development of an implementation guide on substance use screening and brief intervention for use in pediatric settings. The guide is available at [https://www.aap.org/en-us/Documents/Substance\\_Use\\_Screening\\_Implementation\\_Final.pdf](https://www.aap.org/en-us/Documents/Substance_Use_Screening_Implementation_Final.pdf). In addition, questions about provision of alcohol SBI have been added to the 2015 National Ambulatory Medical Healthcare Survey, providing population-based data on physician practices regarding alcohol SBI. Data will be available and analyzed in 2017. NCBDDD also continues to identify partners across multiple sectors, including insurers, employers, medical associations, and private organizations, to advance evidence-based strategies to prevent FASDs and risky drinking. For example, in 2016, NCBDDD worked with Brandeis University and the National Association of Chronic Disease Directors to convene a health policy forum in Massachusetts that brought together leaders from healthcare systems, health plans, provider groups, and hospitals to discuss the possible role state and local leaders can play in promoting the use of alcohol SBI.

## **Indian Health Service (IHS)/HHS**

The IHS Division of Behavioral Health (DBH) is responsible for the Alcohol and Substance Abuse Program (ASAP) through funding of federal, urban, and tribally administered programs. Funding for tribal programs is administered pursuant to the Indian Self-Determination and Education Assistance Act (ISDEAA), 25 U.S.C. §§ 450 *et seq.* Nearly 85 percent of the ASAP budget is administered under ISDEAA contracts or compacts made directly with tribally

administered programs, which aim to provide community-based, holistic, and culturally appropriate alcohol and substance use prevention and treatment services. ASAP is unique in that it is a nationally coordinated and integrated behavioral health system that includes tribal and federal collaboration to prevent or otherwise minimize the effects of alcoholism and drug dependencies in AI/AN communities. The aim of ASAP is to achieve optimum relevance and efficacy in delivery of alcohol and drug dependency prevention, treatment, and rehabilitation services, while respecting and incorporating the social, cultural, and spiritual values of Native American communities.

### **Activities Related to Underage Drinking**

Alcohol abuse in AI/AN communities is recognized as a high-risk public health behavior. The effects of alcohol can begin in the early stages of prenatal development and continue across the lifespan. Programs are therefore focused on family-oriented prevention activities rooted in the culture of the individual tribes and communities in which they operate. In recognition of this shifting dynamic of local control and ownership of ASAP in Native American communities, the IHS DBH has shifted focus from direct-care services to a technical assistance and supportive role.

**Youth Regional Treatment Centers (YRTCs):** IHS currently provides recurring funding to 11 tribally and federally operated YRTCs to address the ongoing issues of substance misuse and co-occurring disorders among AI/AN youth. Through education and culture-based prevention initiatives, evidence- and practice-based models of treatment, family strengthening, and recreational activities, youths can overcome challenges and recover their lives to become healthy, strong, and resilient leaders in their communities.

The YRTCs provide a range of clinical services rooted in a culturally relevant holistic model of care. These services include clinical evaluation; substance misuse education; group, individual, and family psychotherapy; art therapy; adventure-based counseling; life skills; medication management or monitoring; evidence-based/practice-based treatment; continuing care relapse prevention; and posttreatment follow-up services.

A new YRTC serving the Southern California area had its grand opening on March 1, 2017. Two additional YRTCs to be located in Northern California and the Portland area are in the planning stages. The Portland YRTC is slated to open later this year and the Northern California YRTC is currently in the permitting process.

**Methamphetamine and Suicide Prevention Initiative (MSPI):** The IHS MSPI is a nationally coordinated program focusing on providing much-needed methamphetamine and suicide prevention and intervention resources for AI/AN communities. This initiative promotes the use and development of evidence- and practice-based models that represent culturally appropriate prevention and treatment approaches to methamphetamine abuse and suicide prevention from a community-driven context. The goals of the MSPI are to:

- Increase tribal, Urban Indian Health Program (UIHP), and federal capacity to operate successful methamphetamine prevention, treatment, and aftercare, as well as suicide prevention, intervention, and postintervention services, through implementing community and organizational needs assessment and strategic plans.



- Develop and foster data-sharing systems among tribal, UIHP, and federal behavioral health service providers to demonstrate efficacy and impact.
- Identify and address suicide ideations, attempts, and contagions among AI/AN populations through the development and implementation of culturally appropriate and community relevant prevention, intervention, and postintervention strategies.
- Identify and address methamphetamine use among AI/AN populations through the development and implementation of culturally appropriate and community-relevant prevention, treatment, and aftercare strategies.
- Increase provider and community education on suicide and methamphetamine use by offering appropriate trainings.
- Promote positive AI/AN youth development and family engagement through the implementation of early intervention strategies to reduce risk factors for suicidal behavior and substance misuse.

This initiative supports 159 MSPI projects across Indian Country, consisting of 124 tribal awardees, 18 urban grantees, and 17 federal awards benefiting direct service tribes. A total of 91 MSPI projects are focused on AI/AN youth to prevent suicide and substance use.

***Addressing Fetal Alcohol Spectrum Disorder:*** IHS supports the Northwest Portland Area Indian Health Board FASD training project with the University of Washington Fetal Alcohol Drug Unit, a research-based project that focuses on FASD interventions available to tribal sites throughout the United States but is primary to sites in Oregon, Idaho, and Washington. Also, in collaboration with the University of Washington, the Northwest Tribal FASD Project provides education and training on FASD and community readiness and assists communities in Idaho, Oregon, and Washington to set up an all-systems-based response to FASD.

***Indian Children's Program:*** IHS also funds the Indian Children's Program (ICP), which provides services to meet the needs of AI/AN children 0–18 years old with special needs, including FASD, residing or attending school in the southwest region of the United States. The TeleBehavioral Health Center of Excellence (TBHCE) has begun revamping ICP into a nationwide resource center. This revised ICP will focus on training clinicians on developmental and neurobiological issues that can affect AI/AN children, and providing expert consultation to help clinicians successfully diagnose, manage, and treat these conditions. The TBHCE ICP provided 152 hours of training on Autism Spectrum Disorders. Regarding FASD, several trainings were provided, for a total of 369 hours of training via six webinars. A formal FASD training series will start in FY 2017 in addition to the expert consultation clinic. In addition, IHS participates in the Interagency Coordinating Committee on FASDs (ICCFASD), an interagency task force led by NIAAA that addresses multidisciplinary issues relevant to FASD.

## National Institute on Alcohol Abuse and Alcoholism (NIAAA)/HHS

### Activities Specific to Underage Drinking

***Underage Drinking Research Initiative:*** The Underage Drinking Research Initiative (UDRI) is a key program of NIAAA. The goal of this initiative is to better understand the factors that compel youth to begin, continue, and escalate drinking, and for some, progress to alcohol use disorder (AUD). This initiative seeks to understand and address underage drinking within the context of overall development, and considers the biological, psychological, and social processes

occurring during adolescence. This paradigm shift, along with advances in epidemiology, developmental psychopathology, and the understanding of human brain development and behavioral genetics, provided the scientific foundation for the *Surgeon General's Call to Action to Prevent and Reduce Underage Drinking* (OSG, 2007). The developmental approach continues to inform the work of ICCPUD and the related efforts of its member federal agencies and departments, including the work of the Behavioral Health Coordinating Council, and provides the theoretical framework for NIAAA's underage drinking programs.

***Developing Screening Guidelines for Children and Adolescents:*** Data from NIAAA's National Epidemiologic Survey on Alcohol and Related Conditions (NESARC) (see Appendix B) indicate that people between ages 18 and 24 have the highest prevalence of AUD in the U.S. population—meaning that, for most, drinking started in adolescence. These data, together with those from other national surveys (SAMHSA's National Survey on Drug Use and Health [NSDUH], Monitoring the Future [MTF], and CDC's YRBSS [see Appendix B]) showing the popularity of binge drinking among adolescents, prompted NIAAA to produce a guide for screening children and adolescents for risk for alcohol use, alcohol consumption, and AUD.

The screening guide for children and adolescents, *Alcohol Screening and Brief Intervention for Youth: A Practitioner's Guide*, which became available in 2011, was developed by NIAAA in collaboration with a working group of experts. As part of a multiyear process, the working group heard from a number of research scientists, analyzed data from both cross-sectional national surveys and proprietary longitudinal studies, and worked with pediatricians from general pediatrics as well as pediatric substance misuse specialty practices. The process culminated in the development of an easy-to-use, age-specific, two-question screener for current and future alcohol use. The *Guide* also provides background information on underage drinking and detailed supporting material on brief interventions, referral to treatment, and patient confidentiality. The screening process enables pediatric and adolescent health practitioners to provide information to patients and their parents about the effects of alcohol on the developing body and brain in addition to identifying those who need any level of intervention. The *Guide* was produced in collaboration with the American Academy of Pediatrics, which recommends screening all adolescents regarding alcohol use and which endorsed the *Guide*. As of 2016, more than 215,000 copies of the *Guide* have been distributed.

In 2011, NIAAA issued a Funding Opportunity Announcement (FOA) titled "Evaluation of NIAAA's Alcohol Screening Guide for Children and Adolescents" to solicit applications to evaluate the new NIAAA alcohol screener for youth. Although the questions were empirically developed, were based on a vast amount of data from national surveys as well as numerous prospective studies, and had high sensitivity and specificity in the sample studied, it is important that the precision of the screener be evaluated in practice. Applications were sought that would evaluate the two-question screener in youth ages 9 to 18: (1) as a predictor of alcohol risk, alcohol use, and alcohol problems including AUD and (2) as an initial screen for other behavioral health problems (e.g., other drug use, smoking, conduct disorder). Six 5-year projects were funded to evaluate the guide in a variety of settings, including primary care, a network of pediatric emergency rooms, juvenile justice, and the school system, and with youth who have a chronic health condition. These studies are beginning to publish results that support the utility of the NIAAA screening questions for identifying youth at risk, those who have an AUD, or both.



In 2013, NIAAA issued an online training course based on its very popular youth alcohol screening *Guide*. The course helps train healthcare professionals to conduct rapid, evidence-based alcohol SBI with youth. NIAAA produced the course jointly with Medscape, a leading provider of online continuing medical education. The course presents three engaging case scenarios of youth at different levels of risk for alcohol-related harm. The scenarios illustrate the streamlined, four-step clinical process outlined in NIAAA's *Guide*. More than 37,700 healthcare providers received continuing medical education credit for completing the course. The course is no longer available for credit from Medscape; however, the content is available at <http://www.medscape.org/viewarticle/806556>.

**Research on Underage Drinking:** NIAAA supports a broad range of underage drinking research, including studies on the epidemiology and etiology of underage drinking, the neurobiology of underage drinking, the prevention of underage drinking, and the treatment of AUD among youth. Studies also assess short- and long-term consequences of underage drinking. A high-priority area described in more detail below is alcohol's effects on the developing adolescent brain.

NIAAA staff have collaborated with the National Institute on Child Health and Human Development's NEXT Generation Health Study, a 7-year longitudinal assessment of a representative sample of U.S. adolescent and young adults starting at grade 10. Several papers on underage drinking have been published from the study's data (Li, Simons-Morton, & Hingson, 2013; Li, Simons-Morton, Brooks-Russell, Ehsani, & Hingson, 2014; Li, Simons-Morton, Vaca, & Hingson, 2014; Hingson, Zha, White, & Simons-Morton, 2015).

**Research on the Impact of Adolescent Drinking on the Developing Brain:** The powerful developmental forces of adolescence cause widespread, significant changes to the brain and nervous system, including increased myelination of neural cells (presumably reflecting enhanced brain connectivity) and normal "pruning" of infrequently used synapses and neural pathways in specific regions of the brain. A key question is the extent to which adolescent drinking affects the developing human brain. A range of studies including research on rodents, studies of youth who are alcohol-dependent, and recent longitudinal work beginning with youth before they begin drinking, suggest that alcohol use during adolescence, particularly heavy (frequent bingeing) use, can have deleterious short- and long-term effects.

In 2010, NIAAA launched the Neurobiology of Adolescent Drinking in Adulthood (NADIA) initiative to support animal studies to clearly define the persistent effects of adolescent alcohol exposure and begin to explore the neurobiological mechanisms underlying these effects. In 2011, NIAAA followed the completion of a series of initial human pilot studies with an FOA titled "Longitudinal Studies on the Impact of Adolescent Drinking on the Adolescent Brain" soliciting applications to more fully address the following issues: (1) what are the long-term and shorter term effects of child and adolescent alcohol exposure on the developing human brain; (2) what are the effects of timing, dose, and duration of alcohol exposure on brain development; (3) to what extent do these effects resolve or persist over time; (4) how do key covariates factor into alcohol's effects on the brain; and (5) the potential identification of early neural, cognitive, and affective markers that may predict AUD and onset or worsening of mental illness during adolescence and adulthood. Seven projects were funded in FY 2012 under this FOA, collectively the National Consortium on Alcohol and Neurodevelopment in Adolescence (NCANDA).

Building on NCANDA results, NIAAA, NIDA, and other NIH Institutes launched the Adolescent Brain Cognitive Development (ABCD) study. This large, multisite, longitudinal study will follow a nationally representative sample of 10,000 children ages 9 and 10 into early adulthood, and will use noninvasive neuroimaging and cognitive, academic, social, emotional, and biological assessments to determine how childhood experiences interact with children's changing biology to affect brain development and other outcomes. On September 25, 2015, 13 awards were made, including for a coordinating center, a data analysis and informatics center, and 11 research project sites across the country. Recruitment of subjects for ABCD is under way.

***College Drinking Prevention Initiative:*** The work of this initiative, which began more than a decade ago, continues to support and stimulate studies of the epidemiology and natural history of college-student drinking and related problems. Its ultimate goal is to design and test interventions that prevent or reduce alcohol-related problems among college students. NIAAA continues to have a sizable portfolio of projects that target college-age youth. Importantly, NIAAA convened a new College Presidents' Working Group in 2010 to (1) provide input to the Institute on future research directions, (2) advise the Institute about what new NIAAA college materials would be most helpful to college administrators and in what format, and (3) recommend strategies for communicating with college administrators.

In response to the College Presidents' Working Group's request that NIAAA develop a "matrix" to help college administrators and staff navigate the many interventions available for addressing alcohol misuse on college campuses, NIAAA commissioned a team of experts to develop such a decision tool. The tool, launched in September 2015, provides information about individual- and environmental-level strategies that have been or might be used to address alcohol use among college students. For each strategy, information is provided about the amount and quality of available research; estimated effectiveness; estimated cost and barriers related to implementation; and time to implement—factors that may be relevant to campus and community leaders as they evaluate their current approaches and as they consider and select additional strategies to address college-student drinking using a comprehensive approach. An interactive web presence for the College Alcohol Intervention Matrix (CollegeAIM) was launched at the same time as the print version. Since its launch in FY 2016, the CollegeAIM website has received more than 35,000 visitors, nearly 11,000 print copies of the CollegeAIM booklet have been distributed, and the booklet has been downloaded more than 4,000 times. CollegeAIM is the result of a multiyear collaboration and an extensive review of decades of research, much of it funded by NIAAA. NIAAA's goal is to provide science-based information in an accessible and practical way to facilitate its use as a foundation for college drinking prevention and intervention activities.

***Building Health Care System Responses to Underage Drinking:*** The overarching goal of this program was to stimulate primary care health-delivery systems in rural and small urban areas to address the critical public health issue of underage drinking. This was a two-phase initiative (both phases now complete). In the first phase, systems strengthened their capacity to become research platforms for evaluating the extent of underage drinking in the areas they serve and increased their ability to reduce it. In the second phase, the systems prospectively studied the development of youth alcohol use and alcohol-related problems in their service areas, and implemented interventions and evaluated their effectiveness in reducing underage drinking.

Four Phase I awards were made, and subsequently two 5-year Phase II awards were made. The findings of one of the two Phase II projects have led to a new NIAAA-supported study focused on preventing alcohol, tobacco, and other drug misuse, as well as driving under the influence, in an American Indian rural community.

**Brief Intervention Research:** Brief interventions are short, therapeutic encounters intended to reduce underage and harmful drinking and the progression to alcohol use disorder. Brief interventions are usually combined with screening and referral to treatment (referred to as Screening, Brief Intervention, and Referral to Treatment). Brief interventions have been well studied in college populations, where the prevalence of underage and harmful drinking and their consequences is high but amenable to change. One example of such an approach is Brief Alcohol Screening and Intervention for College Students (BASICS). Other evidence-based brief interventions for delivery in college settings exist (see NIAAA’s College Alcohol Intervention Matrix).

**Adolescent Treatment Research Program:** Since its inception in 1998, NIAAA’s adolescent treatment research program has funded over approximately 40 NIH grants across several important areas of inquiry, most of which have been randomized, controlled clinical trials. These include behavioral intervention trials, pharmacotherapy trials, implementation and health services studies, and investigations into the recovery and relapse risk process. The main objective of the program is to design and test innovative, developmentally tailored interventions that use evidence-based knowledge to improve alcohol treatment outcomes in adolescents. Results of many of these projects will yield an integrated perspective on the efficacy and mechanisms of action of family systems-based, cognitive-behavioral, brief motivational, recovery-based, and guided self-change interventions across diverse subpopulations of adolescents within a range of treatment settings. Furthermore, these projects will provide a greater understanding of the recovery and relapse risk process as well as inform treatment providers about options available for adolescents with alcohol problems.

**Multicomponent Community Interventions for Youth:** In 2011, NIAAA funded a project titled “Cherokee Nation Prevention Trial: Interactive Effects of Environment & SBIRT,” which is creating, implementing, and evaluating an integrated community-level intervention to prevent underage drinking and the associated negative consequences among American Indian and White youth in rural high-risk communities in northeastern Oklahoma. Recent findings from the study showed that high school students exposed to either a school-based universal alcohol screening and brief intervention or a community-organized policy approach to underage drinking prevention reported reduced alcohol consumption compared with controls.

**Publications:** NIAAA issued a screening guide for children and adolescents for use by healthcare practitioners titled *Alcohol Screening and Brief Intervention for Youth: A Practitioner’s Guide* in 2011, which the Institute continues to distribute broadly. NIAAA also disseminates information about prevention of underage drinking for a range of audiences through a variety of other publications, including factsheets (e.g., on underage drinking [[http://pubs.niaaa.nih.gov/publications/UnderageDrinking/Underage\\_Fact.pdf](http://pubs.niaaa.nih.gov/publications/UnderageDrinking/Underage_Fact.pdf)], on college drinking, and on *Parenting to Prevent Childhood Alcohol Use* [2010]); an updated and expanded version of its booklet *Make a Difference—Talk to Your Child About Alcohol* (English and Spanish); two issues of *Alcohol Research & Health: Alcohol and Development in Youth: A Multidisciplinary Overview* (2004/2005) and *A Developmental Perspective on Underage*

*Alcohol Use* (2009); and several *Alcohol Alerts*, including *Underage Drinking: Why Do Adolescents Drink, What Are the Risks, and How Can Underage Drinking Be Prevented?* (2006) and *A Developmental Perspective on Underage Alcohol Use* (2009); and a number of seasonal factsheets focusing on underage drinking issues surrounding high school graduation, the first weeks of college, and spring break.

With respect to drinking by students in U.S. colleges and universities, key resources include the widely cited report from NIAAA's college drinking task force, *A Call to Action: Changing the Culture of Drinking at U.S. Colleges* (NIAAA, 2002); a brief update on college drinking titled *What Colleges Need to Know Now: An Update on College Drinking Research* (2007); and the CollegeAIM guide and website launched in 2015 (<http://www.collegedrinkingprevention.gov/collegeaim>).

NIAAA also sponsored and edited a special 2008 supplement to the journal *Pediatrics* titled *Underage Drinking: Understanding and Reducing Risk in the Context of Human Development*. Additional publications include a special July 2009 supplement to the *Journal of Studies on Alcohol and Drugs* on NIAAA's rapid response initiative to reduce college drinking and *Update on the Magnitude of the Problem*; a 2009 article in the journal *Alcohol Research & Health* titled "A Developmental Perspective on Underage Alcohol Use"; and the lead article in the December 2010 issue of the *American Journal of Preventive Medicine*, "Alcohol risk management in college settings: The Safer California Universities Randomized Trial."

In addition, two issues of NIAAA's webzine, the *NIAAA Spectrum*, highlight underage and college drinking:

[http://www.spectrum.niaaa.nih.gov/archives/v4i1Feb2012/media/pdf/NIAAA\\_Spectrum\\_Newsletter\\_Feb2012.pdf](http://www.spectrum.niaaa.nih.gov/archives/v4i1Feb2012/media/pdf/NIAAA_Spectrum_Newsletter_Feb2012.pdf) and

<http://www.spectrum.niaaa.nih.gov/archives/v4i3Sept2012/default.html>.

**NIAAA Website:** The NIAAA website, <http://www.niaaa.nih.gov>, provides information and resources on the science and prevention of underage drinking, including links to NIAAA's college website (which includes CollegeAIM) and its youth-targeted website:

- **College Drinking Prevention Website:** NIAAA's website addressing alcohol use among college students (<http://www.collegedrinkingprevention.gov>) was recently redesigned and updated to permit easier navigation by topic or by audience. Updated features include new statistics, recent research papers, and presentations from task force participants along with a new section on choosing the right college.
- **CollegeAIM:** Located on the College Drinking Prevention website, NIAAA's CollegeAIM is available in an interactive format with (1) matrices that allow users to compare intervention options and create custom printouts of selected strategies and related references and potential resources; (2) a form-fillable PDF of the strategy planning worksheet for ready comparison of ratings of current and possible new strategies; and (3) detailed, practical answers to many frequently asked questions.
- **Cool Spot Website for Kids:** This website (<http://www.thecoolspot.gov>), targeted to youth ages 11–13, provides information on underage drinking, including effective refusal skills. Recent upgrades include a wide range of new sound effects and voiceovers throughout the site, a dedicated teacher and volunteer corner for use in middle-school classrooms or afterschool programs, and innovative ways to teach young people about peer pressure and

resistance skills through a guided reading activity, along with two lesson plans that accompany the site's interactive features.

### **Activities Related to Underage Drinking**

***Alcohol Policy Information System (APIS):*** APIS is an electronic resource that provides authoritative, detailed information on alcohol-related policies in the United States at both state and federal levels. Designed primarily for researchers, APIS encourages and facilitates research on the impact and effectiveness of alcohol-related policies. Although not dedicated to underage drinking policies, APIS does provide information on policies relevant to underage drinking (e.g., retail alcohol outlet policies for preventing alcohol sales and service to those under age 21). Recognizing the changing legal environment, NIAAA has expanded APIS to include policies related to recreational use of marijuana.

***Longitudinal and Genetic Epidemiology Studies and National Epidemiologic Survey on Alcohol and Related Conditions (NESARC):*** A number of longitudinal studies following subjects first identified as adolescents (along with genetic epidemiology studies) are particularly pertinent to underage drinking, as is NESARC, which includes people ages 18 to 21. Such studies could potentially enhance understanding of the etiology, extent, and consequences of underage alcohol consumption. Analysis of NESARC data indicates that 18- to 24-year-olds have the highest prevalence of alcohol dependence of any age group in the general population, underscoring the need for enhanced early prevention efforts. In 2012, NIAAA launched the NESARC III, the third in a series of NESARC surveys, which captured information on alcohol use disorder and other related mental health conditions from a large, nationally representative sample of the U.S. population. DNA samples were also collected and are being stored for future analyses. Data from the NESARC III survey provide important information about co-occurring alcohol use disorder and related disorders, as well as data about overall health that can be used to inform advances in prevention and treatment.

## **National Institute on Drug Abuse (NIDA)/HHS**

### **Activities Related to Underage Drinking**

***Strong African American Families (SAAF) Program:*** SAAF is a family-centered risk behavior prevention program that enhances protective caregiving practices and youth self-regulatory competence. SAAF consists of separate parent and youth skill-building curricula and a family curriculum. Evaluations have confirmed SAAF's efficacy for 11-year-olds in preventing, across several years, the initiation of risk behaviors, including alcohol use; enhancing protective parenting practices; and increasing youth self-regulatory capabilities. The program was effective when primary caregivers had clinical-level depressive symptoms and when families reported economic hardship; it can also ameliorate genetic risk for involvement in health-compromising risk behaviors across preadolescence. A randomized controlled trial of SAAF that targeted African American adolescents in high school ( $N=502$ ) found that 22 months after baseline, the intervention had a significant impact on substance use and substance use problems (including alcohol), conduct problems, and depression symptoms for youth in the intervention condition, compared with youth in the control condition (Brody et al., 2012). Two randomized trials of SAAF examined the impact of the intervention in the context of genetic risk for increased alcohol use (Brody, Chen, & Beach, 2013). Results revealed that youth at increased genetic risk who did not receive SAAF intervention (control condition) showed greater increases in alcohol



use over a 2-year period, compared with youth with genetic risk who did receive SAAF and youth without genetic risk who were assigned to either condition. Thus, SAAF was found to moderate genetic risk for alcohol use.

***Adults in the Making (AIM):*** AIM is a drug abuse prevention intervention designed for rural African American adolescents during their high school years and their families. The six-session program supports the transition to adulthood by focusing on family protective factors and self-regulatory processes to increase resiliency, decrease alcohol use, and decrease the development of substance use problems during young adulthood. A randomized controlled trial of AIM for older adolescents (average age 17) and their families was conducted ( $N=347$ ). Assessments were completed at baseline, 6.4, 16.6, and 27.5 months post baseline. AIM had a significant impact on reducing escalation of alcohol use and development of substance use problems for the intervention condition, compared with the control condition, for participants who were at higher risk at baseline (Brody et al., 2012). Reductions in risk-taking, intentions, and willingness to use alcohol and drugs, and perceptions of peers who use substances accounted for the effects of the intervention on outcomes for the higher risk youth (Brody et al., 2012).

***After Deployment: Adaptive Parenting Tools (ADAPT):*** Adapted from an evidence-based Parent Management Training-Oregon (PMTO) model intervention, Parenting through Change, the ADAPT program is designed for military families with a parent reintegrating from the conflicts in Afghanistan and Iraq. ADAPT is a modified version of PMTO that is enhanced with web-based supports and is specific to military families and culture. ADAPT uses small-group parenting sessions that provide support and skills for positive parent-child interactions, emotion regulation, and effective parenting practices. Previous research on PMTO interventions for families from universal and high-risk populations (e.g., divorcing families, low-income families, youth with early-onset conduct problems) has demonstrated that the program is effective in reducing coercive parenting and increasing positive parenting. Longitudinal follow-up studies have shown positive effects of PMTO on a broad array of outcomes, including child and parent adjustment, youth substance use and related behavior problems, and other areas of family functioning.

A study of the ADAPT model was recently conducted with 400 reintegrating Army National Guard (ARNG) families with 6- to 12-year-old children to test the effectiveness of the intervention for improving parenting and reducing child risk for substance use and related behavior problems and satisfaction with the program. An article describes the need for programs such as ADAPT, the PMTO evidence base supporting the program, and recommendations for providers for supporting parenting among military families as a way to reduce youth risk factors and promote well-being (Gewirtz, Erbes, Polusny, Forgatch, & Degarmo, 2011). Early findings from the study testing ADAPT with integrating ARNG families, among the first 42 families assigned to the program, are that participation rates were high for both mothers and fathers and satisfaction was high across all 14 sessions of the intervention. These preliminary findings suggest the program is both feasible and acceptable (Gewirtz, Pinna, Hanson, & Brockberg, 2014). Early findings based on the team's examination of characteristics of parents who may be most likely to use online components or attend face-to-face meetings revealed that use of different delivery options varied by participant characteristics (e.g., received incentives, level of education, number of months of deployment, deployed mother vs. deployed father). The findings imply that parents may be drawn to delivery options of a parenting program (online

vs. face-to-face sessions) depending on education level, incentives to engage, and military experience (Doty, Rudi, Pinna, Hanson, & Gewirtz, 2016).

**Family-Based Substance Use Prevention Program:** This is a family-based, internet-delivered substance use prevention program for early adolescent Asian American girls. The intervention focused on enhancing mother–daughter communication and increasing maternal monitoring while also increasing girls’ resilience to resist substance use. The program included nine interactive sessions delivered online, which included interactive modules for the girls and mothers to complete together. For this study, 108 Asian American mother–daughter dyads were recruited through online advertisements and from community service agencies and randomly assigned to the intervention described or to a test-only control arm. At the 2-year follow-up, mother–daughter dyads who participated in the intervention had higher levels of mother–daughter closeness and communication and higher levels of maternal monitoring and family rules against substance use compared with the controls. Girls in the intervention arm showed sustained improvement in self-efficacy and refusal skills and lower intentions to use substances in the future. Of importance, girls in the intervention arm reported fewer instances of alcohol and marijuana use and prescription drug misuse, compared with girls in the control arm (Fang & Schinke, 2013). In a follow-up study, the effect of the intervention on adolescent girls’ substance use outcomes through family relationships and adolescent self-efficacy over 2 years was examined using path models. Findings showed that receiving the intervention produced a positive effect on girls’ family relationships at 1-year follow-up. This improvement was associated with girls’ increased self-efficacy, which in turn led to decreased alcohol use, marijuana use, and future intention to use substances among girls at the 2-year follow-up (Fang & Schinke, 2014).

**Coping Power:** Coping Power is a multicomponent child and parent preventive intervention directed at preadolescent children at high risk for aggressiveness and later substance misuse and delinquency. The Coping Power Child Component is derived from an anger coping program primarily tested with highly aggressive boys and shown to reduce substance use. It is a 16-month program for children in the 5th and 6th grades. Group sessions usually occur before or after school or during nonacademic periods. Training focuses on teaching children how to identify and cope with anxiety and anger; control impulsiveness; and develop social, academic, and problem-solving skills at school and home. Parents are also trained throughout the program. Efficacy and effectiveness studies show Coping Power to have preventive effects on youths’ aggression, delinquency, and substance use (including alcohol use). In a study of the intensity of training provided to practitioners, greater reductions in children’s externalizing behaviors and improvements in children’s social behaviors and academic skills occurred for those whose counselors received more intensive Coping Power training than for those in the basic Coping Power training or control conditions (Lochman et al., 2009).

NIDA funded a study of Coping Power comparing the child component delivered in the usual small-group format with a newly developed individual format to determine whether the latter will produce greater reductions in substance use, children’s externalizing behavior problems, and delinquency at a 1-year follow-up assessment. This study included 365 4th-grade children randomly assigned by their school to group coping power (GCP) or individual coping power (ICP). Analyses of longitudinal assessments of teacher and parent reports of behavior collected from baseline through 1-year follow-up revealed that children in both conditions reduced



teacher- and parent-reported externalizing behavior problems and internalizing problems by the end of the 1-year follow-up. However, the findings revealed that improvement in teacher-reported outcomes were significantly greater for children receiving the individual version of the program. In addition, the findings showed children with low initial levels of inhibitory control to respond poorly in teacher-rated outcomes to group intervention compared with those who received the individually delivered intervention (Lochman et al., 2015). NIDA is also supporting an adaptation study of Coping Power with fewer in-person child and parent sessions that are augmented by multimedia, internet-based intervention content.

***EcoFIT (previously Adolescent Transitions Program; also referred to as Family Check-Up [FCU]):*** This tiered intervention targeted to children, adolescents, and their parents recognizes the multiple environments of youth (e.g., family, caregivers, peers, school, neighborhood). EcoFIT in schools uses a tiered approach to provide prevention services to students in middle and junior high school and their parents. The universal intervention level, directed to parents of all students in a school, establishes a Family Resource Room to engage parents, establish parenting practice norms, and disseminate information about risks for problem behavior and substance use. The selective intervention level uses the FCU, which offers family assessment and professional support to identify families at risk for problem behavior and development of youth substance use and mental health problems. The indicated level, the Parent Focused curriculum, provides direct professional support to parents to make the changes indicated by the FCU. Services may include behavioral family therapy, parenting groups, or case management services. Findings showed that the EcoFIT model reduced substance use in high-risk students 11–14 years old (grades 6–9), with an average of 6 hours of contact time with the parents. Adolescents whose parents engaged in the FCU had less growth in substance use and problem behaviors from ages 11–18, including arrests (Connell, Dishion, Yasui, & Kavanagh, 2007; Stormshak & Dishion, 2009).

Another study of the FCU on outcomes through grade 9, delivered in middle school with a sample of ethnically diverse families, found that youth whose parents engaged in the program had significantly lower rates of growth in behavioral health problems from grades 6–9 compared with a matched control group. This included lower rates of growth in involvement with deviant peers and alcohol use (Van Ryzin, Stormshak, & Dishion, 2012).

The FCU has been consistently associated with reductions in youth antisocial behavior, deviant peer group affiliation, and substance use. In a more recent study, the proximal changes in student-level behaviors that account for links between implementation of the FCU and changes in youth problem behavior were explored using data from a randomized controlled trial efficacy study of the FCU with students followed from 6th through 8th grades. The findings were that assignment to the FCU intervention was related to increased levels of students' self-regulation from 6th to 7th grades, which in turn reduced the risk for growth in antisocial behavior; involvement with deviant peers; and alcohol, tobacco, and marijuana use through the 8th grade (Fosco, Frank, Stormshak, & Dishion, 2013). The *Eunice Kennedy Shriver* National Institute on Child Health and Human Development funded a study in 2012, with cofunding from NIDA, to examine the role of parent–youth relationships in late adolescence on substance use and abuse during the transition to adulthood. This study also evaluates the preliminary efficacy of a late-adolescence version of the FCU for preventing escalation of substance use during this developmental period and promoting positive behavioral health outcomes in early adulthood.

***Strengthening Families Program for Parents and Youth 10–14 (SFP 10–14):*** SFP is a seven-session skill-building program for parents, youth, and families to strengthen parenting and family functioning and to reduce risk for substance misuse and related problem behaviors among youth. Program implementation and evaluation have been conducted through partnerships that include state university researchers, cooperative extension system staff, local schools, and community implementers. Longitudinal comparisons with control group families showed positive effects on parents' child management practices (e.g., setting standards, monitoring children, applying consistent discipline) and on parent–child affective quality. In addition, an evaluation of this program found delayed initiation of substance use at the 6-year follow-up. Other findings showed improved youth resistance to peer pressure to use alcohol, reduced affiliation with antisocial peers, and reduced levels of problem behaviors. Importantly, conservative benefit–cost calculations indicate returns of \$9.60 per dollar invested in SFP 10–14. A longitudinal study of SFP 10–14 and LST together and LST alone found that 5.5 years after baseline (end of grade 12), both interventions together and LST alone reduced growth in substance initiation. Both interventions also prevented more serious substance use outcomes among youth at high risk (use of at least two substances) at baseline. SFP (Iowa Strengthening Family Program, SFP 10–14), alone and in combination with other universal school-based prevention interventions, has also been found to have an impact on prescription drug use in late adolescence and young adulthood (Spoth et al., 2013). In addition, a study that used data from three randomized trials of SFP, delivered in middle school, found significant long-term effects on prescription opioid misuse and prescription drug misuse overall during late adolescence and young adulthood (Spoth et al., 2013). This study supports the potential for broad public health impact of universal prevention interventions.

A long-term follow-up was conducted of a randomized trial of the multicomponent SFP 10–14 plus LST compared with LST alone, or a minimal contact control condition, following youth during late adolescence and emerging adulthood to further understand the long-term public health impact of universal prevention. Findings from a replication randomized controlled trial to extend the earlier study to examine outcomes into young adulthood showed reduced substance misuse in young adulthood through delayed substance use initiation in adolescence and revealed greater intervention benefits for those at higher risk for substance misuse (Spoth, Trudeau, Redmond, & Shin, 2014, 2016).

***Good Behavior Game (GBG):*** GBG is a universal preventive intervention that provides teachers with a method of classroom behavior management. It was tested in randomized prevention trials in 1st- and 2nd-grade classrooms in 19 Baltimore City public schools beginning in the 1985–1986 school year and was replicated in the 1986–1987 school year with a second cohort. The intervention was aimed at socializing children to the student role and reducing early antecedents of substance misuse and dependence, smoking, and antisocial personality disorder—specifically, early aggressive or disruptive behavior problems. Analyses of long-term effects in the first-generation sample (1985–1986) at ages 19–21 show that, for men displaying more aggressive and disruptive behaviors in 1st grade, GBG significantly reduced drug and alcohol abuse and dependence disorders, regular smoking, and antisocial personality disorder. Currently, NIDA is supporting a long-term second-generation (1986–1987) follow-up through age 25, including DNA collection for gene x environment analyses. NIDA supported a trial of GBG delivery in a whole-school-day context that emphasizes reading achievement, along with pilot research on models for implementing GBG in entire school districts. In addition, NIDA supported a pilot

study for formative research on the large-scale implementation of GBG within a school district that could inform a system-level randomized trial on scaling up GBG. The pilot research focused on developing district partnerships; determining community-level factors that influence program implementation; and ensuring the acceptance, applicability, and relevance of measures and intervention design requirements for a large-scale trial. The conceptual framework guiding the development of the partnership and lessons learned are described in an article (Poduska, Gomez, Capo, & Holmes, 2012) that also addresses the implications for implementing evidence-based universal prevention programs such as GBG through research and practice partnerships.

***Life Skills Training (LST):*** LST addresses a wide range of risk and protective factors by teaching general personal and social skills, along with drug resistance skills and normative education. This universal program consists of a 3-year prevention curriculum for students in middle or junior high school, with 15 sessions during the first year, 10 booster sessions during the second year, and 5 sessions during the third year. The program can be taught in grades 6, 7, and 8 (for middle school) or grades 7, 8, and 9 (for junior high school). LST covers three major content areas: drug resistance skills and information, self-management skills, and general social skills. The program has been extensively tested and found to reduce the prevalence of tobacco, alcohol, and illicit drug use relative to controls by 50 to 87 percent. NIDA currently funds a study examining the dissemination, adoption, implementation, and sustainability of LST.

***Community-Level Studies:*** Community-level studies address questions related to the dissemination and implementation of evidence-based substance use prevention programs. Examples include the following:

- ***Communities That Care (CTC):*** An operating system for quality implementation of evidence-based preventive interventions targeted to specific risk and protective factors within the community, CTC provides a framework for assessing and monitoring community-level risk and protective factors, training, technical assistance, and planning and action tools for implementing science-based prevention interventions through community service settings and systems. The Community Youth Development Study (CYDS) is testing CTC in 7 states with 12 matched pairs of communities randomized to receive the CTC system or serve as controls. CYDS targets youth in grades 6–12. Participating communities selected and implemented evidence-based prevention interventions based on their community profile of risk and protective factors. A panel of 4,407 5th graders was recruited and followed annually to assess impact of the CTC system on substance use and related outcomes. Annual surveys of youth in grades 6, 8, 10, and 12 were also conducted.

CTC has demonstrated significant effects on substance use outcomes and delinquency from grades 5 through 10, including alcohol outcomes. For example, from grades 5–8, youth in the intervention condition had lower incidences of alcohol, cigarette, and smokeless tobacco initiation and significantly lower delinquent behavior than those in the control condition (Hawkins et al., 2008; Hawkins et al., 2009). At grade 10, the odds of initiating alcohol use by this grade were significantly lower (38 percent lower) in CTC communities than in the control communities (Hawkins et al., 2012). Youth in CTC communities also had a lower prevalence of current cigarette use and past-year delinquent and violent behavior than youth in control communities (Hawkins et al., 2012). At 12th grade, students in the CTC communities were more likely to have abstained from drinking alcohol, smoking cigarettes, and any drug use than students in the control communities. There were no significant

differences in the prevalence of past-month or past-year substance use for youth in the CTC communities versus in the control communities. The findings at 12th grade suggest that the CTC system continued to prevent initiation of substance use through 12th grade, 8 years after implementation of CTC, but did not produce reductions in current levels of risk in 12th grade (Hawkins, Oesterle, Brown, Abbott, & Catalano, 2014).

Arthur, Hawkins, Brown, Briney, and Oesterle (2010) examined the implementation of core intervention elements by coalitions in CYDS and found that, compared with control coalitions, CYDS coalitions implemented significantly more of the CTC core elements (e.g., using community-level data on risk and protective factors to guide selection of effective prevention programs) and also implemented significantly higher numbers of tested, effective prevention programs. In addition, CTC communities had greater sustainability of tested and effective programs and delivered the programs to more children and parents than control communities (Fagan, Arthur, Hanson, Briney & Hawkins, 2011). Also, greater adoption of the CTC science-based approach to prevention was found to mediate the effects of CTC on youth outcomes in 8th grade (Brown et al., 2014). This finding supports use of the CTC model to impact youth outcomes at the community level. An economic analysis of CTC outcomes through 8th grade found a benefit–cost ratio of \$5.30 per dollar invested (Kuklinski, Briney, Hawkins, & Catalano, 2012). A more recent economic analysis of CTC outcomes through grade 12 found a benefit–cost ratio of \$8.22 per dollar invested (Kuklinski, Fagan, Hawkins, Briney, & Catalano, 2015). CTC materials are in the public domain and can be accessed for free through SAMHSA and through the Center for Communities that Care at the University of Washington.

- *PROMoting School/Community-University Partnerships to Enhance Resilience (PROSPER)*: An innovative partnership model for the diffusion of evidence-based preventive interventions that reduce youth substance use and other problem behaviors, the PROSPER partnership model links land-grant university researchers, the cooperative extension system, the public school system, and community stakeholders. A randomized trial of PROSPER was conducted in 28 school districts in rural and semiurban communities in Iowa and Pennsylvania, blocked on size, and randomly assigned to the PROSPER partnership model or to a usual programming control condition. Approximately 10,000 6th graders recruited across two cohorts were enrolled in the study along with approximately 1,200 students and their parents. In the PROSPER condition, communities received training and support to implement evidence-based prevention through the partnership and selected interventions from a menu of efficacious and effective universal prevention programs.

Analyses 18 months after baseline revealed significant effects, compared with the control condition, on lifetime/new-user rates of substance use, particularly reduced new-user rates of marijuana, methamphetamine, ecstasy, and inhalant use; lower rates of initiation of gateway and illicit substance use; and lower rates of past-year marijuana and inhalant use and drunkenness (Spoth et al., 2007). Similar results were found at 4.5 years past baseline, with youth in the PROSPER condition reporting significantly lower lifetime/new-user rates of marijuana, cigarettes, inhalants, methamphetamine, ecstasy, alcohol use, and drunkenness compared with the control condition (Spoth et al., 2011). At grades 11 and 12, significant impacts on substance use were maintained for multiple substance use outcomes, and there were significantly greater impacts on youth at higher risk at baseline (Spoth et al., 2013).

In terms of alcohol outcomes, there was a significant effect on frequency of drunkenness at grade 11 and a marginal effect on frequency of driving after drinking at grade 11 for the overall sample. Both of these outcomes were significant for youth at higher risk at baseline (Spath et al., 2013). A continuation study was funded in 2012 to understand the effects of PROSPER in emerging adulthood for participants who received evidence-based interventions in middle school. Reductions in substance misuse, antisocial behaviors, sexual risk behaviors, and improvements in healthy adult functioning are being examined. Effects of PROSPER through 6.5 years past baseline include reductions in conduct problem behaviors. Significant effects were found for students during 9th–12th grades. Somewhat stronger effects were found for the higher risk subsample who had initiated substance misuse prior to the intervention (Spath et al., 2015).

- *Community Monitoring Systems—Tracking and Improving the Well-being of America’s Children and Adolescents: Community Monitoring Systems* is a monograph that describes federal, state, and local monitoring systems that provide estimates of problem prevalence; risk and protective factors; and profiles regarding mobility, economic status, and public safety indicators. Data for these systems come from surveys of adolescents and archival records. Monitoring the well-being of children and adolescents is a critical component of efforts to prevent psychological, behavioral, and health problems and to promote successful adolescent development. Research during the past 40 years has helped identify aspects of child and adolescent functioning that are important to monitor. These aspects, which encompass family, peer, school, and neighborhood influences, have been associated with both positive and negative outcomes for youth. As systems for monitoring well-being become more available, communities will become better able to support prevention efforts and select prevention practices that meet community-specific needs. This NIDA publication is available online at <http://www.drugabuse.gov/publications/community-monitoring-systems-tracking-improving-well-being-americas-children-adolescents>.

***Preventing Drug Use among Children and Adolescents—A Research-Based Guide for Parents, Educators, and Community Leaders, 2nd Edition:*** This booklet is based on a literature review of all NIDA prevention research from 1997 through 2002. Before publication, it was reviewed for accuracy of content and interpretation by a scientific advisory committee and reviewed for readability and applicability by a Community Anti-Drug Coalitions of America (CADCA) focus group. The publication presents the principles of prevention; information on identifying and using risk and protective factors in prevention planning; applying principles in family, school, and community settings; and summaries of effective prevention programs. The booklet is available at <https://www.drugabuse.gov/publications/preventing-drug-abuse-among-children-adolescents/acknowledgments>

***National Drug and Alcohol Facts Week (NDAFW):*** NDAFW is a health observance week for teens that aims to provide accurate information about alcohol, tobacco, and drug abuse. During this week, NIDA and NIAAA also hold a Drug and Alcohol Facts Chat Day, where scientific staff from NIDA, NIAAA, and NIMH respond to questions and concerns from students on substance use and mental health topics. A companion NIDA publication, titled *Drug Facts: Shatter the Myths*, is also a resource for NDAFW. This publication answers teens’ most frequently asked questions about alcohol, tobacco, and drug use. The 2017 NDAFW was held in January 2017. Information on NDFW can be found at <http://drugfactsweek.drugabuse.gov>.



**Family Check-Up (FCU)—Positive Parenting Prevents Drug Abuse:** NIDA developed a web-based tool demonstrating parenting skills that have been found to help prevent initiation and progression of drug use among youth. The tool presents five questions regarding specific parenting skills (e.g., communication with preadolescents) and provides a video clip for each that shows positive and negative examples of the skill. Additional videos and resources are provided for parents to practice positive parenting skills. This tool is based on research on the FCU conducted by Dr. Thomas Dishion and colleagues at Oregon State University and the Oregon Social Learning Center. The FCU tool is available on the NIDA website: <http://www.drugabuse.gov/family-checkup>.

**Monitoring the Future (MTF):** MTF is an ongoing study of substance misuse (including alcohol) behaviors and related attitudes of secondary school students, college students, and young adults. Students in grades 8, 10, and 12 participate in annual surveys (8th and 10th graders since 1991, and 12th graders since 1975). MTF also surveys adults through age 55. Within the past 5 years, 42,000 to 47,000 students have participated in the survey each year. Follow-up questionnaires are mailed to a subsample of each graduating class every 2 years until age 35 and then every 5 years thereafter through age 55. Results from the survey are released each fall. The 2015 survey results show a continued long-term decline in the use of many illicit substances, including marijuana, alcohol, and tobacco, and misuse of some prescription medications, among the nation's teens. Information on current findings from MTF can be found on the NIDA website at <http://www.drugabuse.gov/related-topics/trends-statistics/monitoring-future>.

## Substance Abuse and Mental Health Services Administration (SAMHSA)/HHS

### Activities Specific to Underage Drinking

***Summit on Behavioral Health Issues Among College Students:*** On March 16–17, 2015, SAMHSA convened this summit to bring together SAMHSA staff and prevention practitioners from the field to discuss SAMHSA’s Strategic Initiative on Prevention of Substance Abuse and Mental Illness and its implications for colleges and universities, as well as inform future potential products (e.g., funding, materials, training and technical assistance). Approximately 50 individuals representing institutions of higher education, states, national organizations, and federal agencies met to discuss current and emerging prevention issues related to underage drinking, prescription drug misuse, suicide, and mental health promotion related to college students.

***“Talk. They Hear You.” National Media Campaign:*** SAMHSA’s Center for Substance Abuse Prevention (CSAP) continues with the national rollout of “Talk. They Hear You.,” a national media campaign to prevent underage drinking among youth ages 9–15 by providing parents and caregivers with information and resources they need to start addressing the issue of alcohol with their children early. The campaign features a series of TV and print PSAs in English and Spanish that show parents “seizing the moment” to talk with their children about alcohol. By modeling behaviors through the PSAs, parents can see the many “natural” opportunities for initiating the conversation about alcohol with their children. The campaign continues to expand its reach, and to date has distributed the PSAs to 10,525 outlets across the United States, including major airports, public transportation, billboards, broadcast and cable TV networks, radio stations, newspapers, and select magazines that reach parents. Since campaign inception, the PSAs have been distributed to all 50 states and more than 350 cities including the Greater Washington, DC, area.

The “Talk. They Hear You.” website (<http://www.samhsa.gov/underagedrinking>) includes tools and information for parents and communities to help prevent underage drinking. In 2015, SAMHSA introduced an updated version of the “Talk. They Hear You.” application that features a science-based, interactive mobile application tool that allows parents to use avatars to practice conversations with their children about alcohol. As of November 4, 2015, the application had been downloaded 4,935 times through the Apple App Store, Google Play, and Windows 10 Store.

A conservative estimate of the overall reach of the campaign to date is 5.67 billion media impressions, or the number of times people have seen the campaign ads or messages. These figures are supplemented in part by a recent placement in national retailers. “Talk. They Hear You.” has the support of more than 40 national groups, including CADCA and the National Parent Teacher Association, which are assisting SAMHSA in disseminating the campaign.

***Underage Drinking Prevention Education Initiatives:*** This SAMHSA/CSAP effort provides resources, message development, public outreach and education, and partnership development for preventing underage alcohol use among youth up to age 21. The initiative provides ongoing support for the ICCPUD web portal and the nationwide Communities Talk: Town Hall Meetings to Prevent Underage Drinking initiative, Too Smart To Start (TSTS), the State/Territory Videos



Project, and other national and community-based prevention initiatives conducted by SAMHSA and CSAP.

- *ICCPUD Web Portal:* SAMHSA, on behalf of ICCPUD, maintains a web portal (<http://www.stopalcoholabuse.gov>) dedicated to the issue of underage drinking. This portal consolidates comprehensive research and resources developed by the federal agencies of ICCPUD. The portal includes information on underage drinking statistics (i.e., prevalence, trends, consequences), evidence-based approaches, and other resources and materials that support prevention efforts. The web portal also contains on-demand copies of all webinars hosted by the ICCPUD agencies about evidence-based prevention of underage drinking. Direct links are provided to federally supported websites designed to prevent substance misuse, including alcohol. Information is intended to serve all stakeholders (e.g., community-based organizations involved in prevention, policymakers, parents, youth, educators). During 2016, SAMHSA added 158 news and research summaries to the ICCPUD web portal, reflecting the broad range of programs, products, services, initiatives, and research introduced or advanced by ICCPUD agencies throughout the year. SAMHSA also enhanced the Communities Talk section of the ICCPUD web portal to improve the relevancy and accessibility of resources, by performing a content audit of highly viewed sections and enhancing the layout to increase visual interest. In 2016, the web portal received a monthly average of 1,269 visits per day, and the average time spent on the site was 11 minutes and 46 seconds.
- *Town Hall Meetings:* In 2016, SAMHSA, as the lead agency for ICCPUD, supported a sixth round of Town Hall Meetings and renamed the initiative Communities Talk: Town Hall Meetings to Prevent Underage Drinking. This placed a renewed emphasis on the initiative's focus, raising awareness of underage drinking as a public health problem and mobilizing communities around its evidence-based prevention. SAMHSA announced the new initiative name with a launch event that was webcast nationally. The event attracted a broad audience, with 904 in-person and online attendees. Due to the successful launch, as well as expanded outreach and partnership development by SAMHSA, more than 1,500 Communities Talk events were held nationwide in 2016, with over 1,420 communities registering to hold one or more events. As a result of expanded outreach to IHEs, more than 200 IHEs registered to hold Communities Talk events, doubling the number of IHE events from 2014 to 2016.

Feedback from host organizations, via a survey approved by the Office of Management and Budget, indicates that these events are an effective approach for raising public awareness of underage drinking as a public health problem and mobilizing communities around its evidence-based prevention. Most of the 2016 events focused on ways to reduce underage access to alcohol, such as through environmental prevention (e.g., compliance checks) and parental involvement. In addition, these events launched or strengthened collaboration among underage drinking prevention stakeholders. In planning Communities Talk meetings, most of the event organizers reported collaborating with other organizations, and more than two thirds of them plan to collaborate with other agencies and programs in follow-up efforts to prevent and reduce underage drinking. SAMHSA is developing a summary report on the 2016 Communities Talk events.

- *Partnership Development:* During 2016, SAMHSA increased its efforts to engage new partners and stakeholders—including the National Parent Teacher Association, the American Library Association, and HealthLink—leading to promotion of the Communities Talk

initiative through organization blogs, websites, and newsletters. To support partners, SAMHSA responded to more than 3,014 requests for Communities Talk technical assistance via telephone and/or email. Expanded outreach to IHEs resulted in more than 200 IHEs registering as primary Communities Talk event organizers.

- *Too Smart to Start (TSTS)*: TSTS is a national community education program targeting youth and teens as well as their parents, other caregivers, and educators. The program actively involves entire communities in sending clear, consistent messages about why children should reject underage drinking. The TSTS website provides factsheets, the Ready, Set, Listen! Game, and other information that encourages parents to talk with children about alcohol use. It also provides lesson plans for 5th- and 6th-grade classroom use on the effects of alcohol on the brain and body (<http://www.toosmarttostart.samhsa.gov>). In 2016, SAMHSA released a mobile application, Alcohol's Effects On the Brain (AlcoholFX), in response to requests from 5th- and 6th-grade classroom educators for more interactive materials about underage drinking prevention. AlcoholFX is available for free in the Apple App Store and in the Android Google Play Store.
- *Higher Education Video Pilot Project: College Drinking: Prevention Perspectives Video Series*: In 2016, SAMHSA developed the first episode in the College Drinking: Prevention Perspectives video series. The series will assist the higher education field in creating a format for sharing ideas, success stories, and best practices with their local communities on underage drinking prevention strategies. These videos will highlight stories of successful underage and harmful drinking prevention on college campuses as reflected by the professionals who have implemented these programs. The first episode, Lessons Learned at Frostburg State University, focuses on the value of top-down involvement in preventing student alcohol use and consequences, and contains interviews with Jonathan Gibraltar, Ph.D., former President of Frostburg State University, as well as members of his President's Alcohol Task Force. Dr. Gibraltar also is Chair of NIAAA's College Presidents Working Group on student alcohol use and an advocate of prevention.

***Strategic Prevention Framework Network State Incentive Grant (SPF SIG) Program***: The SPF SIG program is both an infrastructure and a service delivery grant program. The program supports an array of activities to help grantees build a solid foundation for delivering and sustaining effective substance misuse prevention services and reducing substance misuse problems. Following the SPF's five-step process, SPF SIG grantees develop comprehensive plans for prevention infrastructure and systems at the state and tribal levels. Ultimately, SPF SIG states/tribes assist and support selected subrecipient communities to implement effective programs, policies, and practices to reduce substance misuse and its related problems. Eighty-five percent of the SPF SIG grant award must be allocated to communities to address identified priority substance misuse problems. CSAP has awarded SPF SIGs to 50 states, the District of Columbia, 8 U.S. territories, and 19 tribes. Cohort I grants were awarded in FY 2004, Cohort II in FY 2005, Cohort III in FY 2006, Cohort IV in FY 2009, Cohort V in FY 2010, and Cohort VI in 2012. Cohort VI consists of Idaho, the final state to receive SPF SIG funding. The SPF SIG program provides the foundation for success of the SPF - Partnerships for Success (PFS) Grant Program.

All SPF SIGs support the goals of the underage drinking initiative, because all grant tasks, including needs assessment, capacity building, planning, implementation, and evaluation, must

be carried out with consideration for the issue of underage drinking. As of 2014, 77 of the 79 grantees funded in Cohorts I through VI had approved SPF SIG plans and had disseminated funds to communities. In FY 2013, 64.6 percent of grantee states in Cohorts I, II, III, IV, and V demonstrated a decrease in past 30-day use of alcohol among respondents ages 12–20, down from 78.0 percent in FY 2012. Likewise, 42.0 percent demonstrated a decrease for individuals age 21 or older, down from 56 percent in FY 2012.

***Strategic Prevention Framework Partnerships for Success (SPF PFS) Program:*** The SPF PFS program was initiated in FY 2009 with the goals of reducing substance use–related problems; preventing the onset and reducing the progression of substance use disorders; strengthening prevention capacity and infrastructure at the state and community levels in support of prevention; and leveraging, redirecting, and realigning statewide funding streams for substance misuse prevention. Beginning in FY 2012, the PFS program concentrated on addressing two of the nation’s top substance use prevention priorities: underage drinking among youth and young adults ages 12–20 and prescription drug misuse among individuals ages 12–25. SAMHSA awarded 15 grants in 2012. In FY 2013, 16 grants were awarded, and in FY 2014, 21 PFS grants were awarded.

SPF PFS grantees are expected to meet several key requirements. First, states must use a data-driven approach to identify which of the substance use prevention priorities they propose to address using the SPF PFS funds. States must use SPF PFS funds to address one or both of these priorities. At their discretion, states may also use SPF PFS funds to target an additional, data-driven prevention priority in their state. Second, states must develop an approach to funding communities of high need (i.e., subrecipients) that ensures that all funded communities receive ongoing guidance and support from the state, including technical assistance and training. Grants awarded in FY 2014 included tribal applicants. These grantees were encouraged to address marijuana and heroin use as emergent priority issues. Of the 52 states/tribes awarded funding, 42 have chosen to target underage drinking. Nine of the 42 have chosen underage drinking as their sole priority.

***Strategic Prevention Framework Partnerships for Success (SPF PFS) Program II:*** Over a 3-year period, the SPF -PFS II is designed to address two of the nation’s top substance use prevention priorities: (1) underage drinking among people ages 12–20 and (2) prescription drug misuse among people ages 12–25. PFS II grantees are permitted to choose a subset of these respective age ranges for the two prevention priorities based on their data findings. The SPF PFS II is also intended to bring SAMHSA’s SPF to a national scale. These awards provide an opportunity for recipients of the Substance Abuse Prevention and Treatment Block Grant (SABG) that have completed a SPF SIG and are not currently funded through SAMHSA’s PFS grants to acquire additional resources to implement the SPF process at the state and community levels. Equally important, the SPF PFS II program promotes alignment and leveraging of prevention resources and priorities at the federal, state, and community levels.

SPF PFS II grantees are expected to meet several key requirements. First, states must use a data-driven approach to identify which of the substance use prevention priorities they propose to address using the SPF PFS II funds. States must use SPF PFS II funds to address one or both of these priorities. At their discretion, states may also use SPF PFS II funds to target an additional, data-driven prevention priority in their state. Second, states must develop an approach to funding communities of high need (i.e., subrecipients) that ensures that all funded communities

receive ongoing guidance and support from the state, including technical assistance and training. Of the 15 states awarded funding, 11 have chosen to target underage drinking. Three of the 11 have chosen underage drinking as their sole priority.

***STOP Act Grant Program:*** In December 2006, the STOP Act was signed into public law establishing the STOP Act grant program. The program required SAMHSA's CSAP to provide \$50,000 per year for 4 years to current or previously funded Drug-Free Communities Program (DFC) grantees to enhance implementation of evidence-based practices that are effective in preventing underage drinking. It was created to strengthen collaboration among communities, the federal government, and state, local, and tribal governments; enhance intergovernmental cooperation and coordination on the issue of alcohol use among youth; and serve as a catalyst for increased citizen participation and greater collaboration among all sectors and organizations of a community that have demonstrated a long-term commitment to reducing alcohol use among youth.

STOP Act grant recipients are required to develop strategic plans using SAMHSA's Strategic Prevention Framework process, which includes a community needs assessment, an implementation plan, a method to collect data, and the evaluation, monitoring, and improvement of strategies being implemented to create measurable outcomes. Grantees are required to report every 2 years on four core Government Performance and Results Act (GPRA) measures: frequency of use (past 30 days), perception of risk or harm, perception of parental disapproval, and attitude toward peer use across at least three grades from grades 6 through 12. SAMHSA's CSAP currently funds 97 community coalitions in 29 states across the United States. CSAP awarded 80 grants in Cohort III (which extends from FY 2012 to FY 2016) and 17 grants in Cohort IV (which extends from FY 2013 to FY 2017).

An evaluation of STOP grants from 2009 through 2013 showed that 1) underage drinking outcomes improved with the implementation of both DFC and STOP Act grants, showing the importance of funding such community grant programs; and 2) the largest impact on underage drinking outcomes was achieved when funds were used for both new individual and enhanced environmental strategies.

### **Activities Related to Underage Drinking**

***Substance Abuse Prevention and Treatment Block Grant (SABG):*** The SABG is a major funding source for substance use prevention and treatment in the United States, including prevention and treatment of alcohol use disorders among adolescents. SABG grantees are required to use at least 20 percent of their grant allotment on primary prevention services targeted to individuals not in need of substance use disorder treatment. Many grantees use prevention funding to target the prevention of alcohol use, particularly among youth. Almost all (98.3 percent) of SABG grantees reported that they planned to use 2015 SABG funding to target underage drinking, making alcohol use among youth the most targeted prevention priority among SABG grantees.

***Partnership for Success (PFS): State and Community Prevention Performance Grant:*** PFS is designed to provide states with up to 5 years of funding to achieve quantifiable decline in statewide substance misuse rates, incorporating a strong incentive to grantees that have met or exceeded their prevention performance targets by the end of the third year of funding. Grant

awards were made to states with the infrastructure and demonstrated capacity to reduce substance misuse problems and achieve specific program outcomes. The overall goals of the PFS are to reduce substance misuse-related problems; prevent the onset and reduce the progression of substance misuse, including childhood and underage drinking; strengthen capacity and infrastructure at the state and community levels in support of prevention; and leverage, redirect, and realign statewide funding streams for prevention. Four states were funded in Cohort I and one state was funded in Cohort II of the grant.

***National Helpline (1-800-662-HELP):*** Individuals with alcohol or illicit drug problems or their family members can call the SAMHSA National Helpline for referral to local treatment facilities, support groups, and community-based organizations. The Helpline is a confidential, free, 24-hour-a-day, 365-days-a-year information service available in English and Spanish. Information can be obtained by calling the toll-free number or visiting the online treatment locator at <http://www.samhsa.gov/treatment>.

***State Adolescent Treatment Enhancement and Dissemination (SAT-ED) Grant:*** SAT-ED brings together stakeholders across the state/territory systems serving adolescents (12–18 years old) to develop and enhance a coordinated network that will develop policies, expand workforce capacity, disseminate EBPs, and implement financial mechanisms and other reforms to improve the integration and efficiency of the treatment and recovery support system for adolescent substance use and co-occurring substance use and mental disorders.

***State Adolescent and Transitional Aged Youth Treatment Enhancement and Dissemination (SYT-ED) Grant:*** SYT-ED brings together stakeholders across the state/tribal systems serving adolescents and transitional-age youth to develop and enhance a coordinated network that will develop policies, expand workforce capacity, disseminate EBPs, and implement financial mechanisms and other reforms to improve the integration and efficiency of the adolescent and transitional-age youth substance use and co-occurring substance use and mental disorders treatment and recovery support system. The population targeted is 12–24 years old.

***Screening, Brief Intervention, Referral, and Treatment (SBIRT) Grants:*** SBIRT involves implementation of a system in community and specialist settings that screens for and identifies individuals with substance use-related problems. Depending on the level of problems identified, the system either provides for a brief intervention in a generalist setting or motivates and refers individuals with high-level problems and probable substance dependence disorder diagnoses to a specialist setting for assessment, diagnosis, and brief or long-term treatment. This includes training in self-management and involvement in mutual help groups as appropriate. SBIRT grants are administered by SAMHSA's CSAT. Several SBIRT grantees have developed programs that are available to individuals under age 21, and/or serve Native Americans and rural populations. In FY 2017, CSAT awarded 8 new state demonstration grants to states that had never been awarded a grant, and 13 new SBIRT Student Training grants situated across the country. Additional SBIRT information, including related publications, is available at <http://www.samhsa.gov/sbirt>.

***Offender Reentry Program (ORP):*** This CSAT program addresses the needs of juvenile and adult offenders who use substances and are returning to their families and communities from incarceration in prisons, jails, or juvenile detention centers. ORP forms partnerships to plan, develop, and provide community-based substance use disorder treatment and related re-entry



services for target populations. The juvenile ORP targets youths ages 14–18, and the adult ORP includes adults ages 19–20.

***Program to Provide Treatment Services for Family, Juvenile, and Adult Treatment Drug Courts:*** By combining the sanctioning power of courts with effective treatment services, drug courts break cycles of child abuse and neglect, criminal behavior, alcohol and drug use, and incarceration or other penalties. Motivational strategies are developed and used to help adolescents deal with the often powerful negative influences of peers, gangs, and family members. SAMHSA/CSAT funds Juvenile Treatment Drug Court grants to provide services to support substance use disorder treatment, assessment, case management, and program coordination for those in need of drug court treatment services.

***Programs for Improving Addiction Treatment:*** SAMHSA/CSAT supports a variety of programs to advance the integration of new research into service delivery and improve addiction treatment nationally. For example, the Addiction Technology Transfer Center (ATTC) Network identifies and advances opportunities for improving addiction treatment. It assists practitioners and other health professionals in developing their skills and disseminates the latest science to the treatment community, providing academic instruction to those beginning their careers as well as continuing education opportunities and technical assistance to people already working in the addictions field. Ten ATTCs are located in the 10 HHS-designated regions, and 4 ATTCs focus on areas of specific issues in addiction treatment (Hispanic/Latino issues, AI/AN issues, rural and frontier issues, and SBIRT). For more information on the ATTC Network, including related publications and resources, see <http://www.ATTCNetwork.org>.

In addition, CSAT has produced several Treatment Improvement Protocols (TIPs) that address a wide array of concerns. These TIPs include TIP 16: *Alcohol and Drug Screening of Hospitalized Trauma Patients*; TIP 24: *A Guide to Substance Abuse Services for Primary Care*; TIP 31: *Screening and Assessing Adolescents for Substance Use Disorders*; TIP 32: *Treatment of Adolescents with Substance Use Disorders*; TIP 34: *Brief Interventions and Brief Therapies for Substance Abuse*; TIP 36: *Substance Abuse Treatment for Persons with Child Abuse and Neglect Issues*; and TIP 39: *Substance Abuse Treatment and Family Therapy*. Another relevant CSAT publication is the five-volume, evidence-based *Cannabis Youth Treatment* series.

***Fetal Alcohol Spectrum Disorders (FASDs):*** SAMHSA’s FASD Center for Excellence (CFE) is an alcohol prevention initiative addressing innovative techniques and effective strategies for preventing alcohol use among women of childbearing age and providing assistance to people and families affected by FASD. States, communities, juvenile justice systems, and academic institutions are in the process of improving their service delivery systems and policies and procedures to screen at intake for FASD among children, youth, and adults and refer individuals for interventions or for diagnosis, if necessary. These systems also participate in surveillance to create sustainable evidence-based responses to FASD. This initiative does not specifically target underage drinkers, but it is expected that through the current FASD CFE’s collaboration with SAMHSA/CSAP underage drinking programs, more children, youth, and adults will be reached, educated, and trained on co-occurring issues (substance use/abuse) across the lifespans of individuals with FASD.

The FASD CFE website (<http://www.fasdcenter.samhsa.gov>) reported 187,467 unique visitors and 493,276 total visits from January to December 2011 and 160,364 unique visitors and

429,991 total visits from January to September 2012. SAMHSA is also a member of ICCFASD, comprising federal partners such as NIAAA, HRSA, IHS, and the National Center for Birth Defects and Disabilities of the CDC.

***Tribal Training and Technical Assistance Center:*** The Tribal TTA Center provides TTA on mental and substance use disorders, suicide prevention, and promotion of mental health to federally recognized tribes, other AI/AN communities, SAMHSA tribal grantees, and organizations serving Indian Country. The TTA is culturally relevant, evidence based, and holistic. It is designed to support Native communities in their self-determination efforts through infrastructure development and capacity building, as well as program planning and implementation. TTA includes targeted site visits, virtual learning communities, Gatherings of Native Americans, and Tribal Action Plan training.

***Office of Indian Alcohol and Substance Abuse (OIASA):*** OIASA is responsible for aligning, leveraging, and coordinating with federal agencies and departments in carrying out the responsibilities delineated in the Tribal Law and Order Act. The office director chairs the Indian Alcohol and Substance Abuse Interagency Coordinating Committee. This committee coordinates across federal agencies responsible for addressing alcohol and substance use issues, including the Department of Interior’s Bureau of Indian Affairs and Bureau of Indian Education, DOJ’s Office of Justice Programs and Office of Tribal Justice, and HHS’ IHS and other agencies in charge of assisting Indian Country.

***Safe Schools/Healthy Students (SS/HS) Initiative:*** SS/HS seeks to create healthy learning environments that help students thrive, succeed in school, and build healthy relationships. A central goal of the initiative is to prevent children from consuming alcohol and drugs, and the implementation of evidence-based programs such as Class Action, Family Matters, and Project Alert helps achieve this goal. The initiative also supports a variety of prevention activities involving families and communities such as “Safe Home Pledges” that ask parents to commit to maintaining a safe and alcohol-free environment (e.g., not serve alcohol to minors) and public forums and town hall meetings on drug and alcohol abuse. The results demonstrate that the initiative has been successful in reducing alcohol consumption among students at participating SS/HS school districts. Between year 1 and year 3 of the grant, the percentage of students who reported drinking declined from 25.4 percent to 22.4 percent (according to GPRA data). This represents a decrease from 27,521 students drinking in Year 1 to 24,270 students drinking in year 3. Furthermore, more than 80 percent of school staff reported the SS/HS grant helped reduce alcohol and other drug use among students. Reported 30-day alcohol use decreased nearly 12 percent from year 1 to year 3 of the grant (25.4 percent to 22.4 percent) for the 2005–2007 cohorts. This correlates to approximately 3,250 fewer students drinking in year 3, enough to fill 130 classrooms.

***Implementing Evidence-Based Prevention Practices in Schools (Prevention Practices in Schools):*** This grant program provides funding to schools to implement the Good Behavior Game, a universal classroom preventive evidence-based practice provided to school-aged children. It has been proven to reduce antisocial behavior, alcohol and tobacco addiction, and suicidal ideation in young adults. Disruptive and aggressive behavior in classrooms as early as the 1st grade has been identified as a risk factor for the development of substance misuse, antisocial behavior, and violent criminal behavior. The GBG was rigorously tested in clinical



trials in Baltimore City public schools. Prevention Practices in Schools is a pilot grant program in its third year of a 5-year grant and has reached 16,019 of students so far.

**National Survey on Drug Use and Health (NSDUH):** Conducted annually by SAMHSA's Center for Behavioral Health Statistics and Quality (CBHSQ), the NSDUH is a survey of the civilian, noninstitutionalized population of the United States age 12 or older. It is the primary national source of both national and state information on use of illicit drugs, alcohol, and tobacco. Estimates also include substance use disorders, substance use disorder treatment, mental health measures, mental health service use, and co-occurring substance use disorders. Approximately 68,000 persons are confidentially interviewed in NSDUH each year through in-person residential visits.

**Behavioral Health Services Information System (BHSIS):** BHSIS, conducted by SAMHSA's CBHSQ, is the primary source of national data on substance use disorder treatment services. BHSIS offers information on treatment facilities with special programs for adolescents as well as demographic and substance use characteristics of adolescent treatment admissions. BHSIS comprises the following components:

- *Inventory of Behavioral Health Services (I-BHS)* is a list of all known public and private substance use and mental health treatment facilities in the United States and its territories.
- *National Survey of Substance Abuse Treatment Services (N-SSATS)* is an annual survey of all substance use disorder treatment facilities in the I-BHS. It collects data on location, characteristics, services offered, and usage. It is used to update the National Directory of Drug and Alcohol Abuse Treatment Programs and the online Behavioral Health Treatment Services Locator.
- *National Mental Health Services Survey (N-MHSS)* is an annual survey of all mental health treatment facilities. It collects data on location, characteristics, services offered, and usage. It is used to update the Behavioral Health Treatment Facility Locator.
- *Treatment Episode Data Set (TEDS)* is a compilation of data on the demographic and substance use characteristics of admissions to and discharges from substance use disorder treatment, primarily at publicly funded facilities. State administrative systems routinely collect treatment admission information and submit it to SAMHSA in a standard format.

**Drug Abuse Warning Network (DAWN):** Conducted by SAMHSA, DAWN was a nationally representative public health surveillance system that continuously monitored drug-related visits to hospital emergency departments. DAWN ceased data collection at the end of 2011. Between 2012 and 2016, SAMHSA continued to analyze and report existing DAWN data.

In 2012, SAMHSA began a partnership with the National Center for Health Statistics (NCHS) to incorporate DAWN into the National Hospital Care Survey (NHCS). The NHCS combines two NCHS surveys, the National Hospital Ambulatory Medical Care Survey (NHAMCS) and the National Hospital Discharge Survey (NHDS), as well as DAWN. By moving DAWN into the NHCS, SAMHSA improved response rate with a large, nationally representative sample of hospital emergency departments, reduced cost, and expanded information collected (e.g., health insurance coverage information, diagnoses, treatment, ability to track emergency department patients admitted into the hospital through the emergency department). In addition, the NHCS will collect data on mental health-related emergency department visits. Under this new data collection effort, SAMHSA will publish drug- and mental-health-related visit data as

SAMHSA's Emergency Department Surveillance System (SEDSS). SAMHSA continues to work with NCHS to implement content and develop the survey methodology and statistical design. Currently, NCHS is working to recruit hospitals with publishable data.

***Substance Abuse Prevention Interagency Working Group (IWG) and Treatment Coordination Group (TCG):*** ONDCP coordinates the IWG and the TCG. Both groups comprise federal agencies whose programs and initiatives related to substance use support the goals of the National Drug Control Strategy. Agency representatives identified major issues for focus: preventing substance use, including nonmedical use of opioid pain relievers and heroin use, and expanding treatment and recovery support services. These groups have helped shape the National Drug Control Strategy. Underage drinking is also a key area of attention. In 2012, ONDCP along with its federal partners participated in several events on underage drinking with associations and institutions of higher education. The goal was to encourage implementation of EBPs and strategies and foster ongoing collaboration and communication on effective programs, policies, and practices.

***Drug Free Communities Support Program (DFC):*** The DFC Program, created by the Drug-Free Communities Act of 1997, is the nation's leading effort to mobilize communities to prevent youth substance use. DFC is a program of the Office of National Drug Control Policy administered by SAMHSA under an interagency agreement. DFC provides grants to community coalitions to strengthen the infrastructure among local partners to create and sustain a reduction in local youth substance use. Recognizing the fundamental concept that local problems need local solutions, the program requires funded coalitions to implement environmental strategies—broad initiatives aimed at addressing the entire community through adaptation of policies and practices related to youth substance use. Since 1997, the program has funded more than 2,000 community coalitions and mobilized community coalition members throughout the United States, the District of Columbia, Puerto Rico, American Samoa, and the Federated States of Micronesia (Palau).

To support the DFC goal of increased community collaboration regarding prevention of youth substance use, DFC grantees are required to engage community members from 12 sectors in order to conduct their work. Based on the median number of staff and active sector members from each community coalition, the FY 2013 DFC grantees mobilized approximately 25,000 individuals to engage in youth substance use prevention work. DFC grantees report core measures data every 2 years on four substances—alcohol, tobacco, marijuana, and illicit use of prescription drugs—for at least three grade levels between 6th and 12th grades. Grantees collect data on the following four measures: past 30-day use, perception of risk or harm of use, perception of parental disapproval of use, and perception of peer disapproval of use. Among the four core substances tracked by DFC, alcohol is reported by coalitions to be the most prevalent substance used at the high school level (92.7 percent of grantees) and at the middle school level (79.9 percent of grantees). In the past 10 years of program evaluation, DFC-funded communities have achieved significant reductions in youth substance use. The 2014 DFC National Evaluation Report found significant decreases in youth substance use across alcohol, marijuana, tobacco, and illicit use of prescription drugs, and generally found increases in youth perception of risk. For additional information, visit the DFC website at <https://www.whitehouse.gov/ondcp/drug-free-communities-support-program>.

***National Youth Anti-Drug Media Campaign:*** Through its teen brand “Above the Influence” (ATI), the National Youth Anti-Drug Media Campaign provided ongoing messaging and tools to prevent teen use of drugs and alcohol. Among the channels used to reach youth were an ATI Facebook page, an ATI website, and teen-targeted national media coupled with local outreach. In May 2014, the ATI Campaign was transitioned to the Partnership for Drug-Free Kids. The Partnership had been a close collaborator of the ATI campaign since its launch in 2005 and is committed to maintaining teens’ awareness and engagement with the brand at the national level through donated and social media efforts, and will continue to support local outreach activities at the following website: <http://www.ATIpartnerships.com>.

***National Registry of Evidence-based Programs and Practices (NREPP):*** NREPP is a searchable online registry of mental health and substance use interventions that are reviewed and rated by independent reviewers. It identifies scientifically tested approaches to preventing and treating mental and substance use disorders that can be readily disseminated to the field. NREPP exemplifies SAMHSA’s work to improve access to information on tested interventions and thereby reduce lag between the creation of scientific knowledge and its practical application in the field. For every intervention NREPP reviews, it publishes an intervention summary on its website describing the intervention, its targeted outcomes, and expert ratings of the quality of the research and its readiness for dissemination. This information helps individuals and organizations determine whether a particular intervention may meet their needs. SAMHSA advises having direct conversations with intervention developers and other contacts listed in the summary before selecting and implementing an intervention. As of December 2016, when the new, more rigorous review system was implemented, there were 92 completed reviews, of which 62 are new programs and 30 are re-reviews of legacy programs (those previously posted on the NREPP website). For more information on NREPP and its enhanced review criteria, visit <http://www.nrepp.samhsa.gov>.

***Center for the Application of Prevention Technologies (CAPT):*** SAMHSA’s CAPT is a national TTA system committed to regional, state, and local efforts to prevent substance use and misuse, and to strengthening and building the nation’s prevention workforce. SAMHSA’s CAPT provides face-to-face and virtual TTA services to 76 entities (50 states, 17 tribes, and 9 jurisdictions) receiving funding through any of the following SAMHSA grant programs: SPF State/Tribal Incentive Grants (SPF SIGs/TIGs); PFS II, 2013 and 2014; and the SABG.

During FY 2014 and FY 2015, CAPT provided a range of services focusing on underage drinking prevention. CAPT facilitated a national peer-sharing conference call titled “From Underage Drinking to Rx Drugs: Lessons for Addressing New Prevention Priorities.” The event included presentations from PFS II and PFS 2013 grantees, and provided an opportunity for grantees to discuss their successes developing partnerships with new stakeholders, as well as their experiences implementing an assortment of evidence-based strategies. Participants included state and tribal practitioners from New York, Tennessee, Delaware, Illinois, Indiana, Oklahoma, Texas, Iowa, South Dakota, Colorado, Rocky Mountain Tribal Leaders Council, California Native America Health Center, Idaho, Oregon, and Cook Inlet Tribal Council.

CAPT also worked to strengthen the capacity of multiple states, tribes, and jurisdictions across the country to prevent underage drinking. For example, CAPT delivered a virtual training to Montana’s T/TA contractors, evaluators, and subrecipients on environmental change strategies to prevent underage drinking. The training reviewed examples of environmental strategies and

explored opportunities for using the SPF process to identify and implement such strategies. CAPT staff members trained individuals in Guam on preventing underage drinking among the island's LGBTQ population. The training explored risk and protective factors associated with underage drinking, evidence-based programs and strategies shown to address salient factors, and opportunities to develop partnerships with other organizations that provide services to LGBT individuals.

Also in FY 2015, CAPT provided the 4-day Substance Abuse Prevention Skills Training (SAPST) 22 times to 215 prevention practitioners. Seven of the trainings were for prevention practitioners working in states, tribes, and jurisdictions; 5 were customized SAPSTs for practitioners serving AI/AN, and 10 were trainings-of-trainers (TOT) events designed to develop the capacity of grantees to deliver the SAPST independently. Grounded in current research, the SAPST prepares practitioners to implement the five steps of SAMHSA's SPF: assessment, capacity-building, planning, implementation, and evaluation.

Finally, the CAPT developed a number of tools to support the prevention of underage drinking. For example, the CAPT revised two existing decision-support tools to highlight current research on college/campus populations: *Risk and Protective Factors Associated with Binge or Episodic Drinking Among Adolescents and Young Adults* and *Strategies to Prevent Binge or Heavy Episodic Drinking Among Adolescents and Young Adults*.

## **Office of the Assistant Secretary for Health (OASH), Office of the Surgeon General (OSG), and Office of Adolescent Health (OAH)/HHS**

### **Activities Specific to Underage Drinking**

***“Facing Addiction in America,” the Surgeon General’s Report on Alcohol, Drugs, and Health, and the Surgeon General’s 2007 Call to Action and Guides:*** In 2016, the first-ever *Surgeon General’s Report on Alcohol, Drugs, and Health* was released. This report reviews what is known about substance misuse, including underage alcohol use, and how that knowledge can be used to address substance misuse and related consequences. It is available at <https://addiction.surgeongeneral.gov>. In addition, the ICCPUD agencies continue to promote the 2007 *Surgeon General’s Call to Action* and the accompanying *Guides to Action* as a key source of information on addressing the national health problem of underage drinking. The *Surgeon General’s Call to Action* and the *Guides* are available at <http://www.surgeongeneral.gov/library/calls/index.html>.

### **Activities Related to Underage Drinking**

***National Prevention Strategy: America’s Plan for Better Health and Wellness:*** In June 2011, the National Prevention, Health Promotion, and Public Health Council announced the release of the National Prevention Strategy, a comprehensive plan to help increase the number of Americans who are healthy at every stage of life. Included in the Prevention Strategy is the section “Preventing Drug Abuse and Excessive Alcohol Use,” which specifically addresses the need to prevent excessive alcohol use, including underage drinking. Recommendations made in this section of the strategy identify the need for more stringent alcohol control policies, advocate for the creation of environments that empower young people not to drink, and promote the use of SBIRT to screen for abuse. OSG continues to work with the 20 federal departments and agencies that compose the National Prevention Council to support implementation of the

National Prevention Strategy. More information is available from the 2014 Annual Status Report at <http://www.surgeongeneral.gov/initiatives/prevention/about/index.html>.

**Office of Adolescent Health Website:** The OAH website provides resources for parents and adolescents who are struggling with alcohol use (<http://www.hhs.gov/ash/oah/adolescent-health-topics/substance-abuse/alcohol.html> and <http://www.hhs.gov/ash/oah/resources-and-publications/info/parents/other-conversations/alcohol>). State-level data on adolescent alcohol use are at <http://www.hhs.gov/ash/oah/adolescent-health-topics/substance-abuse/fact-sheets>.

**Adolescent Health: Think, Act, Grow (TAG):** In November 2014, OAH announced TAG. OAH worked with 80 youth-related organizations to develop this national call to action to promote all aspects of adolescent health. The TAG section of the OAH website includes free resources for youth-serving professionals, family members, and teens, including state and national data and a TAG Playbook and Toolkit. Planned TAG activities include Twitter chats, webcasts, and additional free materials for download. More information about TAG is at <http://www.hhs.gov/ash/oah/tag>.

## **Office of Juvenile Justice and Delinquency Prevention (OJJDP), Department of Justice (DoJ)**

### **Activities Specific to Underage Drinking**

**Enforcing the Underage Drinking Laws (EUDL):** The EUDL block grant program has provided national leadership in ensuring that states, territories, and communities have the information, training, and resources needed to enforce underage drinking laws since 1998. Because of reductions in funding for the EUDL initiative in FY 2014, the OJJDP was no longer able to support the block grant program. Alternatively, in FY 2014, OJJDP directed all available EUDL funding to support a new initiative, Tribal Healing to Wellness Court, that addressed underage alcohol access and consumption by Native youth minors in five competitively selected tribes. Those programs remained active in FY 2015.

**Underage Drinking Enforcement Training Center (UDETC):** UDETC provided TTA to adults and youth as a major component of the EUDL program. UDETC identified science-based strategies, published supporting documents, delivered training, and provided technical assistance to support the enforcement of underage drinking laws for 16 years. Starting in 1999, UDETC worked with EUDL coordinators in all 50 states, the District of Columbia, and 5 U.S. territories to coordinate TTA for prevention and reduction of underage drinking. UDETC accomplished its mission by providing onsite trainings; expert technical assistance by UDETC staff; onsite strategic technical assistance visits; and online virtual trainings (including distance learning courses, national webinars [formerly audio teleconferences], targeted webinars, national conferences, and a EUDL symposium that included strategic meetings with OJJDP and grantees; podcasts; a dedicated website; numerous documents and toolkits, listserv communications to EUDL coordinators and the field; and research support). As a national program starting in 1999, UDETC responded to more than 45,632 technical assistance topic requests with an average of 2,852 technical assistance requests each year (1,419 from January to August 2015); completed 182 national audio calls/webinars reaching more than 30,556 individuals; conducted 888 onsite trainings reaching 38,201 participants; had more than 3,107 participants complete 7 distance learning courses; developed more than 390 publications, success stories, distance learning



courses, toolkits, judicial newsletters, and resource alerts to the field; and had more than 42 million website hits. The UDETC also published 31 evidence-based publications with several focused on helping states and local communities enforce alcohol retail establishment compliance with underage drinking laws, including:

- *Guide to Responsible Alcohol Sales: Off Premise Clerk, Licensee and Manager Training*—Offers sales personnel training tools that support management policies to prevent sales of alcohol to those under age 21.
- *Preventing Sales of Alcohol to Minors: What You Should Know About Merchant Education Programs*—Describes such programs and their role in comprehensive community strategies to reduce underage drinking. It also identifies necessary components and resources for more information.
- *Reducing Alcohol Sales to Underage Purchasers: A Practical Guide to Compliance Check Investigations*—Indicates the importance of enforcement in retail establishments as the cornerstone of enforcing underage drinking laws and provides the essential elements of carrying out compliance checks using minors or young-looking adults.
- *Strategies for Reducing Third-Party Transactions of Alcohol to Underage Youth*—Dissuades adults from providing alcohol to underage people. Also discusses the problem of nonretail sources of alcohol for underage drinkers and describes the essential elements of shoulder-tap operations, along with other techniques, to deter adults from buying or providing alcohol to underage drinkers.
- *Regulatory Strategies for Preventing Youth Access to Alcohol: Best Practices*—Provides information on the regulations that are most important in reducing youth access to alcohol and underage drinking. It shares best practices for establishing appropriate laws and regulations, suggests priorities for regulatory and enforcement efforts, and discusses implementation issues crucial for the successful adoption and implementation of these regulatory strategies.
- *Law Enforcement Guide to False Identification*—Provides information on the prevalence of illegal identification (ID) use, common security measures and tools used to detect them, and steps for checking IDs that increase the likelihood of detection. Information engages law enforcement and retailers to help reduce illegal ID use in their communities.

Additional publications to support enforcement and prevention work, including 161 success stories (four in 2015 plus a final success story summary document, 1999–2015) that featured measurable outcomes, were made available on the UDETC website at <http://www.udetc.org>. On October 16, 2015, the UDETC officially closed due to lack of funding. Once it closed, certain resources from the website were made available through other OJJDP contractors.

#### ***EUDL Discretionary Program:***

- *OJJDP FY 2014 EUDL Tribal Healing to Wellness Court Responses to Underage Drinking Initiative:* This program supports efforts of Tribal Healing to Wellness Courts to develop or enhance their capacity to address issues related to youth younger than 21 years of age who possess and consume alcohol. Such capacity development and enhancements are for (1) reducing the number of alcohol-related offenses and alcohol-related traffic injuries or fatalities where this age group's use of alcohol may have been a factor, (2) increasing the number of activities to deter underage drinking, (3) increasing the number of youth who participate in activities to deter underage drinking, and (4) decreasing the number of crimes



against people or property where youth younger than 21 consuming alcohol may have been a factor. In addition to supporting program implementation and direct service activities in five tribes, this initiative funded a single cooperative agreement to a TTA provider to support project sites. The tribes funded were the Yurok Tribe in California, Lac du Flambeau Band of Lake Superior Chippewa Indians in Wisconsin, Southern Ute Indian Tribe in Colorado, White Earth Band of Chippewa Indians in Minnesota, and Winnebago Tribe of Nebraska. The Cooperative Agreement was awarded to the Center for Court Innovation in New York. The TTA provider is developing technical assistance plans for each site, working closely with each tribe to develop their strategic plans and providing TTA for the tribes as needed. Although EUDL funds were no longer available for FY 2015, OJJDP chose to expand this work in FY 2015 through its Coordinated Tribal Assistance Solicitation.

- *OJJDP EUDL Partnership with the USAF:* In FY 2012, OJJDP issued a third solicitation for discretionary EUDL to build on the EUDL/USAF partnerships. Grant activity continued in the two demonstration states of Nevada and California. Due to base populations at the intervention sites (Nellis AFB, Nevada, and Joint Base Charleston, South Carolina), the current program involves partnerships with the USAF and United States Navy. OJJDP is funding and managing ICF International’s evaluation of the sites funded in FY 2012.

## Office of National Drug Control Policy (ONDCP)

### Activities Related to Underage Drinking

***National Youth Anti-Drug Media Campaign:*** Through its teen brand “Above the Influence” (ATI), the National Youth Anti-Drug Media Campaign provided ongoing messaging and tools to prevent teen use of drugs and alcohol. Among the channels used to reach youth were an ATI Facebook page, an ATI website, and teen-targeted national media coupled with local outreach. In May 2014, the ATI Campaign was transitioned to the Partnership for Drug-Free Kids. The Partnership was a close collaborator of the ATI campaign since its launch in 2005 and is committed to maintaining teens’ awareness and engagement with the brand at the national level through donated and social media efforts and will continue to support local outreach activities at the following website: <http://www.ATIpartnerships.com>.

***Drug-Free Communities (DFC) Support Program:*** The DFC Program, created by the Drug-Free Communities Act of 1997, is the nation’s leading effort to mobilize communities to prevent youth substance use. Directed by ONDCP in partnership with SAMHSA, DFC provides grants to community coalitions to strengthen the infrastructure among local partners to create and sustain a reduction in local youth substance use. Recognizing the fundamental concept that local problems need local solutions, the program requires funded coalitions to implement environmental strategies—broad initiatives aimed at addressing the entire community through the adaptation of policies and practices related to youth substance use. Currently, the program has funded more than 2,000 community coalitions and mobilized nearly 9,000 community coalition members throughout the United States, the District of Columbia, Puerto Rico, American Samoa, and the Federated States of Micronesia (Palau). DFC grantees collect data every 2 years on four substances—alcohol, tobacco, marijuana, and prescription drugs—for at least three grade levels between 6th and 12th grades. Grantees collect data on the following four measures: past 30-day use, perception of risk or harm of use, perception of parental disapproval of use, and perception of peer disapproval of use. Among the four core substances tracked by

DFC, alcohol is reported by coalitions to be the most prevalent substance used at the high school level (94 percent of grantees) and at the middle school level (89 percent of grantees). In the past 10 years of program evaluation, DFC-funded communities have achieved significant reductions in youth substance use. Significant reductions in past 30-day use have been reported for alcohol, tobacco, and marijuana use at both the middle school and high school levels.

***Demand Reduction Interagency Working Group (IWG):*** In 2009, ONDCP reinstated the IWG, comprising 35 federal agencies whose missions involve some connection to substance abuse. Agency leaders identified four major cross-cutting issues: prevention and education, prescription drugs, electronic health records, and data. These committees helped shape the 2010, 2011, 2012, and 2013 National Drug Control Strategies. The issue of underage drinking received great attention in several of these IWG committees. In 2012, ONDCP along with its federal partners, participated in several events with associations and institutions of higher education on underage drinking to encourage implementation of EBPs that are motivational and empowering along with the development of strategies that foster ongoing collaboration and communication on policy, curriculum development, programs, and resources on college and university campuses.

## **National Highway Traffic Safety Administration (NHTSA)/Department of Transportation (DOT)**

### **Activities Specific to Underage Drinking**

***Programs Encouraging States to Enact Minimum Drinking Age and Zero Tolerance Laws:*** NHTSA implemented congressionally mandated programs to encourage states to enact minimum drinking age and zero tolerance laws. Zero tolerance laws establish very low BAC limits of .02 g/dL or less for drivers under the MLDA of 21. Minimum drinking age laws make it unlawful for people under age 21 to possess alcohol. All 50 states and the District of Columbia have enacted both laws. NHTSA continues to monitor state compliance with these federal mandates. Failure to comply results in financial sanctions to the states.

### **Activities Related to Underage Drinking**

NHTSA supports the work of national organizations to address underage drinking and driving prevention. Several examples follow:

***National Organizations for Youth Safety (NOYS):*** Since 1994, NHTSA has supported a variety of NOYS-led efforts to build partnerships that save lives, prevent injuries, and promote safe and healthy lifestyles among all youth while encouraging youth empowerment and leadership. Specifically, NHTSA supports NOYS's annual Teen Driver Safety Summit, which convenes, educates, and engages youth leaders, and a Youth Correspondents Advisory Board that leads the development and delivery of peer-to-peer messages about traffic safety, including the prevention of underage drinking and driving.

***Students Against Destructive Decisions (SADD):*** Under a cooperative agreement, the SADD National Student of the Year is eligible for a summer leadership opportunity at NHTSA. Additionally, NHTSA assisted SADD to develop and implement education and enforcement activities to promote young driver safety and specifically to reduce underage drinking and driving.

**State Highway Safety Funding:** NHTSA provides federal funding to states and local communities through State Highway Safety Offices (SHSOs). Funds may be used for activities related to underage drinking and driving under the following programs: 402 (state and community programs), 405 (national priority safety programs including impaired driving and occupant protection incentive grants), 154 (open container transfers), and 164 (repeat offender transfers).

**Youth Traffic Safety Media:** NHTSA maintains Parents Central, which provides overviews, recommendations, and facts about teen driver safety, and is available at <http://www.safercar.gov/parents/TeenDriving/teendriving.htm>.

The accompanying media campaign, 5 to Drive, shares tips, resources, and ideas for setting ground rules and specifying consequences related to alcohol, seat belts, speed, distraction, and extra passengers. Additional communications news, campaign materials, and marketing techniques are available at the Traffic Safety Marketing website: <http://www.trafficsafetymarketing.gov>.

To address the issue of underage drinking and driving, NHTSA joined with the Ad Council to launch a PSA campaign that targets new drivers 16 and 17 years old, and is built around the idea of “Underage Drinking and Driving: The Ultimate Party Foul.” The campaign includes a TV ad, a Tumblr site, web banners, outdoor advertising, and a branded emoji keyboard that is available on both the iOS and Android platforms.

### Exhibit 3.1: Expenditures by Select Interagency Coordinating Committee on Preventing Underage Drinking (ICCPUD) Agencies for Programs Specific to Underage Drinking

ICCPUD Agency	FY 2010 actual	FY 2011 actual	FY 2012 actual	FY 2013 actual	FY 2014 actual	FY 2015 actual	FY 2016 actual
CDC	\$1,200,000	\$1,041,730	\$1,081,200	\$986,587	\$949,894	\$1,100,000	\$900,000
ED	\$40,580,995	\$8,782,000 <sup>a</sup>	— <sup>b</sup>	— <sup>b</sup>	— <sup>b</sup>	0	0
NIAAA	\$56,000,000 <sup>c</sup> \$2,000,000 <sup>d</sup>	\$57,000,000	\$62,000,000	\$62,000,000	\$59,350,175	\$52,190,438	\$55,177,270
SAMHSA <sup>e</sup>	\$62,542,390	\$63,779,872	\$67,953,616	\$84,555,315	\$89,422,285	\$103,104,523	\$104,332,643
OJJDP <sup>f</sup>	\$25,000,000	\$20,708,500	\$4,862,895	\$5,000,000	\$2,500,000	0	0
NHTSA	\$625,000	\$600,000	\$645,000	\$600,000	\$600,000	\$600,000	\$600,000
TOTAL	\$187,948,385	\$151,912,102	\$136,542,711	\$153,141,902	\$152,822,354	\$156,944,961	\$161,009,913

<sup>a</sup> ED's Office of Safe and Drug Free Schools received significant budget cuts in FY 2011, and this figure represents continuation costs for the Grants to Reduce Alcohol Abuse program, which was eliminated in FY 2012. In FY 2011, ED also provided support (\$1,874,450) for the Higher Education Center for Alcohol and Other Drug Abuse and Violence Prevention, which focused in part on underage drinking on college campuses.

<sup>b</sup> In FYs 2012 and 2013, ED consolidated the functions of the HEC Center into a new technical assistance center, the NCSSE. However, the exact amount of funding of that Center specific to underage drinking cannot be determined. Similarly, although underage drinking prevention was one activity among many in certain grant projects funded by ED in FYs 2011, 2012, and 2013, the exact amount of funding specific to underage drinking cannot be determined. Not included, as in prior years, are estimates of SS/HS grant activity that focuses on alcohol abuse prevention.

<sup>c</sup> NIAAA FY 2010 non-American Recovery and Reinvestment Act (ARRA) funding

<sup>d</sup> NIAAA FY 2010 ARRA funding

<sup>e</sup> FY 2010–2013 figures include SPF SIG, UAD, Adult Media Campaign, STOP Act grants, and ICCPUD. FY 2010–2013 figures also include PFS, which is a subset of SPF SIG.

<sup>f</sup> OJJDP's EUDL program received significant budget cuts in FY 2012. Support for EUDL programming was \$25 million annually from FY 1998 until FY 2011, when there was a reduction to \$5 million, which resulted in the elimination of the EUDL block grant program for all states and territories.

# CHAPTER 4

## Report on State Programs and Policies Addressing Underage Drinking

### CHAPTER 4.1

#### Introduction

The Sober Truth on Preventing Underage Drinking (STOP) Act, enacted in 2006 and reauthorized in 2016, recognizes the critical role that states play in the national effort to reduce underage drinking, particularly in their role as regulators of the alcohol market. The Act’s preamble includes this statement of the sense of Congress:

Alcohol is a unique product and should be regulated differently than other products by the States and Federal Government. States have primary authority to regulate alcohol distribution and sale, and the Federal Government should support and supplement these State efforts. States also have a responsibility to fight youth access to alcohol and reduce underage drinking. Continued State regulation and licensing of the manufacture, importation, sale, distribution, transportation, and storage of alcoholic beverages are ... critical to ... preventing illegal access to alcohol by persons under 21 years of age.

The Act directs the Secretary of the Department of Health and Human Services (HHS), working with the Interagency Coordinating Committee on the Prevention of Underage Drinking (ICCPUD), to provide an annual report on state activities pertaining to underage drinking prevention programs, policies, related enforcement efforts, and state expenditures.

This year’s report provides the following information for the 50 states and the District of Columbia (henceforth referred to as “states”):

- Chapter 4.2 contains information on 26 underage drinking prevention policies focused on reducing youth access to alcohol and youth involvement in drinking and driving. Consistent with the STOP Act requirement to report on “evidence-based best practices to prevent and reduce underage drinking and provide treatment services to those youth who need them,” most policies have been identified as best practices by a variety of relevant federal agencies. (See “Underage Drinking Prevention Policies” and “Best Practices” in this chapter.)
- Chapter 4.3 contains data from a survey of the states addressing underage drinking enforcement programs; programs targeted to youth, parents, and caregivers; collaborations, planning, and reports; and state expenditures on the prevention of underage drinking. (See “State Survey” and “Enforcement” in this chapter.)

## Underage Drinking Prevention Policies

Chapter 4.2 presents summaries of 26 underage drinking prevention policies. Each summary describes the policy’s key components, the status of the policy across states, and trends over time. Volumes II and III contain individual state reports that describe the status of these policies in each state.

Seventeen of these policies were included in original STOP Act legislation or were recommended by Congress during the 2009–2010 appropriations process. The remaining nine policies were added by the ICCPUD following input from various stakeholders. This report obtained data for 16 of the policies from the National Institute on Alcohol Abuse and Alcoholism’s (NIAAA) Alcohol Policy Information System (APIS).

It is important to note that not all of these state policies will apply on tribal lands. Some will vary by tribe and land type. Such variations are beyond the scope of this report.



The following policies are included (underlined policies are available on APIS):<sup>30</sup>

### **Laws Addressing Minors in Possession of Alcohol**

1. Underage possession
2. Underage consumption
3. Internal possession by minors
4. Underage purchase and attempted purchase
5. False identification

### **Laws Targeting Underage Drinking and Driving**

6. Youth blood alcohol concentration (BAC) limits
7. Loss of driving privileges for alcohol violations by minors
8. Graduated driver's licenses

### **Laws Targeting Alcohol Suppliers**

9. Furnishing of alcohol to minors
10. Compliance check protocols
11. Penalty guidelines for sales to minors
12. Responsible beverage service
13. Minimum ages for off-premises sellers
14. Minimum ages for on-premises servers and bartenders
15. Outlet siting near schools
16. Dram shop liability
17. Social host liability
18. Hosting underage drinking parties
19. Retailer interstate shipment
20. Direct sales/shipments
21. Keg registration
22. Home delivery
23. High-proof grain alcoholic beverages

### **Laws Affecting Alcohol Pricing**

24. Alcohol taxes
25. Drink specials
26. Wholesale pricing

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<sup>30</sup> For a detailed chart of non-APIS policies in each state, go to [stopalcoholabuse.gov](http://stopalcoholabuse.gov) and see "Supplemental Materials for 2016 RTC."

## Best Practices

Each of the underage drinking prevention policies analyzed in Chapter 4.2 was determined to be a best practice by ICCPUD, and specifically chosen to be studied and included in this Report to Congress. Additionally, the majority of these policies were identified as best practices by one or more of the following five sources:

- Community Preventive Services Task Force (*Guide to Community Preventive Services. Preventing Excessive Alcohol Consumption*; Community Preventive Services Task Force, 2016).
- The Surgeon General (*The Surgeon General’s Call to Action to Prevent and Reduce Underage Drinking*; Office of the Surgeon General, 2007).
- Institute of Medicine (*Reducing Underage Drinking: A Collective Responsibility*; NRC and IOM, 2004).
- National Institute on Alcohol Abuse and Alcoholism (*CollegeAIM: Alcohol Intervention Matrix*, NIAAA).
- The Surgeon General (*Facing Addiction in America: The Surgeon General’s Report on Alcohol, Drugs, and Health*; Office of the Surgeon General, 2016).

Exhibit 4.1.1 lists the 26 policies analyzed in Chapter 4.2. An “X” indicates that a given policy is identified as a best practice by ICCPUD and one or more of the five sources listed above.

As depicted in Exhibit 4.1.1, 17 policies are identified as best practices by at least one source document (in addition to ICCPUD), and more than half of the policies are identified as best practices by two or more source documents.

One policy—Outlet Siting Near Schools—was addressed at a more general level by three of the sources: the Community Services Prevention Task Force, the NIAAA *CollegeAIM*, and the 2016 Surgeon General’s Report. These sources included restrictions on alcohol outlet density as a best practice without specifically endorsing the reduction of alcohol outlet density near schools.

Four policies (Wholesaler Pricing, Minimum Age for On-premises Servers, Minimum Age for Off-premises Servers, and Internal Possession) are included on NIAAA’s APIS website.

Direct Sales and Retailer Interstate Shipment are closely linked to the Home Delivery policy (which is identified as a best practice by one source). Some of the less frequently identified policies reflect more recent concerns and may not have been thoroughly studied at the time the federal source documents were prepared.

Each of these policies is evidence-based and supporting research is included after each policy description. It is important to note that the data supporting each of the 26 policies are different. Some policies find greater or lesser support in the research literature and in the source documents.

## State Survey

Chapter 4.3 provides a cross-state report summarizing the findings from the annual STOP Act State Survey, and presents data on variables amenable to quantitative analysis. In addition to the individual state reports on policy status (described above), Volumes II and III include reports of each state’s complete survey response.

**Exhibit 4.1.1: Underage Drinking Prevention Policies – Best Practices**

<b>Underage Drinking Prevention Policies</b>	<b>Recommended by the Community Preventive Services Task Force</b>	<b>Addressed in the Surgeon General's Call to Action</b>	<b>IOM Report, Reducing Underage Drinking: A Collective Responsibility</b>	<b>CollegeAIM (Alcohol Intervention Matrix; NIAAA)</b>	<b>Facing Addiction in America: The Surgeon General's Report on Alcohol, Drugs and Health</b>
<b>Policies included in original STOP Act legislation or added in 2009–2010 appropriations</b>					
Purchase or attempt to purchase alcohol by minor		X	X	X	
Consumption by minor		X	X	X	
Possession by minor		X	X	X	
False identification/Incentives for retailers to use ID scanners or other technology		X	X	X	
Penalty guidelines for violations of furnishing laws by retailers					
Furnishing or sale to a minor		X	X	X	
Hosting underage drinking parties		X	X	X	X
Dram-shop liability	X		X	X	X
Social-host liability			X	X	X
Compliance checks	X	X	X	X	X
Mandatory/voluntary server-seller training (responsible beverage service programs)		X	X	X	
Direct sales (internet/mail order)					
Home delivery			X		
Graduated driver's licenses		X	X		
Increasing alcohol tax rates	X		X	X	X
Restrictions on drink specials		X	X	X	
Wholesaler pricing provisions					
<b>Additional policies reviewed and adopted by ICCPUD</b>					
Keg registration		X	X	X	
Minimum age for on-sale server					
Minimum age for off-sale server					
Internal possession					
Youth BAC limits (zero tolerance)		X	X		X
Loss of driving privileges for alcohol violations by minors (use/lose law)					X
Outlet siting near schools					
Retailer interstate shipment					
High-proof grain alcoholic beverages					

Content of the STOP Act State Survey was derived directly from the STOP Act, covering topics and using terminology from the Act. Since 2011, this survey has collected data on the following topics:

- Enforcement programs to promote compliance with underage drinking laws and regulations
- Programs targeted to youth, parents, and caregivers to deter underage drinking
- State interagency collaborations to implement prevention programs, state best-practice standards, and collaborations with tribal governments
- The amount that each state invests on the prevention of underage drinking

Much of the quantitative analysis of the survey data presented in Chapter 4.3 is related to enforcement of alcohol policies. The following section discusses the importance of enforcement in greater detail.

## Enforcement

A significant component of the STOP Act's mission is to collect data and report on each state's performance in enforcing policies designed to prevent or reduce underage drinking. To that end, the annual STOP Act State Survey includes a section devoted to enforcement of these laws, and covers the types of programs or actions implemented, whether they are conducted at both the state and local level, number(s) of enforcement actions taken (when available), state expenditures on enforcement activities, and more. The following discussion of enforcement provides the background and context for these data.

### Concepts

#### Mechanisms

Typically, an alcohol policy seeks to change the behavior of targeted individuals, groups, or organizations. The intended change in behavior may or may not occur, depending in part on the extent to which the policy is enforced.

It is important to distinguish between compliance and enforcement. Compliance is the extent to which an individual, organization, group, or population acts in accordance with a specific public policy. Enforcement is the sum total of actions taken by public entities to increase compliance. Enforcement includes three components: policing, adjudication, and sanctioning. Enforcement data collected by the STOP Act State Survey generally combine adjudication and sanctioning because the latter usually requires the former.

The role of enforcement in policy effectiveness varies depending on the nature of the policy. At one extreme, policies such as alcohol taxes are virtually self-enforcing in that sellers must regularly report sales data. By contrast, laws that prohibit sales to minors require relatively high enforcement levels to achieve desirable levels of compliance. For the latter, detecting a violation may require regular compliance checks and recording sources of alcohol from minor in possession (MIP) arrests.

The impact of enforcement on compliance with alcohol policies is a function of both actual and perceived levels of enforcement (i.e., levels of policing, adjudication, and sanctioning). *Actual* enforcement levels may vary depending on the strategies employed (e.g., random vs. complaint-based compliance checks) and on quantitative differences in policing, adjudication, and

sanctioning (e.g., numbers of officers on patrol, severity of sanctions). *Perception* of the probability of apprehension (policing), swiftness and certainty of a penalty (adjudication), and severity of the penalty (sanctioning) also affect compliance with a particular policy. These perceptions are key factors in the extent to which an alcohol-related policy functions as a deterrent to illegal behavior (Ross, 1992). Factors that affect these perceptions, such as publicity about enforcement efforts, may be construed as part of enforcement (Hingson et al., 1996). Compliance may also be affected by extra-legal factors (See Exhibit 4.1.2).

**Exhibit 4.1.2: Contextual Factors Affecting Compliance<sup>31</sup>**

Variable	Relevance to Enforcement	Relevance to Compliance
<b>Knowledge and awareness on the part of enforcement personnel and the public</b>	Enforcement personnel who lack knowledge of a law or policy or lack skills in using enforcement technologies (e.g., field identification of intoxication) may be less effective in enforcement activities.	Increasing public awareness of the existence or enforcement of a policy and efforts to enforce it tend to increase compliance.
<b>Costs</b>	Increasing costs of enforcement (either absolute or relative to benefits) can decrease the attractiveness of an enforcement effort to policymakers, who must balance enforcement against other priorities.	Policy complexity may tend to reduce compliance if (1) the burden of complying is increased in terms of details that must be addressed, work that is required, or costs that must be incurred, or (2) the risk that noncompliance with specific
<b>Complexity</b>	All else being equal, complex laws or policies may be more difficult to enforce (detect and prosecute) than simple laws or policies.	When laws or policies are complex, compliance may be reduced (1) due to the sheer amount of detail involved in complying, (2) due to the work and cost involved in complying, or (3) if the risk of detection of small deviations is low.
<b>Norms</b>	Enforcement personnel tend to act in accordance with prevailing norms, more vigorously enforcing laws and policies prohibiting behavior that is counter-normative in a given community than behavior that is socially acceptable.	Avoidance of specific behaviors may be as much a function of social acceptability as of legal proscriptions. Thus, for a given level of enforcement, compliance may vary as a function of community norms.
<b>Public support</b>	High public support can facilitate enforcement through allocation of public funds, political support for public officials who advocate strong enforcement, or formal or informal cooperation between citizens and public safety officials.	Public support is a visible manifestation of norms. As such, public support for a given law or policy should tend to increase compliance.
<p><i>Note:</i> For further discussion and analyses of these factors and a literature review, see: <a href="https://alcoholpolicy.niaaa.nih.gov/Enforcement_and_Compliance.html">https://alcoholpolicy.niaaa.nih.gov/Enforcement_and_Compliance.html</a>. Also see Holder (1998) and Gruenewald, Treno, Taff, &amp; Klitzner (1997).</p>		

<sup>31</sup> Adapted from the Alcohol Policy Information System (APIS), Enforcement and Compliance Resource, Table 3 (Sample Contextual Factors), [http://alcoholpolicy.niaaa.nih.gov/uploads/Table\\_3\\_-\\_Sample\\_Contextual\\_Factors\\_12\\_18\\_07.pdf](http://alcoholpolicy.niaaa.nih.gov/uploads/Table_3_-_Sample_Contextual_Factors_12_18_07.pdf).

A large body of literature addresses the factors related to effective enforcement (Klitzner, 2002; Klitzner & Sole-Brito, 2002; Levy, 2002). It is important to note that policies and their enforcement cannot be distinguished easily in practice. Laws may specify sanctions (e.g., use/lose laws) or enforcement practices (e.g., administrative license revocation).

According to Ross (1984), *deterrence theory* is the most widely used model of enforcement effectiveness. This theory stipulates that undesirable behavior will be reduced by the extent that those targeted by enforcement activities (e.g., alcohol retailers) perceive that threatened sanctions are certain, severe, and promptly imposed (celerity). Ross argued that severity is largely irrelevant when certainty of punishment is low and, conversely, that even mild penalties have a deterrent effect when sanctions are a near certainty (e.g., parking enforcement). As noted by Klitzner and Sole-Brito (2002), Ross is essentially stating that deterrence is a multiplicative function of the perceived risk of being punished and the perceived severity of penalties. The importance of celerity is debatable, because the most commonly cited example (administrative license revocation for impaired driving offenses) increases both celerity and certainty. Although deterrence literature is largely focused on criminal activity, the same concepts apply in a variety of other areas not generally considered criminal, for example, compliance with health care regulations (Bartrum & Bryant, 1997; Walker, 2002).

Deterrence is generally divided into two types, deterrence aimed at convicted offenders (secondary or specific deterrence) and deterrence aimed at the general public (primary or general deterrence). Incapacitation (supervision, incarceration, a number of hybrids such as electronic monitoring, license revocation, etc.) is a widely used form of specific or secondary deterrence in the United States. Whatever effects incapacitation may have on individuals' propensity to engage in future crime, they are less likely to recidivate while incarcerated or under supervision.

Vingilis (1990) suggested that the importance of classical deterrence diminishes as norms against a behavior increase. Social norms may change through social marketing or other media campaigns (e.g., aimed at reducing drinking and driving), altering the dynamic of deterrence. When norms are strong, only those who are "abnormally socialized" need an additional motivation to behave. The author argues that the behavior of most citizens is governed by informal social sanctions, and cautions that (a) effective enforcement and deterrence are interactions among individuals and environments and (b) deterrence is dynamic, with the population that is deterred by a given enforcement activity constantly in flux.

## Measures

Research literature relies on three types of measurements to assess the extent and effectiveness of enforcement interventions. *Categorical measures* assess which of a set of possible enforcement strategies (e.g., random vs. complaint-based compliance checks) or sanctions (e.g., use/lose penalties) are implemented in a jurisdiction. *Quantitative measures* assess the resources devoted to enforcement (personnel, budgets, specialized equipment), number of enforcement activities (e.g., shoulder tap operations) conducted, number or percentage of persons or entities targeted, number of sanctions imposed, and severity of sanctions imposed. These measures are sometimes referred to as "enforcement pressure." *Surrogate measures* use compliance rates (e.g., number of retail outlets that fail compliance checks, number of MIP arrests, or number of young people and retailers that actually receive sanctions) to measure enforcement. These measures reflect an



amalgam of both enforcement and compliance (Gruenewald et al., 1997) and should be viewed with some caution.<sup>32</sup>

## Literature

Historically, studies that have tested enforcement interventions in relation to outcomes (e.g., incidents of drinking and driving and underage drinking parties) make clear that enforcement can result in greater compliance and better public health outcomes (Preusser, Ulmer, & Preusser, 1992). However, enforcement of underage drinking policies is often uneven, inconsistent, and sporadic, and outcomes generally diminish over time (Ferguson, Fields, & Voas, 2000; Forster et al., 1994; Montgomery, Foley, & Wolfson, 2006; Mosher, Toomey, Good, Harwood, & Wagenaar, 2002; Preusser et al., 1992; Voas, Lange, & Tippetts, 1998; Wagenaar & Wolfson, 1995; Wolfson, Wagenaar, & Hornseth, 1995).

Of all enforcement practices, compliance checks (or decoy operations) have been most frequently studied (and are one focus of the STOP Act State Survey data presented later in this report). These practices, in which trained underage (or apparently underage) operatives (“decoys”) working with law enforcement officials enter retail alcohol outlets and attempt to purchase alcohol, are a way of reducing sales of alcohol to minors. The 2003 IOM report on preventing underage drinking (NRC and IOM, 2004) includes the recommendation that compliance checks be carried out regularly and comprehensively at the state and local levels. The 2016 *Surgeon General’s Report on Alcohol, Drugs, and Health* (HHS, Office of the Surgeon General, 2016) describes the use of compliance checks as “an effective way to reduce alcohol consumption by minors.”

The effectiveness of compliance checks depends on consistency. To illustrate, a national study collected data from state alcohol beverage control agencies and a random sampling of local law enforcement agencies (Erickson, Smolenski, Toomey, Carlin, & Wagenaar, 2013; Rutledge et al., 2013). Respondents were asked to report on the number of compliance checks they conducted and on such recommended practices as (a) checking all outlets in their jurisdiction; (b) conducting checks at least three or four times a year; and (c) conducting a follow-up check of establishments within 3 months of having failed a compliance check. Thirty-nine percent of local agencies and 79 percent of state agencies indicated they conducted compliance checks (Toomey, Lenk, Nelson, Jones-Webb, & Erickson, 2012). Although 60 percent of the agencies reported checking all outlets in their jurisdiction, only one-fifth conducted checks three to four times a year, and one third conducted follow-up checks. Only 4 to 6 percent conducted all three recommended practices (Erickson et al., 2014). As with previous studies, the use of compliance checks to enforce underage sales policies was found to be uneven and inconsistent in intensity.

A number of studies have used experimental designs to determine whether increasing the number of compliance checks results in lower rates of sales to minors. The NIAAA-funded Community Trials Project conducted experimental interventions to reduce underage drinking in three cities, including a six-fold increase in compliance checks in a randomly selected group of test outlets. At follow-up, the test outlets were half as likely to sell to minors as control sites (Grube, 1997). In

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<sup>32</sup> To be fully useful as measures of enforcement, these data must be corrected for enforcement pressure. However, measures of enforcement pressure can be difficult and expensive to obtain. Accordingly, arrests, compliance check failures, and similar data are often used in enforcement research.

Concord, New Hampshire, an enhanced enforcement campaign employed quarterly compliance checks of all off-sale licensees, enhanced administrative penalties, and included a media campaign (Centers for Disease Control and Prevention, 2004b). Similar to the Community Trials Project, this campaign resulted in a 64-percent reduction in sales to minors, and a temporary reduction in alcohol consumption and binge drinking among high school students. A multi-community time series trial, Complying with the Minimum Drinking Age (CMDA), also tested increased enforcement compliance checks, comparing this strategy with training retail outlet managers to reduce risks associated with alcohol sales (Wagenaar, Toomey, & Erickson, 2005). Although the effects of the training program were mixed, the compliance check intervention resulted in an immediate 17 percent reduction in underage sales. Over a 3-month period, these effects decayed completely in the case of off-sale premises and by half among on-sale premises. Data from the CMDA study also demonstrated that the effects of compliance checks may spill over to neighboring establishments (Erickson et al., 2013). Outlets that had a close neighbor that had been checked were less likely to serve to underage-appearing decoys.

Some of these experimental studies have included media campaigns to increase (a) public awareness of enforcement efforts, (b) the perception of risk of arrest, or (c) the perception of risk of sanctions. As discussed above, these perceptions can play an important role in compliance with the law. When community-based interventions to prevent underage drinking or other alcohol-related harms include a media campaign, this may increase public perception of the likelihood that the law will be enforced and violators sanctioned. The comprehensive, multifaceted Saving Lives Program was undertaken in six Massachusetts communities to reduce alcohol-impaired driving and related problems (Hingson et al., 1996). In addition to enhanced enforcement and educational programs, media campaigns were implemented to increase public awareness of the issue. Among other results, these communities showed a 42 percent decline in alcohol-related fatal crashes relative to the rest of the state. Awareness of enforcement notably increased among teenagers. For example, the percentage of this group that believed the license of a person caught drinking and driving could be suspended before a trial increased from 61 percent to 76 percent in the test communities, compared with no change in the rest of the state. The Community Trials Project discussed above also combined enhanced enforcement with local media coverage. Highly visible enhanced enforcement, such as roadside checkpoints, also served to increase both actual enforcement and perceived risk of arrest (Grube, 1997; Holder et al., 2000). This combination of environmental strategies resulted in lower volumes of self-reported drinking and fewer nighttime crashes.

A key determinant of enforcement effectiveness is the resources devoted to enforcement actions. A study that examined the relationship among underage alcohol policies in 50 California cities, enforcement of these policies, and adolescent alcohol use, identified an inverse relationship between the funding of enforcement of underage drinking laws and frequency of past-year underage alcohol use (Paschall, Grube, Thomas, Cannon, & Treffers, 2012). Similarly, a study of binge drinking among college students found a significant association between binge drinking rates and state ratings for resources devoted to enforcement (Nelson, Naimi, Brewer, & Wechsler, 2005).

## Practices

The STOP Act State Survey includes questions about the practices used by the states and (to the extent known) by local law enforcement to enforce underage drinking policies. Whether at the

point of sale or through other forms of illegal access to alcohol, these practices aim to both prevent current underage possession and consumption and deter future incidents.

In addition to compliance checks (discussed above), two other enforcement strategies are employed at the point of sale to prevent youth access to alcohol: Cops in Shops and shoulder tap operations (NRC and IOM, 2004; Paschall, Flewelling, & Grube, 2009). In the Cops in Shops program, developed by the Century Council (sponsored by the alcohol industry), undercover law enforcement officers pose as employees or customers in retail alcohol outlets to catch underage persons who attempt to purchase alcohol or adults who purchase alcohol for minors. Cops in Shops campaigns involve voluntary participation of retailers and are often well publicized, with the goal of educating the public and deterring underage access to alcohol.

Shoulder tap operations are another type of decoy operation. Because young people may perceive asking an adult to purchase alcohol for them as a less risky strategy for obtaining alcohol, this is another important point of access for law enforcement to address. In actual transactions, both the underage person and the adult are in violation of the law. In shoulder tap operations, trained young people (decoys) approach individuals outside of retail alcohol outlets and ask them to make an alcohol purchase. If the adult makes the purchase and gives it to the decoy, law enforcement may cite or arrest the adult.

Away from the point of sale, youth frequently are able to access alcohol at parties or other social gatherings. Parties are often cited as a high-risk setting for underage alcohol consumption and are linked to impaired driving, violence, and property damage (Hoover, 2005). In response, many local law enforcement agencies have used party patrols to intervene. Party patrols (or party dispersal) operations are patrols that identify underage drinking parties, make arrests, and issue citations at underage drinking parties. Police may use local noise or nuisance ordinances as the basis for entering the premises of parties involving underage drinking. They may conduct regular weekend patrols of locations where underage parties or gatherings are known to occur (NRC and IOM, 2004).

The data collected by the STOP Act State Survey provide greater insight into the use of such practices as compliance checks, Cops in Shops, shoulder tap operations, and party patrols by states and local jurisdictions. Together with the data collected on MIP arrests, penalties imposed for sales to minor violations (fines, license suspensions and revocations), and state expenditures on enforcement, they provide a more detailed picture of the underage drinking enforcement environment at both the state and national levels.



# CHAPTER 4.2

## POLICY SUMMARIES

## Laws Addressing Minors in Possession of Alcohol

### Underage Possession, Consumption, and Internal Possession

#### Policy Description

As of January 1, 2016, all 50 states and the District of Columbia prohibit possession of alcoholic beverages (with certain exceptions) by those under age 21. In addition, most but not all jurisdictions have statutes that specifically prohibit the consumption of alcoholic beverages by those under age 21.

In recent years, a number of jurisdictions have enacted laws prohibiting “internal possession” of alcohol by persons less than 21 years old. These provisions typically require evidence of alcohol in the minor’s body, but do not require any specific evidence of possession or consumption. Internal possession laws are especially useful to law enforcement in making arrests or issuing citations when breaking up underage drinking parties. Internal possession laws allow officers to bring charges against underage individuals who are neither holding nor drinking alcoholic beverages in the presence of law enforcement officers. As with laws prohibiting underage possession and consumption, jurisdictions that prohibit internal possession may apply various statutory exceptions to these provisions.

Although all jurisdictions prohibit possession of alcohol by minors, some jurisdictions do not specifically prohibit underage alcohol consumption. In addition, some jurisdictions that do prohibit underage consumption allow for exceptions for consumption that differ from those that apply to underage possession. Jurisdictions that may prohibit underage possession or consumption may or may not address the issue of internal possession.

Some jurisdictions allow exceptions to possession, consumption, or internal possession prohibitions when a family member consents or is present. Jurisdictions vary widely in terms of which relatives may consent or must be present for this exception to apply and in what circumstances the exception applies. Sometimes a reference is made simply to “family” or “family member” without further elaboration.

Some jurisdictions allow exceptions to possession, consumption, or internal possession prohibitions on private property. Jurisdictions vary in the extent of the private property exception, which may extend to all private locations, private residences only, or in the home of a parent or guardian only. In some, a location exception is conditional on the presence or consent of a parent, legal guardian, or spouse.

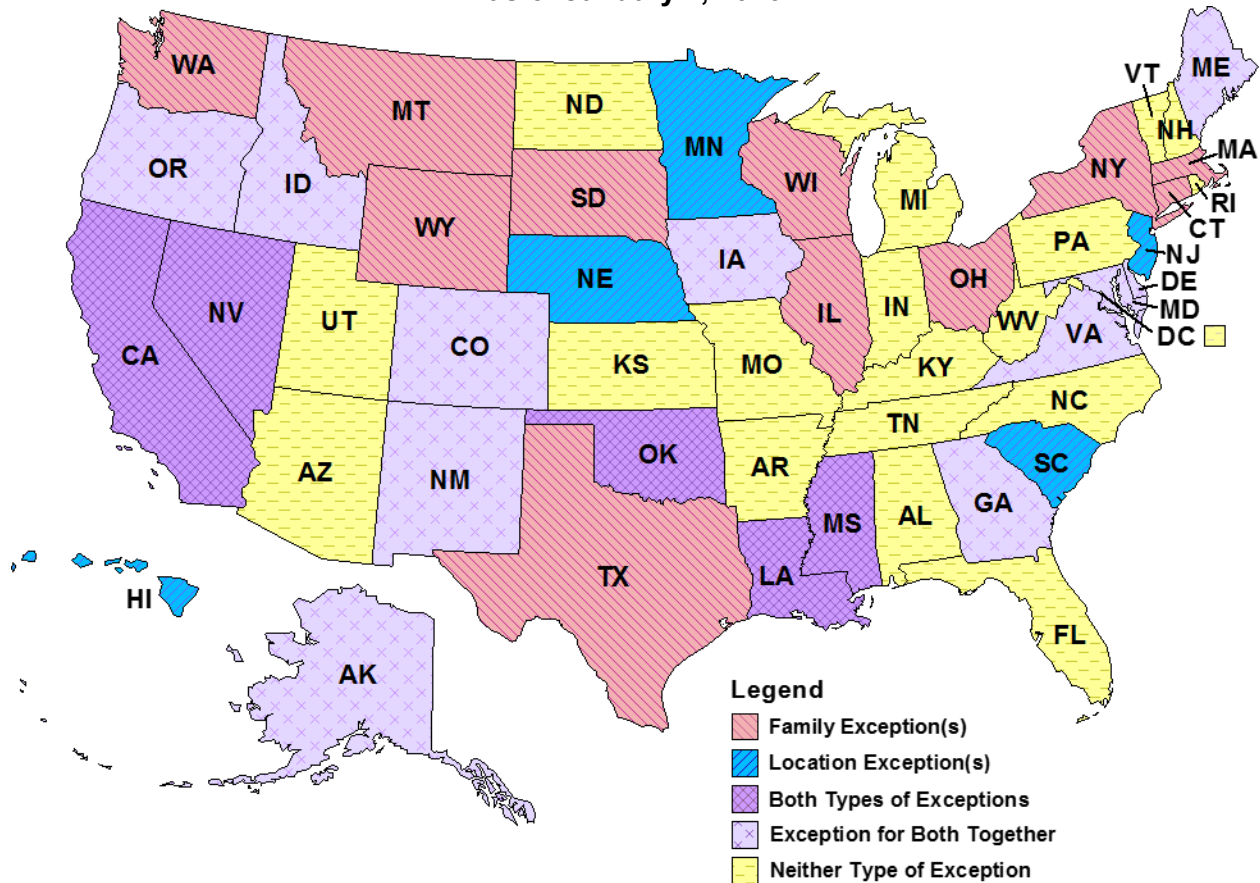
With respect specifically to consumption laws, some jurisdictions prohibit underage consumption only on licensed premises.

#### Status of Underage Possession Policies

As of January 1, 2016, all 50 states and the District of Columbia prohibit possession of alcoholic beverages by those under age 21. Twenty-seven jurisdictions have some type of family exception, 21 have some type of location exception, and 19 have neither (see Exhibit 4.2.1). Some location exceptions limit the location to the parent/guardian’s residence, some apply to any private residence, and some apply to any private location.



**Exhibit 4.2.1: Exceptions to Minimum Age of 21 for Possession of Alcohol as of January 1, 2016**



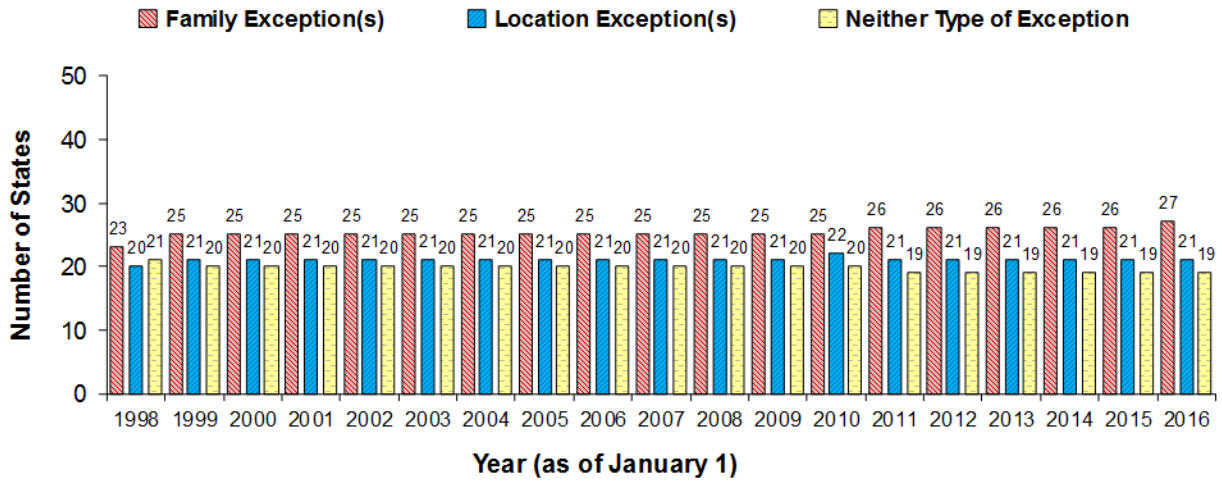
**Trends in Underage Possession Policies**

During the period between 1998 and 2016, the number of jurisdictions with family exceptions rose from 23 to 27, the number with location exceptions rose from 20 to 21, and the number of jurisdictions with neither exception decreased from 21 to 19 (see Exhibit 4.2.2).

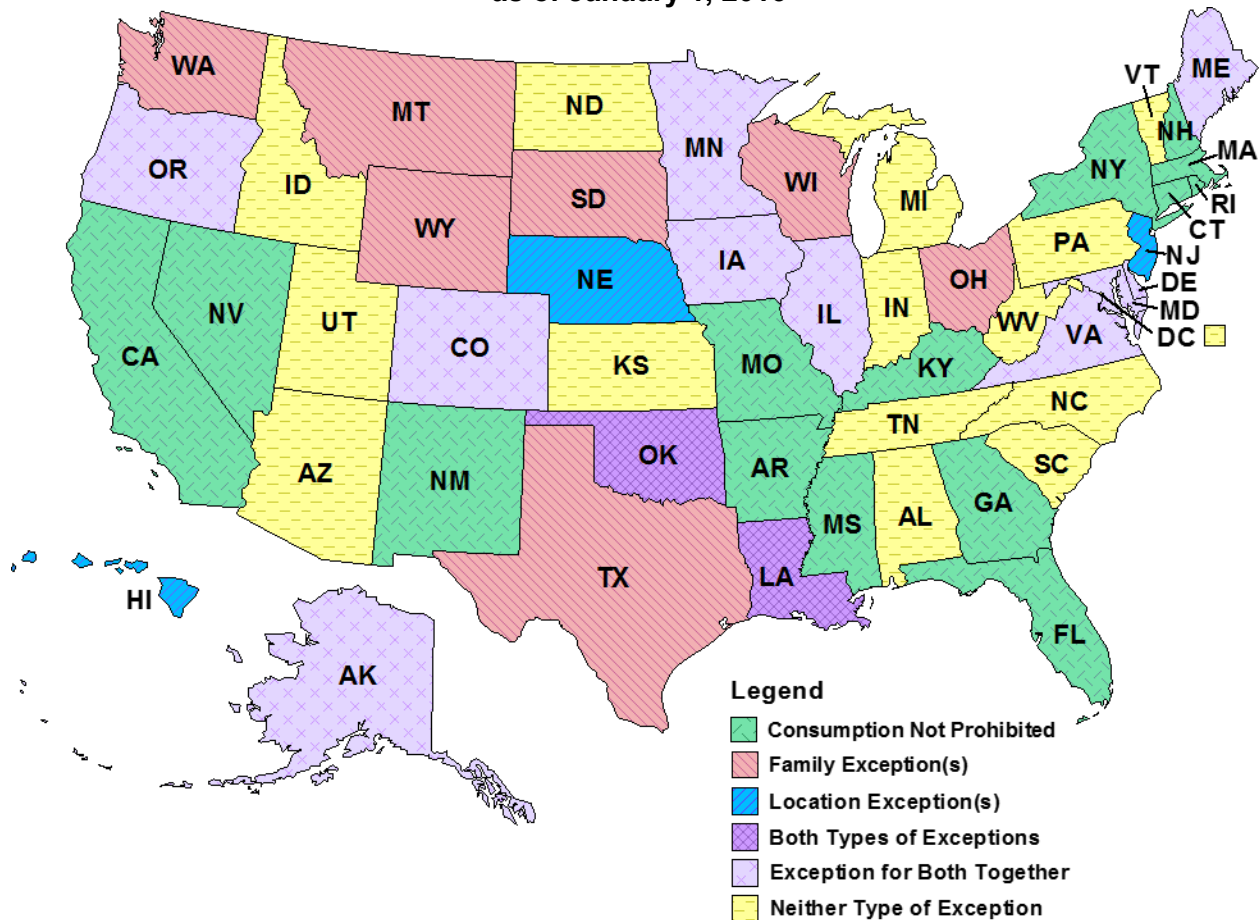
**Status of Underage Consumption Policies**

As of January 1, 2016, 37 jurisdictions prohibit consumption of alcoholic beverages by those under age 21. Of those, 19 permit family exceptions to the law, 15 permit location exceptions, and 14 permit neither type of exception (see Exhibit 4.2.3). Seven states (Montana, Ohio, South Dakota, Texas, Washington, Wisconsin, and Wyoming) permit only family exceptions; three states (Hawaii, New Jersey, and Nebraska) permit only location exceptions. Twelve states had both types of exceptions, with 11 states permitting underage consumption only if both family and location criteria are met.

**Exhibit 4.2.2: Number of States with Family and Location Exceptions to Minimum Age of 21 for Possession of Alcohol, January 1, 1998, through January 1, 2016**



**Exhibit 4.2.3: Exceptions to Minimum Age of 21 for Consumption of Alcohol as of January 1, 2016**



**Trends in Underage Consumption Policies**

As Exhibit 4.2.4 illustrates, during the period between 1998 and 2016, the number of jurisdictions that did not prohibit underage consumption decreased from 24 to 14. Location exceptions rose from 9 to 15; family exceptions rose from 13 to 19; and the number of jurisdictions with neither type of exception rose from 13 to 14.

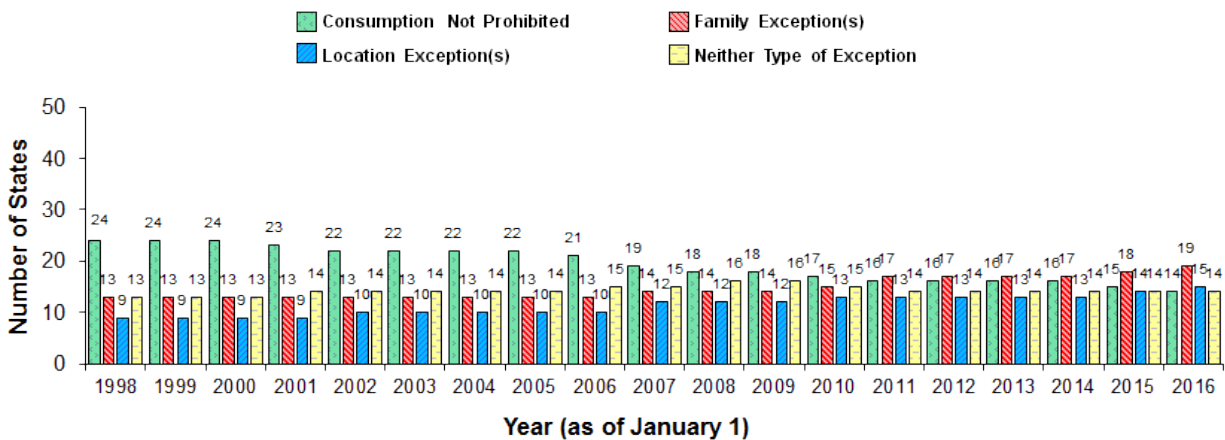
**Status of Underage Internal Possession Policies**

As of January 1, 2016, nine states prohibit internal possession of alcoholic beverages for anyone under age 21 (see Exhibit 4.2.5). Of the nine states that prohibit internal possession, six do not make any exceptions. In contrast, Colorado has exceptions for situations in which parents or guardians are present and give consent and the possession occurs in any private location. South Carolina’s law makes an exception for internal possession in the homes only of parents or guardians. Wyoming makes exceptions for situations in which parents, guardians, and spouses are present.

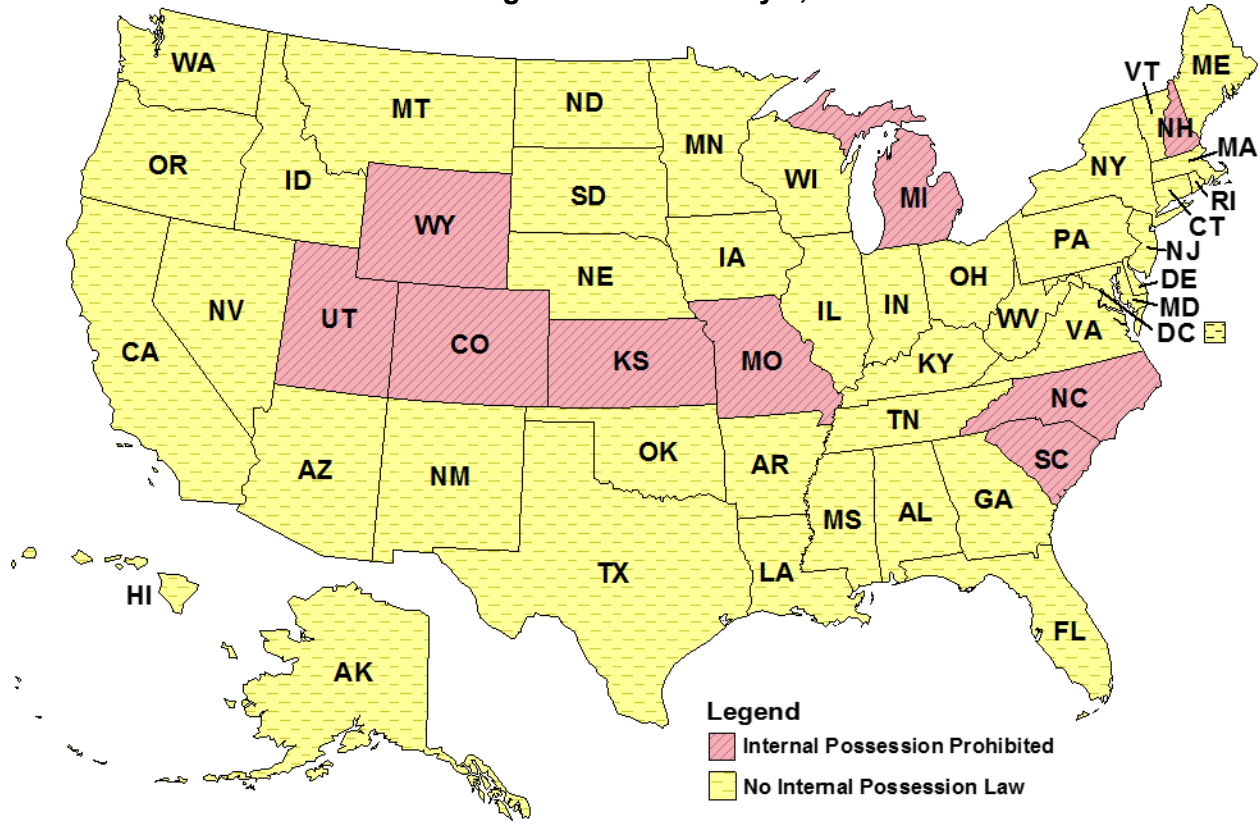
**Trends in Underage Internal Possession Policies**

As Exhibit 4.2.6 illustrates, during the period between 1998 and 2016, the number of states that prohibit underage internal possession grew steadily from two to nine. The most recent state to enact a prohibition on internal possession is Wyoming.

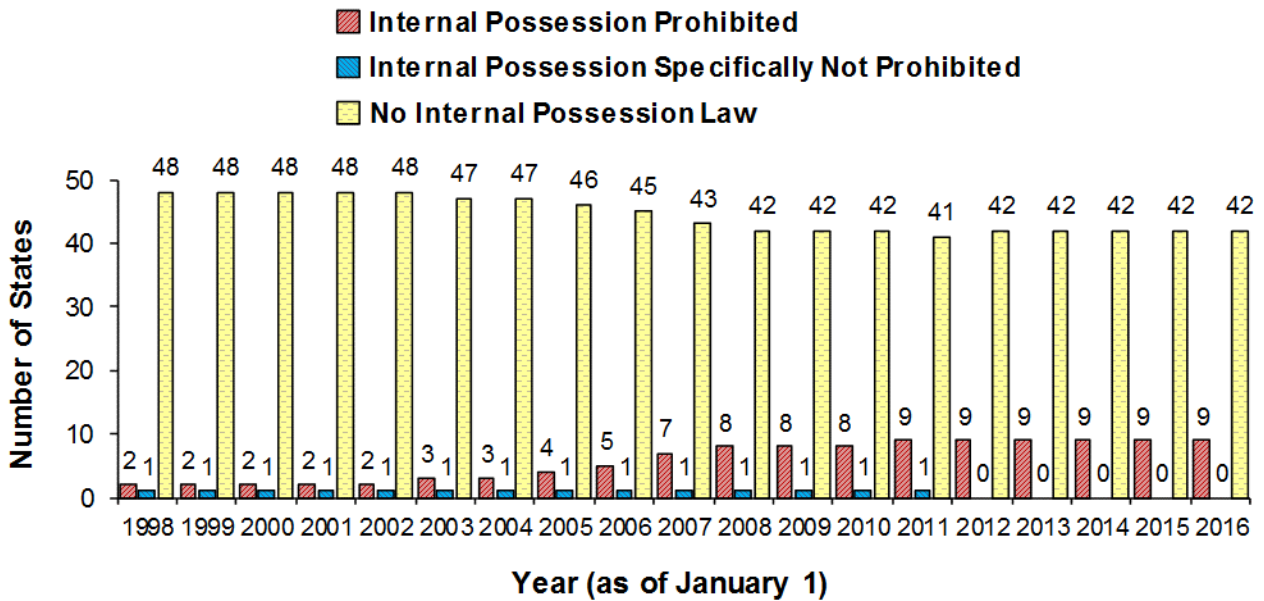
**Exhibit 4.2.4: Number of States with Family and Location Exceptions to Minimum Age of 21 for Consumption of Alcohol, January 1, 1998, through January 1, 2016**



**Exhibit 4.2.5: Prohibition of Internal Possession of Alcohol by Persons Under Age 21 as of January 1, 2016**



**Exhibit 4.2.6: Distribution of States with Laws Prohibiting Internal Possession of Alcohol by Persons Under Age 21, January 1, 1998, through January 1, 2016**



## References and Further Information

All data for underage possession, consumption, and internal possession policy topics were obtained at <http://www.alcoholpolicy.niaaa.nih.gov> from the Alcohol Policy Information System (APIS; follow links to the policy titled “Underage Possession/Consumption/Internal Possession of Alcohol”). APIS provides further descriptions of this set of policies and its variables, details regarding state policies, and a review of the limitations associated with the reported data. To see definitions of the variables for this policy, visit [stopalcoholabuse.gov](http://stopalcoholabuse.gov) and follow links to the Report to Congress, Supplemental Materials, Definitions of Variables in Legal Policies. in Legal Policies.

- Albers, A. B., Siegel, M., Ramirez, R. L., Ross, C., DeJong, W., & Jernigan, D. H. (2015). Flavored alcoholic beverage use, risky drinking behaviors, and adverse outcomes among underage drinkers: Results from the ABRAND study. *American Journal of Public Health, 105*(4), 810–815.
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## Underage Purchase and Attempted Purchase

### Policy Description

Most states, but not all, prohibit minors from purchasing or attempting to purchase alcoholic beverages. A minor purchasing alcoholic beverages can be prosecuted for possession because, arguably, a sale cannot be completed until there is possession on the part of the purchaser. Purchase and possession are nevertheless separate offenses. A minor who purchases alcoholic beverages is potentially liable for two offenses in states that have both prohibitions (see the “Underage Possession/Internal Possession/Consumption” section of this report for further discussion).<sup>1</sup> A significant minority of youths purchase or attempt to purchase alcohol for themselves, sometimes using falsified identification (see the “False Identification” section of this report).

Such purchases increase the availability of alcohol to underage persons, which, in turn, increases underage consumption. Prohibitions and associated sanctions on alcohol purchases by underage persons can be expected to depress rates of purchase and attempted purchase by raising the monetary and social costs of this behavior. Such laws provide a primary deterrent (preventing attempted purchases) and a secondary deterrent (reducing the probability that persons sanctioned under these laws will attempt to purchase in the future).

In some states, a person under age 21 is allowed to purchase alcoholic beverages as part of a law enforcement action. Most commonly, these actions are checks on merchant compliance or stings to identify merchants who illegally sell alcoholic beverages to minors. This allowance for purchase in the law enforcement context may exist even though a state does not have a law specifically prohibiting underage purchase.

### Status of Underage Purchasing Policies

As of January 1, 2016, 46 states and the District of Columbia prohibit underage purchase or attempted purchase of alcohol; the remaining four states (Delaware, Indiana, New York, and Vermont) do not (see Exhibit 4.2.7). Underage persons are allowed to purchase alcohol for law enforcement purposes in 24 states including Indiana, even though Indiana does not have an underage purchase statute. The other states without underage purchase statutes have no allowances for such purchases made for law enforcement purposes.

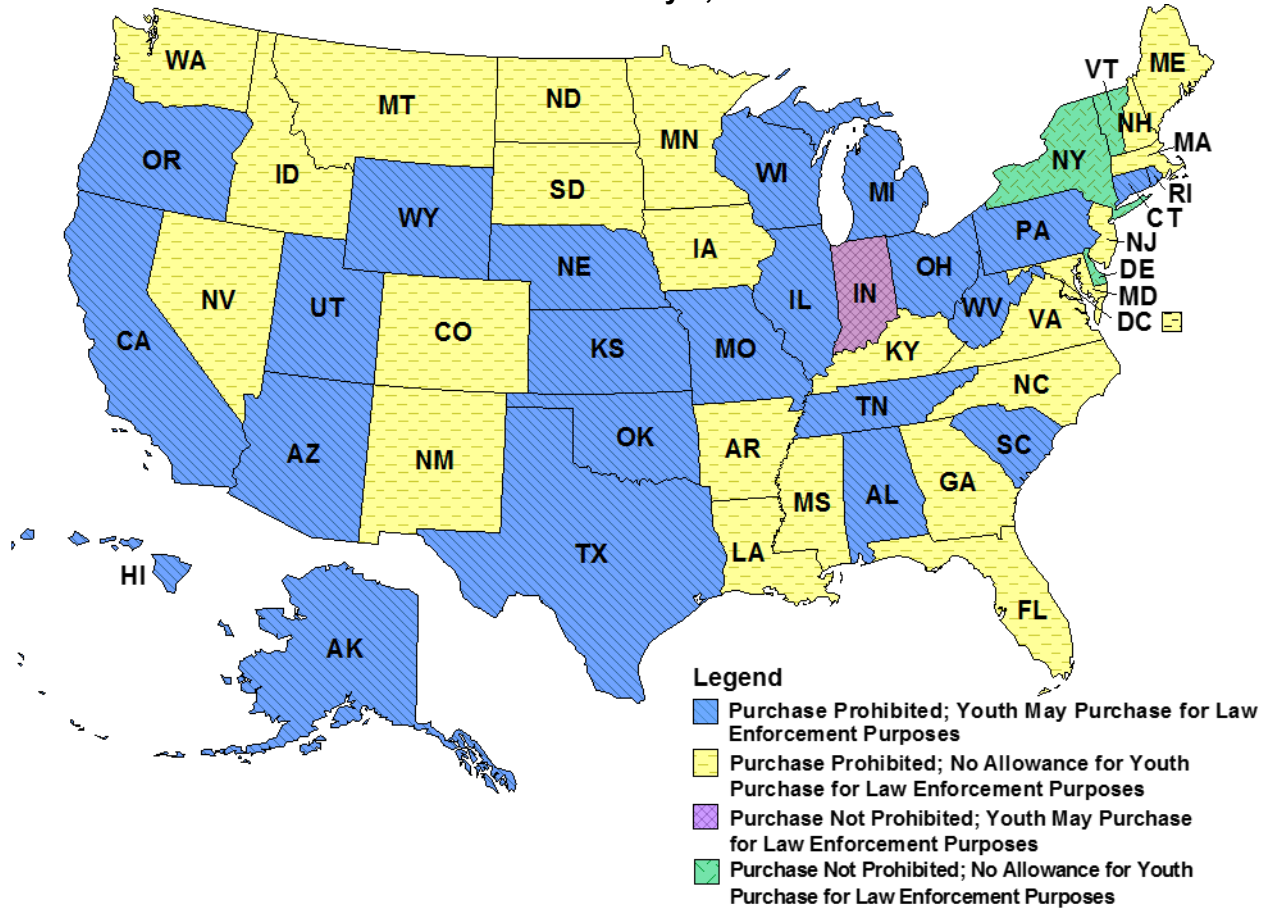
### Trends in Underage Purchasing Policies

Since 1998, the number (47) of jurisdictions prohibiting underage purchase of alcohol has remained the same. During that period, the number of states with allowances for underage purchase for enforcement purposes has steadily increased, from 9 in 1998 to 24 in 2016 (Exhibit 4.2.8).

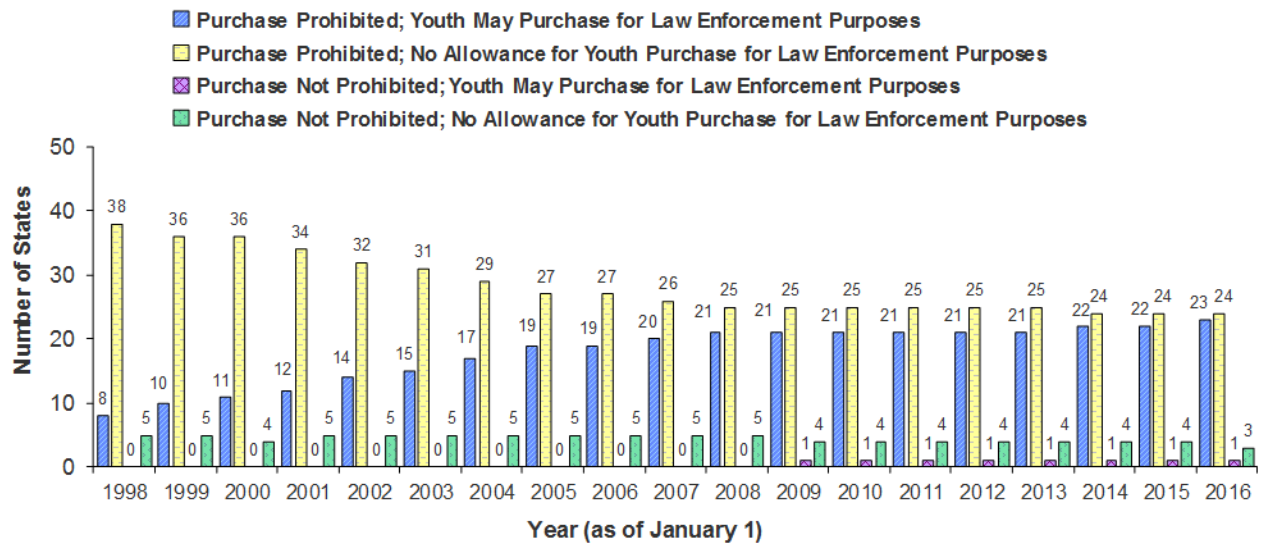
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<sup>1</sup> Some states have laws that specifically prohibit both underage purchase and attempted purchase of alcohol. An attempted purchase occurs when a minor takes concrete steps toward committing the offense of purchasing whether or not the purchase is consummated. Courts in states that include only the purchase prohibition in their statutes would likely treat attempted purchase as a lesser included offense. It can, therefore, be assumed that all states that prohibit purchase also prohibit attempted purchases. The two offenses are therefore not treated separately in this report.

**Exhibit 4.2.7: Underage Purchase of Alcohol for Law Enforcement Purposes as of January 1, 2016**



**Exhibit 4.2.8: Underage Purchase of Alcohol for Law Enforcement Purposes, January 1, 1998, through January 1, 2016**



## References and Further Information

All data for this policy were obtained from the Alcohol Policy Information System (APIS) at <http://www.alcoholpolicy.niaaa.nih.gov>. Follow links to the policy titled “Underage Purchase of Alcohol.” APIS provides further descriptions of this policy and its variables, details regarding state policies, and a review of the limitations associated with the reported data. To see definitions of the variables for this policy, visit [stopalcoholabuse.gov](http://stopalcoholabuse.gov) and follow links to the Report to Congress, Supplemental Materials, Definitions of Variables in Legal Policies.

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## False Identification (“False ID”)

### Policy Description

Alcohol retailers are responsible for ensuring that sales of alcoholic beverages are made only to individuals who are legally permitted to purchase alcohol. Inspecting government-issued identification (driver’s license, nondriver ID card, passport, and military ID) is one major mechanism for ensuring that buyers meet minimum age requirements. In attempting to circumvent these safeguards, minors may obtain and use apparently valid ID that falsely states their age as 21 or over. Age may be falsified by altering the birthdate on a valid ID, obtaining an invalid ID card that appears to be valid, or using someone else’s ID.

Compliance check studies suggest that underage drinkers may have little need to use false ID because retailers often make sales without any ID inspection. However, concerns about false ID remain high among educators, law enforcement officials, retailers, and government officials. Current technology, including high-quality color copiers and printers, has made false ID easier to fabricate, and the internet provides ready access to a large number of false ID vendors.

All states prohibit use of false ID by minors to obtain alcohol. In addition to basic prohibitions, states have adopted a variety of legal provisions pertaining to false ID for obtaining alcohol. These provisions can be divided into three basic categories:

- Provisions that target minors who possess and use false ID to obtain alcohol
- Provisions that target those who supply minors with false ID, either through lending of a valid ID or production of invalid (“fake”) IDs
- Provisions that assist retailers in avoiding sales to potential buyers who present false IDs

Government-issued IDs are used for a number of age-related purposes other than the purchase of alcohol: registering to vote, enlisting in the military, entering certain entertainment venues, and so on. The Alcohol Policy Information System (APIS) confines its analysis to statutes and regulations relating to the use of false identification for the purpose of obtaining alcohol.

For further discussion of policies pertaining to the purchase of alcohol by minors, see the “Underage Purchase and Attempted Purchase” section of this report; for policies that mandate training of servers to detect false identification, see the “Responsible Beverage Service” section of this report; and for policies on license suspension or revocation, see the “Loss of Driving Privileges for Alcohol Violations by Minors” section of this report.

### Status of False ID Policies

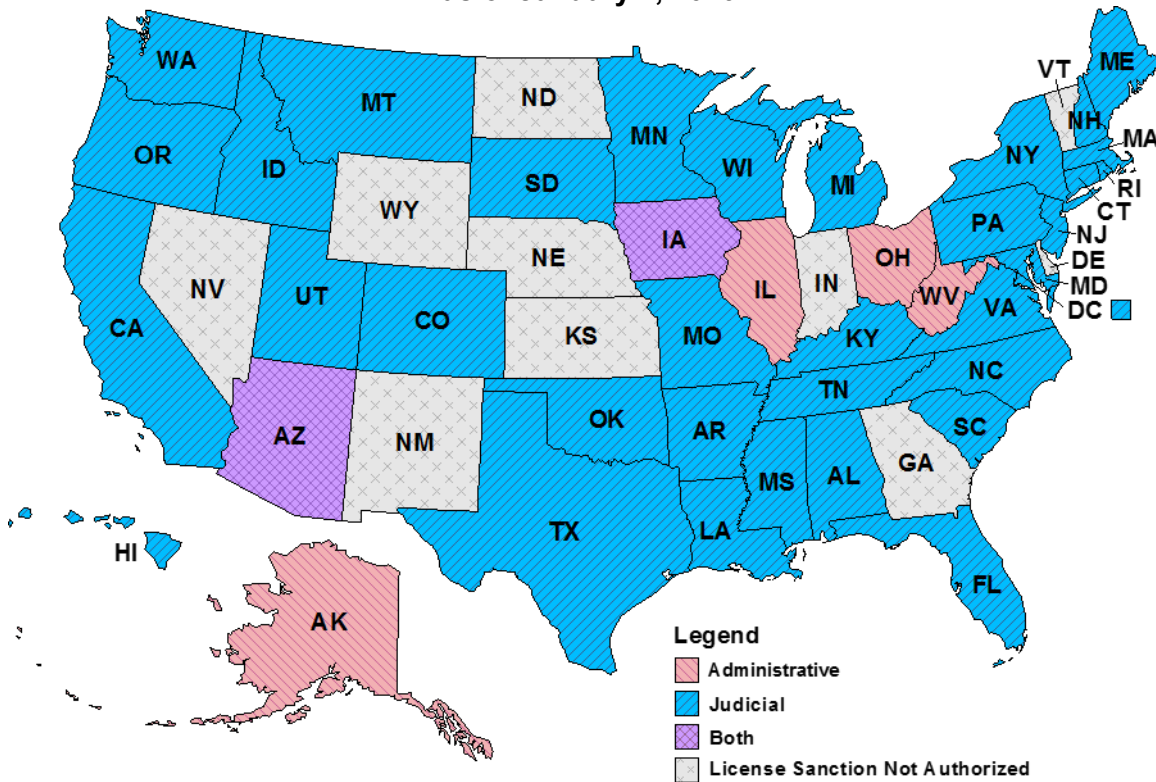
#### *Provisions That Target Minors*

As of January 1, 2016, all states and the District of Columbia prohibit minors from using false IDs to obtain alcohol (see Exhibit 4.2.9). All but nine states (Delaware, Georgia, Kansas, Nebraska, Nevada, New Mexico, North Dakota, Vermont, and Wyoming) authorize suspension of minors’ driver’s licenses for using a false ID in the purchase of alcohol. In all but five states (Alaska, Illinois, Indiana, Ohio, and West Virginia), the suspension is through judicial proceedings.

Two states (Arizona and Iowa) allow for both judicial and administrative proceedings for license sanctions.



**Exhibit 4.2.9: Procedure for Imposing License Sanction for Use of False ID as of January 1, 2016**



**Provisions That Target Suppliers**

As of January 1, 2016, 25 states have laws that target suppliers of false IDs; 24 prohibit lending, transferring, or selling false IDs to minors for the purpose of purchasing alcohol; and 13 prohibit manufacturing such licenses.

**Retailer Support Provisions**

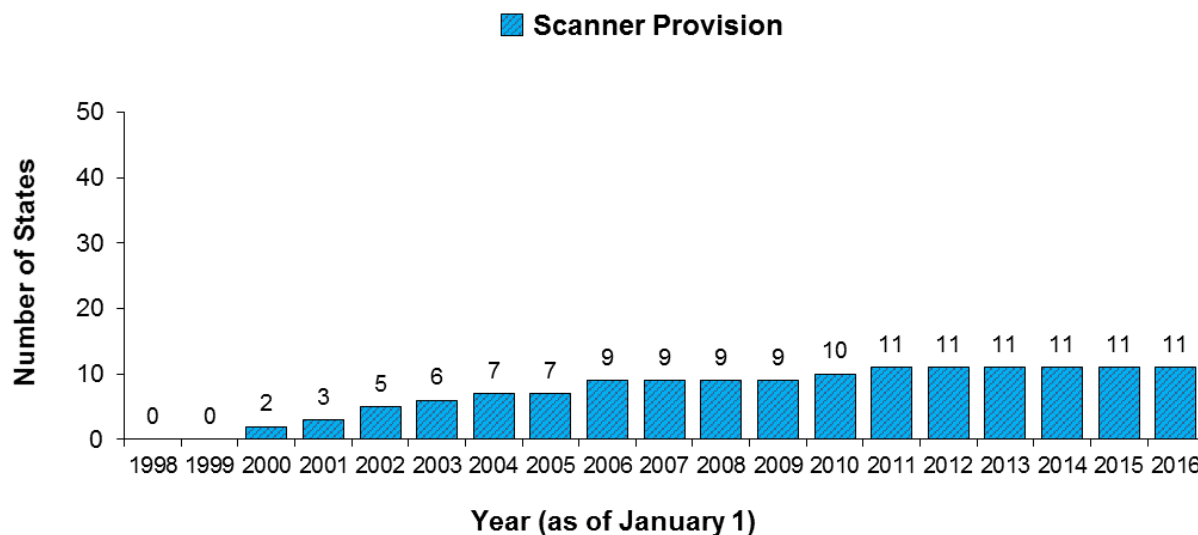
Retailer support provisions vary widely across the states. In prosecution involving an illegal underage alcohol sale, 44 states and the District of Columbia provide for some type of affirmative defense (the retailer shows that he/she reached a good faith or reasonable conclusion that the false ID was valid); 44 states have laws requiring distinctive licenses for persons under age 21; 11 states permit retailers to seize apparently false IDs; 11 states provide incentives for the use of scanners; 4 states (Arkansas, Colorado, South Dakota, and Utah) allow retailers to detain minors; and 5 states (Alaska, Oregon, New Hampshire, Utah, and Wisconsin) permit retailers to sue minors for damages.

**Trends in False ID State Policies**

State false ID policies that target minors and suppliers have been relatively stable for the last 12 years. During this period, Hawaii, Maine, Mississippi, and South Dakota implemented judicial license revocation, and Missouri enacted a law making it illegal to lend, transfer, or sell false IDs to minors. By contrast, states have been actively enacting four of the retailer support provisions. All 11 scanner provisions were enacted over the last 12 years (see Exhibit 4.2.10). Two of the specific affirmative defense laws (Arizona and Vermont), two of the right-to-detain-minors laws



**Exhibit 4.2.10: Number of States With Scanner Provisions in False ID Laws, January 1, 1998, through January 1, 2016**



(Arkansas and South Dakota), and four of the right-to-sue-minors laws (Alaska, New Hampshire, Utah, and Wisconsin) were enacted during this time period. Idaho and Georgia are exceptions to the general trend; in 2007, Idaho rescinded its law permitting retailers to seize apparently false IDs. In 2015, Georgia eliminated its license suspension penalty.

### References and Further Information

All data for this policy were obtained from the APIS at <http://www.alcoholpolicy.niaaa.nih.gov>. Follow links to the policy titled “False Identification for Obtaining Alcohol.” APIS provides further descriptions of this policy and its variables, details regarding state policies, and a review of the limitations associated with the reported data. To see definitions of the variables for this policy, visit [stopalcoholabuse.gov](http://stopalcoholabuse.gov) and follow links to the Report to Congress, Supplemental Materials, Definitions of Variables in Legal Policies.

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## Laws Targeting Underage Drinking and Driving

### Youth Blood Alcohol Concentration Limits (underage operators of noncommercial motor vehicles)

#### Policy Description

Blood alcohol concentration (BAC) limits policies establish the maximum amount of alcohol a minor can have in his or her bloodstream when operating a motor vehicle. BAC is commonly expressed as a percentage. For instance, a BAC of 0.08 percent means that a person has 8 parts alcohol per 10,000 parts blood in the body. State laws generally specify BAC levels in terms of grams of alcohol per 100 milliliters of blood (often abbreviated as grams per deciliter, or g/dL). BAC levels can be detected by breath, blood, or urine tests. The laws of each jurisdiction specify the preferred or required types of tests used for measurement.

There is strong scientific evidence that, as BAC increases, the cognitive and motor skills needed to operate a motor vehicle are increasingly impaired. BAC statutes establish criteria for determining when the operator of a vehicle is sufficiently impaired to constitute a threat to public safety and is, therefore, violating the law. Currently, all states and the District of Columbia mandate a BAC limit of 0.08 g/dL for adult drivers.

Owing to differences between young people and adults (e.g., body mass, physiological development, driving experience), young people's ability to safely operate a motor vehicle is impaired at a lower BAC than for adults. Partly as a result of financial incentives established by the federal government, all jurisdictions in the United States have enacted low BAC limits for underage drivers. Laws establishing very low legal BAC limits of 0.02 g/dL or less for drivers under the legal drinking age of 21 are widely referred to as zero-tolerance laws.

A per se BAC statute stipulates that if the operator has a BAC level at or above the per se limit, a violation has occurred without regard to other evidence of intoxication or sobriety (e.g., how well or poorly the individual is driving). In other words, exceeding the BAC limit established in a per se statute is itself a violation.

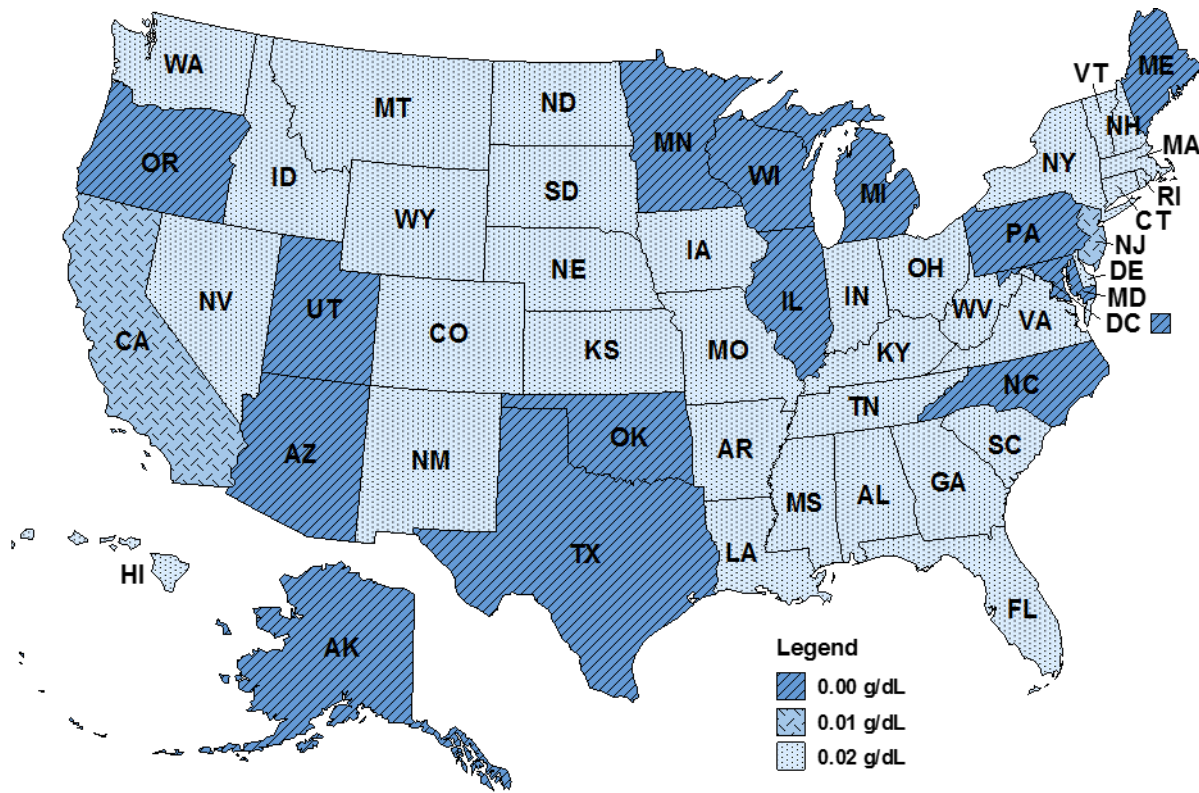
#### Status of Youth BAC Limit Policies

As of January 1, 2016, all states have per se youth BAC statutes (see Exhibit 4.2.11). Thirty-four states set the driving BAC limit for underage persons at 0.02 g/dL. The District of Columbia and 14 states consider any underage alcohol consumption while driving to be a violation of the law and have set the limit to 0.00 g/dL. Two states (California and New Jersey) have set the underage BAC limit to 0.01 g/dL.

#### Trends in Youth BAC Limit Policies

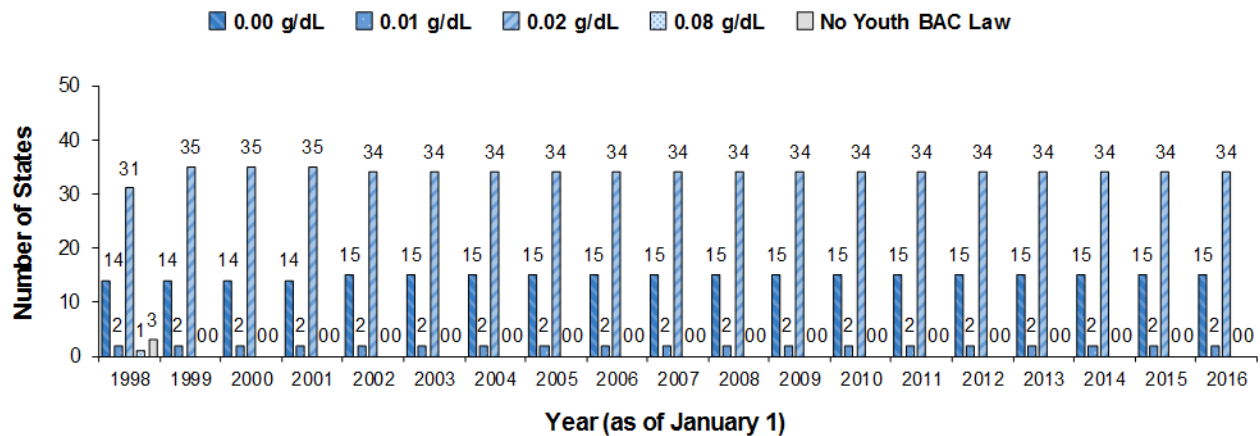
Since 1998, all states have had zero tolerance (0.02 g/dL or lower) youth BAC limit laws (see Exhibit 4.2.12). In the period between 1999 and 2016, the number of states mandating specific BAC limits for underage drivers remained constant with the exception of one state (Maryland), which lowered its underage BAC limit from 0.02 to 0.00 g/dL. Prior to 1998, three states (South Carolina, South Dakota, and Wyoming) had no youth BAC limits and one (Mississippi) set the limit at 0.08 g/dL.

**Exhibit 4.2.11: BAC Limits for Youth Operators as of January 1, 2016**



All States Use the *Per Se* Rule

**Exhibit 4.2.12: Distribution of Youth (underage operators of noncommercial motor vehicles) BAC Limit Laws, January 1, 1998, through January 1, 2016**



**References and Further Information**

All data for this policy were obtained from the Alcohol Policy Information System (APIS) at <http://www.alcoholpolicy.niaaa.nih.gov>. Follow links to the policy titled “Blood Alcohol Concentration Limits: Youth (Underage Operators of Noncommercial Motor Vehicles).” APIS provides further descriptions of this policy and its variables, details regarding state policies, and a review of the limitations associated with the reported data. To see definitions of

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## Loss of Driving Privileges for Alcohol Violations by Minors (“Use/Lose” Laws)

### Policy Description

Use/lose laws authorize suspension or revocation of driving privileges as a penalty for underage purchase, possession, or consumption of alcoholic beverages. States began enacting these statutes in the mid-1980s to deter underage drinking by imposing a punishment that young people would consider significant: the loss of a driver’s license. In most states, use/lose laws make it mandatory to impose driver’s license sanctions in response to underage alcohol violations. State laws vary as to the type of violation (purchase, possession, or consumption of alcohol) that leads to these sanctions and how long suspensions or revocations stay in effect.

State laws specific to minors (purchase, possession, and consumption of alcoholic beverages) are described in the “Underage Purchase and Attempted Purchase,” “Underage Possession,” “Underage Consumption,” and “Internal Possession by Minors” sections of this report.

### Status of Loss of Driving Privileges Policies

#### *Upper Age Limits*

Twenty-five states and the District of Columbia set age 21 as the upper limit for which use/lose laws apply. Fourteen states set the upper limit at age 18, and one state (Wyoming) sets the limit at age 19. In four states (Arkansas, Hawaii, Tennessee, and Virginia), some sanction conditions vary depending on whether the violator is under age 18 or under age 21.

#### *Authority to Impose License Sanctions*

The vast majority of jurisdictions (33 states and the District of Columbia) have made license suspension or revocation mandatory in cases of underage alcohol violations (see Exhibit 4.2.13). Nine states have made this a discretionary penalty for such violations, and 10 states have no use/lose law. One state (Hawaii) makes this a discretionary penalty for minors below age 18, but mandatory for violators ages 18 through 20. (The total of states is greater than 51 because some have both mandatory and discretionary laws.)

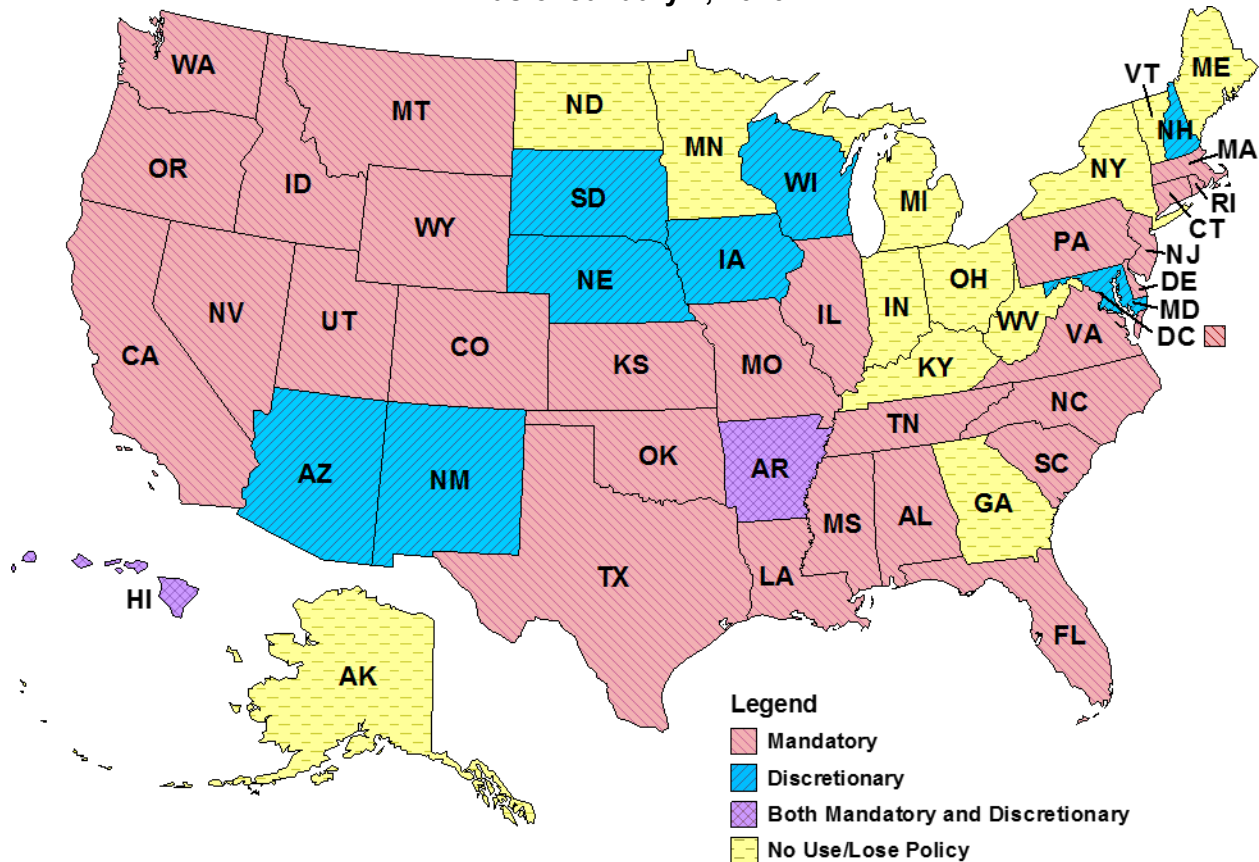
#### *Trends in Loss of Driving Privileges Policies*

Between 1998 and 2016, the number of jurisdictions that made license suspension or revocation mandatory in cases of underage alcohol violations increased from 25 to 31 (see Exhibit 4.2.14). During this period, the number of jurisdictions with no use/lose laws decreased from 17 to 12, and the number with discretionary authority to impose use/lose sanctions started the time period at 10 and, with some changes in intervening years, is at 10 once again.

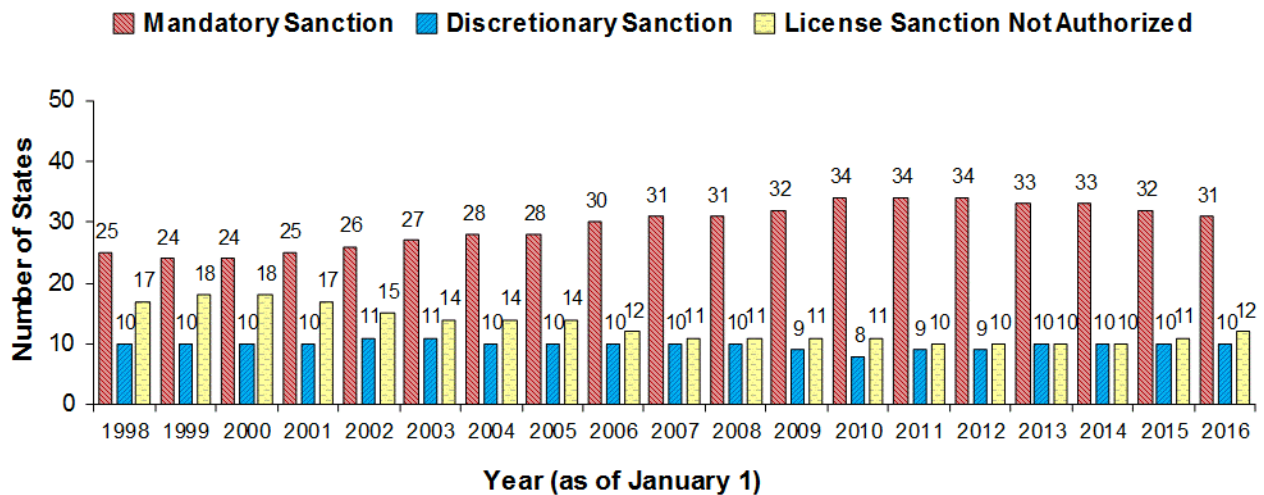
### References and Further Information

Data for this policy were obtained from the Alcohol Policy Information System (APIS) at <http://www.alcoholpolicy.niaaa.nih.gov>. Follow links to the policy titled “Loss of Driving Privileges for Alcohol Violations by Minors (“Use/Lose” Laws).” APIS provides further descriptions of this policy and its variables, details regarding state policies, and a review of the limitations associated with the reported data. To see definitions of the variables for this policy, visit [stopalcoholabuse.gov](http://stopalcoholabuse.gov) and follow links to the Report to Congress, Supplemental Materials, Definitions of Variables in Legal Policies.

**Exhibit 4.2.13: License Suspension/Revocation for Alcohol Violations by Minors as of January 1, 2016**



**Exhibit 4.2.14: Distribution of License Suspension/Revocation Procedures for Alcohol Violations by Minors, January 1, 1998, through January 1, 2016**



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## Graduated Driver's Licenses

### Policy Description

Graduated driver licensing (GDL) is a system designed to delay full licensure for teenage automobile drivers, thus allowing beginning drivers to gain experience under less risky conditions. Teenagers are targeted because they are at the highest risk for motor vehicle crashes, including alcohol-related crashes. By imposing restrictions on driving privileges, GDL reduces the chances of teenagers driving while intoxicated.

A fully developed GDL system has three stages: a minimum supervised learner's period, an intermediate license (once the driving test is passed) that limits unsupervised driving in high-risk situations, and a full-privilege driver's license available after completion of the first two stages. Beginners must remain in each of the first two stages for set minimum time periods.

The learner's stage has three components:

- Minimum age at which drivers can operate vehicles in the presence of parents, guardians, or other adults
- Minimum holding periods during which learner's permits must be held before drivers advance to the intermediate stage of the licensing process
- Minimum age at which drivers become eligible to drive without adult supervision

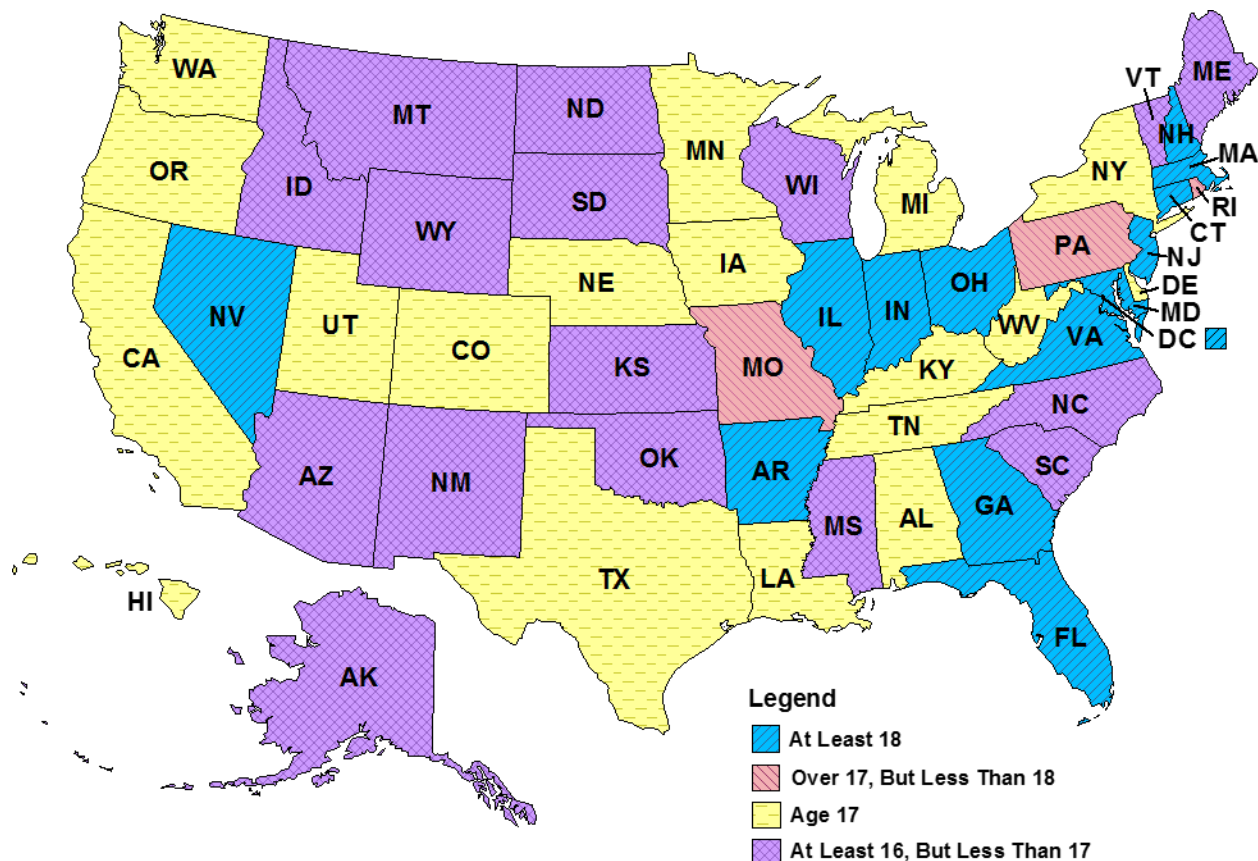
The intermediate stage of GDL law has five components:

- Minimum age at which drivers become eligible to drive without adult supervision
- Unsupervised night-driving prohibitions
- Primary enforcement of night-driving provisions
- Passenger restrictions, which set the total number of passengers allowed in vehicles driven by intermediate-stage drivers
- Primary enforcement of passenger restrictions

“Primary enforcement” refers to the authority given to law enforcement officers to stop drivers for the sole purpose of investigating potential violations of night-driving or passenger restrictions. Law enforcement officers in states without primary enforcement can investigate potential violations of these provisions only as part of an investigation of some other offense. Primary enforcement greatly increases the chance that violators will be detected. The single component for the license stage of GDL is the minimum age at which full licensure occurs and both passenger and night-driving restrictions are lifted.

### Status of Graduated Driver Licensing Policies

All 51 jurisdictions have some form of GDL policy and all states have full three-stage criteria (see Exhibit 4.2.15). The minimum ages for each stage and the extent to which the other restrictions are imposed vary across jurisdictions. An important GDL provision related to traffic safety is the minimum age for full licensure. Fifteen jurisdictions allow full licensure on the 18th birthday; three jurisdictions permit it at age above 17 but under 18; and 17 permit it on the 17th birthday. The remaining 16 jurisdictions permit full licensure to those who are under 17 but at least 16 years old. All but one jurisdiction has night-driving restrictions; the hours during which these restrictions apply vary widely among jurisdictions, but fall largely between 6 p.m. and

**Exhibit 4.2.15: Minimum Age of Full Driving Privileges Laws as of January 1, 2016**

1 a.m. Thirty-eight jurisdictions have primary enforcement of night-driving restrictions. Forty-seven jurisdictions place passenger restrictions on drivers with less than full licensure, and 32 of those have primary enforcement of these restrictions.

### Trends in Graduated Driver Licensing Policies

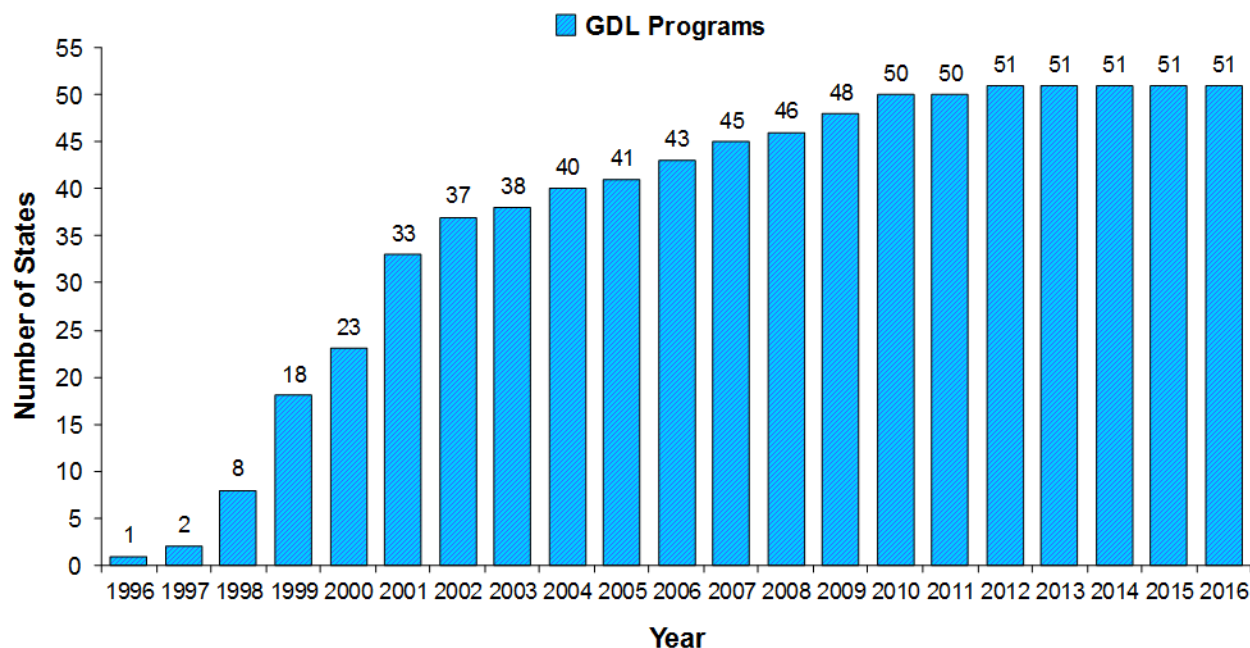
Since the mid-1990s, states enacting three-stage GDL laws have steadily increased (see Exhibit 4.2.16). On January 1, 1996, only one state (Maryland) had such a law, but by 2000, 23 jurisdictions had enacted three-stage GDL laws, and by 2012, that number had risen to 51.

### References and Further Information

Legal research for this topic is planned and managed by the Substance Abuse and Mental Health Services Administration (SAMHSA) and conducted under contract by The CDM Group, Inc. Historical data for the years 1996 through 2004 were obtained from Chen, Baker, and Li (2006). Data from January 1, 2005, until December 31, 2008, were obtained from the Insurance Institute for Highway Safety ([http://www.iihs.org/laws/pdf/us\\_licensing\\_systems.pdf](http://www.iihs.org/laws/pdf/us_licensing_systems.pdf)).



**Exhibit 4.2.16: Number of States (and District of Columbia) with Three-Stage GDL Policies, July 1, 1996 through January 1, 2016**



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## Laws Targeting Alcohol Suppliers

### Furnishing Alcohol to Minors

#### Policy Description

All states prohibit furnishing alcoholic beverages to minors by both commercial servers (bars, restaurants, retail sales outlets) and noncommercial servers. However, examination of case law would be required to determine with certainty that the prohibition applies to both commercial and noncommercial servers in all states. Additionally, most states include some type of exception (of the types listed below) to their furnishing laws.

Most underage persons obtain alcohol from adults, including parents, older siblings and peers, or strangers solicited to purchase alcohol for the minor. However, some underage persons purchase alcohol for themselves from merchants who fail to comply with laws prohibiting sale to minors or by using false ID (see the “False Identification” section of this report). These sources increase the availability of alcohol to youths, which, in turn, increases underage consumption. Prohibitions and associated sanctions on furnishing to underage persons can be expected to depress rates of furnishing by raising the monetary and social costs of this behavior. Such laws provide a primary deterrent (preventing furnishing) and a secondary deterrent (reducing the chances of persons sanctioned under these laws furnishing in the future).

Two types of exceptions to underage furnishing laws are discussed in this analysis:

- Family exceptions permit parents, guardians, or spouses to furnish alcohol to minors; some states specify that the spouse must be of legal age and others do not.
- Location exceptions permit furnishing alcohol in specified locations and may limit the extent to which family members can furnish to minors. No state has an exception for furnishing on private property by anyone other than a family member.

Some states provide sellers and licensees with one or more defenses against a charge of furnishing alcoholic beverages to a minor. Under these provisions, a retailer who provides alcohol to a minor will not be found in violation of the furnishing law if he or she can establish one of these defenses. This policy topic tracks one such defense: some states require that the minor who initiated a transaction be charged for possessing or purchasing the alcohol before the retailer can be found in violation of the furnishing law (see the “False Identification” section of this report for information on defenses associated with minors using false ID). Many states also have provisions that mitigate or reduce the penalties imposed on retailers if they have participated in responsible beverage service (RBS) programs; see the “Responsible Beverage Service” section of this report for further discussion.

In some states, furnishing laws are closely associated with laws that prohibit hosting underage drinking parties. These laws target hosts who allow underage drinking on property they own, lease, or otherwise control (see the “Hosting Underage Drinking Parties” section of this report for further discussion). Hosts of underage drinking parties who also supply the alcohol consumed or possessed by minors may be in violation of two distinct laws: furnishing alcohol to minors and allowing underage drinking to occur on property they control.

Also addressed in this report are social host liability laws, which impose civil liability on hosts for injuries caused by their underage guests. Although related to party hosting laws, social host

liability laws are distinct. They do not establish criminal or civil offenses, but instead allow injured parties to recover damages by suing social hosts of events at which minors consumed alcohol and later were responsible for injuries. The commercial analog to social host liability laws is dram shop laws, which prohibit commercial establishments—bars, restaurants, and retail sales outlets—from furnishing alcoholic beverages to minors. See the “Social Host Liability” and “Dram Shop Liability” portions of this report for further discussion.

## Status of Underage Furnishing Policies

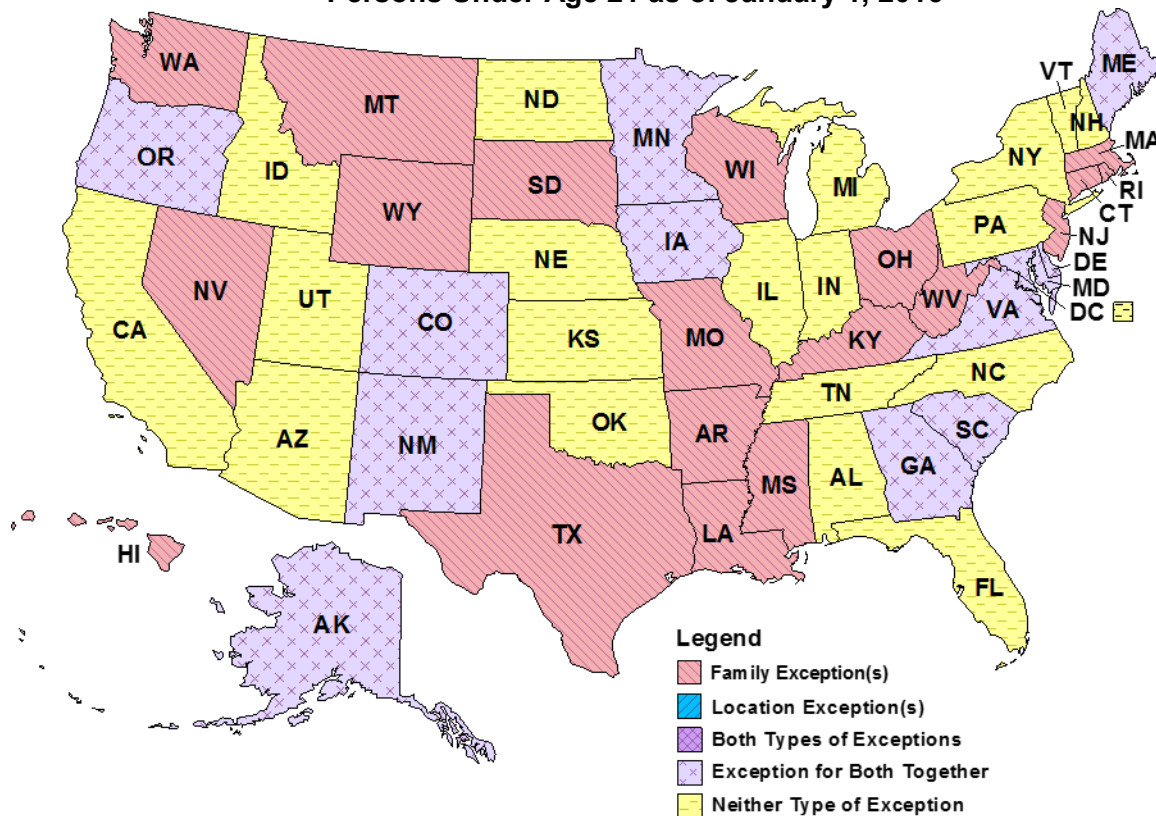
### *Exceptions to Furnishing Prohibitions*

As of January 1, 2016, all states prohibit the furnishing of alcoholic beverages to minors (see Exhibit 4.2.17). Nineteen states and the District of Columbia have no family or location exceptions to this prohibition. The remaining 31 states permit parents, guardians, or spouses to furnish alcohol to their underage children or spouses. Of these, 12 states limit the exception to certain locations (3 states, any private location; 7 states, any private residence; 2 states, parents’ or guardians’ homes only).

### *Affirmative Defense for Sellers and Licensees*

As of January 1, 2016, the underage furnishing laws of two states (Michigan and South Carolina) include provisions requiring that the seller/licensee be exonerated of charges of furnishing alcohol to a minor unless the minor involved is charged.

**Exhibit 4.2.17: Exceptions to Prohibitions on Furnishing Alcohol to Persons Under Age 21 as of January 1, 2016**



### Trends in Underage Furnishing Policies

State policies prohibiting the furnishing of alcohol to minors have remained stable over the last 10 years. As of January 1, 1998, all states prohibited underage furnishing (see Exhibit 4.2.18).

### References and Further Information

All data for this policy were obtained from the Alcohol Policy Information System (APIS) at <http://www.alcoholpolicy.niaaa.nih.gov>. See the policy titled “Furnishing Alcohol to Minors.” APIS provides further descriptions of this policy and its variables, details regarding state policies, and a review of the limitations associated with the reported data. To see definitions of the variables for this policy, visit [stopalcoholabuse.gov](http://stopalcoholabuse.gov) and follow links to the Report to Congress, Supplemental Materials, Definitions of Variables in Legal Policies.

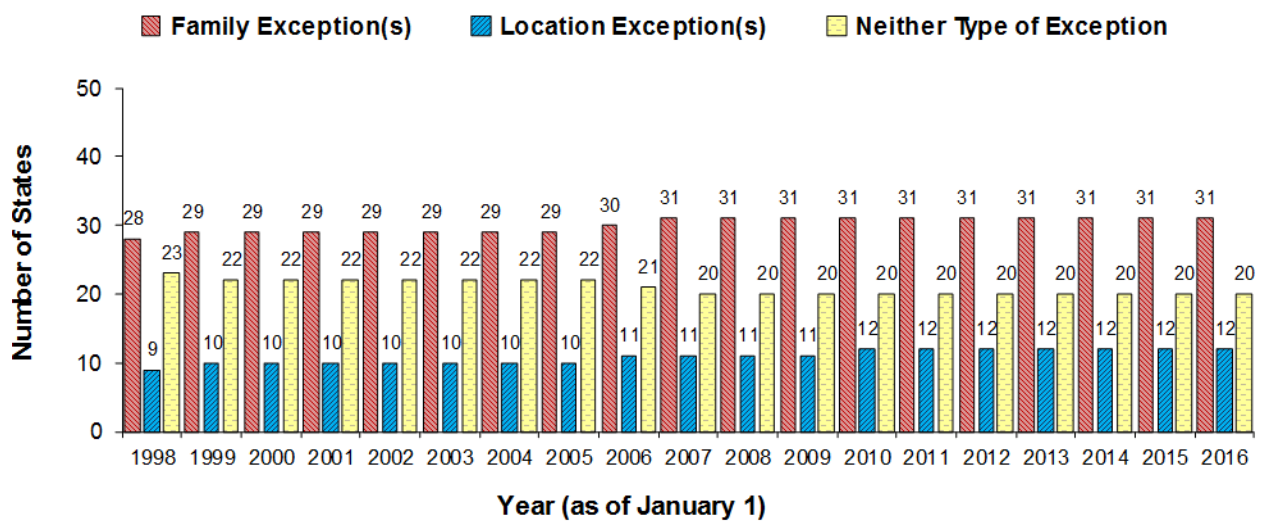
Albers, A. B., Siegel, M., Ramirez, R. L., Ross, C., DeJong, W., & Jernigan, D. H. (2015). Flavored alcoholic beverage use, risky drinking behaviors, and adverse outcomes among underage drinkers: Results from the ABRAND study. *American Journal of Public Health, 105*(4), 810–815.

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**Exhibit 4.2.18: Number of States with Family and Location Exceptions to Prohibition on Furnishing Alcohol to Persons under Age 21, January 1, 1998, through January 1, 2016**





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## Compliance Check Protocols

### Policy Description

Compliance checks involve an underage operative (a “decoy”)—working either with local law enforcement officials or with agents from the state alcoholic beverage control agency (ABC)—who enters an alcohol retail establishment and attempts to purchase an alcoholic beverage from a server, bartender, or clerk. The protocols for these compliance checks vary from state to state, but in general follow a similar outline. An underage person (allowable ages vary by state) serves as a decoy. Decoys are generally instructed to act and dress in an age-appropriate manner. The decoy enters an alcohol retail outlet to attempt to purchase a predetermined alcohol product (e.g., a six-pack of beer at an off-sale establishment or a mixed drink at an on-sales establishment). Typically, an undercover enforcement officer from a local police department or the state ABC agency observes the decoy. Audio and video recording equipment may also be used or required. State rules vary regarding a decoy’s use of legitimate ID cards (driver’s licenses, etc.), although a few states allow decoys to verbally exaggerate their age. If a purchase is made successfully, the establishment and the clerk or server may be subject to an administrative or criminal penalty.

Most, but not all, states permit law enforcement agencies to conduct compliance checks on a random basis. A few states permit the checks only when there is a basis for suspecting that a particular licensee has sold alcohol to a minor in the past. To ensure that state and local law enforcement agencies are following uniform procedures, most states have issued formal compliance check protocols or guidelines. If the protocols are not followed, then the administrative action against the licensee may be dismissed. The protocols are therefore designed to ensure that law enforcement actions are fair and reasonable and to provide guidelines to licensees for avoiding prosecution.

Compliance checks of off- and on-premise licensed alcohol retailers are an important community tool for reducing illegal alcohol sales to minors and promoting community normative change. The 2004 Institute of Medicine (IOM) report, *Reducing Underage Drinking: A Collective Responsibility*, calls for (a) regular, random compliance checks; (b) administrative penalties, including fines and license suspensions that increase with each offense; (c) enhanced media coverage for the purposes and results of compliance checks; and (d) training for alcohol retailers regarding their legal responsibility to avoid selling alcohol to underage youths.

Compliance checks have both educational and behavior change goals:

- Change or reinforce social norms that underage drinking is not acceptable by publicizing noncompliant retailers.
- Educate the community, including parents, educators, and policymakers, about the ready availability of alcohol to youth, which may not be considered a major issue.
- Increase alcohol retailers’ perception that violation of sales to minors laws will be detected and punished, creating a deterrent effect.
- Decrease the likelihood that retailers will sell alcohol to minors, thereby reducing youth access to alcohol.

Numerous studies support the contribution of compliance checks to reducing underage access to alcohol. During the early to mid-1990s, before systematic compliance check programs were

widely implemented, studies indicated that underage buyers were able to purchase alcohol without showing age identification in 47 to 97 percent of attempts (Forster et al., 1994; Forster, Murray, Wolfson, & Wagenaar, 1995; Preusser & Williams, 1992; Wagenaar & Wolfson, 1995). Observed rates of compliance have increased since then, and several studies suggest that the use of compliance checks does lead to reductions in sales to underage buyers. For example, Grube (1997) demonstrated that outlets subject to compliance checks were about as half as likely to sell alcohol on a post-test purchase survey as outlets in the comparison sites. Similarly, in Concord, New Hampshire, sales to youth decreased from 28 percent to 10 percent after quarterly compliance checks (coupled with increased penalties and a media campaign) at 539 off-premise alcohol establishments (CDC, 2004). And in a large study in Minnesota, sales to youth were reduced immediately by 17 percent in alcohol establishments that experienced a check (Wagenaar, Toomey, & Erickson, 2005). Additional analyses also found that establishments situated near another neighborhood establishment that had been checked within the last 90 days were less likely to sell alcohol to young-appearing buyers, but that these effects decay rapidly over time (Erickson, Smolensi, Toomey, Carlin, & Wagenaar, 2013). The 2016 *U.S. Surgeon General's Report on Alcohol, Drugs, and Health* found that compliance checks are an effective strategy for reducing alcohol consumption by minors and can be implemented in conjunction with other population-level alcohol policies (HHS, Office of the Surgeon General, 2016).

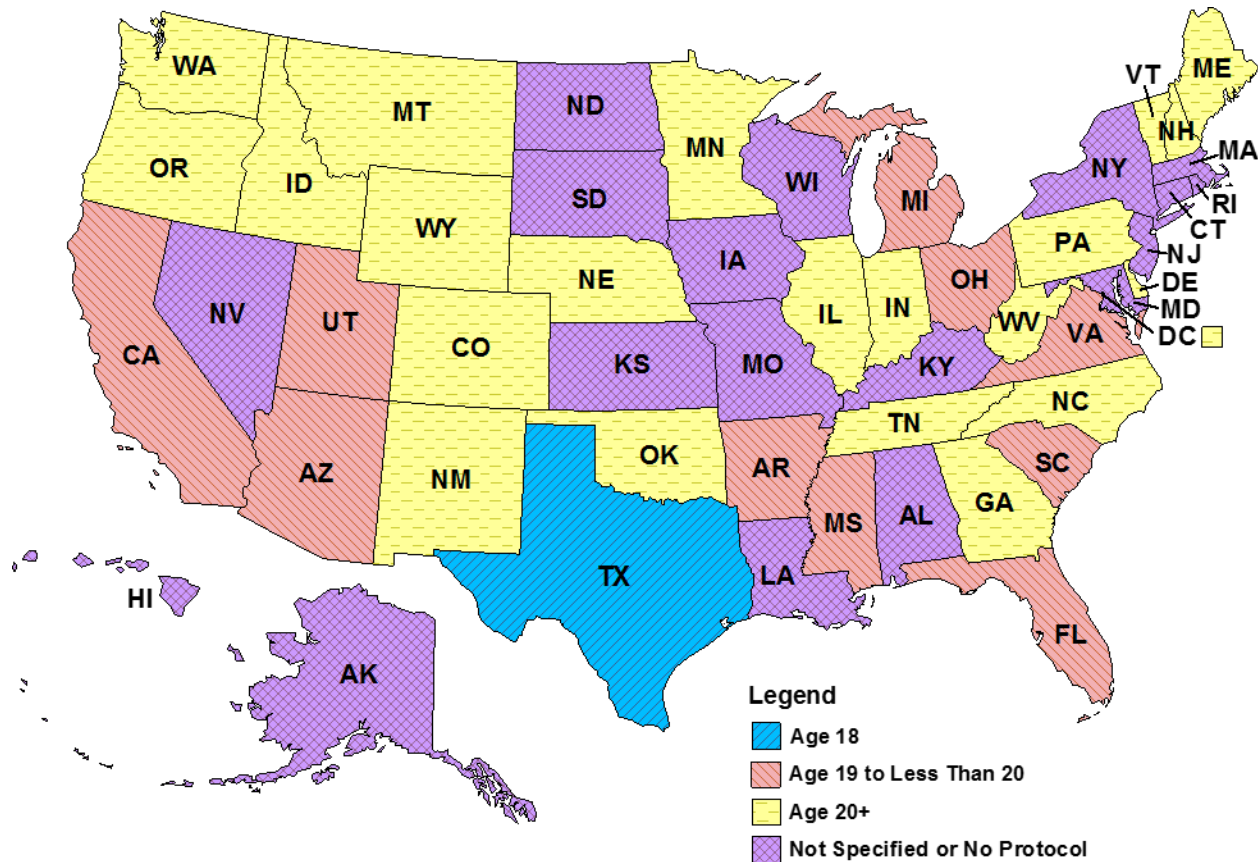
### Status of Compliance Check Protocols

Data for this policy were coded from formal compliance check protocols or guidelines. A total of 35 states have formal, written protocols; the remaining states either do not have these protocols or these protocols are not readily available to the public. Compliance check protocols are generally issued by the state police or the state ABC agency. Guidelines vary somewhat in specificity and detail, possibly reflecting differences in the purposes of the checks and the evidentiary standards in each jurisdiction.

The maximum age of the decoy varies from 18 to 21 (only one state lists 21 as the maximum age), with the majority of states requiring that the maximum age of the decoy be 20 (see Exhibit 4.2.19). The minimum age of the decoy ranges from 15 to 18, with the majority of states requiring 18 as the minimum age of the decoy. Thirty-one jurisdictions have guidelines for the decoys' appearance (e.g., appropriately dressed for age, and no hats, excessive makeup, or facial hair). These requirements vary widely by state. At least one state uses an age panel to ensure that the decoys appear underage. Five states allow decoys to verbally exaggerate their age in some situations. Decoy training is mandatory in 15 states. Approximately one third of the states (13) require decoys to have valid identification in their possession at the time of the check.

### References and Further Information

Legal research and data collection for this topic are planned and managed by the Substance Abuse and Mental Health Services Administration (SAMHSA) and conducted under contract by The CDM Group, Inc. To see definitions of the variables for this policy, visit [stopalcoholabuse.gov](http://stopalcoholabuse.gov) and follow links to the Report to Congress, Supplemental Materials, Definitions of Variables in Legal Policies.

**Exhibit 4.2.19: Maximum Age of Compliance Check Decoys in 2016**

Centers for Disease Control and Prevention. (2004). Enhanced enforcement of laws to prevent alcohol sales to underage persons—New Hampshire, 1999–2004. *Morbidity and Mortality Weekly Report*, 53(21), 452–454.

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- Preusser, D. F., & Williams, A. F. (1992). Sales of alcohol to underage purchasers in three New York counties and Washington, D.C. *Journal of Public Health Policy, 13*(3), 306–317.
- Preusser, D. F., Williams, A. F., & Weinstein, H. B. (1994). Policing underage sales. *Journal of Safety Research, 25*, 127–133.
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- Wagenaar, A. C., Toomey, T. L., & Erickson, D. J. (2005). Preventing youth access to alcohol: Outcomes from a multi-community time-series trial. *Addiction, 100*, 335–345.
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## Penalty Guidelines for Sales/Service to Minors

### Policy Description

In the majority of states, alcoholic beverage control (ABC) agencies are responsible for adjudicating administrative charges against licensees, including violations for sales or service to those under age 21. Alcohol law enforcement seeks to increase compliance with laws by increasing the level of perceived risk of detection and sanctions. Such deterrence involves three key components: perceived likelihood that a violation will lead to apprehension and sanction, swiftness with which the sanction is imposed, and severity of the sanction (Ross, 1992). As stated in the 2004 IOM report, *Reducing Underage Drinking: A Collective Responsibility*, the effectiveness of alcohol control policies depends heavily on the “intensity of implementation and enforcement and on the degree to which the intended targets are aware of both the policy and its enforcement.” The report recommends that “enforcement agencies should issue citations for violations of underage sales laws, with substantial fines and temporary suspension of license for first offenses and increasingly stronger penalties thereafter, leading to permanent revocation of license after three offenses.” See Chapter 4.1 of this report for a more comprehensive review of enforcement and deterrence research and strategies.

Although alcohol law enforcement agencies may issue the citations, adjudication of the cases is usually handled by another division or agency. States typically include administrative penalties in their statutory scheme prohibiting sales to minors. Penalty provisions are usually broad, allowing for severe penalties but delegating responsibility for determining actual penalties in particular cases to the ABC agencies or other agencies responsible for adjudicating the cases. Penalties may include warning letters, fines, license suspensions, a combination of fines and suspensions, or license revocation. Agencies may consider both mitigating and aggravating circumstances as well as the number of violations within a given time period, with repeat offenders usually receiving more severe sanctions.

Many ABC agencies issue penalty guidelines to alert licensees to the sanctions that will be imposed for first, second, and subsequent offenses, providing a time period for determining repeat offenses. The agency may treat the guidelines as establishing a set penalty or range of penalties or may treat them as providing guidance, allowing for deviation at the agency’s discretion.

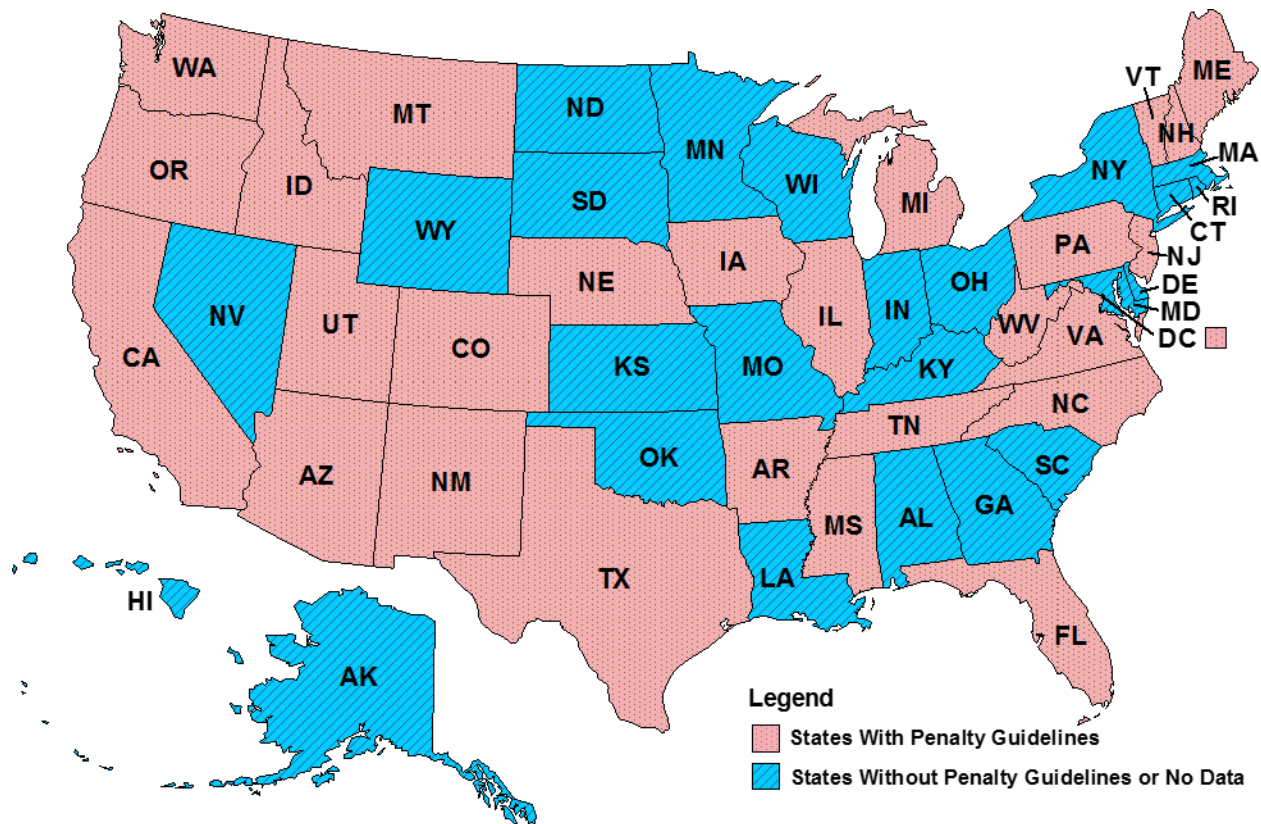
Penalty guidelines that establish firm, relatively severe penalties (particularly for repeat offenders) can increase the deterrent effect of the policy and its enforcement and can increase licensees’ awareness of the risks associated with violations.

### Status of Penalty Guidelines for Sales/Service to Minors

At least 27 jurisdictions have defined administrative penalty guidelines for licensees who sell alcohol to an underage youth (see Exhibit 4.2.20). The remaining 24 states either do not have penalty guidelines or do not make them readily available to the public. The guidelines may be based on statute, regulations, and internal policies developed by the agency.

Guidelines vary widely across states. For example, while a few states may issue warning letters for first offenses if there are no aggravating circumstances, the majority of states impose fines or suspensions. Minimum fines for a first offense range from \$50 to \$2,000, with most states in the \$250 to \$1,000 range. Fines are typically in lieu of suspensions for first offenses, with some



**Exhibit 4.2.20: States with Penalty Guidelines as of January 1, 2016**

states allowing licensees to choose between the two sanctions. Three states (California, Florida, and New Mexico) have adopted the IOM recommendation that licenses should be revoked after three offenses, and an additional seven states have guidelines that state that licenses are to be revoked for a fourth offense.

As an example, Texas can impose an 8- to 12-day license suspension for a first offense or fine the licensee \$300 per day of license suspension. Fines increase to as much as \$25,000 for subsequent offenses (in Utah), with license suspension days increasing to as many as 180 days for subsequent violations (Idaho). Time periods for defining repeat offenses range from 1 to 4 years.

States also vary in the specificity of their guidelines. Many states list a set penalty or a relatively limited range of penalties. For example, Florida lists a \$1,000 fine and a 7-day suspension for a first offense while Arizona's guideline provides for penalties ranging from a \$1,000–\$2,000 fine to up to a 30-day suspension for first offenses. See Chapter 4.3, the Cross-State Survey Report, for a review of penalties actually imposed by states for selling to and serving minors.

### References and Further Information

Legal research and data collection for this topic are planned and managed by the Substance Abuse and Mental Health Services Administration (SAMHSA) and conducted under contract by The CDM Group, Inc. To see definitions of the variables for this policy, visit [stopalcoholabuse.gov](http://stopalcoholabuse.gov) and follow links to the Report to Congress, Supplemental Materials, Definitions of Variables in Legal Policies. For further information and background, see:

National Research Council & Institute of Medicine. (2004). *Reducing Underage Drinking: A Collective Responsibility*. Washington, DC: National Academies Press.

Ross, H. L. (1992). *Confronting Drunk Driving: Social Policy for Saving Lives*. Binghamton, NY: Vail-Ballou Press.

## Responsible Beverage Service

### Policy Description

Responsible beverage service (RBS) training policies set requirements or incentives for retail alcohol outlet participation in programs that (a) develop and implement policies and procedures for preventing alcohol sale and service to minors and intoxicated persons, and (b) train licensees, managers, and servers/sellers to implement RBS policies and procedures effectively.

Server/seller training focuses on procedures for serving and selling and checking age identification, and techniques for recognizing signs of intoxication and intervening with intoxicated patrons. Manager training includes server/seller training, policy and procedures development, and staff supervision. RBS programs typically have distinct training curricula for on- and off-sale establishments because of the differing characteristics of these retail environments. All RBS programs focus on preventing sale and furnishing to minors.

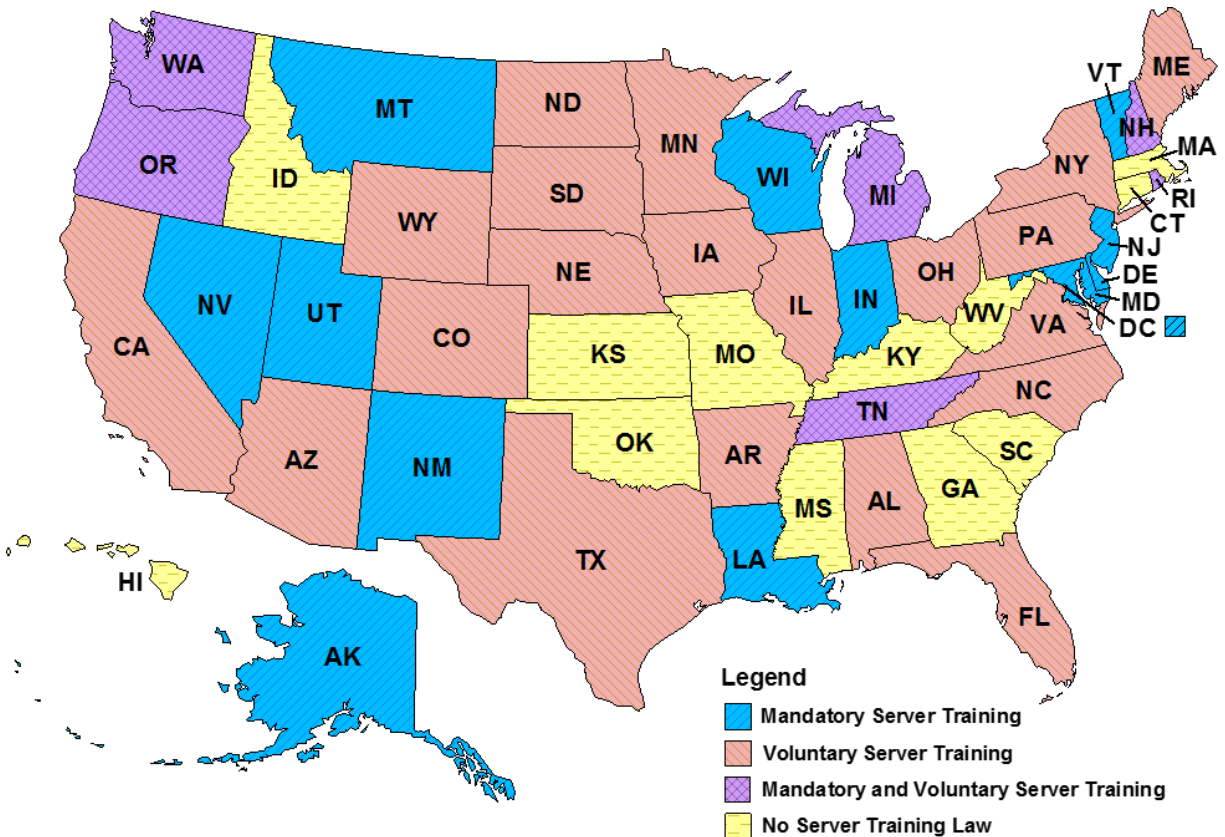
RBS training can be mandatory or voluntary. A program is considered mandatory if state provisions require at least one specified category of individual (e.g., servers/sellers, managers, or licensees) to attend training. States may have either mandatory programs, voluntary programs, or both. For example, a state may make training for new licenses mandatory while also offering voluntary programs for existing licensees. Alternatively, a state may have a basic mandatory program while also offering a more intensive voluntary program that provides additional benefits for licensees choosing to participate in both.

States with voluntary programs usually provide incentives for retailers to participate in RBS training but do not impose penalties for those who decline involvement. Incentives vary by state and include (a) a defense in dram shop liability lawsuits (cases filed by injured persons against retail establishments that provided alcohol to minors or intoxicated persons who later caused injuries to themselves or third parties); (b) discounts for dram shop liability insurance; (c) mitigation of fines or other administrative penalties for sales to minors or sales to intoxicated persons; and (d) protection against license revocation for sales to minors or intoxicated persons.

See the “Dram Shop Liability” section of this report for further discussion of this policy. The “Furnishing of Alcohol to Minors” section has additional information regarding prevention of alcohol sales to minors, and the “False Identification” section includes materials related to age identification policies.

### Status of Responsible Beverage Service Training Policies

As of January 1, 2016, 37 states and the District of Columbia have some type of RBS training provision (see Exhibit 4.2.21). Of these, 18 states and the District of Columbia have some form of mandatory provision, and 26 states provide for voluntary training. Of the 18 mandatory states, 15 states and the District of Columbia apply their RBS training provisions to both on- and off-sale establishments; 2 states (Michigan and Rhode Island) apply them to on-premises establishments only; and New Jersey limits its provisions to off-sale establishments. Thirteen of the mandatory states and the District of Columbia apply their provisions to both new and existing establishments, and four states (Michigan, New Hampshire, New Jersey, and Wisconsin) apply them to new establishments only.

**Exhibit 4.2.21: Responsible Beverage Service as of January 1, 2016**

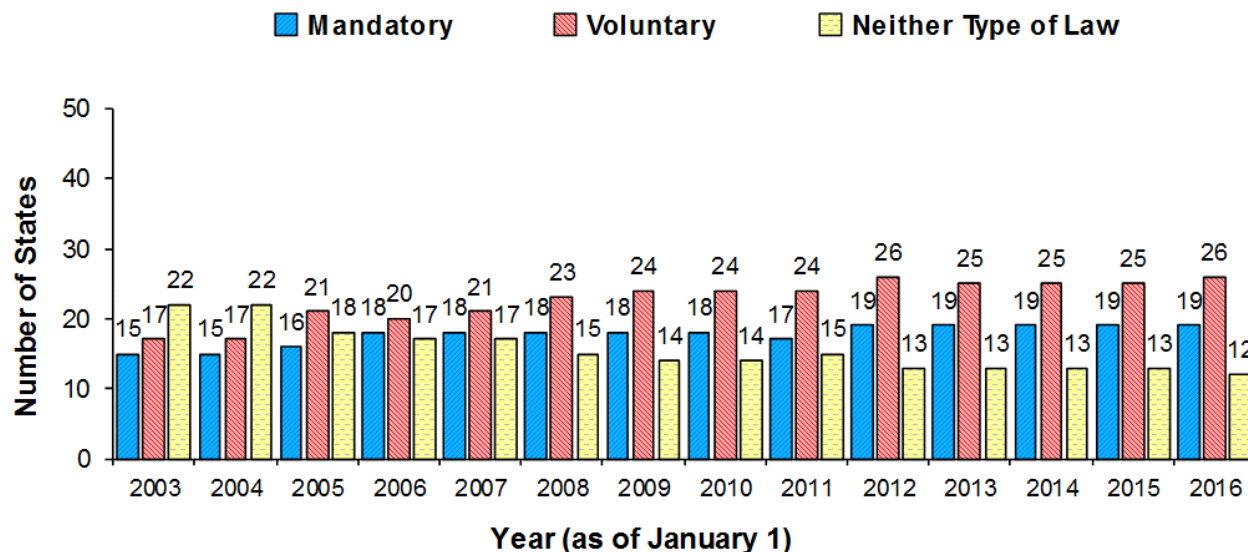
Six states (Michigan, New Hampshire, Oregon, Rhode Island, Tennessee, and Washington) have both mandatory and voluntary provisions:

- Michigan: Mandatory provisions apply to new on-premises establishments; voluntary provisions apply to existing on-premises establishments.
- New Hampshire: Mandatory provisions apply to new on- and off-premises establishments; voluntary provisions provide incentives available to both types of establishments.
- Oregon: Both voluntary and mandatory provisions apply to both types of establishments, with voluntary provisions offering incentives for participation in both.
- Rhode Island: Mandatory provisions apply to existing on-premises establishments. Voluntary provisions offer dram shop liability defense incentives and do not specify which type of establishment may participate.
- Tennessee: Mandatory provisions apply to new and existing on- and off-premises establishments. Voluntary provisions offer mitigation of fines or other administrative penalties for sales to minors or sales to intoxicated persons.
- Washington: Mandatory provisions are applicable to new and existing on- and off-premises establishments. Voluntary provisions are applicable to new, off-premises establishments.

### Trends in RBS Policies

Between 2003 and 2016, the number of states with mandatory policies increased from 15 to 19, and the number of states with voluntary policies rose from 17 to 26 (see Exhibit 4.2.22). The number of states with no RBS training policy decreased from 22 to 12.

**Exhibit 4.2.22: Number of States with Responsible Beverage Service, January 1, 2003, through January 1, 2016**



Note: some jurisdictions have both types of laws

### References and Further Information

All data for this policy were obtained from the Alcohol Policy Information System (APIS) at <http://www.alcoholpolicy.niaaa.nih.gov>. Follow links to the policy titled “Beverage Service Training and Related Practices.” APIS provides further descriptions of this policy and its variables, details regarding state policies, and a review of the limitations associated with the reported data. To see definitions of the variables for this policy, visit [stopalcoholabuse.gov](http://stopalcoholabuse.gov) and follow links to the Report to Congress, Supplemental Materials, Definitions of Variables in Legal Policies.

Chinman, M., Burkhart, Q., Ebener, P., Fan, C. C., Imm, P., Osilla, K. C., . . . Wright, A. (2011). The premises is the premise: Understanding off- and on-premises alcohol sales outlets to improve environmental alcohol prevention strategies. *Prevention Science, 12*(2), 181–191.

Danaher, B. G., Dresser, J., Shaw, T., Severson, H., Tyler, M., Maxwell, E., & Christiansen, S. M. (2012). Development and process evaluation of a web-based responsible beverage service training program. *Substance Abuse Treatment, Prevention, and Policy, 7*, 41.

Dresser, J., Starling, R., Woodall, W. G., Stanghetta, P., & May, P. A. (2011). Field trial of alcohol-server training for prevention of fetal alcohol syndrome. *Journal of Studies on Alcohol and Drugs, 72*(3), 490–496.

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- Saltz, R. F. (2011). Enlisting bars and restaurants in the prevention of intoxication and subsequent harms: Why it matters. *American Journal of Preventive Medicine, 41*(3), 353–354.
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## Minimum Ages for Off-Premises Sellers

### Policy Description

Most states have laws that specify a minimum age for employees who sell alcoholic beverages in off-premises establishments such as liquor stores. A small number require sellers to be at least 21, but most states permit sellers to be younger. Some states allow any person to sell alcohol regardless of age. Other variations across states include minimum age requirements for conducting sales transactions with customers and allowing younger employees to stock coolers with alcohol or bag purchased alcohol. Age restrictions may also vary based on the type of off-premises establishment or type of alcohol being sold. For example, younger persons may be allowed to sell beer but not wine or distilled spirits. Younger persons may also be allowed to sell alcohol in grocery or convenience stores rather than liquor stores. Some states permit younger minimum selling ages only if a manager or supervisor is present.

State laws specifying the minimum age for employees who sell alcoholic beverages for on-premises consumption are described in the “Minimum Ages for On-Premises Servers and Bartenders” section of this report.

### Status of Age of Seller Policies

#### *Minimum Age of Sellers and Types of Beverages*

Most jurisdictions specify the same minimum age for sellers of all types of alcoholic beverages (see Exhibit 4.2.23). As of January 1, 2016, 10 states specify that off-premises sellers must be 21 or older. Three states (Idaho, Indiana, and Nebraska) require off-premise sellers to be 19 or older; 16 states and the District of Columbia have set the minimum age at 18. Four states (Arizona, Maine, Nevada, and New Hampshire) set the minimum age between 16 and 17. Ten states do not specify any minimum age for sellers.

Minimum age requirements in the remaining 14 states vary by type of alcohol, with age requirements generally higher for the sale of distilled spirits and lower for beer. Florida, New York, and North Carolina set a minimum age of 18 for the sale of spirits and have no age minimum for beer or wine. Alabama and South Carolina have a minimum age of 21 for the sale of spirits but no minimum for beer and wine. Vermont sets a minimum age of 16 for selling beer and wine, but does not specify a minimum age for selling spirits.

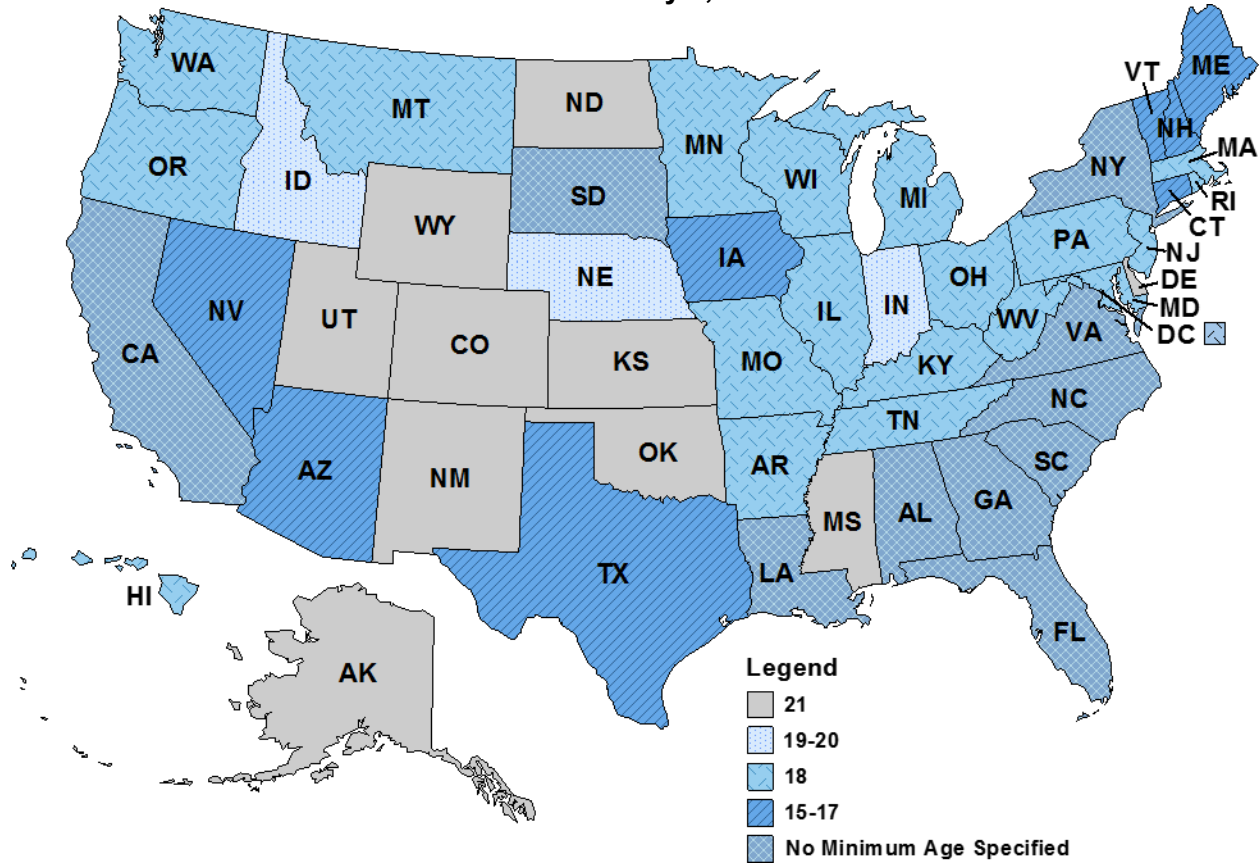
#### *Manager or Supervisor Presence*

Thirteen states require that a supervisor or manager be present when an underage seller conducts an alcoholic beverage transaction.

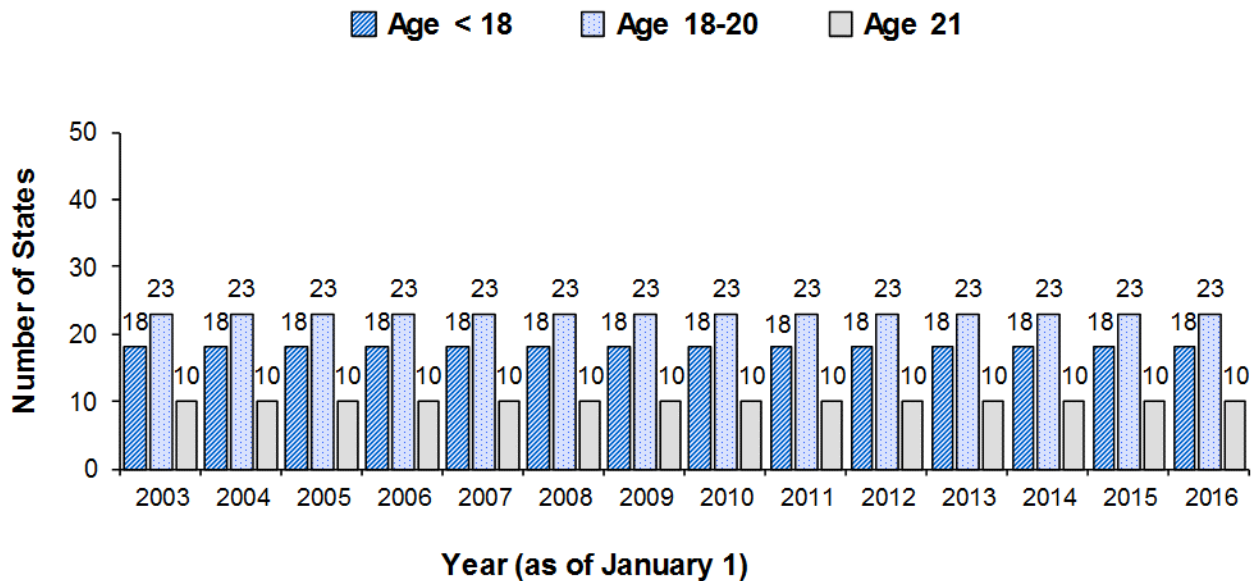
### Trends in Age of Seller Policies

There were no changes in age of seller policies across states between 2003 and 2016 (see Exhibit 4.2.24).

**Exhibit 4.2.23: Minimum Age To Sell Beer for Off-Premises Consumption as of January 1, 2016**



**Exhibit 4.2.24: Distribution of Minimum Ages for Off-Premises Sellers of Beer, January 1, 2003, through January 1, 2016**



## References and Further Information

All data for this policy were obtained from the Alcohol Policy Information System (APIS) at <http://www.alcoholpolicy.niaaa.nih.gov>. Follow links to the policy titled “Minimum Ages for Off-Premises Sellers.” APIS provides further descriptions of this policy and its variables, details regarding state policies, and a review of the limitations associated with the reported data. To see definitions of the variables for this policy, visit [stopalcoholabuse.gov](http://stopalcoholabuse.gov) and follow links to the Report to Congress, Supplemental Materials, Definitions of Variables in Legal Policies.

Fell, J. C., Scherer, M., Thomas, S., & Voas, R. (2016). Assessing the impact of twenty underage drinking laws. *Journal of Studies on Alcohol and Drugs*, 77(2), 249–260.

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National Research Council & Institute of Medicine. (2004). *Reducing Underage Drinking: A Collective Responsibility*. Washington, DC: National Academies Press.

Reboussin, B. A., Song, E. Y., & Wolfson, M. (2011). The impact of alcohol outlet density on the geographic clustering of underage drinking behaviors within census tracts. *Alcoholism: Clinical and Experimental Research*, 35(8), 1541–1549.

Wagenaar, A. C., Toomey, T. L., & Erickson, D. J. (2005). Complying with the minimum drinking age: Effects of enforcement and training interventions. *Alcoholism: Clinical and Experimental Research*, 29(2), 255–262.

## Minimum Ages for On-Premises Servers and Bartenders

### Policy Description

All states specify a minimum age for employees who serve or dispense alcoholic beverages. Generally, the term “servers” refers to waitpersons, and “bartenders” refers to individuals who dispense alcoholic beverages. These restrictions recognize that underage employees, particularly those who are unsupervised, may lack the maturity and experience to conduct adequate checks of age identification and to resist pressure from underage peers to complete illegal sales.

States vary widely in terms of minimum age requirements for servers and bartenders. In some states, the minimum age for both types of employee is 21, but others set lower minimum ages, particularly for servers. No state permits underage bartenders while prohibiting underage servers. Some states permit servers or bartenders younger than 21 to work only in certain types of on-premises establishments, such as restaurants, or to serve only certain beverage types, such as beer or wine. Underage servers and bartenders may be allowed only if legal-age managers or supervisors are present when underage persons are serving alcoholic beverages or tending bar. State laws setting a minimum age for employees who sell alcohol at off-premises establishments are described in the “Minimum Ages for Off-Premises Sellers” section of this report.

### Status of Age of Server Policies

#### *Age of Servers*

As of January 1, 2016, Alaska, Nevada, and Utah specify that on-premises alcohol servers of beer, wine, or distilled spirits must be 21 or older (see Exhibit 4.2.25). Only one state (Maine) allows 17-year-olds to be servers. Ten states specify that servers be at least 19 or 20, and the remaining 36 states and the District of Columbia allow 18-year-old servers.

#### *Age of Bartenders*

Minimum ages for bartenders are generally higher than for servers across the states. Nineteen states and the District of Columbia limit bartending to persons 21 or older. Five states (Arizona, Idaho, Kentucky, Nebraska, and Ohio) specify that bartenders be at least 19 or at least 20. Twenty-five states allow 18-year-olds to bartend, while only one state (Maine) allows 17-year-olds to bartend. Minimum ages for serving beer, wine, and distilled spirits are identical in all but three states: Maryland, North Carolina, and Ohio. Maryland and North Carolina require bartenders to be 21 to serve spirits, but permit 18-year-olds to dispense beer and wine; Ohio requires bartenders to be 21 to serve wine and distilled spirits, but those 19 and older are allowed to dispense beer.

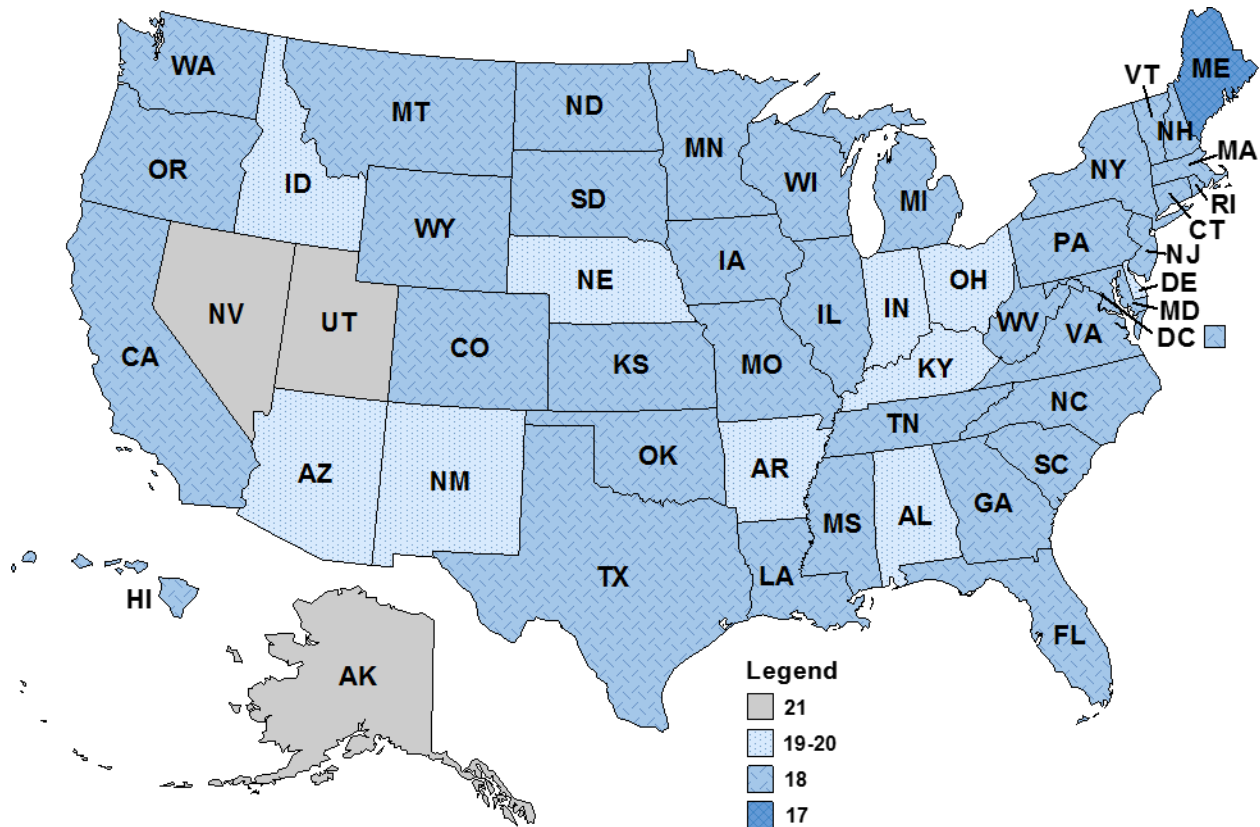
#### *Manager or Supervisor Presence*

Ten states require that a supervisor or manager be present when an underage seller conducts an alcoholic beverage transaction.

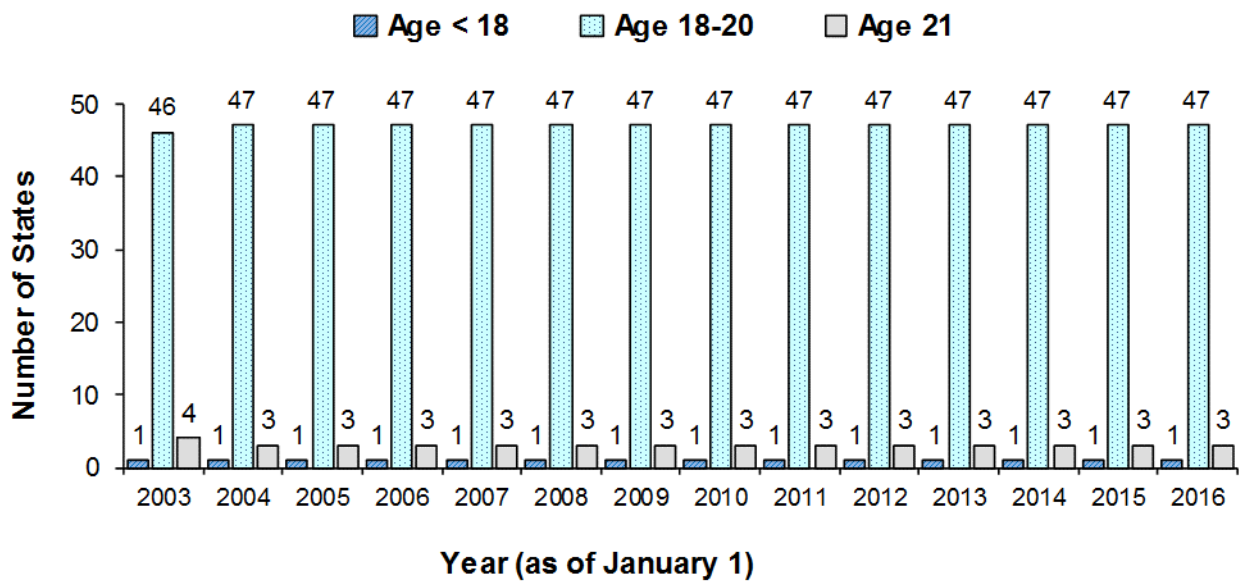
### Trends in Age of Server Policies

State policies for ages of servers and bartenders in on-premises establishments have been generally stable over the last decade (see Exhibit 4.2.26). Between 2003 and 2016, Arkansas lowered its minimum age for servers from 21 to 19, and North Dakota lowered its age for servers from 19 to 18.

**Exhibit 4.2.25: Minimum Ages for On-Premises Servers (Beer) as of January 1, 2016**



**Exhibit 4.2.26: Distribution of Minimum Ages for On-Premises Servers of Beer, January 1, 2003, through January 1, 2016**



## References and Further Information

All data for this policy were obtained from the Alcohol Policy Information System (APIS) at <http://www.alcoholpolicy.niaaa.nih.gov>. Follow links to the policy titled “Minimum Ages for On-Premises Servers and Bartenders.” APIS provides further descriptions of this policy and its variables, details regarding state policies, and a review of the limitations associated with the reported data. To see definitions of the variables for this policy, visit [stopalcoholabuse.gov](http://stopalcoholabuse.gov) and follow links to the Report to Congress, Supplemental Materials, Definitions of Variables in Legal Policies.

Fell, J. C., Scherer, M., Thomas, S., & Voas, R. (2016). Assessing the impact of twenty underage drinking laws. *Journal of Studies on Alcohol and Drugs*, 77(2), 249–260.

National Institute on Alcohol Abuse and Alcoholism. (2006). *Young Adult Drinking*. Alcohol Alert, No. 68. Retrieved from <http://pubs.niaaa.nih.gov/publications/aa68/aa68.htm>

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Wagenaar, A. C., Toomey, T. L., & Erickson, D. J. (2005). Complying with the minimum drinking age: Effects of enforcement and training interventions. *Alcoholism: Clinical and Experimental Research*, 29(2), 255–262.



## Distance Limitations Applied to New Alcohol Outlets Near Universities, Colleges, and Primary and Secondary Schools

### Policy Description

Policies that limit the placement of retail alcohol outlets near colleges and schools are designed to make alcohol less accessible to children and youth by keeping alcohol sales physically distant from locations where underage people congregate. In addition, such policies aim to reduce the social availability of alcohol by limiting youth exposure to alcohol consumption.

### Outlets Near Colleges and Universities

Alcohol outlet density in general is linked to excessive alcohol consumption and related harms according to research collected and evaluated by the Community Preventive Services Task Force and presented in the *Community Guide* (Campbell et al., 2009; Task Force on Community Preventive Services, 2009). The *Community Guide* recommends the use of regulatory authority, for example through zoning and licensing, to reduce alcohol outlet density.

Limiting the location of retail outlets near colleges and universities and their high concentrations of underage drinkers is one way to implement this recommendation in a high-risk setting. The National Institute on Alcohol Abuse and Alcoholism (NIAAA) publication, *A Call to Action: Changing the Culture of Drinking at U.S. Colleges*, includes limiting alcohol outlet density as an evidence-based, recommended strategy for reducing college drinking (NIAAA, 2002).

Research shows a correlation between underage drinking and retail outlet density near college and university campuses. In a study of eight universities, outlet density was correlated with heavy and frequent drinking among college students, including underage students (Weitzman, Folkman, Folkman, & Wechsler, 2003). Another study found that both on- and off-premises alcohol outlet densities were associated with campus rape offense rates; the effect of on-campus densities was reduced when student drinking levels were considered (Scribner et al., 2010). A third study examined “secondhand” effects of drinking on residential neighborhoods near college campuses, and concluded that limiting the number of outlets near colleges, particularly those colleges with high rates of binge drinking, could mitigate the secondhand effects (Wechsler, Lee, Hall, Wagenaar, & Lee, 2002). A 1996 study found higher rates of drinking and binge drinking among college students when there were higher numbers of alcohol outlets within one mile of campus (Chaloupka & Wechsler, 1996).

### Outlets Near Primary and Secondary Schools

Limiting outlets near primary and secondary schools is another way to reduce alcohol outlet density in a high-risk setting of underage drinking, although there is no research comparable to that for universities that focuses specifically on the relationship between drinking by K–12 students and the proximity of alcohol outlets to their schools.

### Types of Outlet Density Restrictions

Outlet density restrictions typically require that alcohol outlets be located a certain distance from a school. Such restrictions may regulate the location of retail outlets near colleges and universities, near primary and secondary schools, or near both categories of schools. Some restrictions limit the sale of alcohol directly on university campuses. Outlet density

restrictions may apply to off-premises retailers, on-premises retailers, or both types of retailers. Restrictions may also apply to the sale of beer, wine, spirits, or some combination of the three.

Distance requirements vary widely, from 100 feet (the distance a primary or secondary school in Illinois must be from an off-premises outlet) to 1.5 miles (the distance a university in California must be from an outlet selling wine or spirits). Restrictions that mandate greater distances are more likely to promote the goals of keeping alcohol away from underage drinkers and reducing their exposure to alcohol marketing.

Distance restrictions apply to the issuance of new licenses, and retail alcohol outlets that were in business prior to the enactment of the restriction may still be allowed to operate within the restricted zone. In these cases, the distance restriction would prevent increased alcohol outlet density without necessarily reducing density or eliminating the presence of retail establishments in the restricted zone.

## **Status of Outlet Density Restrictions**

### ***Colleges and Universities***

Twelve states have some type of restriction on outlet density near colleges and universities, whereas 39 have no restrictions. Of the 12 states with restrictions, 11 have restrictions that apply to both on-premises and off-premises outlets. Kansas' restriction applies only to off-premises outlets.

Nearly all of the restrictions apply to beer, wine, and spirits. California's and Mississippi's restrictions apply only to wine and spirits, North Carolina's restriction applies to beer and wine, and West Virginia's applies only to beer. Exhibit 4.2.27 draws attention to states with restrictions on colleges and universities and shows whether restrictions apply to off- or on-premises outlets.

### ***Primary and Secondary Schools***

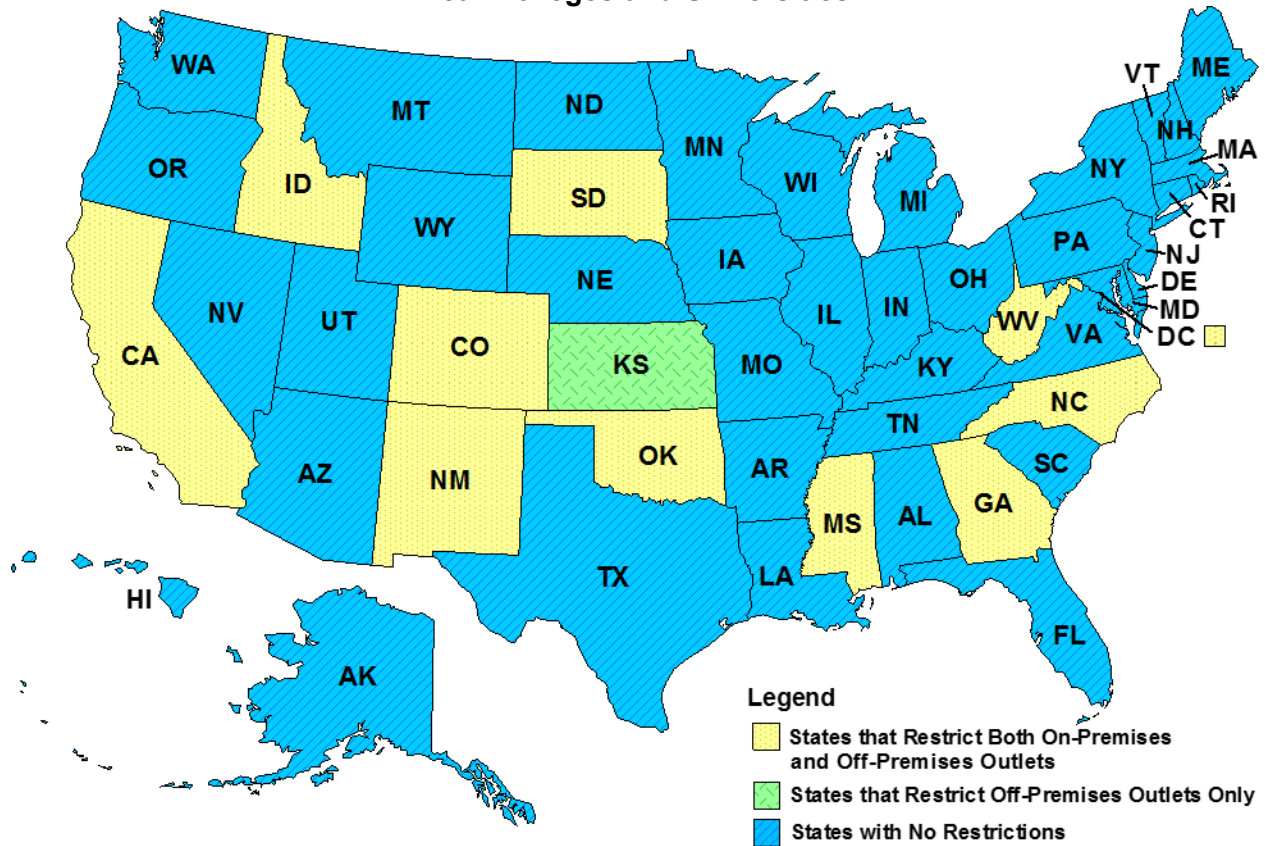
Many more states have laws restricting outlet location near primary and secondary schools: 31 states have some restriction, whereas 20 states have none. Of the 31 states restricting outlet location, 23 apply restrictions to both off- and on-premises locations. The restrictions apply only to on-premises locations in six states: Florida, Hawaii, Idaho, Maine, Montana, and Rhode Island. Arkansas and Kansas restrict only off-premises locations.

Most of the restrictions apply to beer, wine, and spirits. Restrictions in Arkansas, New York, Mississippi, and Wisconsin apply to wine and spirits; North Carolina's restrictions apply only to beer and wine, and West Virginia's restrictions apply only to beer. Exhibit 4.2.28 shows the states with restrictions on primary and secondary schools and shows whether the restrictions apply to off-premises or on-premises outlets.

## **References and Further Information**

Legal research and data collection for this topic are planned and managed by the Substance Abuse and Mental Health Services Administration (SAMHSA) and conducted under contract by The CDM Group, Inc. To see definitions of the variables for this policy, visit [stopalcoholabuse.gov](http://stopalcoholabuse.gov) and follow links to the Report to Congress, Supplemental Materials, Definitions of Variables in Legal Policies. For further information and background see:

**Exhibit 4.2.27: States with Restrictions on Placement of Retail Outlets Near Colleges and Universities**



Campbell, C. A., Hahn, R. A., Elder, R., Brewer, R., Chattopadhyay, S., Fielding, J., . . . Task Force on Community Preventive Services. (2009). The effectiveness of limiting alcohol outlet density as a means of reducing excessive alcohol consumption and alcohol-related harms. *American Journal of Preventive Medicine*, 37, 556–569.

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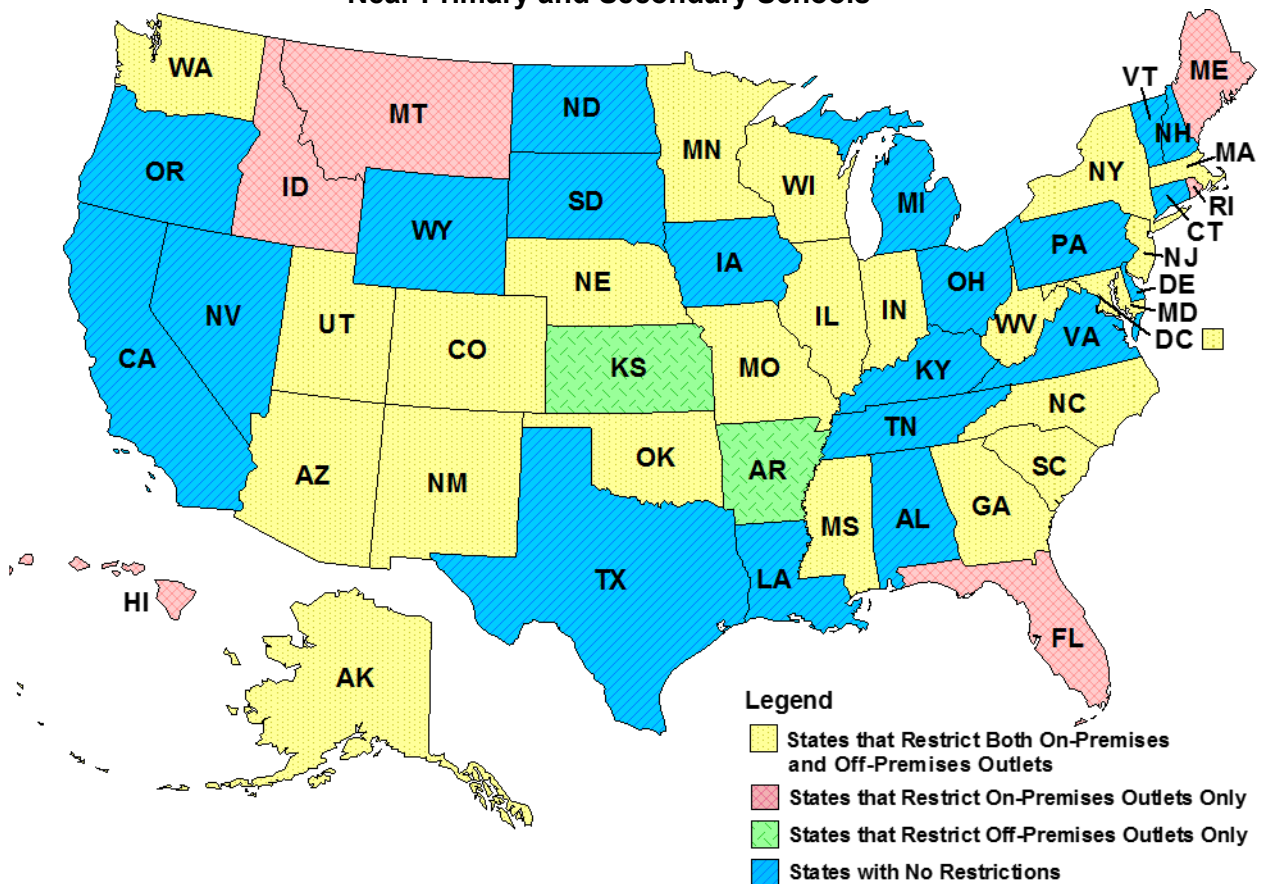
Chaloupka, F. J., & Wechsler, H. (1996). Binge drinking in college: The impact of price, availability, and alcohol control policies. *Contemporary Economic Policy*, 14(4), 112–124.

Erickson, D. J., Carlin, B. P., Lenk, K. M., Quick, H. S., Harwood, E. M., & Toomey, T. L. (2015). Do neighborhood attributes moderate the relationship between alcohol establishment density and crime? *Prevention Science*, 16(2), 254–264.

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**Exhibit 4.2.28: States with Restrictions on Placement of Retail Outlets Near Primary and Secondary Schools**



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## Dram Shop Liability

### Policy Description

Dram shop liability refers to the civil liability that commercial alcohol providers face for injuries or damages caused by their intoxicated or underage drinking patrons.<sup>1</sup> The analysis in this report is limited to alcohol service to minors. The typical factual scenario in legal cases arising from dram shop liability is a licensed retail alcohol outlet furnishing alcohol to a minor who, in turn, causes an alcohol-related motor vehicle crash that injures a third party. In states with dram shop liability, the injured third party (“plaintiff”) may be able to sue the retailer (as well as the minor who caused the crash) for monetary damages. Liability comes into play only if an injured private citizen files a lawsuit. The state’s role is to provide a forum for such a lawsuit; the state does not impose a dram shop-related penalty directly. (This distinguishes dram shop liability from the underage furnishing policy, which results in criminal liability imposed by the state.)

Dram shop liability is closely related to the policy on furnishing alcohol to minors, but the two topics are distinct. Retailers who furnish alcohol to minors may face fines or other punishment imposed by the state as well as dram shop liability lawsuits filed by parties injured as a result of the same incident. Dram shop liability and social host liability (presented elsewhere in this report) are identical, except that the former involves lawsuits filed against commercial alcohol retailers and the latter involves lawsuits filed against noncommercial alcohol providers.

Dram shop liability serves two purposes: (a) it creates a disincentive for retailers to furnish to minors because of the risk of litigation leading to substantial monetary losses, and (b) it allows parties injured as a result of an illegal sale to a minor to gain compensation from those responsible for the injury. The minor causing the injury is the primary and most likely party to be sued. Typically, the retailer is sued through a dram shop claim when the minor does not have the resources to fully compensate the injured party.

Dram shop liability is established by statute or by a state court through “common law.” Common law is the authority of state courts to establish rules by which an injured party can seek redress against the person or entity that negligently or intentionally caused injury. Courts can establish these rules only when the state legislature has not enacted its own statutes, in which case the courts must follow the legislative dictates (unless found to be unconstitutional). Thus, dram shop statutes normally take precedence over dram shop common law court decisions. This analysis includes both statutory and common law dram shop liability for each state.

A common law liability designation signifies that the state allows lawsuits by injured third parties against alcohol retailers for the negligent service or provision of alcohol to a minor. Common law liability assumes the following procedural and substantive rules:

- A negligence standard applies (i.e., the defendant did not act as a reasonable person would be expected to act in like circumstances). Plaintiffs need not show that the defendant acted intentionally, willfully, or with actual knowledge of the minor’s underage status.

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<sup>1</sup> “Dram shop liability” is a legal term that originated in the 19th century. Dram shops were retail establishments that sold distilled spirits by the “dram,” a liquid measure that equals 1 ounce. This form of liability is also known as “commercial host liability.”



- Damages are not arbitrarily limited. If negligence is established, the plaintiff receives actual damages and can seek punitive damages.
- Plaintiffs can pursue claims against defendants without regard for the age of the person who furnished the alcohol and the age of the underage person furnished with the alcohol.
- Plaintiffs must establish only that minors were furnished alcohol and that the furnishing contributed to the injury without regard to the minor’s intoxicated state at the time of sale.
- Plaintiffs must establish key elements of the lawsuit via “preponderance of the evidence” rather than a more rigorous standard (e.g., “beyond a reasonable doubt”).

A statutory liability designation indicates that the state has a dram shop statute. Statutory provisions can alter the common law rules listed above, restricting an injured party’s ability to make successful claims. This report includes three of the most important statutory limitations:

1. Limitations on damages: Statutes may impose statutory caps on the total dollar amount that plaintiffs may recover through dram shop lawsuits.
2. Limitations on who may be sued: Potential defendants may be limited to only certain types of retail establishments (e.g., on-premises but not off-premises licensees), or certain types of servers (e.g., servers above a certain age).
3. Limitations on elements or standards of proof: Statutes may require plaintiffs to prove additional facts or meet a more rigorous standard of proof than would normally apply in common law. Statutory provisions may require a plaintiff to:
  - Establish that the retailer knew the minor was underage or that the retailer intentionally or willfully served the minor.
  - Establish that the minor was intoxicated at the time of sale or service.
  - Provide clear and convincing evidence or evidence beyond a reasonable doubt that the allegations are true.

These limitations can restrict circumstances that can give rise to liability or greatly diminish a plaintiff’s chances of prevailing in a dram shop liability lawsuit, thus reducing the likelihood of a lawsuit being filed. Other restrictions may also apply. For example, many states do not allow “first-party claims,” cases brought by the person who was furnished alcohol for his or her own injuries. This report does not track these additional limitations.

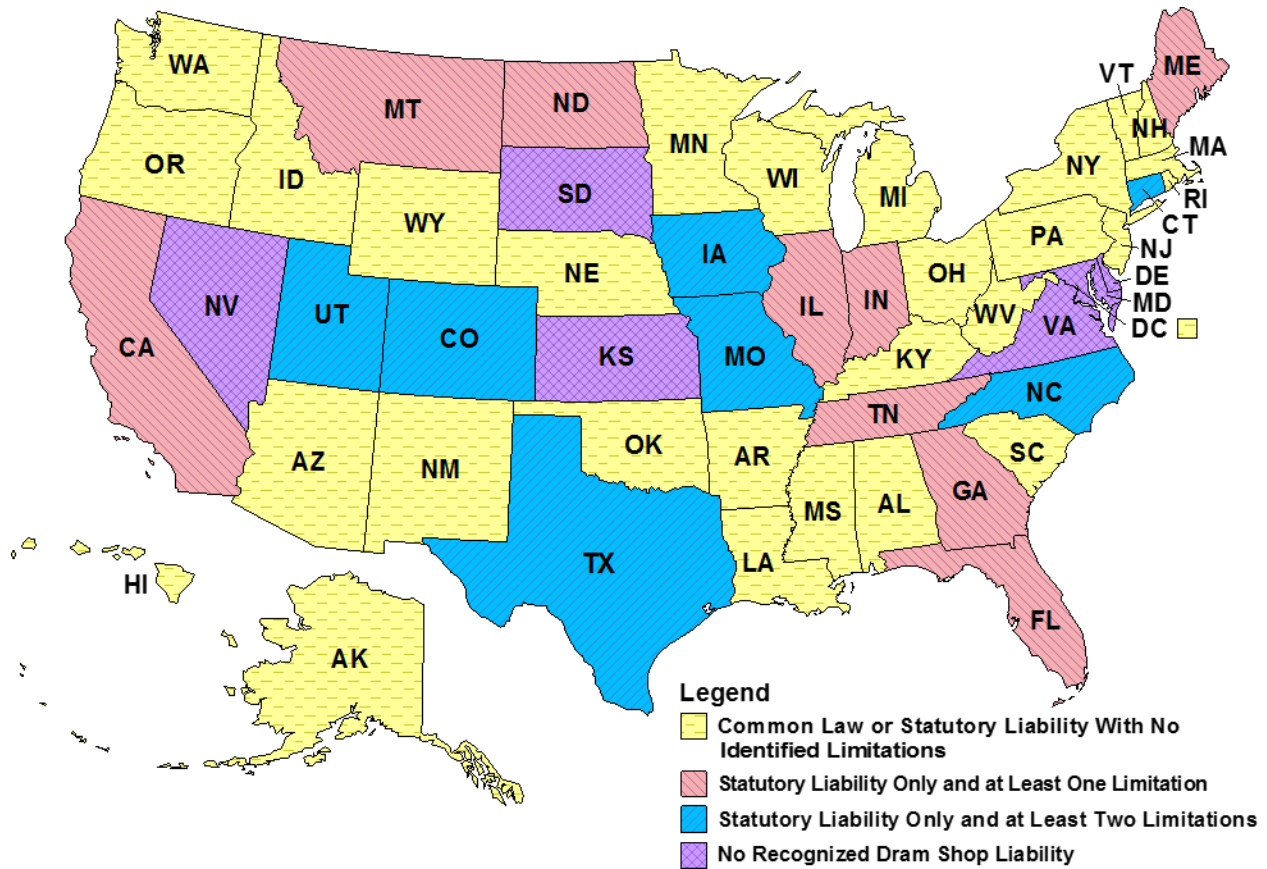
Some states have enacted responsible beverage service (RBS) affirmative defenses. In these states, a defendant can avoid liability if it can establish that its retail establishment had implemented an RBS program and was adhering to RBS practices at the time of the service to a minor. Texas has enacted a more sweeping RBS defense. A defendant licensee can avoid liability if it establishes that (a) it did not encourage the illegal sale and (b) it required its staff, including the server in question, to attend RBS training. Proof that RBS practices were being adhered to at the time of service is not required. See the “RBS Training” policy topic in this report for more information.

### **Status of Dram Shop Liability**

As of January 1, 2016, 45 jurisdictions imposed dram shop liability as a result of statutory or common law or both (see Exhibit 4.2.29). The District of Columbia and 28 states have either common law liability or statutory liability or both with no identified limitation. The remaining



**Exhibit 4.2.29: Common Law/Statutory Dram Shop Liability and Limitations as of January 1, 2016**



16 states impose one or more limits on statutory dram shop liability: 7 states limit the damages that may be recovered, 4 states limit who may be sued, and 12 states require stricter standards for proof of wrongdoing than for usual negligence. Eight states provide an RBS defense for alcohol outlets (see Exhibit 4.2.30). Seven states provide an affirmative RBS defense, and one state provides a complete RBS defense.

**Trends in Dram Shop Liability for Furnishing Alcohol to a Minor**

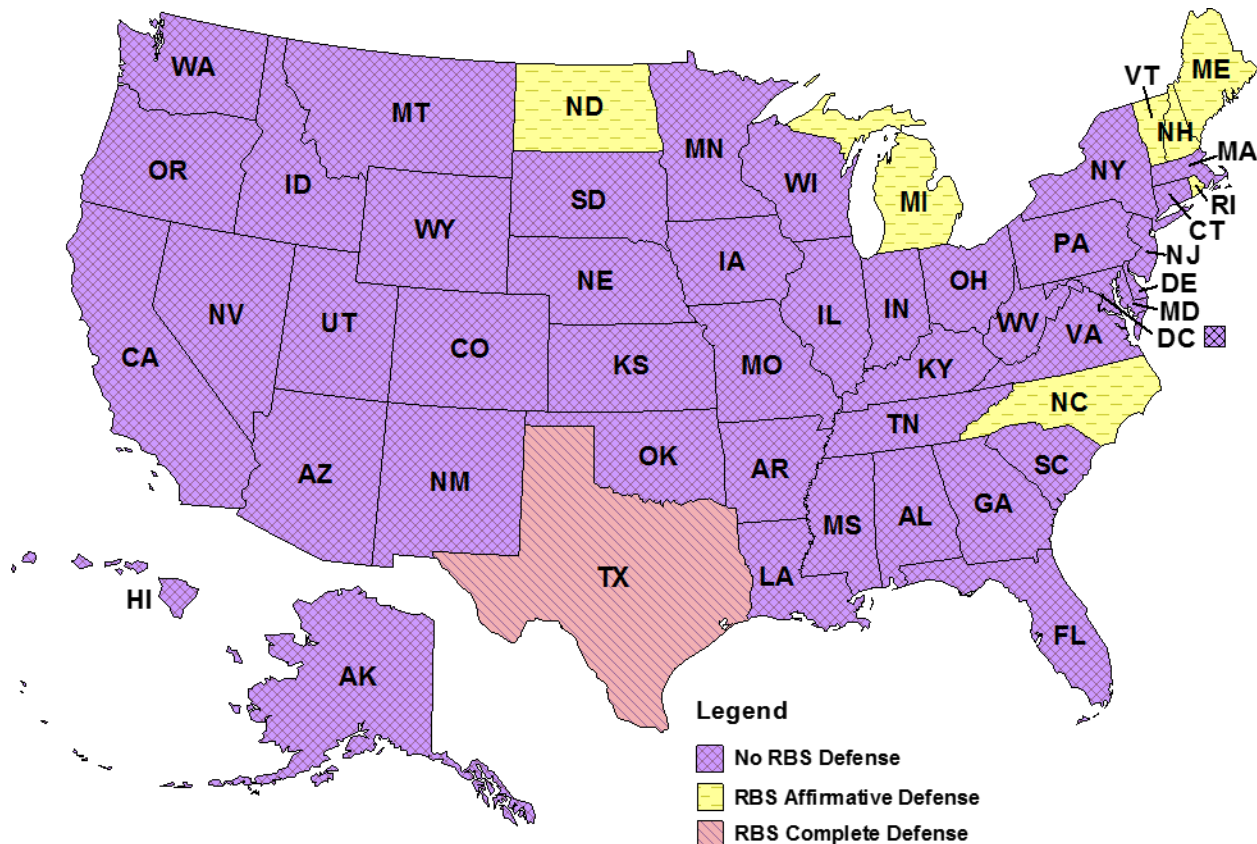
Between 2009 and 2016, the number of jurisdictions that permit dram shop liability remained constant and three states (Colorado, Illinois, and Maine) increased the dollar limits on damages.

**References and Further Information**

Legal research and data collection for this topic are planned and managed by the Substance Abuse and Mental Health Services Administration (SAMHSA) and conducted under contract by The CDM Group, Inc. To see definitions of the variables for this policy, visit [stopalcoholabuse.gov](http://stopalcoholabuse.gov) and follow links to the Report to Congress, Supplemental Materials, Definitions of Variables in Legal Policies.

Fell, J. C., Scherer, M., Thomas, S., & Voas, R. B. (2016). Assessing the impact of twenty-underage drinking laws. *Journal of Studies on Alcohol and Drugs*, 77(2), 249–260.

**Exhibit 4.2.30: Responsible Beverage Service Program Defenses Against Dram Shop Liability Across the United States as of January 1, 2016**



Holder, H., Janes, K., Mosher, J., Saltz, R., Spurr, S., & Wagenaar, A. (1992). *Final Report: Evaluation of Dram Shop Liability and the Reduction of Alcohol-Related Traffic Problems*. National Highway Traffic Safety Administration, DTNH22-87-R-07254.

Holder, H., Janes, K., Mosher, J., Saltz, R., Spurr, S., & Wagenaar, A. (1993). Alcoholic beverage server liability and the reduction of alcohol-involved problems. *Journal of Studies on Alcohol*, 54, 23–36.

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Rammohan, V., Hahn, R. A., Elder, R., Brewer, R., Fielding, J., Naimi, T. S., . . . Zometa, C. (2011). Effects of dram shop liability and enhanced overservice law enforcement initiatives on excessive alcohol consumption and related harms: Two community guide systematic reviews. *American Journal of Preventive Medicine*, 41(3), 334–343. doi:10.1016/j.amepre.2011.06.027.

Scherer, M., Fell, J. C., Thomas, S., & Voas, R. B. (2015). Effects of dram shop, responsible beverage service training, and state alcohol control laws on underage drinking driver fatal crash ratios. *Traffic Injury Prevention*, 16(Suppl. 2), S59–S65.

## Social Host Liability

### Policy Description

Social host liability refers to the civil liability that noncommercial alcohol providers face for injuries or damages caused by their intoxicated or underage drinking guests. The analysis in this report does not address social host liability for serving adult guests. The typical factual scenario in legal cases arising from social host liability involves an underage drinking party at which the party host furnishes alcohol to a minor who, in turn, injures a third party in an alcohol-related incident (often a motor vehicle crash). In states with social host liability, injured third parties (“plaintiffs”) may be able to sue social hosts (as well as the minor who caused the crash) for monetary damages. Liability comes into play only if injured private citizens file lawsuits. The state’s role is to provide a forum for such lawsuits; the state does not impose social host-related penalties directly. (As discussed below, this distinguishes social host liability from underage furnishing and host party policies, which can result in criminal liability imposed by the state.)

Social host liability is closely related to the furnishing alcohol to a minor and host party policies topics, but the three topics are distinct. Social hosts who furnish alcohol to minors or allow underage drinking parties on their property may face fines or other punishment imposed by the state as well as social host liability lawsuits filed by injured parties stemming from the same incident. Social host liability and dram shop liability (presented elsewhere in this report) are identical policies except that the former involves lawsuits brought against noncommercial alcohol retailers, and the latter involves lawsuits filed against commercial alcohol providers.

Social host liability serves two purposes: (a) it creates disincentives for social hosts to furnish to minors due to the risk of litigation and potentially substantial monetary losses and (b) it allows those injured as a result of illegal furnishing of alcohol to minors to gain compensation from the person(s) responsible for their injuries. Minors causing injuries are the primary and most likely parties to be sued. Typically, social hosts are sued through social host liability claims when minors do not have the resources to fully compensate the injured parties.

Social host liability is established by statute or by a state court through “common law.” Common law refers to the authority of state courts to establish rules by which injured parties can seek redress against persons or entities that negligently or intentionally caused injuries. Courts have the authority to establish these rules only when state legislatures have not enacted their own statutes, in which case, the courts must follow legislative dictates (unless found to be unconstitutional). Thus, social host statutes normally take precedence over social host common law court decisions.

Many states require evidence that social hosts furnished alcohol to the underage guest, although others permit liability if social hosts allowed underage guests to drink on the hosts’ property, even if the hosts did not furnish the alcohol. This analysis does not report the states that have adopted this more permissive standard. The analysis includes both statutory and common law social host liability for each state. A common law liability designation signifies that the state allows lawsuits by injured third parties against social hosts for the negligent service or provision of alcohol to minors in noncommercial settings. Common law liability assumes the following procedural and substantive rules:

- A negligence standard applies (i.e., defendants did not act as reasonable persons would be expected to act in similar circumstances). Plaintiffs need not show that defendants acted intentionally, willfully, or with actual knowledge of minors' underage status.
- Damages are not arbitrarily limited. If successful in establishing negligence, plaintiffs receive actual damages and have the possibility of seeking punitive damages.
- Plaintiffs can pursue claims against defendants without regard to the age of the person who furnished the alcohol and the age of the underage person furnished with the alcohol.
- Plaintiffs must establish only that minors were furnished with alcohol and that the furnishing contributed to injuries without regard to the minors' intoxicated state at the time of the party.
- Plaintiffs must establish the key elements of lawsuits by "preponderance of the evidence" rather than a more rigorous standard (such as "beyond a reasonable doubt").

A statutory liability designation indicates that a state has a social host liability statute. Statutory provisions can alter the common law rules listed above, restricting an injured party's ability to make successful claims. This report includes three of the most important statutory limitations:

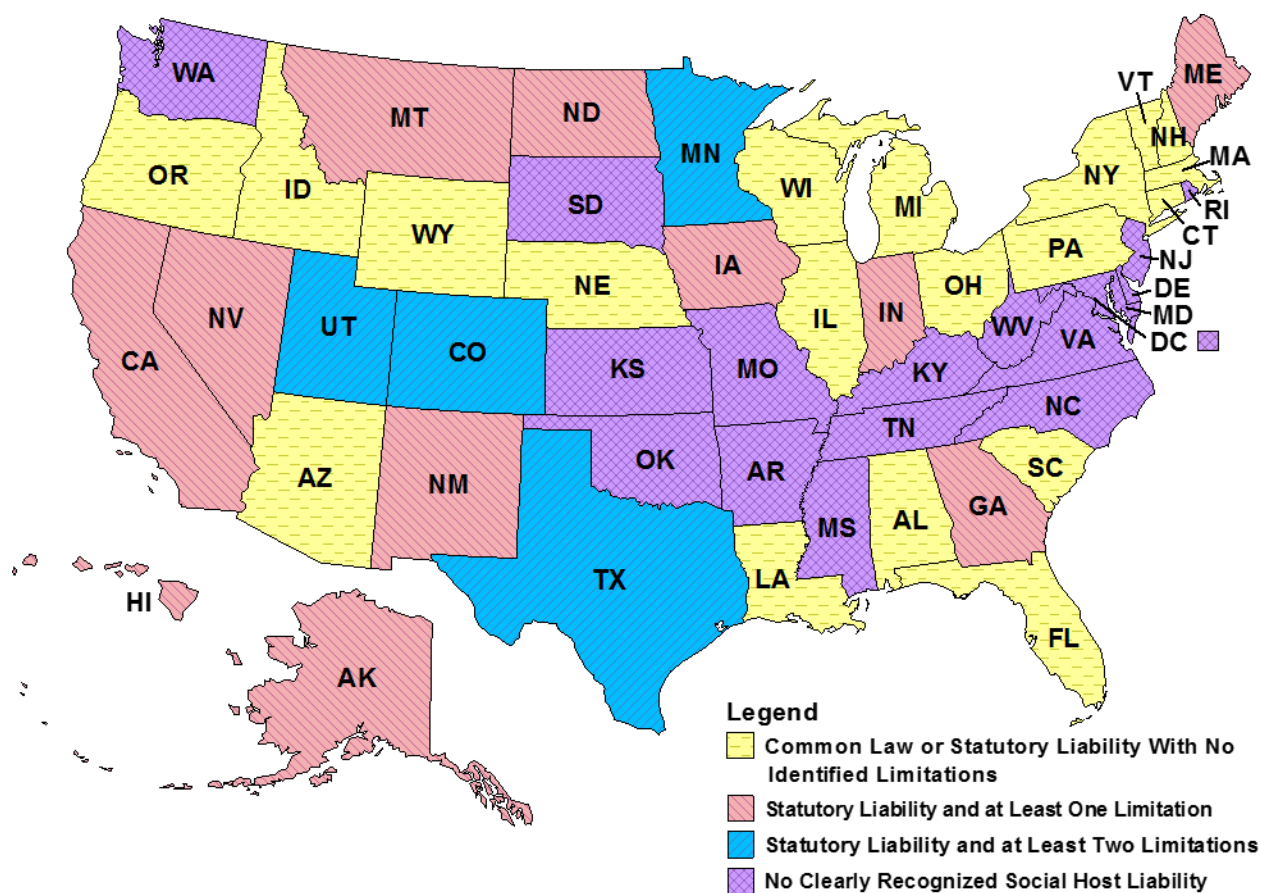
1. Limitations on damages: Statutes may impose statutory caps on the total dollar amount that plaintiffs may recover through social host lawsuits.
2. Limitations on who may be sued: Potential defendants may be limited to persons above a certain age.
3. Limitations on elements or standards of proof: Statutes may require plaintiffs to prove additional facts or meet a more rigorous standard of proof than would normally apply in common law. The statutory provisions may require the plaintiff to:
  - Establish that hosts had knowledge that minors were underage or proof that social hosts intentionally or willfully served minors.
  - Establish that the minors were intoxicated at the time of service.
  - Provide clear and convincing evidence or evidence beyond a reasonable doubt that the allegations are true.

These limitations can limit the circumstances that can give rise to liability or greatly diminish plaintiffs' chances of prevailing in a social host liability lawsuit, thus reducing the likelihood of a lawsuit being filed. Additional restrictions may also apply. For example, many states do not allow "first-party claims," cases brought by the person who was furnished alcohol for his or her own injuries. This report does not track these additional limitations.

### **Status of Social Host Liability**

As of January 1, 2016, 33 states impose social host liability through statute or common law; 15 states and the District of Columbia do not impose social host liability. In two states, there is no statutory liability, and common law liability is unclear (see Exhibit 4.2.31). Eighteen states have either common law liability or statutory social host liability with no identified limitations. Eleven states impose one limit on statutory social host liability, and four states impose two limitations. The count for limitations is as follows: 4 states limit the damages that may be recovered, 4 states limit who may be sued, and 11 states require standards of proof of wrongdoing that are stricter than usual negligence standards.



**Exhibit 4.2.31: Common Law/Statutory Social Host Liability as of January 1, 2016**

### Trends in Social Host Liability for Furnishing Alcohol to a Minor

In the years between 2009 and 2016, the number of states that permit social host liability increased by one. California requires standards of proof of wrongdoing that are stricter than usual negligence standards. One state (Utah) increased the dollar limits on damages.

### References and Further Information

Legal research and data collection for this topic are planned and managed by the Substance Abuse and Mental Health Services Administration (SAMHSA) and conducted under contract with The CDM Group, Inc. To see definitions of the variables for this policy, visit [stopalcoholabuse.gov](http://stopalcoholabuse.gov) and follow links to the Report to Congress, Supplemental Materials, Definitions of Variables in Legal Policies. For additional information and background, see:

Dills, A. K. (2010). Social host liability for minors and underage drunk-driving accidents. *Journal of Health Economics*, 29(2), 241–249.

Fell, J. C., Scherer, M., Thomas, S., & Voas, R. B. (2016). Assessing the impact of twenty-underage drinking laws. *Journal of Studies on Alcohol and Drugs*, 77(2), 249–260.

Friese, B., & Grube, J. W. (2014). Teen parties: Who has parties, what predicts whether there is alcohol and who supplies the alcohol? *Journal of Primary Prevention*, 35(6), 391–396.

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- Stout, E., Sloan, A., Liang, L., & Davies, H. (2000). Reducing harmful alcohol-related  
behaviors: Effective regulatory methods. *Journal of Studies on Alcohol*, 61, 402–412.
- Wagoner, K. G., Sparks, M., Francisco, V. T., Wyrick, D., Nichols, T., & Wolfson, M. (2013).  
Social host policies and underage drinking parties. *Substance Use & Misuse*, 48(1-2), 41–53.  
doi:10.3109/10826084.2012.722158



## Hosting Underage Drinking Parties

### Policy Description

Host party laws establish state-imposed liability against individuals (social hosts) responsible for underage drinking events on property they own, lease, or otherwise control. The primary purpose of these laws is to deter underage drinking parties by raising the legal risk for individuals who allow underage drinking events on property they own, lease, or otherwise control. Underage drinking parties pose significant public health risks. They are high-risk settings for binge drinking and associated alcohol problems including impaired driving. Young drinkers are often introduced to heavy drinking behaviors at these events. Law enforcement officials report that, in many cases, underage drinking parties occur on private property, but the adult responsible for the property is not present or cannot be shown to have furnished the alcohol. Host party laws address this issue by providing a legal basis for holding persons responsible for parties on their property whether or not they provided alcohol to minors.

Host party laws often are closely linked to laws prohibiting the furnishing of alcohol to minors (analyzed elsewhere in this report), although laws that prohibit hosting underage drinking parties may apply without regard to who furnishes the alcohol. Hosts who allow underage drinking on their property and also supply the alcohol consumed or possessed by the minors may be in violation of two distinct laws: furnishing alcohol to a minor and allowing underage drinking to occur on property they control.

Two general types of liability may apply to those who host underage drinking parties. The first, analyzed here, concerns state-imposed liability. State-imposed liability involves a statutory prohibition that is enforced by the state, generally through criminal proceedings that can lead to sanctions such as fines or imprisonment. The second, social host liability (analyzed elsewhere in this report), involves an action by a private party seeking monetary damages for injuries that result from permitting underage drinking on the host's premises.

Although related, these two forms of liability are distinct. For example, an individual may allow a minor to drink alcohol, after which the minor causes a motor vehicle crash that injures an innocent third party. In this situation, the social host may be prosecuted by the state under a criminal statute and face a fine or imprisonment for the criminal violation. In a state that provides for social host civil liability, the injured third party could also sue the host for monetary damages associated with the motor vehicle crash.

State host party laws differ across multiple dimensions, including the following:

- They may limit their application specifically to underage drinking parties (e.g., by requiring a certain number of minors to be present for the law to take effect) or may prohibit hosts from allowing underage drinking on their property generally, without reference to hosting a party.
- Underage drinking on any of the host's properties may be included, or the laws may restrict their application to residences, out-buildings, or outdoor areas.
- The laws may apply only when hosts make overt acts to encourage the party, or they may require only that hosts knew about the party or were negligent in not realizing that parties were occurring (i.e., should have known based on the facts available).
- A defense may be available for hosts who take specific preventive steps to end parties (e.g., contacting police) once they become aware that parties are occurring.

- The laws may require differing types of behavior on the part of the minors at the party (possession, consumption, intent to possess or consume) before a violation occurs.
- Jurisdictions have varying exceptions in their statutes for family members or others, or for other uses or settings involving the handling of alcoholic beverages.

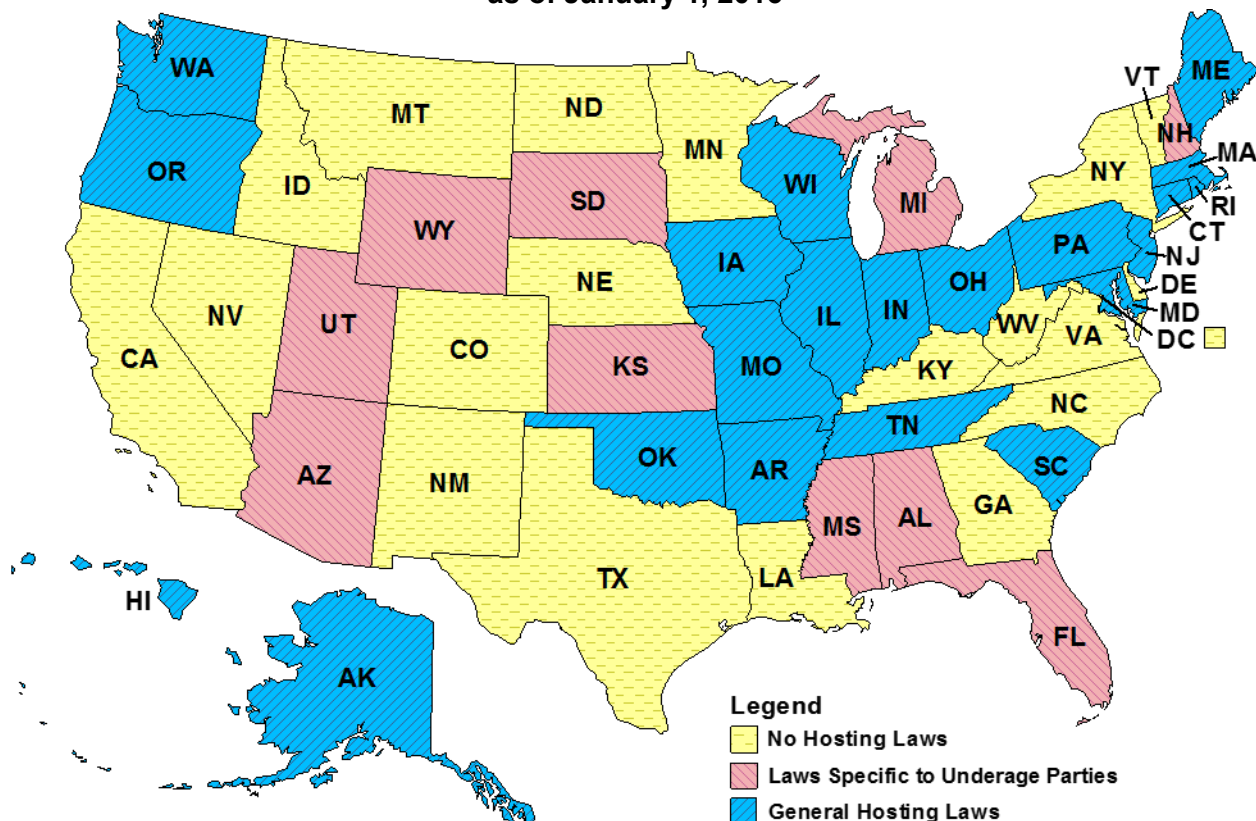
### Status of Host Party Laws

As of January 1, 2016, 21 jurisdictions have general host party laws, 10 have specific host party laws, and 20 have no laws of either sort (see Exhibit 4.2.32). Of the jurisdictions with host party laws, 26 apply to both residential and outdoor property and 4 apply to residential property but not outdoor property. Twenty-nine jurisdictions apply their law to other types of property (e.g., motels, hotels, campgrounds, out-buildings). Eight jurisdictions permit negation of violations when the host takes preventive action; 23 require knowledge standards to trigger liability; 3 rely on a negligence standard; 1 relies on criminal negligence; 4 require an overt act on the part of the host to trigger liability; and 2 require recklessness. Finally, 21 jurisdictions have family exceptions and 5 have resident exceptions.

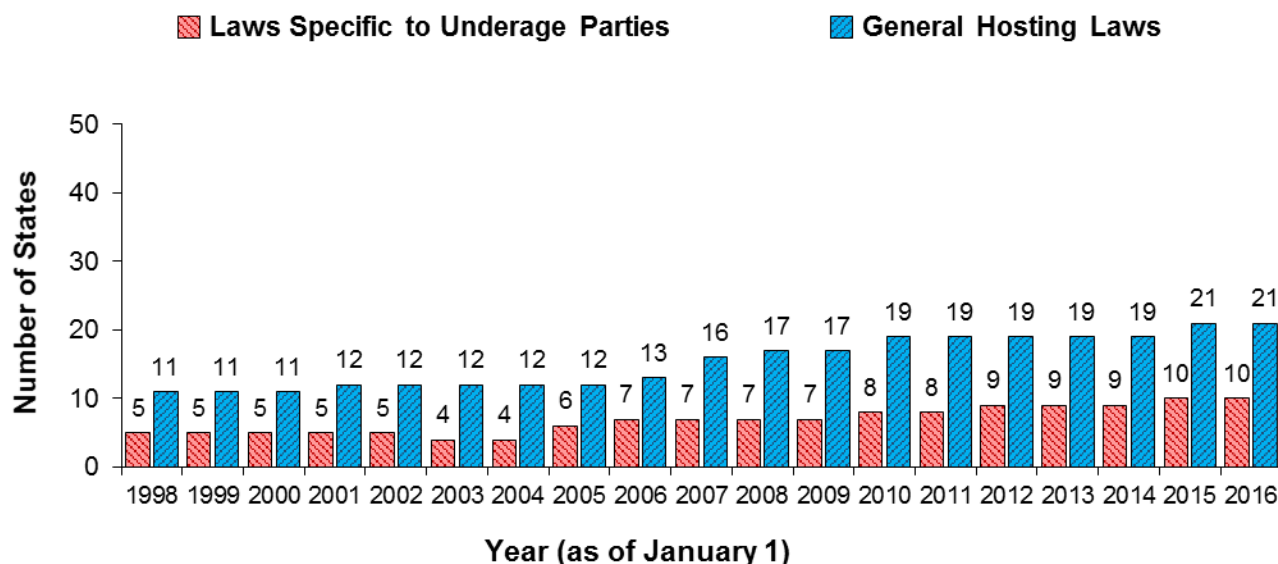
### Trends in Host Party Law Policies

Between 1998 and 2016, the number of jurisdictions that enacted specific host party laws rose from 5 to 10, and the number that enacted general host party laws rose from 11 to 21. In 1998, there were 16 host party laws of both types; in 2016 there are 31 (see Exhibit 4.2.33).

**Exhibit 4.2.32: Prohibitions against Hosting Underage Drinking Parties as of January 1, 2016**



**Exhibit 4.2.33: Number of States with Prohibitions Against Hosting Underage Drinking Parties, January 1, 1998, through January 1, 2016**



### References and Further Information

All data for this policy were obtained from the Alcohol Policy Information System (APIS) at <http://www.alcoholpolicy.niaaa.nih.gov>. Follow links to the policy titled “Prohibitions against Hosting Underage Drinking Parties.” APIS provides further descriptions of this policy and its variables, details regarding state policies, and a review of the limitations associated with the reported data. To see definitions of the variables for this policy, visit [stopalcoholabuse.gov](http://stopalcoholabuse.gov) and follow links to the Report to Congress, Supplemental Materials, Definitions of Variables in Legal Policies.

- Buettner, C. K., Khurana, A., & Slesnick, N. (2011). Drinking at college parties: Examining the influence of student host-status and party-location. *Addictive Behaviors, 36*(12), 1365–1368.
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- Friese, B., & Grube, J. W. (2014). Teen parties: Who has parties, what predicts whether there is alcohol and who supplies the alcohol? *Journal of Primary Prevention, 35*(6), 391–396.
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- National Research Council & Institute of Medicine. (2004). *Reducing Underage Drinking: A Collective Responsibility*. Washington, DC: National Academies Press.

Paschall, M. J., Lipperman-Kreda, S., Grube, J. W., & Thomas, S. (2014). Relationships between social host laws and underage drinking: Findings from a study of 50 California cities. *Journal of Studies on Alcohol and Drugs*, 75(6), 901–907.

Stout, E., Sloan, A., Liang, L., & Davies, H. (2000). Reducing harmful alcohol-related behaviors: Effective regulatory methods. *Journal of Studies on Alcohol and Drugs*, 61, 402–412.

Wagoner, K. G., Sparks, M., Francisco, V. T., Wyrick, D., Nichols, T., & Wolfson, M. (2013). Social host policies and underage drinking parties. *Substance Use & Misuse*, 48(1–2), 41–53. doi:10.3109/10826084.2012.722158

## Retailer Interstate Shipments of Alcohol

### Policy Description

This policy addresses state laws that prohibit or permit retailers to ship alcohol directly to consumers located across state lines, usually by ordering alcohol over the internet. It is related to, but distinct from, both the direct shipment policy, which addresses alcohol shipments to consumers by alcohol producers, and the home delivery policy, which involves retailer deliveries to consumers within the same state.

Retailer interstate shipments may be an important source of alcohol for underage drinkers. In a North Carolina study (Williams & Ribisl, 2012), a group of eight 18- to 20-year-old research assistants placed 100 orders for alcoholic beverages using internet sites hosted by out-of-state retailers. Forty-five percent of the orders were successfully completed and 39 percent were rejected as a result of age verification. The remaining 16 percent of orders failed for reasons believed to be unrelated to age verification (e.g., technical and communications problems with vendors). Most vendors (59 percent) used weak, if any, age verification at the point of order, and, of the 45 successful orders, 23 (51 percent) had no age verification at all. Age verification at delivery was also inconsistently applied.

The North Carolina study reported that there are more than 5,000 internet alcohol retailers, and that the retailers make conflicting claims regarding the legality of shipping alcohol across state lines to consumers. There were also conflicting claims regarding the role of common carriers. The North Carolina study reported that all deliveries were made by such companies, and many internet alcohol retailers list well-known common carriers on their websites. Yet carriers contacted by the study researchers stated they do not deliver packages of alcohol except with direct shipping permits. This suggests confusion regarding state laws addressing interstate retail shipments. North Carolina prohibits such shipments, which means that at least 43 percent of the retailers in the study appeared to have violated the state law.

The National Research Council (NRC)/Institute of Medicine (IOM) report on reducing underage drinking recognized the potential for young people to obtain alcohol over the internet. It recommended that states either ban such sales or require alcohol labeling on packages and signature verification at the point of delivery (NRC and IOM, 2004).

There are several potential barriers to implementing and enforcing bans on retailer interstate alcohol sales, including:

1. States will have difficulty securing jurisdiction over out-of-state alcohol retailers.
2. States may have little incentive to use limited enforcement resources to crack down on in-state alcohol retailers that are shipping out of state because they are not violating state law, taxes are being collected, and any problems occur out of state.
3. Enforcing bans on retailer interstate shipments may prompt online retailers to locate outside the country (many already are foreign-based), creating additional jurisdictional and enforcement problems.

### Types of Restrictions on Interstate Internet Sales

The restrictions addressed in this policy vary by beverage type (beer, wine, distilled spirits). Interstate shipments may be prohibited for one beverage type, more than one beverage type,

or all three beverage types. Some states place restrictions on interstate internet sales including requiring a direct shipping permit and limiting the amount of beverage that may be shipped.

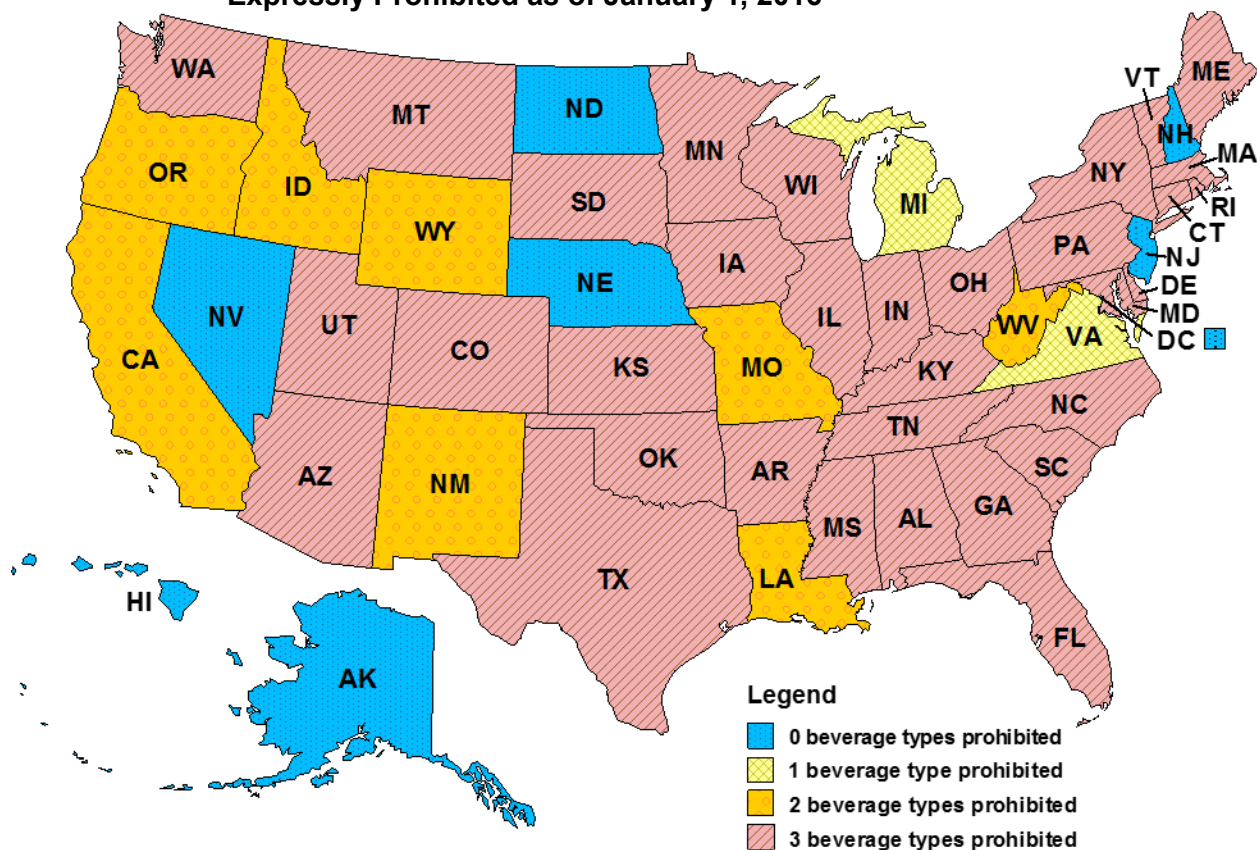
### Current Status of Interstate Internet Sales

As shown in Exhibit 4.2.34, 33 states prohibit retailer interstate sales of all three beverage types, 8 prohibit sales of two beverage types, and 2 prohibit sales of one beverage type. Spirits are the most commonly prohibited beverage (43 states), followed by beer (41 states) and wine (33 states). In eight states, retailer interstate sales laws were deemed uncodable for at least one beverage type (beer, wine, liquor). For the purposes of this summary, these states are treated as *not* expressly prohibiting interstate internet sales for the uncodable beverage types.

### References and Further Information

Legal research and data collection for this topic are planned and managed by the Substance Abuse and Mental Health Services Administration (SAMHSA) and conducted under contract by The CDM Group, Inc. To see definitions of the variables for this policy, visit [stopalcoholabuse.gov](http://stopalcoholabuse.gov) and follow links to the Report to Congress, Supplemental Materials, Definitions of Variables in Legal Policies. For further information and background see:

**Exhibit 4.2.34: Number of Beverage Types for which Interstate Internet Sales are Expressly Prohibited as of January 1, 2016**





National Research Council & Institute of Medicine. (2004). *Reducing Underage Drinking: A Collective Responsibility*. Washington, DC: National Academies Press.

N.C. Gen. Stat. § 18B-102.1; N.C. Gen. Stat. § 18B-109.

Williams, R. S., & Ribisl, K. M. (2012). Internet alcohol sales to minors. *Archives of Pediatrics & Adolescent Medicine*, 166(9), 808–813. doi:10.1001/archpediatrics.2012.265

Williams, R. S., & Schmidt, A. (2014). The sales and marketing practices of English-language internet alcohol vendors. *Addiction*, 109(3): 432-439.

## Direct Sales/Shipments from Producers to Consumers

### Policy Description

State proscriptions against direct sales and shipments of alcohol from producers to consumers date back to the repeal of Prohibition. The initial reason for the proscription was to ensure that the pre-Prohibition-era “tied house system” (under which producers owned or controlled retail outlets directly or both) did not continue after repeal. Opponents of the tied house system argued that producers who controlled retail outlets permitted unsafe retail practices and failed to respond to community concerns. The alternative that emerged was a three-tier production and distribution system with separate production, wholesaling, and retail elements. Thus, producers must distribute products through wholesalers rather than sell directly to retailers or consumers; wholesalers must purchase from producers; and consumers must purchase from retailers.

Modern marketing practices, particularly internet sales that link producers directly to consumers, have led many states to create laws with exceptions to general mandates that alcohol producers distribute their products only through wholesalers. Some states permit producers to ship alcohol to consumers using a delivery service (usually a common carrier). In some cases, these exceptions are responses to legal challenges by producers or retailers arguing that state law unfairly discriminates between in-state and out-of-state producers. The U.S. Supreme Court has held that state laws permitting in-state producers to ship directly to consumers while barring out-of-state producers from doing so violate the U.S. Constitution’s Interstate Commerce Clause, and that this discrimination is neither authorized nor permitted by the 21st Amendment.<sup>1</sup>

One central concern emerging from this controversy is the possibility that direct sales/shipments (either through internet sales or sales made by telephone or other remote communication) will increase alcohol availability to underage persons. Young people may attempt to purchase alcohol through direct sales instead of face-to-face sales at retail outlets because they perceive that detection of their underage status is less likely. These concerns were validated by a study that found that internet alcohol vendors use weak, if any, age verification, thereby allowing minors to successfully purchase alcohol online (Williams & Ribisl, 2012). In response to these concerns, several jurisdictions that permit direct sales/shipments have included provisions to deter youth access. These may include requirements that:

- Consumers have face-to-face transactions at producers’ places of business (and show valid age identification) before any future shipments to consumers can be made.<sup>2</sup>
- Producers/shippers and deliverers verify recipient age, usually by checking recipients’ identification.
- Producers/shippers and deliverers obtain permits or licenses or be approved by the state.
- Producers/shippers and deliverers maintain records that must either be reported to state officials or be open for inspection to verify recipients of shipments.
- Direct shipment package labels include statements that the package contains alcohol and that the recipient must be at least 21 years old.

<sup>1</sup> See, e.g., *Granholm v. Heald*, 544 U.S. 460, 125 S.Ct. 1885 (2005).

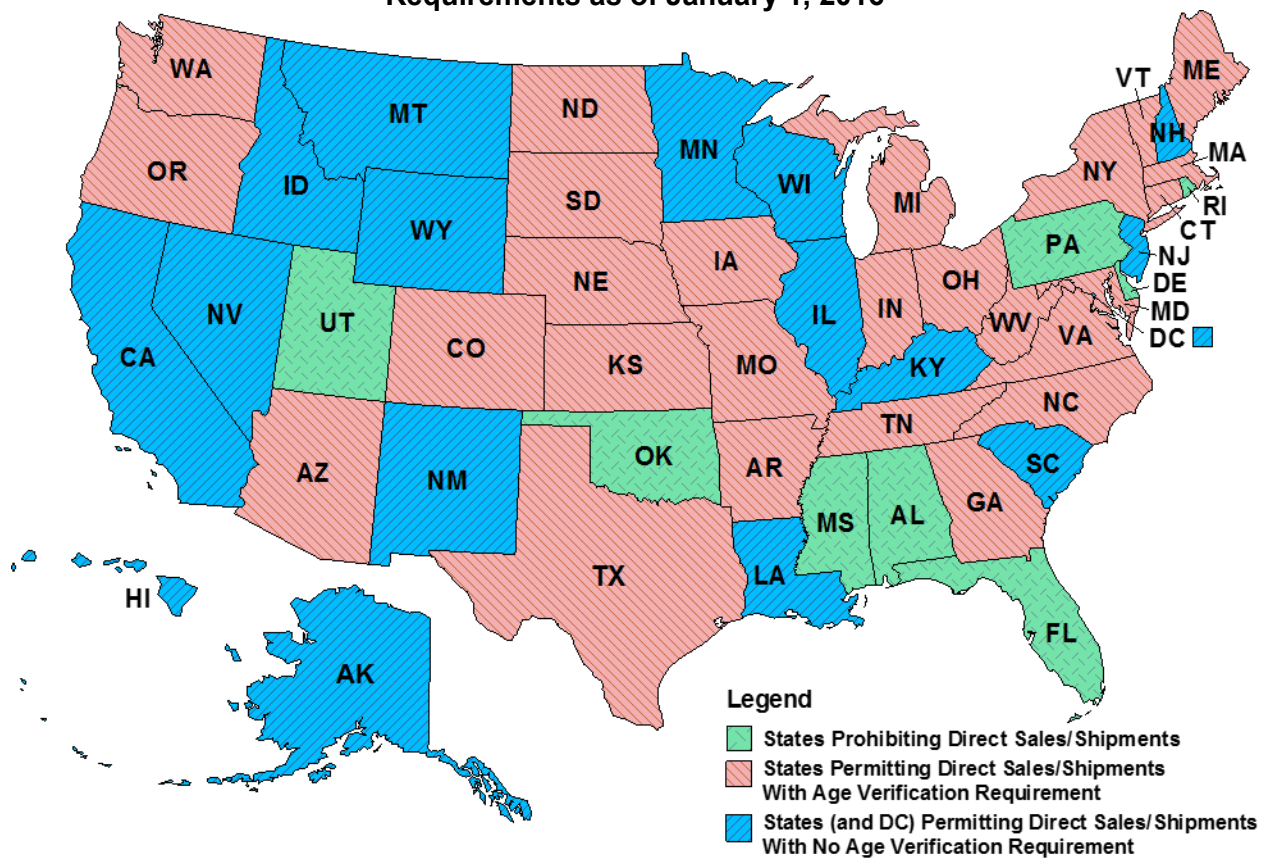
<sup>2</sup> Laws that require face-to-face transactions for all sales prior to delivery are treated as prohibitions on direct sales/shipments.

State laws also vary on the types of alcoholic beverages (beer, wine, distilled spirits) that producers may sell directly and ship to consumers. These and other restrictions may apply to all direct shipments. This report includes only those requirements related to preventing underage sales.<sup>3</sup>

**Status of Direct Sales/Shipment Policies**

As of January 1, 2016, 43 states permit direct sales/shipments from producers to consumers, and 8 prohibit such transactions (see Exhibit 4.2.35). One state (Arkansas) requires face-to-face transactions at producers’ places of business and verification of valid age identification before shipments to the consumer can be made. Forty states require producers to obtain a shipper’s permit or state approval prior to shipping. Of the 43 states permitting direct sales or shipments, 9 require shippers to verify purchaser age, 22 require deliverers to verify recipient age, and 5 require age verification by both shippers and deliverers.

**Exhibit 4.2.35: Direct Sales/Shipment Policies and Age Verification Requirements as of January 1, 2016**



<sup>3</sup> These include caps on the amount that can be shipped; laws that permit only small producers to sell directly to consumers; reporting and taxation provisions unrelated to identifying potential underage recipients; and brand registration requirements. In some cases, exceptions are so limited that a state is coded as not permitting direct sales (e.g., shipments are allowed only by boutique historical distilled spirits producers).

Sixteen states and the District of Columbia do not require any age verification. Thirty-six states require a label stating that the package can be received only by a person over age 21, 35 states require a label stating that the package contains alcohol, and 4 states have no labeling requirements related to underage drinking.

### **Trends in Direct Sales/Shipments Policies**

Between January 1, 2009, and January 1, 2016, eight states added more regulation to their policies. Seven other states (Arkansas, Kansas, Maine, Maryland, New Jersey, New Mexico, South Dakota, and Tennessee) adopted permit systems for allowing direct shipment of wine from producers to purchasers. Previously, New Mexico had allowed direct shipping by wineries only in those states that offered it reciprocal privileges. Alaska, Montana, and Nebraska adopted requirements that package labels state that the recipients of wine shipments must be over 21 and that the package contains alcohol. Iowa adopted requirements in 2010 that age is verified prior to delivery and that labels state that recipients of wine shipments must be over 21. North Dakota adopted age verification requirements at the point of delivery and requirements that the carrier receive state approval and report purchasers' names. New Hampshire adopted a provision regarding collecting purchasers' names. In 2011, Ohio expanded direct shipping privileges to include beer, and in 2013 Vermont did the same. In 2014, Arizona granted direct shipping privileges to craft distilleries producing spirits. During 2015, Indiana removed the requirement that direct wine sellers have an initial face-to-face meeting with a consumer prior to direct shipping to that consumer. Washington adopted a provision to allow craft distilleries to ship spirits. On January 1, 2016, Oregon added beer to the privileges of direct shippers.

### **References and Further Information**

Legal research and data collection for this topic are planned and managed by the Substance Abuse and Mental Health Services Administration (SAMHSA) and conducted under contract by The CDM Group, Inc. To see definitions of the variables for this policy, visit [stopalcoholabuse.gov](http://stopalcoholabuse.gov) and follow links to the Report to Congress, Supplemental Materials, Definitions of Variables in Legal Policies. For further information and background, see:

- Glynn, D. (2011). Comment: Granholm's ends do not justify the means: The twenty-first amendment's temperance goals trump free-market idealism. *Journal of Law, Economics & Policy*, 8, 113.
- Jurkiewicz, C., & Painter, M. (Eds.). (2008). *Social and Economic Control of Alcohol: The 21st Amendment in the 21st Century*. New York: CRC Press.
- Moramarto, M. (2008). *The Twenty-First Amendment, Granholm, and the Future of the Three-Tier System*. Working Paper, Social Science Research Network, December 13, 2008. Retrieved from [http://papers.ssrn.com/sol3/papers.cfm?abstract\\_id=1340198](http://papers.ssrn.com/sol3/papers.cfm?abstract_id=1340198)
- Norton, E. (2006). The Twenty-First Amendment in the twenty-first century: Reconsidering state liquor controls in light of Granholm v. Heald. *Ohio State Law Journal*, 67, 1465–1494.
- Williams, R. S., & Ribisl, K. M. (2012). Internet alcohol sales to minors. *Archives of Pediatrics & Adolescent Medicine*, 166(9), 808–813. doi:10.1001/archpediatrics.2012.265
- Williams, R. S., & Schmidt, A. (2014). The sales and marketing practices of English-language internet alcohol vendors. *Addiction*, 109(3), 432–439. doi:10.1111/add.12411

## **Keg Registration**

### **Policy Description**

Keg registration laws (also called keg tagging laws) require wholesalers or retailers to attach tags, stickers, or engravings with an identification number to kegs exceeding a specified capacity. These laws discourage purchasers from serving underage persons from the keg by allowing law enforcement officers to trace the keg to the purchaser even if he or she is not present at the location where the keg is consumed.

At purchase, retailers are required to record identifying information about the purchaser (e.g., name, address, telephone number, driver's license). In some states, keg laws specifically prohibit destroying or altering the ID tags and provide penalties for doing so. Other states make it a crime to possess unregistered or unlabeled kegs.

Refundable deposits may also be collected for the kegs themselves, the tapper mechanisms used to serve the beer, or both. Deposits are refunded when the kegs and tappers are returned with identification numbers intact. These deposits create an incentive for the purchaser to keep track of the whereabouts of the keg, because a financial penalty is imposed if the keg is not returned.

Some jurisdictions collect information (e.g., location where the keg is to be consumed, tag number of the vehicle transporting the keg) to aid law enforcement efforts, further raising the chances that illegal furnishing to minors will be detected. Some jurisdictions also require retailers to provide warning information at the time of purchase about laws prohibiting service to minors and other laws related to the purchase or possession of the keg.

Disposable kegs complicate keg registration laws. Some of these containers meet the capacity definition for a keg but cannot be easily tagged or traced, as they are meant to be disposed of when empty. Most states do not differentiate disposable from nondisposable kegs, although some have modified keg registration provisions to accommodate this container type.

### **Status of Keg Registration Policies**

#### ***Keg Registration Laws***

As of January 1, 2016, the District of Columbia and 30 states require keg registration, and 19 states do not require keg registration. Minimum keg sizes subject to keg registration requirements range from 2 gallons to 7.75 gallons with the exception of South Dakota, where the requirements are 8 or 16 gallons. Utah alone prohibits keg sales altogether, making a keg registration law irrelevant.

#### ***Prohibited Acts***

Ten states prohibit both the possession of unregistered kegs and the destruction of keg labels. Six states prohibit only the possession of unregistered kegs, 8 prohibit only the destruction of keg labels, and 25 states and the District of Columbia prohibit neither act.

#### ***Purchaser Information Collected***

All 31 jurisdictions with keg registration laws require retailers to collect some form of purchaser information. Of these, 27 require purchasers to provide a driver's license or other government-issued identification. Six jurisdictions (District of Columbia, Georgia, North Carolina, Oregon,

Virginia, and Washington) require purchasers to provide the address at which the keg will be consumed.

### ***Warning Information to Purchasers***

Of the 31 jurisdictions with keg registration laws, 23 states and the District of Columbia require that some kind of warning information be presented to purchasers about the violation of any laws related to keg registration (see Exhibit 4.2.36). Fourteen states and the District of Columbia specify “active” warnings (requiring an action on the part of the purchaser, such as signing a document), and nine states specify “passive” warnings (requiring no action on the part of the purchaser). Seven states do not require that any warning information be given to purchasers.

### **Trends in Keg Registration Policies**

The number of states enacting keg registration laws rose steadily between 2003 and 2008, with an increase from 20 to 31 jurisdictions, and has remained the same since then (see Exhibit 4.2.37).

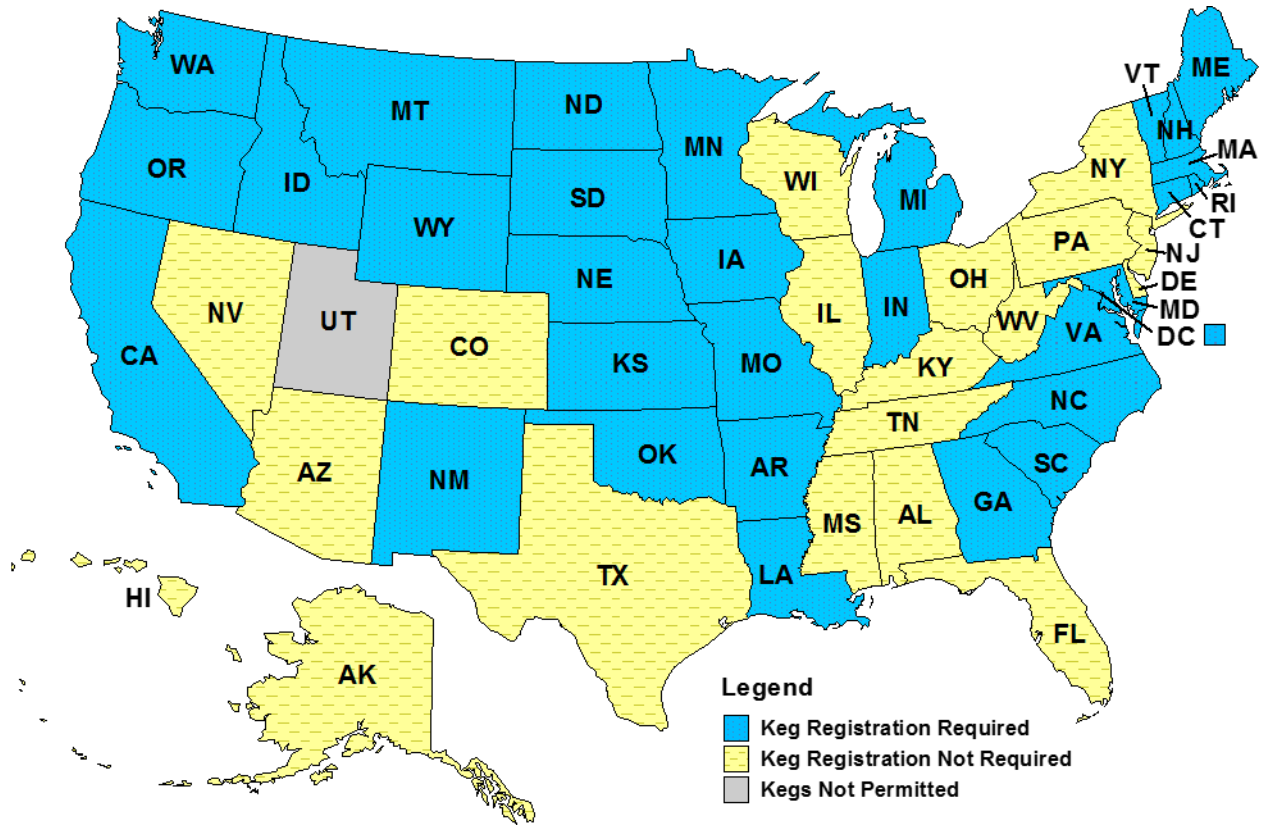
### **References and Further Information**

All data for this policy were obtained from the Alcohol Policy Information System (APIS) at <http://www.alcoholpolicy.niaaa.nih.gov>. Follow links to the policy titled “Keg Registration.” APIS provides further descriptions of this policy and its variables, details regarding state policies, and a review of the limitations associated with the reported data. To see definitions of the variables for this policy, visit [stopalcoholabuse.gov](http://stopalcoholabuse.gov) and follow links to the Report to Congress, Supplemental Materials, Definitions of Variables in Legal Policies.

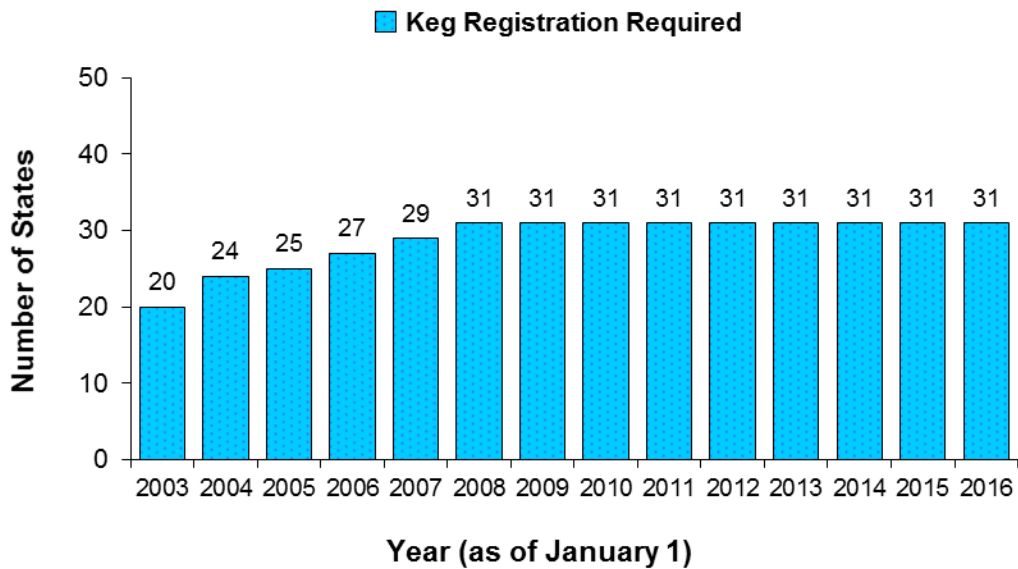
- Boyle, S. C., LaBrie, J. W., Froidevaux, N. M., & Witkovic, Y. D. (2016). Different digital paths to the keg? How exposure to peers' alcohol-related social media content influences drinking among male and female first-year college students. *Addictive Behaviors*, *57*, 21–29. doi:10.1016/j.addbeh.2016.01.011. Epub 2016 Jan 22
- Fell, J. C., Scherer, M., Thomas, S., & Voas, R. B. (2016). Assessing the impact of twenty-underage drinking laws. *Journal of Studies on Alcohol and Drugs*, *77*(2), 249–260.
- Hingson, R., & White, A. (2014). New research findings since the 2007 Surgeon General’s Call to Action to Prevent and Reduce Underage Drinking: A review. *Journal of Studies on Alcohol and Drugs*, *75*(1), 158–169.
- National Institute on Alcohol Abuse and Alcoholism. (2006). *Young Adult Drinking*. Alcohol Alert, No. 68. Retrieved from <http://pubs.niaaa.nih.gov/publications/aa68/aa68.htm>
- Ringwalt, C. L., & Paschall, M. J. (2011). The utility of keg registration laws: A cross-sectional study. *Journal of Adolescent Health*, *48*(1), 106–108.
- Wagenaar, A. C., Harwood, E. M., Silianoff, C., & Toomey, T. L. (2005). Measuring public policy: The case of beer keg registration laws. *Evaluation and Program Planning*, *28*(4), 359–367.



**Exhibit 4.2.36: Keg Registration Laws as of January 1, 2016**



**Exhibit 4.2.37: Number of States with Keg Registration Laws, January 1, 2003, through January 1, 2016**



## Home Delivery

### Policy Description

Home delivery restrictions prohibit or limit the ability of alcohol retailers to deliver alcoholic beverages to customers who are not present at their retail outlet. The University of Minnesota Alcohol Epidemiology Program notes that home delivery of alcohol may increase alcohol availability to youth by increasing opportunities for underage persons to subvert minimum age purchase requirements. Ordering by phone, fax, or email may facilitate deception. Delivery persons may have less incentive to check purchasers' age identification when they are away from the licensed establishment and cannot be watched by a surveillance camera, the liquor store's management, or other customers.

Research on home delivery of alcohol is limited. One study examined the use of home delivery by adult men. The authors report that regular drinkers without a history of alcohol problems were significantly less likely to have had alcohol delivered than problem drinkers. Another study found similar results for underage drinkers. Ten percent of 12th graders and 7 percent of 18- to 20-year-olds in 15 Midwestern communities reported they obtained alcohol through delivery services in the last year. Use of delivery services was more prevalent among young men and among more frequent, heavier drinkers.

A state home delivery law may:

- Specifically prohibit or permit the delivery of beer, wine, or spirits to residential addresses, hotel rooms, conference centers, and so on.
- Permit home delivery, but with restrictions, including:
  - Limits on the quantity that may be delivered.
  - Limits on the time of day or days of the week when deliveries may occur.
  - A requirement that the retail merchant obtain a special license or permit.

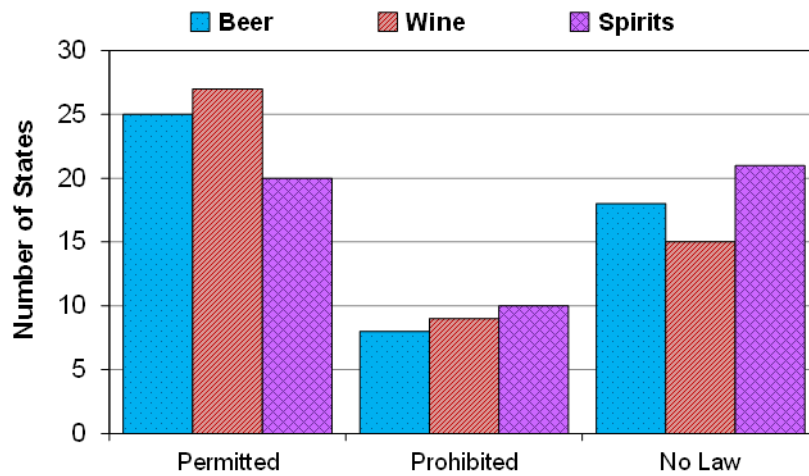
In some states that allow home delivery, local ordinances may restrict or ban home delivery in specific sub-state jurisdictions.

### Status of Home Delivery Policies

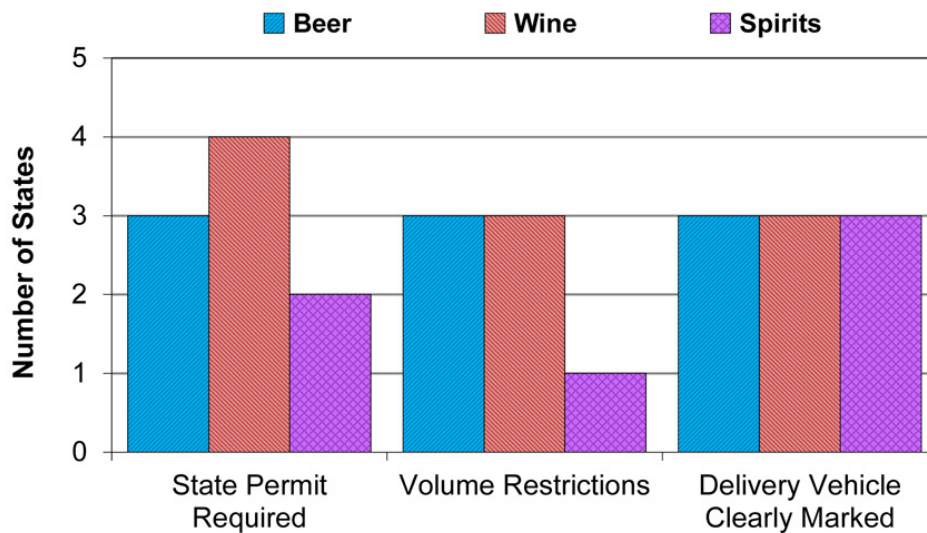
Exhibit 4.2.38 shows the number of states that permit, prohibit, or have no law regarding home delivery of beer, wine, and spirits. As the exhibit shows, 20 states permit home delivery of all three beverages, 8 prohibit delivery of all three, and 15 have no law for any beverage. Eight states have different laws for different beverages. Four of these states (New Hampshire, North Carolina, Oregon, and Virginia) permit delivery of beer and wine but have no law for spirits. Michigan permits beer and wine delivery but prohibits spirits, and Kentucky prohibits wine and spirits delivery but has no law for beer. Louisiana and West Virginia permit home delivery of wine but have no law for beer and spirits.

Of the 25 states that permit home delivery of beer and wine, 11 place at least one restriction on retailers. Of the 20 states that permit home delivery of spirits, 9 place at least one restriction on retailers. Of the two states that permit delivery of wine only, both impose retailer restrictions. Exhibit 4.2.39 shows the distribution of those restrictions imposed by two or more states on home delivery laws: (a) a state permit is required (Colorado, Texas, Virginia, and West

**Exhibit 4.2.38: Home Delivery of Beer, Wine, and Spirits**



**Exhibit 4.2.39: Restrictions Imposed by Two or More States on Delivery of Beer, Wine, and Spirits**



Virginia); (b) the volume that can be delivered is restricted (Indiana, Louisiana, New York, Virginia, and West Virginia); and (c) the delivery vehicle must be clearly marked (New Jersey, New York, and Texas). Two additional states that permit delivery of beer, wine, and spirits place a single, unique restriction on retailers: (a) orders must be in writing (Alaska); (b) written information on fetal alcohol syndrome must accompany the delivered product (Alaska); and (c) a local permit is required to deliver to the retailer’s county or city (Maryland). One state (Washington) that permits delivery of beer and wine requires a special license only for internet orders. Massachusetts requires that each vehicle used for transportation and delivery have a state-issued permit. Oregon requires “for hire” carriers to be approved by the state. Exhibits 4.2.40 through 4.2.42 summarize the status of home delivery for beer, wine, and spirits as of January 1, 2016.

Exhibit 4.2.40: Home Delivery of Beer

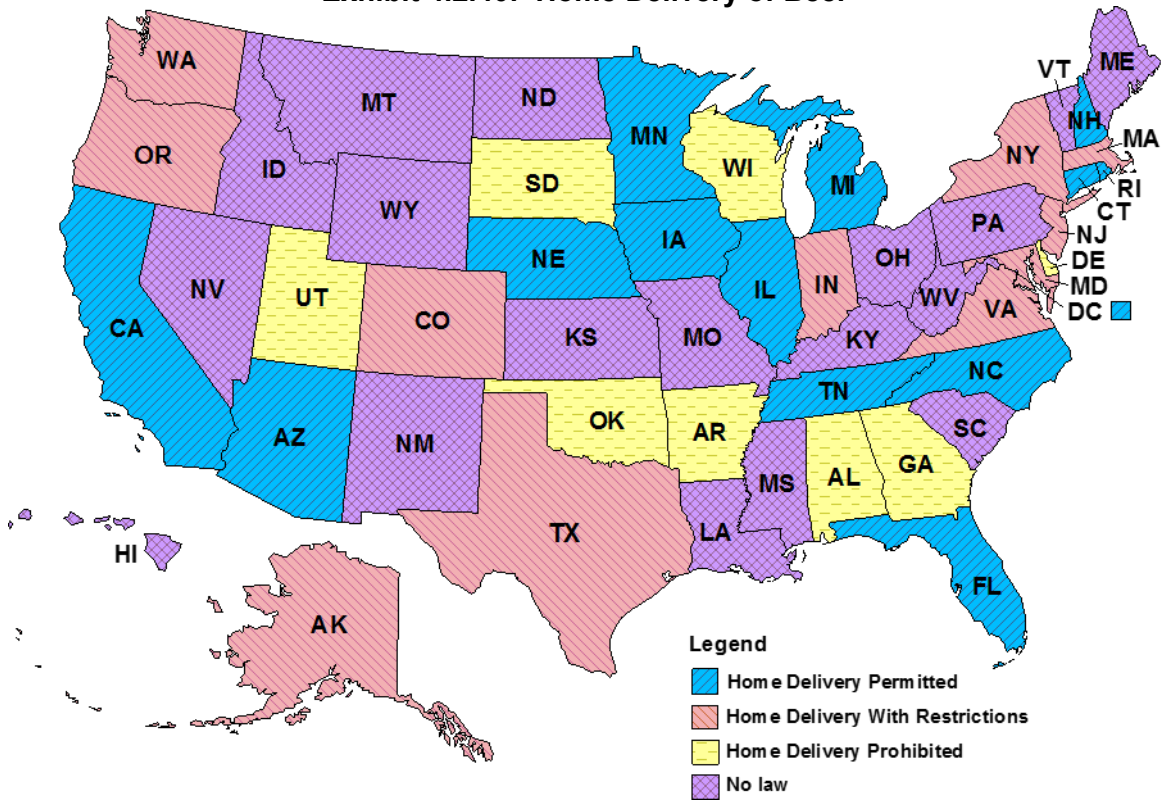


Exhibit 4.2.41: Home Delivery of Wine

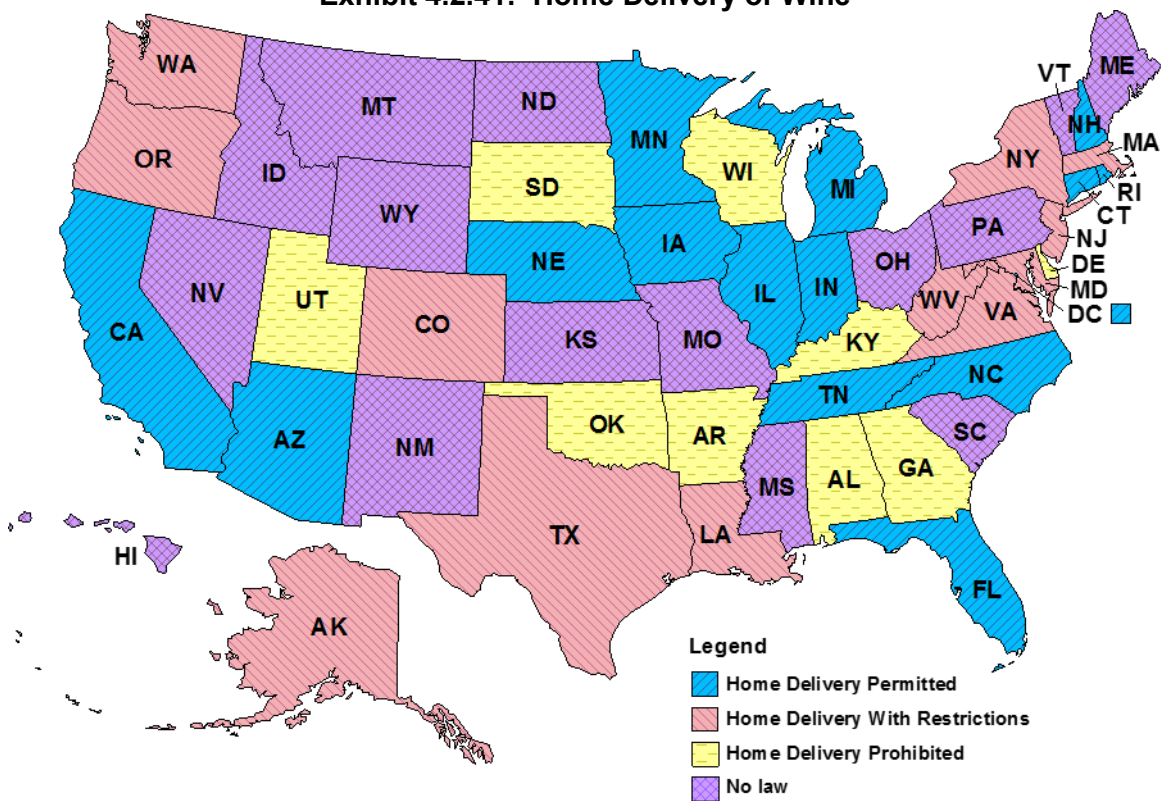
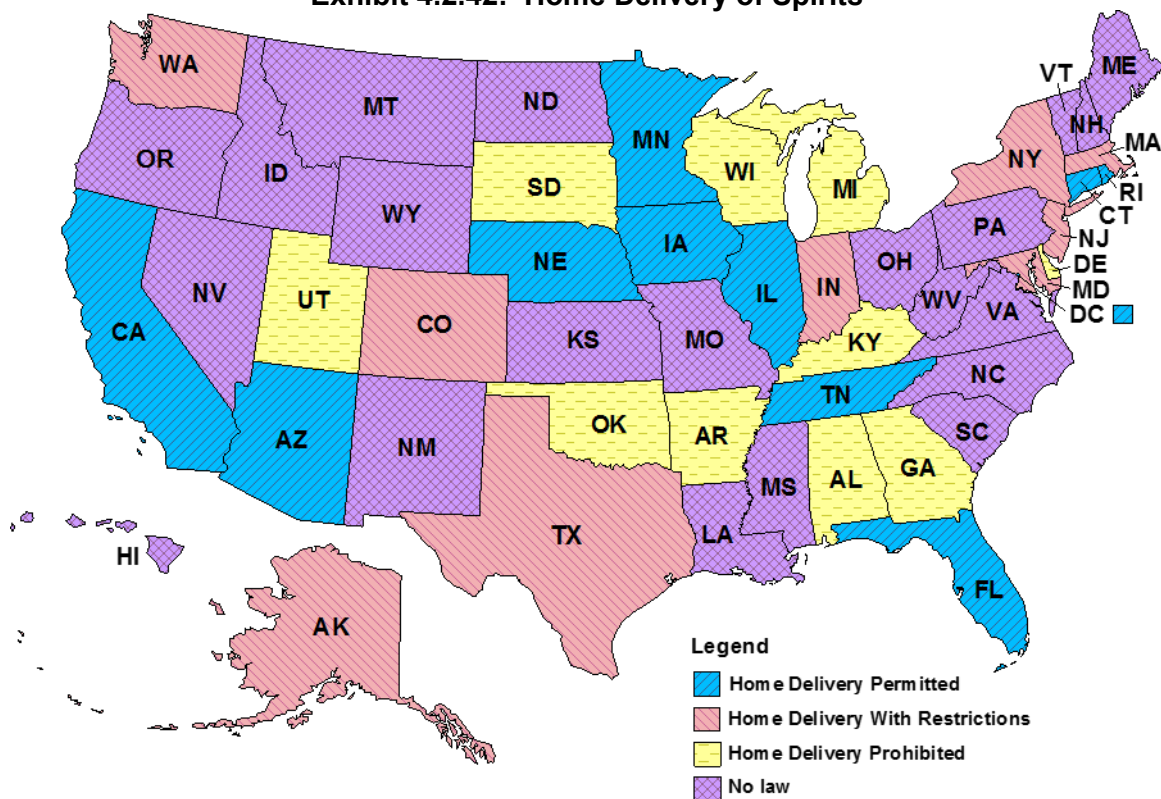




Exhibit 4.2.42: Home Delivery of Spirits



### Trends in Home Delivery Policies

Between 2010 and 2016, three states (Louisiana, Washington, and Tennessee) changed their home delivery policies. Louisiana permitted wine retailers to deliver to consumers in 2011. Washington permitted spirit retailers to deliver to consumers in 2012. In 2014, Tennessee permitted retailers to deliver beer, wine, and spirits.

### References and Further Information

Legal research and data collection for this topic are planned and managed by the Substance Abuse and Mental Health Services Administration (SAMHSA) and conducted under contract by The CDM Group, Inc. To see definitions of the variables for this policy, visit [stopalcoholabuse.gov](http://stopalcoholabuse.gov) and follow links to the Report to Congress, Supplemental Materials, Definitions of Variables in Legal Policies. For further information and background, see:

Alcohol Epidemiology Program Website (n.d.). Retrieved from <http://www.aep.umn.edu/index.php/aep-tools/underage-access>

Fletcher, L. A., Nugent, S. M., Ahern, S. M., & Willenbring, M. L. (1996). The use of alcohol home delivery services by male problem drinkers: A preliminary report. *Journal of Substance Abuse*, 8(2), 251–261.

Fletcher, L. A., Toomey, T. L., Wagenaar, A. C., Short, B., & Willenbring, M. L. (2000). Alcohol home delivery services: A source of alcohol for underage drinkers. *Journal of Studies on Alcohol*, 61, 81–84.

## High-Proof Grain Alcoholic Beverages

### Policy Description

This policy addresses state laws that prohibit or restrict the retail availability of high-proof grain alcoholic beverages as a strategy for reducing underage drinking, particularly underage binge drinking.

High-proof grain alcoholic beverages such as Everclear or Gem Clear represent a type of “neutral spirits” that is odorless and colorless and contains a high percentage of alcohol. The Federal Alcohol and Tobacco Tax and Trade Bureau (TTB) defines “neutral spirits or alcohol” as “spirits distilled from any material at or above 95 percent alcohol by volume (190 proof), and if bottled, bottled at not less than 40 percent alcohol by volume (80 proof)” (Alcohol and Tobacco Tax and Trade Bureau, 2007).<sup>1</sup> Grain spirits are neutral spirits distilled from a fermented mash of grain and stored in oak containers.

High-proof grain alcoholic beverages pose particular risks for young people. They have little or no taste, odor, or color and are often added to cocktails, soft drinks, and fruit punch. This can result in an easy-to-consume concoction with very high alcohol content that is difficult to detect, particularly for inexperienced drinkers, and can lead to binge drinking. A “serving” of alcohol contains 0.6 ounces of ethanol, per NIAAA. This is the amount of ethanol contained in 1.5 ounces of traditional (40 percent ABV) distilled spirits, 5 ounces of 12 percent ABV wine, and 12 ounces of 5 percent ABV beer. Grain alcohol, by contrast, contains approximately twice as much ethanol as traditional distilled spirits. Thus, an equivalent “serving” of grain alcohol would be 0.6 ounces of 95 percent ABV/190 proof or 0.8 ounces of 75.5 percent ABV/151 proof grain alcohol, respectively. This means there are 42 servings of 95 percent ABV/190 proof or 32 servings of 75.5 percent ABV grain alcohol in a 750mL bottle, compared with only 17 servings in a bottle of other types of distilled spirits (such as vodka) of the same size. Research suggests that young people often “overpour” their drinks, making a strong drink even stronger (White et al., 2005). This practice can therefore be particularly hazardous when high-proof grain alcoholic beverages are involved.

Underage binge drinking (defined as five or more drinks in a sitting for men and four or more drinks in a sitting for women) accounts for most of the alcohol consumed by underage youth (Office of Juvenile Justice and Delinquency Prevention, 2005). More than two-thirds of youth binge drink, and more than one fifth of these youth do so frequently (NRC and IOM, 2004). Binge drinking “is associated with drunk driving, risky sexual behavior, physical and sexual assaults, injuries, and suicides” (Naimi, Siegel, DeJong, O’Doherty, & Jernigan, 2015).

Research has found that college students often consume grain alcohol when binge drinking. The Maryland Collaborative to Reduce College Drinking and Related Problems (“the Collaborative”) created and administered the Maryland College Alcohol Survey to 4,209 students from nine schools to measure levels of alcohol use and excessive drinking (Maryland Collaborative to Reduce College Drinking and Related Problems, 2014). It found that among students who had consumed alcohol in the past month, 70 percent reported binge drinking during that time period, with 11.6 percent reporting they consumed grain alcohol. Among high-risk drinkers (those who

<sup>1</sup> Proof is a method of measuring the alcohol content of spirits calculated by multiplying the percent of alcohol by volume (ABV) by two.



binge drank one to four days during the past month), 10.6 percent reported consuming grain alcohol over the last month. Among very high risk drinkers (those who binge drank five or more days during the past month), 22 percent reported consuming grain alcohol over the last month.

Two recent studies looked at rates of high-proof grain alcoholic beverage consumption among all youth. According to an internet panel of 1,032 youth ages 13 to 20, 5.8 percent of all youth reported consuming high-alcohol-content grain alcoholic beverages in the past 30 days (Siegel et al., 2014), and 2.4 percent of youth reported binge drinking such beverages in the past 30 days (Naimi et al., 2015). Of youth who drank high-alcohol-content grain alcoholic beverages, 35.1 percent reported binge drinking. Naimi and colleagues also computed a market share ratio, the “proportion of binge reports accounted for by a particular alcohol type ... or category ... divided by its overall market share (i.e., percent of all drinks consumed) among the entire youth sample.” A number greater than 1.0 means “for a particular alcohol type or category, the number of binge drinking reports is disproportionately large relative to its market share.” The market share ratio for high-proof grain alcoholic beverages was the fifth highest (out of 19 alcohol types or categories), at 1.59. Given the characteristics of this product and given that it is frequently mixed with punch or similar beverages, however, some youth may have consumed it unknowingly, and thus may not have reported consuming it in the studies, so the above statistics may underreport its consumption.

In many states, youth can easily obtain these beverages at low prices. The cost per ounce of ethanol for grain alcohol ranges from 52¢ to 82¢. This is substantially lower than beer (\$1.93 per ounce of ethanol), vodka (\$1.85 per ounce of ethanol), or flavored alcoholic beverages (\$2.14 per ounce of ethanol; DiLoreto, 2012). At this strength and price, grain alcohol provides one of the cheapest means to obtain a standard drink of alcohol and to engage in binge drinking.

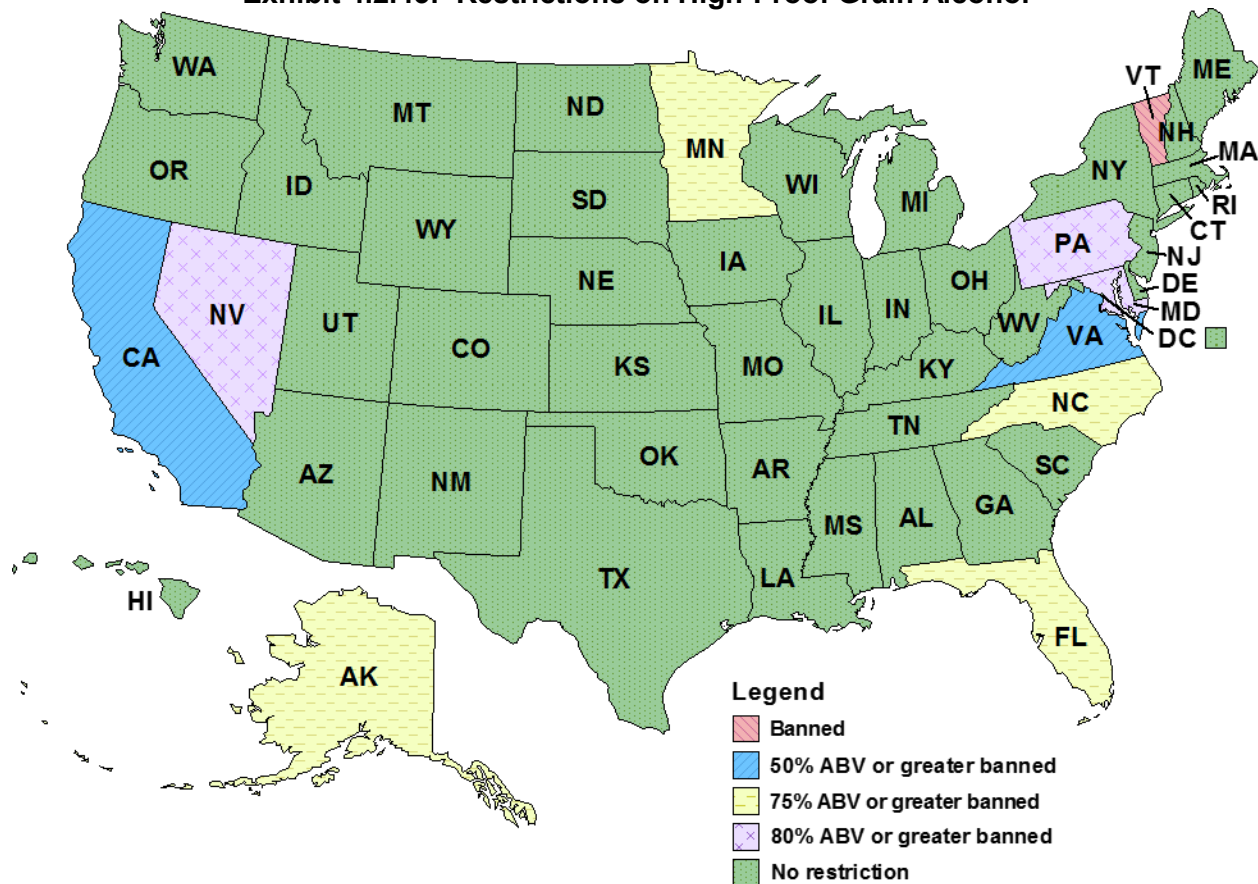
### **Types of Restrictions on Sale of High-Proof Grain Alcoholic Beverages**

Many states prohibit or restrict retail sale of high-proof grain alcoholic beverages. State statutes or regulations may restrict the type of such beverages that can be sold in the state. Control states, where the state government maintains direct control over the distribution and sale of alcoholic beverages at the wholesale and/or retail levels, may also regulate high-proof grain alcoholic beverages through internal policies that are not reflected in statute or regulation (i.e., by determining administratively that the beverages will not be made available at state-run wholesale and/or retail outlets). States that regulate grain alcohol through internal policy, rather than by statute or regulation, are reported as restricting sales only if their internal policies are published in writing. Counties or municipalities may also regulate the sale of high-proof grain alcoholic beverages by local ordinance. Such restrictions are not included in this report.

### **Current Status of Sale of High-Proof Grain Alcoholic Beverages**

Ten states regulate the sale of high-proof grain alcoholic beverages through statute, regulation, or written policy (see Exhibit 4.2.43). Six of these are license states: Alaska, California, Florida, Maryland, Minnesota, and Nevada. The other four are control states: North Carolina, Pennsylvania, Virginia, and Vermont. Two of the 10 states offer exceptions to the restrictions. Minnesota makes an exception for “spirits aged in wood casks for not less than two years.” Pennsylvania makes an exception for products produced by a “limited distillery license.”

Exhibit 4.2.43: Restrictions on High-Proof Grain Alcohol



Five states define the restrictions in terms of alcohol by volume (ABV). California prohibits the sale of beverages greater than 60 percent ABV. Alaska prohibits the sale of beverages greater than 76 percent ABV. Minnesota prohibits 80 percent ABV or more, and Nevada restricts grain alcohol with an ABV of over 80 percent. Maryland makes it illegal to sell grain alcohol with 95 percent ABV or more.

Four states define the restriction in terms of proof. Florida law provides that “[a] distilled spirit greater than 153 proof may not be sold or consumed in the state.” The North Carolina Alcoholic Beverage Control Commission has issued a written statement that the highest proof liquor sold in North Carolina ABC stores will be 151 proof. Pennsylvania restricts sales of alcohol at 190 proof or greater to nonpotable uses. In Virginia, the law states that no “neutral grain spirit or alcohol... shall be sold in government stores at a proof greater than 101.” Vermont simply restricts the purchase of “pure ethyl or grain alcohol” to non-beverage purposes.

### References and Other Information

Legal research and data collection for this topic are planned and managed by the Substance Abuse and Mental Health Services Administration (SAMHSA) and conducted under contract by The CDM Group, Inc. To see definitions of the variables for this policy, visit [stopalcoholabuse.gov](http://stopalcoholabuse.gov) and follow links to the Report to Congress, Supplemental Materials, Definitions of Variables in Legal Policies. For further information and background, see the following resources:

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## Alcohol Pricing Policies

### Alcohol Taxes

#### Policy Description

There is ample evidence that the “economic availability” of alcoholic beverages (i.e., retail price) impacts underage drinking and a wide variety of related consequences. The *Surgeon General’s Call to Action* includes economic availability as a strategy in the context of increasing the cost of underage drinking. Taxes are a major way that alcohol prices are manipulated by policymakers.

The effects of price on reducing underage drinking, college drinking, and binge drinking (including drinking among youth who show signs of alcohol use disorders) are considerable. There are also significant effects on youth traffic crashes, violence on college campuses, and crime among people under 21. Although alcohol taxes are an imperfect index of retail prices, tax rates are relatively easy to measure and provide a useful proxy for economic availability. Based on this and other research, the 2004 NRC/IOM Report, *Reducing Underage Drinking: A Collective Responsibility*, made the following recommendation: “[S]tate legislatures should raise excise taxes to reduce underage consumption and to raise additional revenues for this purpose.”

This policy addresses beer, wine, and distilled spirits taxes. Although some states have separate tax rates for other alcoholic products (e.g., sparkling wine and flavored alcohol beverages), these account for a small market share and are not addressed.

#### Status of Alcohol Taxation

As of January 1, 2016, all license states have a specific excise tax for beer, wine, and spirits. The Federal Government also levies a specific excise tax of \$0.58/gallon for beer, \$1.07/gallon for wine, and \$13.50/gallon for spirits.<sup>1</sup>

Like the federal-specific excise tax, state-specific excise taxes are generally highest for spirits and lowest for beer, roughly tracking the alcohol content of these beverages. Beer-specific excise taxes range from \$0.02 to \$1.29/gallon, wine-specific excise taxes range from \$0.11 to \$2.50/gallon, and spirits-specific excise taxes range from \$1.50 to \$14.25/gallon. The states with the highest excise tax for one beverage may not be the states with the highest excise taxes for other beverages. States may control for one, two, or three categories (beer, wine, and spirits).

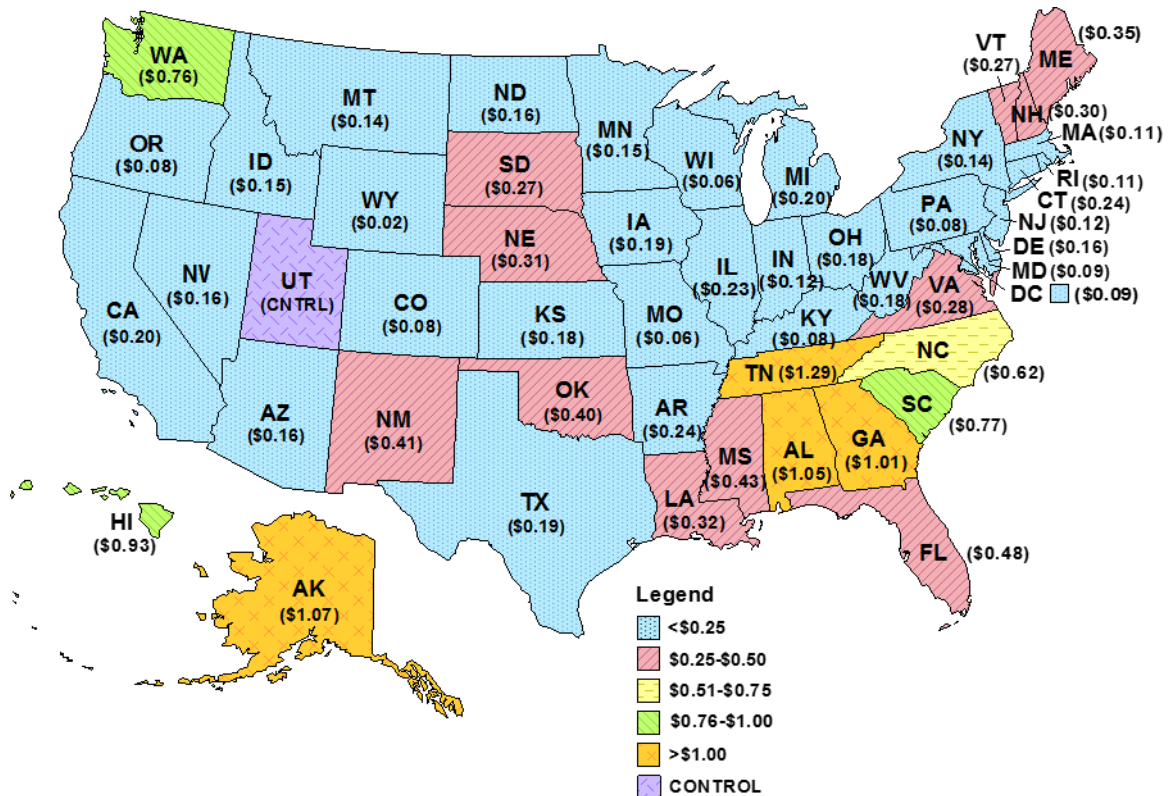
Exhibits 4.2.44 through 4.2.46 show the levels of excise taxes for beer, wine, and spirits across the 50 states and the District of Columbia. Exhibit 4.2.47 shows the ad valorem excise tax or sales tax adjusted ad valorem excise tax rates<sup>2</sup> for license states that have ad valorem excise

<sup>1</sup> “Spirits are taxed at the rate of \$13.50 on each proof gallon and a proportionate tax at the like rate on all fractional parts of a proof gallon. A proof gallon is one liquid gallon of spirits that is 50 percent alcohol at 60 degrees F. Distilled Spirits bottled at 80 proof (40 percent alcohol) would be 0.8 proof gallons per gallon of liquid and taxed at a rate of \$10.80 per gallon. Distilled Spirits bottled at 30 proof (15 percent alcohol) would be 0.3 proof gallons per gallon of liquid and taxed at a rate of \$4.05 per gallon.”

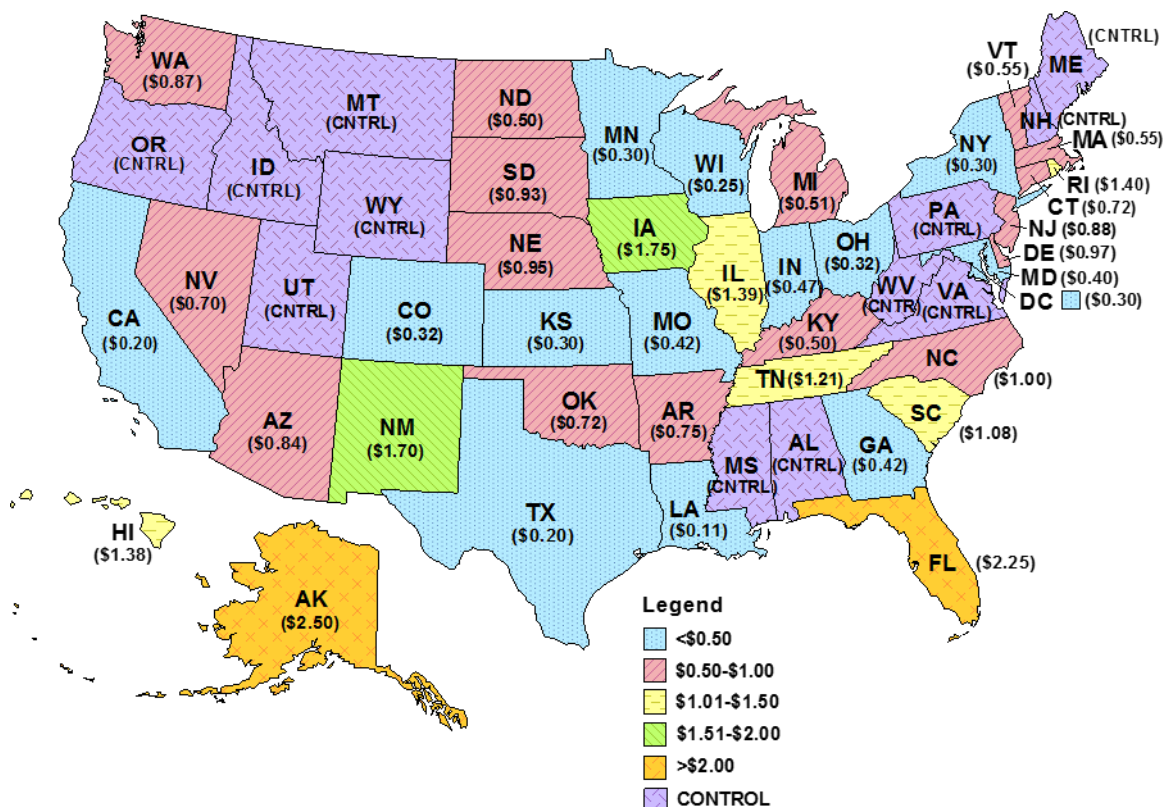
<sup>2</sup> The retail ad valorem excise tax minus the sales tax. Applicable only to states in which sales tax does not apply to alcoholic beverages in order to reflect the actual taxation rate.



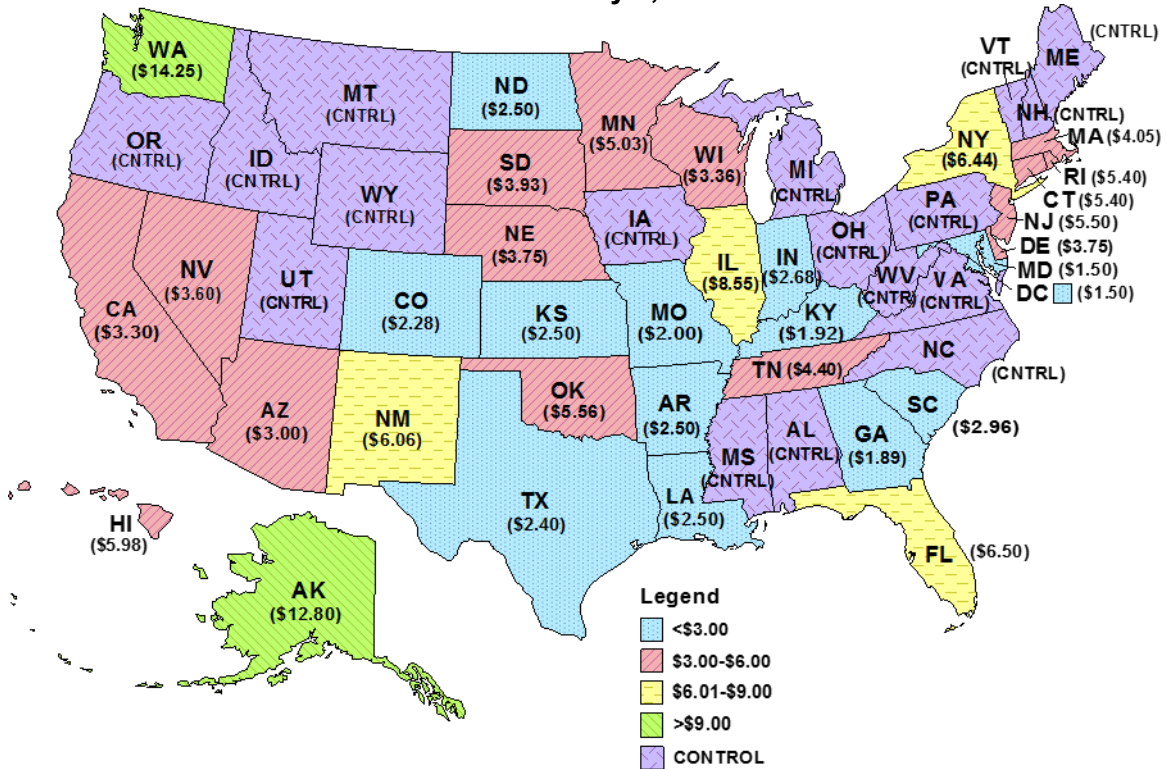
**Exhibit 4.2.44: Specific Excise Tax per Gallon on Beer as of January 1, 2016**



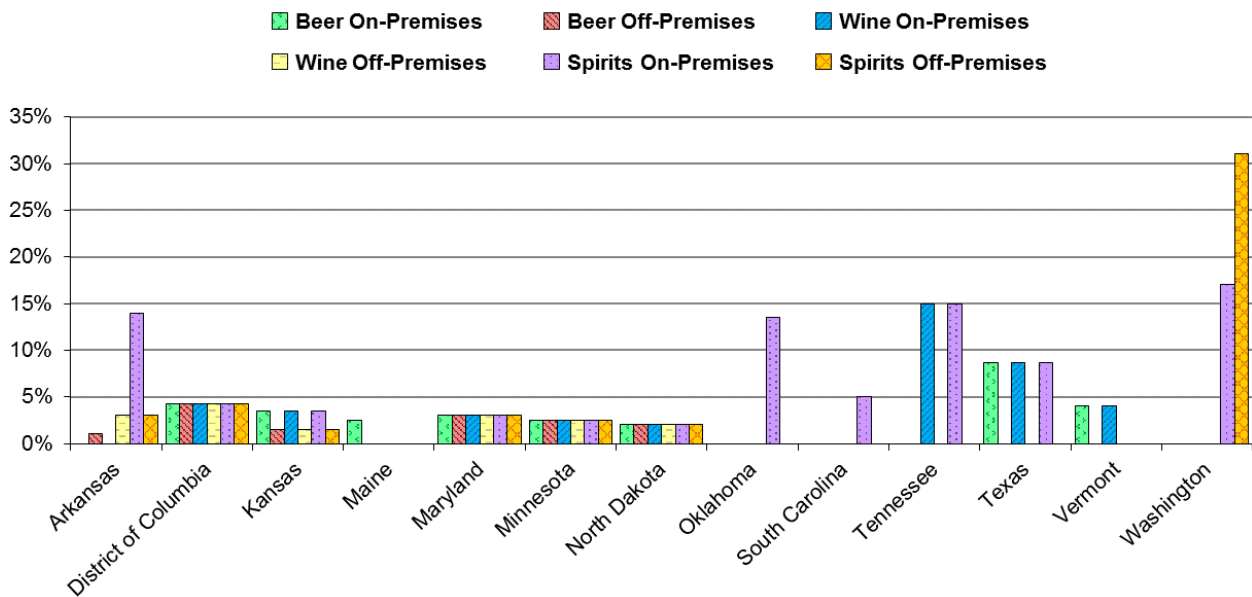
**Exhibit 4.2.45: Specific Excise Tax per Gallon on Wine as of January 1, 2016**



**Exhibit 4.2.46: Specific Excise Tax per Gallon on Distilled Spirits as of January 1, 2016**



**Exhibit 4.2.47: Sales Tax Adjusted Retail Ad Valorem Excise Tax Rates in License States as of January 1, 2016**





taxes. These may be levied at on- or off-sale outlets and may be for beer, wine, and spirits. Beer ad valorem excise tax rates range from 1 to 17 percent for on- and off-premises sales. Wine rates range from 1.7 to 15 percent for on- and off-premises sales. Distilled spirit rates range from 2 to 31 percent for on- and off-premises sales. As shown in Exhibit 4.2.48, trade-off between retail ad valorem excise tax and sales tax is not uncommon.

Additionally, in 2011, voters in Washington approved Initiative Measure 1183, privatizing all aspects of the wholesale distribution and retail sale of beer, wine, and distilled spirits. The Initiative added a new section to the state's statutes on alcohol sales, which includes permitting retail licensees to sell spirits in original containers to consumers for off-premises consumption, and to licensees to sell spirits for on-premises consumption. It ended government involvement in beer and wine distribution and sales. Thus, Washington is no longer a control state.

### Trends in Alcohol Taxes

Alcohol taxes have remained relatively constant for several decades. As illustrated in Exhibit 4.2.49, there have been limited tax increases or decreases in beer, wine, or spirits excise taxes since 2003. These changes do not reflect increases or decreases as a result of changes in sales tax adjusted ad valorem excise tax rates.<sup>3</sup> During this period, there have been 40 tax rate increases across all jurisdictions.

**Exhibit 4.2.48: Number and Percentage of States that Levy an Ad Valorem Excise Tax but Do Not Apply General Sales Tax**

Beverage type	Type of ad valorem excise tax	Number of states that levy this ad valorem excise tax	Number of states that do not apply general sales tax when the ad valorem excise tax is levied	Percentage of states that do not apply general sales tax when the ad valorem excise tax is levied
Beer	Ad valorem excise tax: onsite	9	7	78
	Ad valorem excise tax: offsite	7	4	57
Wine	Ad valorem excise tax: onsite	10	6	60
	Ad valorem excise tax: offsite	9	4	44
Spirits	Ad valorem excise tax: onsite	13	5	39
	Ad valorem excise tax: offsite	9	5	56

<sup>3</sup> The retail ad valorem excise tax minus the sales tax. Applicable only to states in which sales tax does not apply to alcoholic beverages in order to reflect the actual taxation rate.

**Exhibit 4.2.49: Alcohol Tax Changes 2003–2016**

		Beer		Wine		Spirits		Total
		Specific excise tax	Ad valorem excise tax	Specific excise tax	Ad valorem excise tax	Specific excise tax	Ad valorem excise tax	
Number of jurisdictions that:	Increased rates	9	5	9	5	7	5	38
	Decreased rates	1	3	1	3	0	3	7

### References and Further Information

All data for this policy were obtained from the Alcohol Policy Information System (APIS) at <http://www.alcoholpolicy.niaaa.nih.gov>. Follow links to the policies titled “Alcohol Beverage Taxes – Beer,” “Alcohol Beverage Taxes – Wine,” and “Alcohol Beverage Taxes – Distilled Spirits.” APIS provides further descriptions of this policy and its variables, details regarding state policies, and a review of the limitations associated with the reported data. To see definitions of the variables for this policy, visit [stopalcoholabuse.gov](http://stopalcoholabuse.gov) and follow links to the Report to Congress, Supplemental Materials, Definitions of Variables in Legal Policies.

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## Low-Price, High-Volume Drink Specials

### Policy Description

Restrictions on low-price, high-volume drink specials regulate on-premises retailers in their use of various price-related marketing tactics such as happy hours, two-for-one specials, or free drinks that encourage heavier consumption. These promotions are particularly prevalent in college communities, where large numbers of underage students are present.

Research has examined the impact of on-premises retail drink specials on binge drinking among college students. For example, one study measured self-reported binge-drinking rates among college students from 119 colleges, conducted an assessment of marketing practices of on-premises outlets in neighboring communities, and determined whether these communities restricted low-price, high-volume drink specials. The results demonstrated that price-related promotions were significantly correlated with higher binge drinking and self-reported drinking and driving rates among students (Wechsler, Lee, Nelson, & Lee, 2003).

Based on this and other research, the *Surgeon General's Call to Action* concluded that “increasing the cost of drinking can positively affect adolescent decisions about alcohol use,” and recommended “[e]limination of low price, high-volume drink specials, especially in proximity to college campuses, military bases, and other locations with a high concentration of youth.”

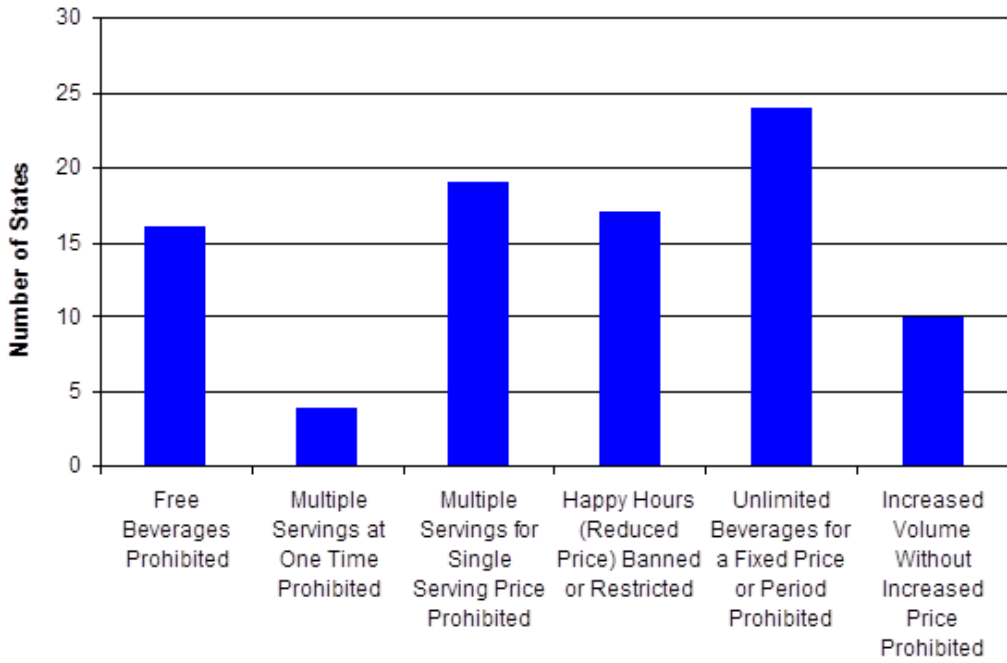
A state law concerning low-price, high-volume drink specials may prohibit or restrict the following practices:

1. Providing customers with free beverages either as a promotion or on a case-by-case basis (e.g., on a birthday or anniversary, as compensation for poor services).
2. Offering additional drinks for the same price as a single drink (e.g., two-for-ones).
3. Offering reduced-price drinks during designated times of day (“happy hours”).
4. Instituting a fixed price for an unlimited amount of drinks during a fixed period of time (e.g., “beat the clock” and similar drinking games).
5. Offering drinks with increased amounts of alcohol at the same price as regular-sized drinks (e.g., double shots for the price of single shots).
6. Service of more than one drink to a customer at a time.

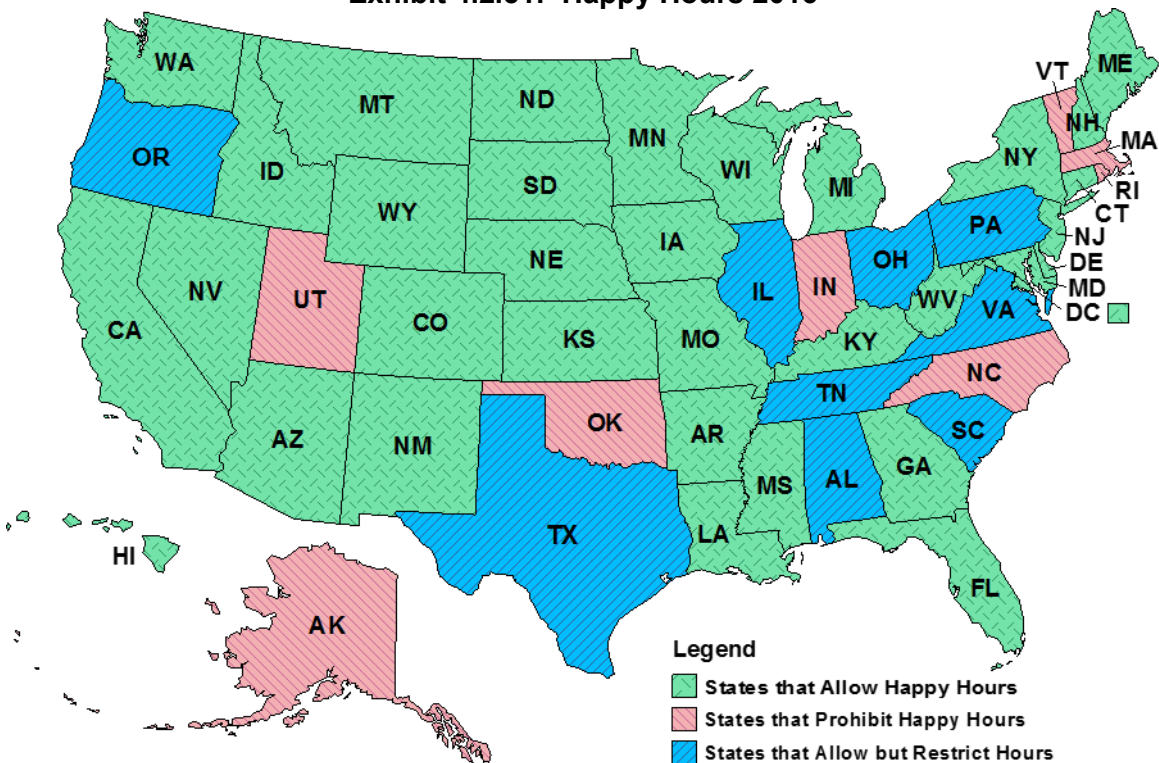
### Status of Low-Price, High-Volume Drink Specials Law

Exhibit 4.2.50 shows the number of states that prohibited the six low-price, high-volume specials listed above. Sixteen states prohibited free beverages. Six additional states (California, New Jersey, New Mexico, South Carolina, Texas, and Washington) allowed a licensee to offer a free drink on a case-by-case basis only (e.g., on a birthday or anniversary, as compensation for poor services). Four states prohibited multiple servings at one time. In one of these states (Tennessee), this prohibition applied only after 10 p.m. Nineteen states prohibited multiple servings for single serving price. Twenty-four states prohibited unlimited beverages for a fixed price or period. In one of these (Louisiana), this prohibition applied only after 10 p.m. Ten states prohibited increased volume without increase in price, with Tennessee making it unlawful after 10 p.m. As shown in Exhibit 4.2.51, eight states prohibited happy hours (reduced prices). Nine additional states allowed happy hours but restricted the hours in which they may be offered.

**Exhibit 4.2.50: Number of States Prohibiting Various Low-Price, High-Volume Drink Specials**



**Exhibit 4.2.51: Happy Hours 2016**



## Trends in Low-Price, High-Volume Drink Specials Law

Since 2011, one state (Pennsylvania) has increased the number of hours during which discounts may be offered. Since 2012, Kansas has changed its law to allow reduced-price drinks during designated times of day and increased volume of an alcoholic beverage. In 2015, Illinois changed its prohibition from multiple servings at one time to prohibiting multiple servings for a single serving price.

## References and Further Information

All data for this policy were obtained from the Alcohol Policy Information System (APIS) at <http://www.alcoholpolicy.niaaa.nih.gov>. Follow links to the policy titled “Drink Specials.” APIS provides further descriptions of this policy and its variables, details regarding state policies, and a review of the limitations associated with the reported data. To see definitions of the variables for this policy, visit [stopalcoholabuse.gov](http://stopalcoholabuse.gov) and follow links to the Report to Congress, Supplemental Materials, Definitions of Variables in Legal Policies. For further information and background, see:

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## Wholesaler Pricing Restrictions

### Policy Description

The 21st Amendment to the Constitution repealed Prohibition and gave states broad authority to regulate alcohol sales within their borders. Most states established a three-tier structure: producers, wholesalers, and retailers. Many states included restrictions on wholesaler pricing practices intended to strengthen the three-tier system, reduce price competition among wholesalers and retailers, and combat corruption and crime in the alcohol market.

Research suggests that the specific wholesaler pricing restrictions described below increase the price of alcohol to consumers. Research also shows that underage consumption and problems are strongly influenced by alcohol prices. One study has suggested that restrictions on certain wholesale pricing practices may have a stronger effect on alcohol pricing than do alcohol taxes.

Some states operate alcohol wholesale operations directly through a state agency, usually limited to distilled spirits, beer with high alcohol content, and wine with high alcohol content.<sup>1</sup> In these cases, the state sets wholesaler prices as part of its administrative function, and statutory provisions are relevant only to that portion of the wholesaler market in the control of private entities. For this policy, an index beverage has been selected: beer (5 percent), wine (12 percent), and spirits (40 percent). If the index beverage is controlled, in whole or in part, by the state at the wholesale level, the state is coded as “control” and no additional coding is displayed.

### Types of Wholesaler Pricing Policies

In general, wholesaler pricing policies fall within four types: (a) restrictions on volume discounts; (b) restrictions on discounting practices; (c) price posting requirements; and (d) restrictions on the ability of wholesalers to provide credit extensions to retailers. These policy categories are closely interrelated but may operate independently of each other. Each is described briefly below.

#### *Volume Discounting Restrictions*

Large retailers often have an advantage over smaller retailers due to the large volumes they are able to purchase at once. This purchasing power allows them to negotiate lower prices on most commodities and therefore offer items at lower prices to consumers. Many states have imposed restrictions on the ability of wholesalers to provide volume discounts—the same price must be charged for products regardless of the amount purchased by individual retailers. The primary purpose of these laws is to protect small retailers from predatory marketing practices of large-volume competitors and to prevent corruption. They have a secondary effect of increasing retail prices generally by making retail price discounting more difficult.

#### *Minimum Pricing Requirements*

States may require wholesalers to establish a minimum markup or maximum discount for each product sold to retailers based on the producer’s price for the product, or states may enact a ban against selling any product below cost. These provisions are designed to maintain stable prices

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<sup>1</sup> For a state-by-state review of control state wholesaler systems, see <http://www.apis.niaaa.nih.gov>.

on alcohol products by limiting price competition at both retail and wholesale levels. In most cases, this increases the retail price to consumers, and thus affects public health outcomes.

### ***Post-and-Hold Provisions***

This policy requires wholesalers to publicly “post” prices of their alcohol products (i.e., provide a list of prices to a state agency for review by the public, including retailers and competitors) and hold these prices for a set amount of time, allowing all retailers the opportunity to make purchases at the same cost. Post-and-hold requirements are typically tied to minimum pricing and price discounting provisions and enhance the states’ ability to enforce those provisions. The wholesalers’ submissions can be reviewed easily to determine whether wholesalers are paying the proper taxes on their products and whether they are providing any illegal price inducements to retailers. Post-and-hold provisions reduce price competition among both retailers and wholesalers because the posted prices are locked in for a set amount of time. They also promote effective enforcement of other wholesaler pricing policies. Some states require wholesalers to post prices but have no “hold” requirement—that is, posted prices may be changed at any time. This is a weaker restriction.

### ***Credit Extension Restrictions***

Wholesalers often provide retailers with various forms of credit (e.g., direct loans or deferred payment of invoices). Many states restrict alcoholic beverage wholesalers’ ability to provide credit to retailers, typically by banning loans and limiting the period of time required for retailers to pay invoices. The primary purpose of the restrictions is to limit the influence of wholesalers on retailer practices. When a retailer is relying on a wholesaler’s credit, the retailer is more likely to promote the wholesaler’s products and to agree to the wholesaler’s demands regarding product placement and pricing. The restrictions have a secondary effect of limiting the retailer’s ability to operate on credit, indirectly increasing retail prices.

### **Federal Court Challenges to State Wholesaler Pricing Restrictions**

As noted earlier, in general, states have broad authority under the 21st Amendment to the Constitution to regulate alcohol availability within their boundaries. That authority has been constrained by U.S. Supreme Court and Federal Court of Appeals cases, which have interpreted the Interstate Commerce Clause and Sherman Antitrust Act<sup>2</sup> to prohibit certain state restrictions on the alcohol market.<sup>3,4</sup> These cases have led to considerable uncertainty regarding the validity

<sup>2</sup> July 2, 1890, ch. 647, 26 Stat. 209, 15 U.S.C. § 1-7.

<sup>3</sup> See, e.g., *California Retail Liquor Dealers Assn. v. Midcal Aluminum, Inc.*, 445 U.S. 97, 100 S.Ct. 937 (1980).

<sup>4</sup> Several federal and state courts have addressed the constitutionality of selected wholesaler pricing practices, with conflicting results. For example, in *Costco Wholesale Corp. v. Maleng*, 522 F.3d 874 (9th Cir. 2008), the plaintiff challenged nine distinct Washington state restrictions governing wholesaler practices, including policies in all four categories described above. The court upheld the state’s volume discount and minimum markup provisions but invalidated the post-and-hold requirements. In *Manuel v. State of Louisiana*, 982 So.2d 316 (3<sup>rd</sup> Cir. 2008), a Louisiana appellate court rejected six separate challenges to the Sherman Act, including the ban on volume discounts. It upheld the state’s ability to regulate alcoholic beverages within the state and concluded that the Sherman Act had to yield to the state’s authority granted under the 21st Amendment. Maryland’s post-and-hold law and volume discount ban were challenged in *TFWS, Inc. v. Franchot*, 572 F.3d 186 (4th Cir. 2009), a complicated case involving multiple appeals and rehearings. On Maryland’s fourth appeal, the court upheld its previous decisions to strike down the two policies.

of state restrictions on alcohol wholesaler prices, and additional challenges to those restrictions are anticipated. In the meantime, this uncertainty has prompted states to reexamine their alcohol wholesaler practices provisions.

## **Status of Wholesaler Pricing Restrictions**

### ***Federal Law***

Federal law addresses restrictions on wholesaler credit practices:

The Federal Alcohol Administration Act provides for regulation of those engaged in the alcohol beverage industry and for protection of consumers (27 U.S.C. § 201 et seq). Under the Act, wholesalers may not induce retailers to purchase beverage alcohol by extending credit in excess of 30 days from the date of delivery (27 U.S.C. § 205(b)(6), 27 C.F.R. § 6.65).

Some states allow wholesalers to extend credit to retailers for a longer period than is permitted under federal law.

### ***State Law***

Exhibits 4.2.52 through 4.2.55 show summary distributions of volume discounts, minimum markup/maximum discount, post-and-hold, and retailer credit for the license states (beer = 50 license states; wine = 43 license states; spirits = 34 license states).<sup>5</sup> Only two license states (Alaska and Rhode Island) have no wholesaler pricing restrictions. Among the remaining states, bans on extending credit and post-and-hold (excluding post only) are the most common wholesaler pricing restrictions (ranging from about a fifth to about half the states depending on beverage type). Other restrictions range from under 10 percent of the license states to about a quarter of the states depending on beverage type.

## **Trends in Wholesaler Pricing Restrictions**

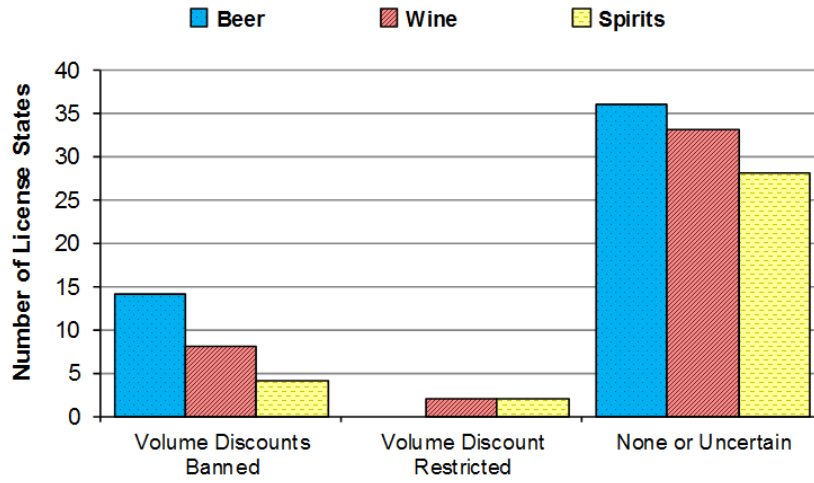
No changes occurred between 2010 and 2015. In April of 2015, West Virginia changed its requirement that wholesalers of beer must post their prices to requiring that they must post-and-hold these prices for 90 days. Idaho removed wine from state control on July 1, 2011, and implemented a ban on retailer credit and volume discounts. A post-and-hold provision of 180 days also went into effect. On November 8, 2011, voters in Washington approved Initiative Measure 1183, which privatized all aspects of the wholesale distribution and retail sale of beer, wine, and distilled spirits effective December 8, 2011. Implementation occurred in 2012. Wholesaler pricing restrictions now ban volume discounts for beer and impose a price posting requirement. Sales below cost and retailer credit provisions are prohibited. Likewise, retailers may not purchase wine or spirits on credit. Spirits may not be sold below cost.

Exhibits 4.2.56 through 4.2.59 present detailed state-by-state information for wholesaler pricing policies for beer.

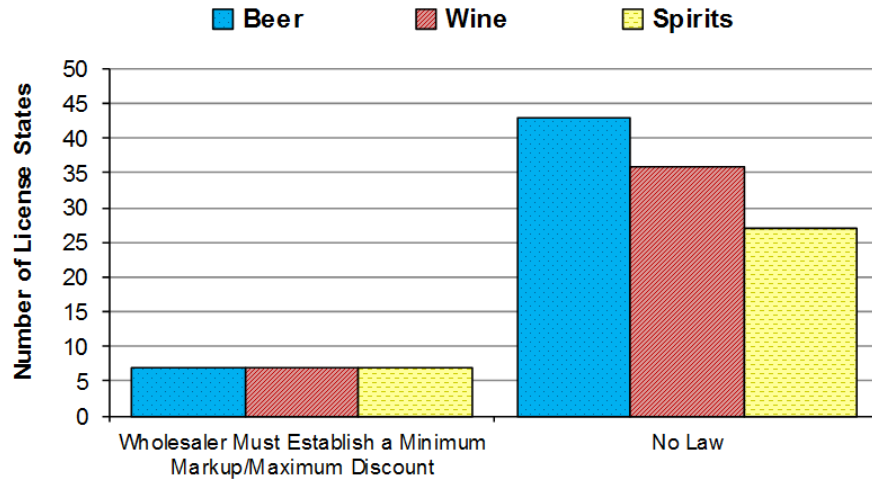
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<sup>5</sup> Comparisons among beverage types must be made with some caution, because the number of license states differs for each beverage.

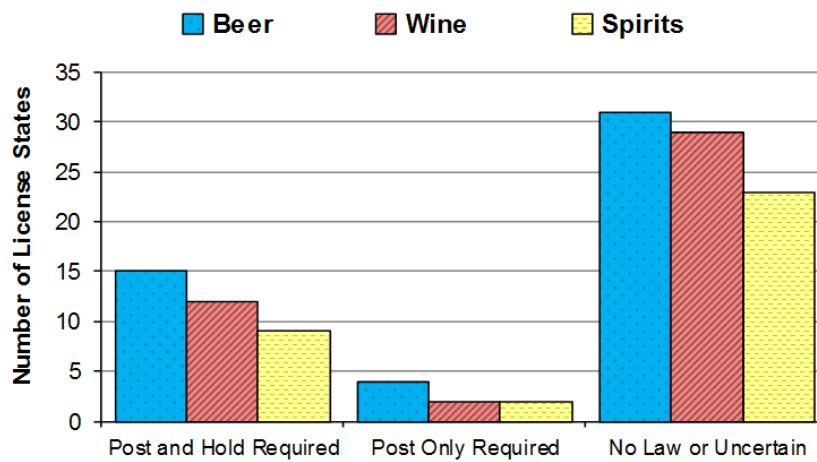
**Exhibit 4.2.52: Volume Discounts**



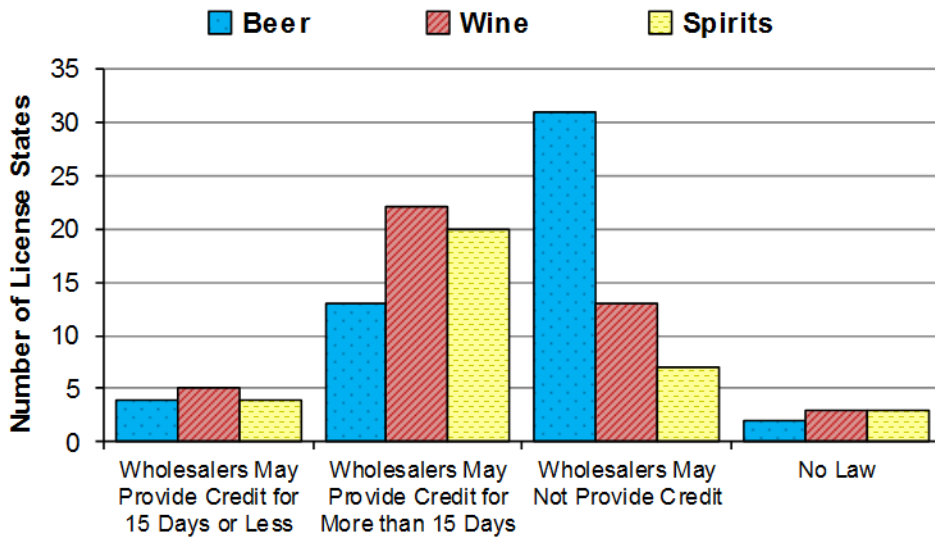
**Exhibit 4.2.53: Minimum Markup/Maximum Discount**



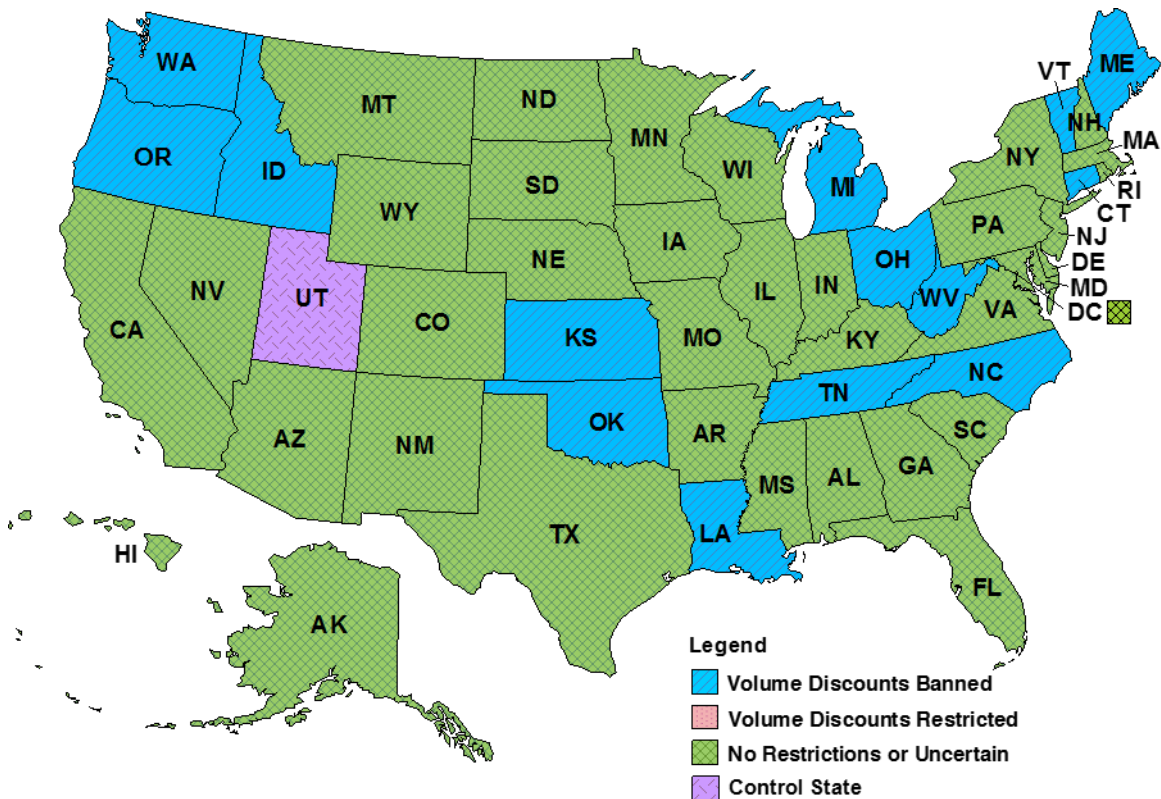
**Exhibit 4.2.54: Post and Hold**



**Exhibit 4.2.55: Retailer Credit**

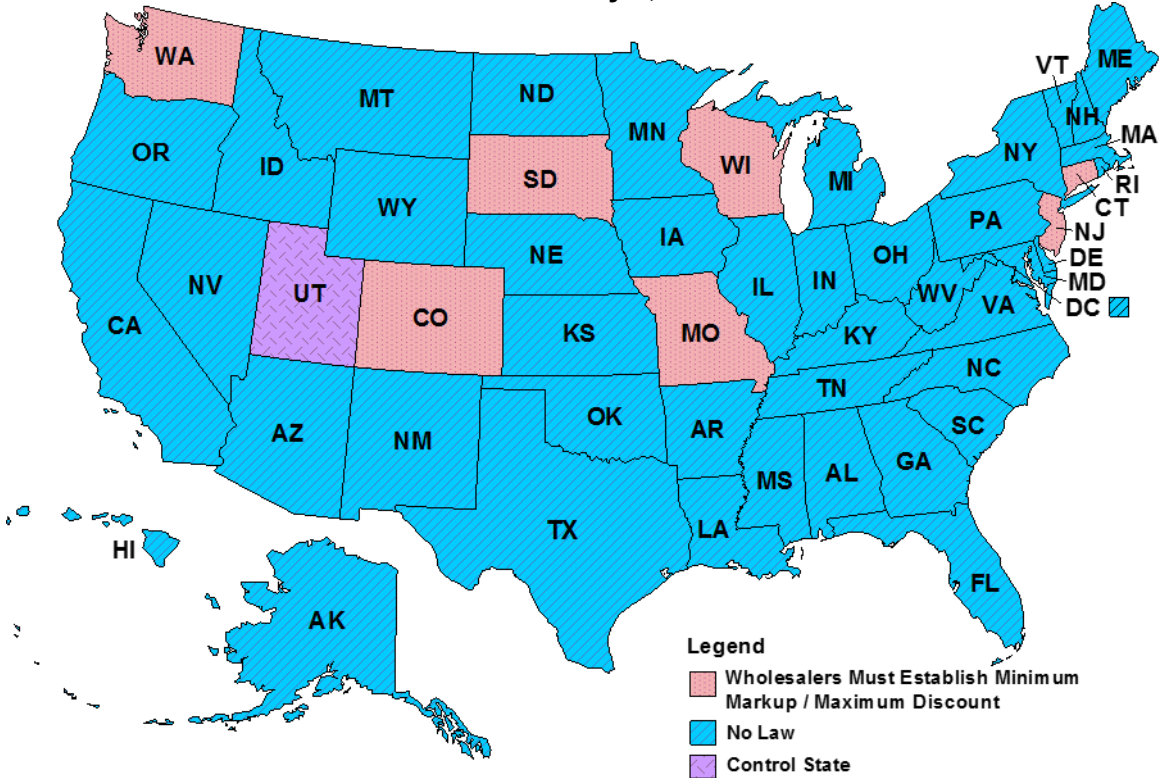


**Exhibit 4.2.56: Volume Discounts for Beer as of January 1, 2016**

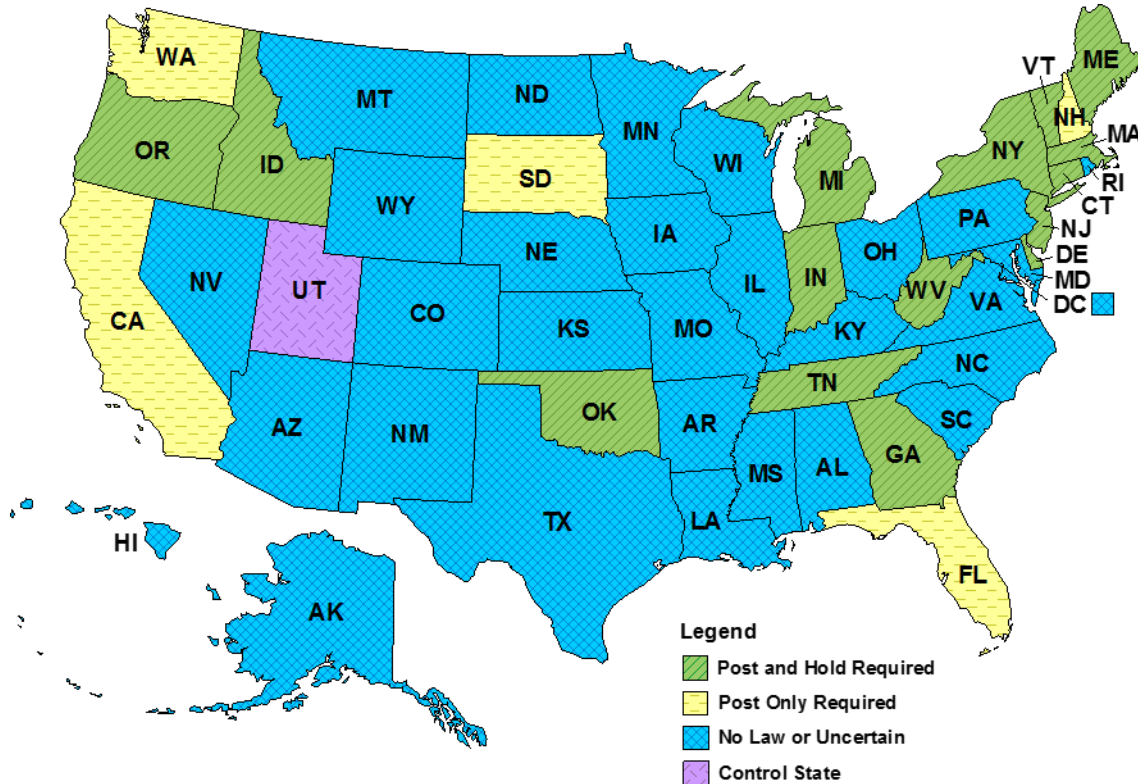




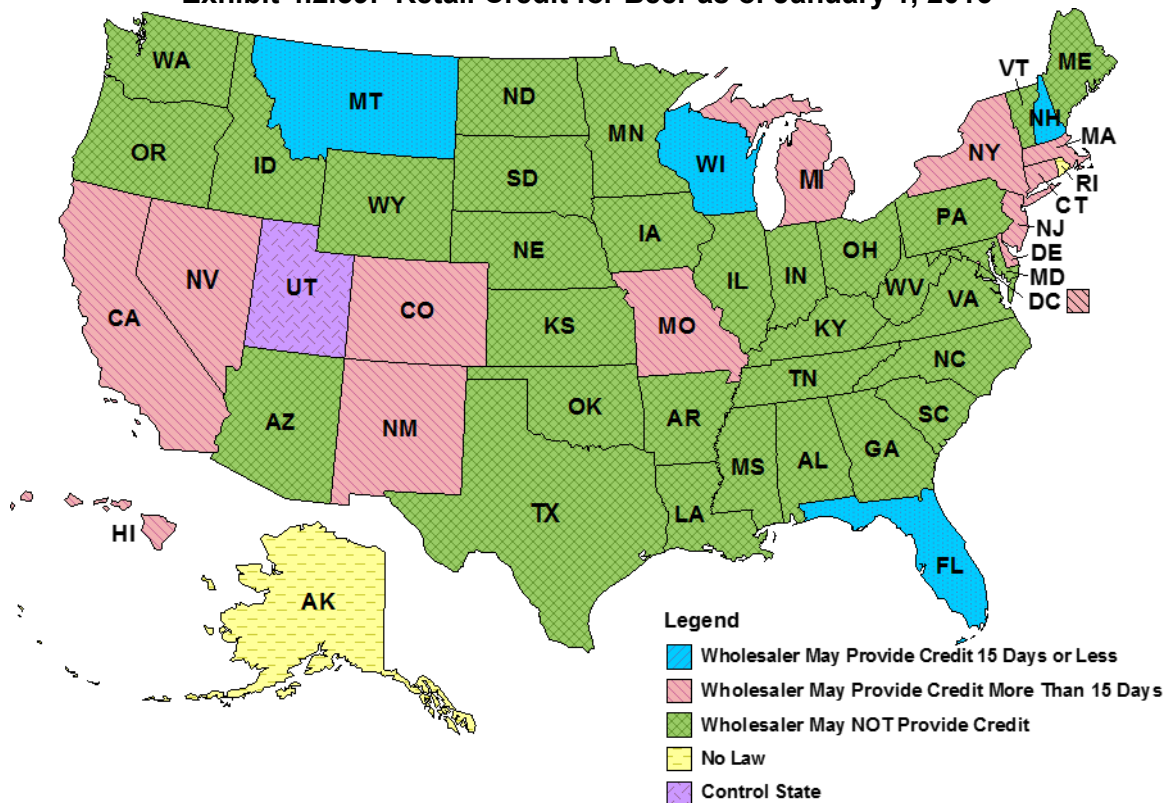
**Exhibit 4.2.57: Minimum Markup, Maximum Discount for Beer as of January 1, 2016**



**Exhibit 4.2.58: Post-and-Hold Requirements for Beer as of January 1, 2016**





**Exhibit 4.2.59: Retail Credit for Beer as of January 1, 2016**

\*MI allows 30 days credit to on-sale retailers but no credit to off-sale retailers

### References and Further Information

All data for this policy were obtained from the Alcohol Policy Information System (APIS) at <http://www.alcoholpolicy.niaaa.nih.gov>. Follow links to the policy titled “Wholesale Pricing Practices and Restrictions.” APIS provides further descriptions of this policy and its variables, details regarding state policies, and a review of the limitations associated with the reported data. To see definitions of the variables for this policy, visit [stopalcoholabuse.gov](http://stopalcoholabuse.gov) and follow links to the Report to Congress, Supplemental Materials, Definitions of Variables in Legal Policies.

Chaloupka, F. (2008, January). *Legal Challenges to State Alcohol Control Policy: An Economist’s Perspective*. Presentation at the Alcohol Policy 14 Conference, San Diego, CA.

Gruenewald, P. J., Ponicki, W. R., Holder, H. D., & Romelsjö, A. (2006). Alcohol prices, beverage quality, and the demand for alcohol: Quality substitutions and price elasticities. *Alcoholism: Clinical and Experimental Research*, 30, 96–105.

National Research Council & Institute of Medicine. (2004). *Reducing Underage Drinking: A Collective Responsibility*. Washington, DC: National Academies Press.



# CHAPTER 4.3

## STATE SURVEY SUMMARY AND RESULTS

## Summary

The Sober Truth on Preventing Underage Drinking (STOP) Act mandates annual collection of data from the 50 states and the District of Columbia on their performance in enacting, enforcing, and creating laws, regulations, and programs to prevent or reduce underage drinking. (Henceforth, the states and the District of Columbia are referred to, together, as “states.”)

Administered since 2011, the STOP Act State Survey has collected data on the following topics:

- Enforcement programs to promote compliance with underage drinking laws and regulations
- Programs targeted to youth, parents, and caregivers to deter underage drinking
- State interagency collaborations to implement prevention programs, best-practice standards, and collaborations with tribal governments
- The amount that each state invests on the prevention of underage drinking

This chapter discusses and details responses to the STOP Act State Survey. Responses demonstrate the states’ commitment to the reduction of underage drinking and its consequences, a key conclusion of the survey. Evidence of this commitment can be seen by the following: (1) all states completed the 90-question survey, (2) most reported numerous program activities, and (3) in many cases, states provided substantial detail about those activities (see individual state summaries).

The results presented in this chapter must be viewed with caution. In many cases, substantial missing data decrease the extent to which a meaningful conclusion can be drawn. Caution must also be exercised in interpreting the changes from 2011 to 2016, given variations in data availability.

### Enforcement Programs

The majority of states collect data on state compliance checks, minor in possession (MIP) charges, and penalties imposed on retail establishments. However, less than one-third of the states collect data on local enforcement efforts. Thus, the ability to draw conclusions about enforcement activities and effectiveness is limited, because a substantial portion of underage drinking law enforcement happens at the local level. Improvements in state enforcement data systems would increase the accuracy of these analyses in future years.

Overall, enforcement activities appear highly variable across the states. Compliance checks and other enforcement activities related to furnishing (Cops in Shops, shoulder tap operations, underage alcohol-related fatality investigations, and enforcement of direct-shipment laws) are fairly widely implemented, although not necessarily at both the state and local levels. The total number of checks is modest, however. Fifty-eight percent of those states conducting checks test 20 percent or fewer of their licensees. Sanctions for furnishing are predominantly fines, which are about nine times more common than suspensions. Revocations are extremely rare; 82 percent of the states that reported revocations revoked one or no licenses. Data on minors in possession (MIP) activities (an index of the enforcement of a variety of laws aimed at deterring underage drinking) revealed medians of 1.14 arrests per 1,000 underage drinking occasions, and 1,227 arrests per 100,000 in a population of 16- to 20-year-olds.

## Programs Targeted to Youth, Parents, and Caregivers

States reported implementing a wide variety of underage-drinking-prevention programs for youth, parents, and caregivers. Many well-known programs were reported, including those focused on life skills, refusal skills, media advocacy, community organizing, and environmental change. The programs are predominantly focused on individuals, with approximately one in five programs focused on environmental change. Data on numbers of program participants were limited, owing perhaps to inherent difficulties in estimating program participation for programs focused on entire populations or subpopulations (e.g., environmental change programs). Thirty-nine percent of the states reported implementing programs to measure or reduce youth exposure to alcohol advertising and marketing.

Evaluation of underage drinking prevention programs is not comprehensive. Fifty-five percent of the programs the states described have been evaluated, and reports are available for 23 percent of these. As with enforcement, assessments of program effectiveness are limited by a lack of relevant data.

Eighty-eight percent of the states reported they had best practice standards for underage-drinking-prevention programs. Eighty-four percent of states with standards reported that a state agency had established their best standards, and nearly three-quarters indicated that they followed a federal standard. More than half (56 percent) included the Substance Abuse and Mental Health Services Administration (SAMHSA) and the Center for Substance Abuse Prevention (CSAP) in their list of agencies from which standards were obtained.

## Collaborations, Planning, and Reports

Eighty-four percent of states reported the existence of a state-level interagency body or committee to coordinate or address underage drinking prevention activities. However, of the states with such a committee, only 12 percent included the governor, and only 12 percent included a representative of the legislature. Close to one half of the states with interagency committees included community coalitions and 44 percent included college or university administrations, campus life departments, or campus police. Nearly one quarter of the states included local law enforcement, and about one in six included youth. Thus, key decisionmakers and local stakeholders were underrepresented on the interagency committees.

States were asked whether they had prepared a plan for preventing underage drinking or issued a report on underage drinking in the past 3 years. Fifty-seven percent of the states had prepared a plan, and 57 percent had issued a report.

## State Expenditures on the Prevention of Underage Drinking

States were asked to estimate state expenditures for two categories of enforcement activities and five types of programs targeted to youth, parents, and caregivers. The largest expenditure category is for community-based programs, followed by K-12 programs. The median of expenditures for programs targeted to youth, parents, and caregivers (\$60,906) is nearly three times that for all enforcement activities (median = \$21,945), and the total dollar amount expended for these non-enforcement programs (approximately \$123.4 million) is 73 times the total dollar amount spent on enforcement (approximately \$1.7 million). Data reporting was incomplete, with response rates ranging from 23 to 86 percent (median = 59 percent) across the five expenditure categories for programs targeting youth, parents, and caregivers. Thus

these results must be viewed with some caution. On the other hand, these data may be difficult for states to assemble, given multiple funding streams and asynchronous fiscal years, among other issues.

### **Comparison of Enforcement Data: 2011–2016**

In the 6 years in which the STOP Act State Survey has been implemented, states varied greatly in their completion of datasets for all years. Fewer than half of the states provided information in all 6 years for eight of the enforcement data categories selected for comparison. Fifty-nine percent of the states provided state compliance check data for all 6 years. Sixty-two percent of the states that reported data for all 6 years reported an increased number of compliance checks between 2011 and 2016. Only six percent of the states reported on local compliance checks and four percent on state expenditures for compliance checks in all 6 years. In all penalty categories, larger percentages of the states reported reduced use of these penalties between 2011 and 2016 than reported increased use.

### **Comment**

The data reveal a wide range of activity in the areas studied, although the activities vary in scope and intensity from state to state. Clearly, all states have areas of strength and areas where improvements can be realized. A recurrent theme is the inadequacy of some state data systems to respond to the data requested in the survey, especially for local law enforcement and expenditures. Accurate and complete data are essential both for describing current activities to prevent underage drinking and for monitoring progress in future state surveys.

## **Introduction**

The STOP Act mandates this annual report on the states' performance in enacting, enforcing, and creating laws, regulations, and programs to prevent or reduce underage drinking. An annual survey of the states, the STOP Act State Survey, is conducted to collect data on many of the performance measures described in the STOP Act. Since 2011, this survey has collected data on the following topics derived directly from the STOP Act:

- Enforcement programs to promote compliance with underage drinking laws and regulations
- Programs targeted to youth, parents, and caregivers to deter underage drinking
- State interagency collaborations to implement prevention programs, best-practice standards, and collaborations with tribal governments
- The amount that each state invests on the prevention of underage drinking

The survey instrument consists of approximately 90 questions divided into four sections consistent with the topics and performance measures described in the STOP Act.

1. Enforcement of underage drinking laws, including:
  - The extent to which states implement checks of retail outlets to assess compliance with laws prohibiting the sale of alcohol to minors and the results of these checks
  - The extent to which the states implement other strategies for underage drinking enforcement, including MIP, Cops in Shops, shoulder tap operations, party patrol operations or programs, and underage alcohol-related fatality investigations
  - Sanctions imposed for violations



2. Underage drinking prevention programs targeted to youth, parents, and caregivers, including data on the number of people served by these programs and whether these programs are evaluated
3. State interagency collaborations to implement prevention programs, best-practice standards, and collaborations with tribal governments
4. State funds invested in the following categories, along with descriptions of any dedicated fees, taxes, or fines used to raise funds:
  - Compliance checks and provisions for technology to aid in detecting false IDs at retail outlets
  - Checkpoints and saturation patrols
  - Community-based, school-based, and higher education-based programs
  - Programs that target youth within the juvenile justice and child welfare systems
  - Other state efforts as deemed appropriate

Survey questions are structured to allow states maximum flexibility in deciding which initiatives to describe and how to describe them. Open-ended questions are used whenever possible to allow states to “speak with their own voices.” The survey offers the opportunity to respond “Don’t Know” or “Data Not Available” in those instances where requested information is not accessible.

This chapter offers a summary of the survey data collected across the 50 states and the District of Columbia. Each state’s full survey responses appear in the State Reports section of this report.

## Methods

State governors and the District of Columbia’s mayor were sent letters requesting confirmation of a designated representative to serve as the contact and be responsible for completing the survey. In most cases, this representative was the same person designated for the 2015 survey. Designated contacts are typically staff members from state substance abuse program agencies and state alcohol beverage control (ABC) agencies.

The survey was uploaded to a web-based platform in four segments, and the designated contacts were sent a link to this platform. They were also sent a copy of the report compiled from their responses to the 2015 survey, so that data that remained unchanged between years could be readily copied into the web survey. Contacts were given technical instructions for filling out the survey.

The online survey was available for completion by the states beginning in April 2016. The CDM Group, Inc., a SAMHSA contractor, provided both telephone and online technical support to state agency staff while the survey was in the field. Representatives from the National Liquor Law Enforcement Association provided review and support for any questions pertaining specifically to enforcement.

As with all State Surveys since 2011, responses were received from all states—a 100 percent response rate. Each state’s response was reviewed by senior staff members, who made inquiries when necessary about apparent omissions, ambiguities, or other content issues. Responses were also copyedited, and the edited responses were returned to each state by email. States either approved the proposed copyedits or provided their own changes, and also provided any requested clarifications.

## Results

Individual state reports provide a full presentation of the survey data submitted by each state. This Results section provides summary information about all variables amenable to quantitative analysis. It is important to keep in mind that each state determined how much information to provide, and that the range of information respondents provided was highly variable.

The results are grouped under five broad headings:

1. Enforcement Programs
2. Programs Targeted to Youth, Parents, and Caregivers
3. Collaborations, Planning, and Reports
4. State Expenditures on the Prevention of Underage Drinking
5. Comparison of Enforcement Data: 2011 to 2016

The final section, Comparison of Enforcement Data: 2011 to 2016, provides a limited comparison of State Survey data collected between 2011 and 2016 for selected activities. It should be noted that not all states reported data for all years. This section should be viewed with this caution in mind.

In all cases, where numerical estimates are reported, the reporting period is the most recent year for which complete data were available to the state. Average values are reported as medians. The median is the numerical value separating the higher half of a sample from the lower half and is the best representation of the “average” value when, as is often the case with the state survey responses, the data include outliers (a data point that is widely separated from the main cluster of data points in a dataset).

### Enforcement Programs

The STOP Act State Survey requested enforcement data<sup>33</sup> in four areas:

1. Whether the state encourages and conducts comprehensive enforcement efforts—such as compliance checks and shoulder tap programs—to prevent underage access to alcohol at retail outlets
2. Whether data are collected on local enforcement efforts to prevent underage access to alcohol
3. The number of compliance checks conducted on alcohol retail outlets, including random checks, checks in response to complaints, checks resulting from previous compliance check failures, and the results of these compliance checks
4. Enforcement of selected state laws aimed at deterring underage drinking (see Chapter 4.3: Policy Summaries) and penalties imposed for violation of these laws, using arrest data for MIP offenses to index enforcement of these laws

Exhibit 4.3.1 shows the percentage of states that collect data on compliance checks, MIP charges, and penalties levied against retail establishments for furnishing alcohol to minors. As illustrated in Exhibit 4.3.1, a majority of states collect data on state compliance checks, MIP charges, and penalties imposed on retail establishments. However, the number of states that

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<sup>33</sup> For charts showing individual state responses to all enforcement program questions on the 2016 survey, visit [stopalcoholabuse.gov](http://stopalcoholabuse.gov) and go to Report to Congress, Supplemental Information, Enforcement Data.

**Exhibit 4.3.1: Percentage of Jurisdictions that Reported Enforcement Data Collection at the State and Local Levels**

	State collects data on compliance checks		State collects data on MIP arrests/citations	State collects data on MIP, including arrests/citations by local law enforcement agencies	State collects data on penalties imposed on retail establishments		
	State-conducted	Locally conducted			Fines	License suspensions	License revocations
<b>Percentage</b>	76%	22%	69%	29%	75%	73%	73%

collect data on local enforcement efforts is limited. Thus, it is likely that the enforcement statistics provided here underestimate the total amount of underage drinking enforcement occurring in the states.

### Compliance Checks

Compliance checks (or decoy operations) are defined as those enforcement actions in which trained underage (or apparently underage) operatives (“decoys”), working with law enforcement officials, enter retail alcohol outlets and attempt to purchase alcohol. States were asked to provide an estimate of the total number of retail licensees in their state so that the percentage of licensees checked annually could be measured. A median of 18 percent of licensed establishments are checked across all 38 states that conduct compliance checks and collect associated data.<sup>34</sup> Exhibit 4.3.2 provides a state-by-state picture of the percentage of licensees checked. Fifty-eight percent of those states conducting checks tested 20 percent or fewer of their licensees, indicating that checking is generally not comprehensive. Nearly all (92 percent) of the states reported that checks were conducted at both on- and off-premise establishments.

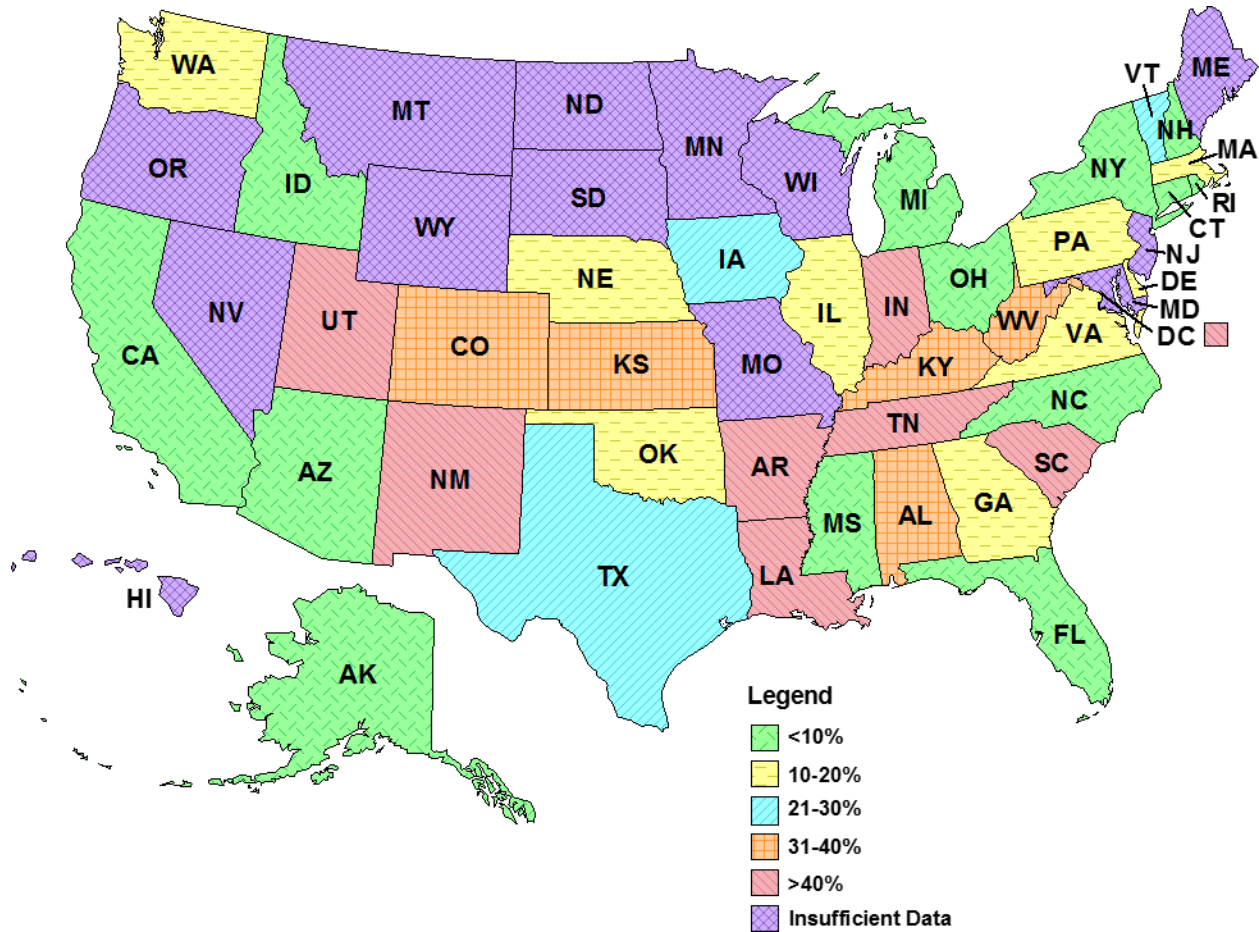
In addition to questions about the number of state checks and check failures, states were asked whether they conduct random compliance checks. Of the 38 states that conduct and collect data on compliance checks, 74 percent indicated that some or all of the checks conducted were done randomly, as opposed to being conducted in response to a complaint or as part of a convenience sample. For 65 percent of the states that report conducting random checks, all state checks were conducted randomly.

Exhibit 4.3.3 compares the number and failure rates of all state compliance checks, those state checks conducted randomly, and local compliance checks. Localities in 11 states also reported conducting compliance checks and collecting data. Seven states report conducting and collecting data for *both* state and local compliance checks; 43 states conduct and collect data on either state or local compliance checks; and 8 states conduct neither state nor local checks. As shown in Exhibit 4.3.3, the number of licensees checked and licensee failures varies widely.

Exhibits 4.3.4 and 4.3.5 provide state-by-state licensee failure rates for all compliance checks conducted by state and local agencies based on data reported by the states. Most state-level checks report failure rates of 20 percent or less, with 9 states reporting higher rates.

<sup>34</sup> One state that conducts compliance checks and collects data on these checks did not provide sufficient information to calculate the percentage of all licenses checked.

**Exhibit 4.3.2: Percentage of Licenses Checked by State**



**Exhibit 4.3.3: Compliance Checks**

	Number of licensees on which checks were conducted		Percentage of licensees on which checks were conducted that failed the checks	
<b>State agencies all checks (n=38)</b>	Median for those that collect data	1,844	Median for those that collect data	15
	Minimum	0	Minimum	0
	Maximum	10,836	Maximum	42
<b>State agencies random checks only (n=17)</b>	Median for those that collect data	1,507	Median for those that collect data	13
	Minimum	152	Minimum	9
	Maximum	10,836	Maximum	38
<b>Local agencies (n=6)</b>	Median for those that collect data	1,449	Median for those that collect data	11
	Minimum	250	Minimum	7
	Maximum	8,499	Maximum	18

*Note:* The “n” figures in this exhibit differ from the total numbers of states that answered “yes” to collecting and conducting state, random, and local compliance checks, because some states provided incomplete data.

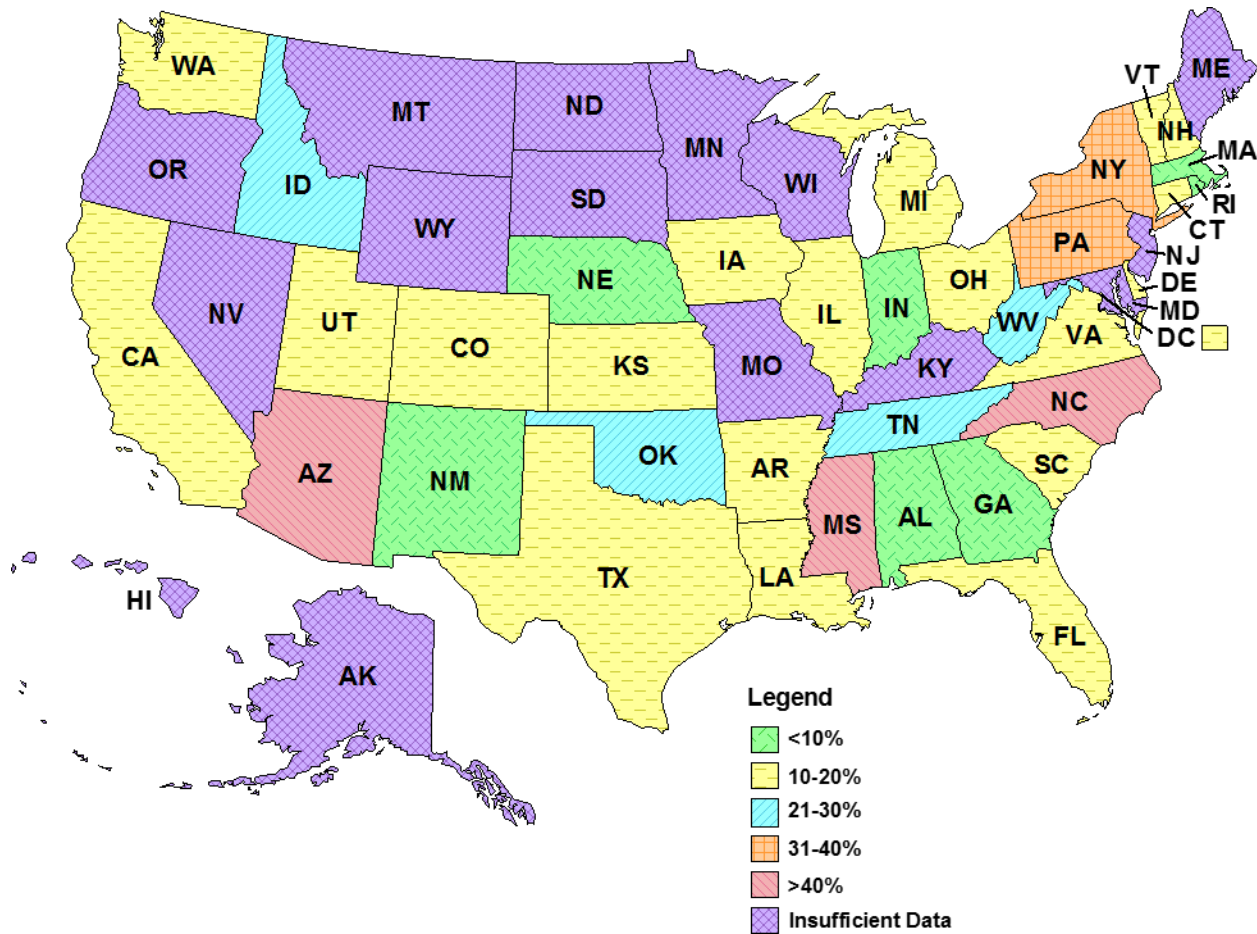
**Exhibit 4.3.4: State Compliance Checks Failure Rate**

Exhibit 4.3.5 highlights the lack of data on local compliance checks for most states. Only 6 states report any data, and all of these states report failure rates of 20 percent or less.

As noted above, there is great variation among the states in the percentage of the total number of outlets checked during this period. Some states indicate that they make multiple checks on single outlets during the year in question, and this may be true of other states. Compliance check protocols also vary by state. For example, states use differing procedures and requirements for choosing underage decoys (see Compliance Check Protocols in Chapter 4.3, Policy Summaries).

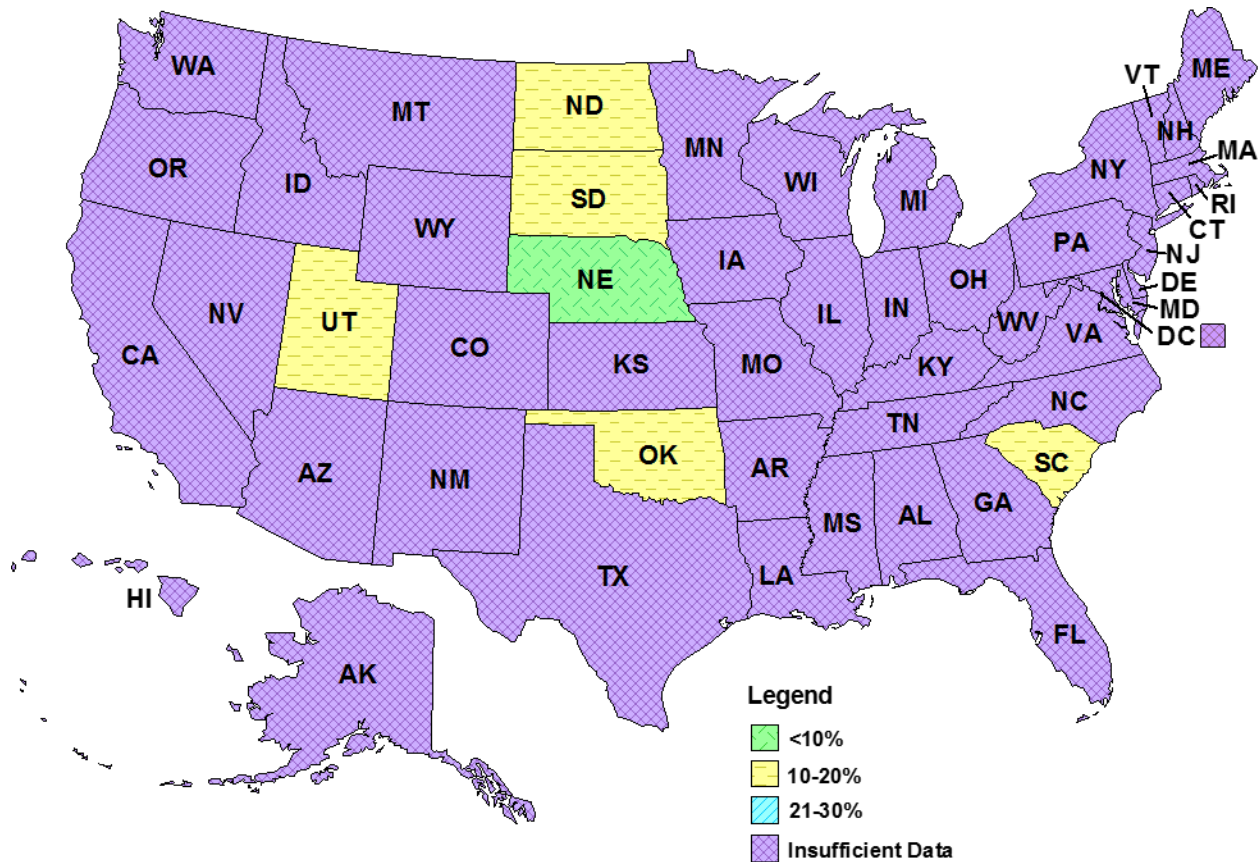
States may also conduct compliance checks randomly in response to complaints or as a result of a previous compliance check failure. Hence, differences in compliance check protocols may affect the number of outlets checked, the frequency of checks at a particular establishment, and the failure rates.

### Other Enforcement Strategies

States were asked to report on four other state and local strategies to enforce underage drinking laws: Cops in Shops, shoulder tap operations, party patrol operations or programs, and underage alcohol-related fatality investigations. Definitions of these enforcement strategies follow.



**Exhibit 4.3.5: Local Compliance Checks Failure Rate**



An expanded discussion of these strategies is found in the Enforcement section in Chapter 4.1:

- **Cops in Shops:** A well-publicized enforcement effort in which undercover law enforcement officers are placed in retail alcohol outlets
- **Shoulder tap:** Trained young people (decoys) approach individuals outside of retail alcohol outlets and ask them to make an alcohol purchase
- **Party patrol operations or programs:** Operations that identify underage drinking parties, make arrests and issue citations, and safely disperse participants
- **Underage alcohol-related fatality investigations:** Investigations to determine the source of alcohol ingested by fatally injured minors

As shown in Exhibit 4.3.6, the most common enforcement activities at both state and local levels are party patrol operations or programs and underage alcohol-related fatality investigations.

**Exhibit 4.3.6: Implementation of Other Enforcement Strategies**

State enforcement: Percentage of states that implement:				Local enforcement: Percentage of states in which localities implement:			
Cops in Shops	Shoulder tap operations	Party patrol operations or programs	Underage alcohol-related fatality investigations	Cops in Shops	Shoulder tap operations	Party patrol operations or programs	Underage alcohol-related fatality investigations
31%	18%	47%	71%	33%	37%	61%	49%

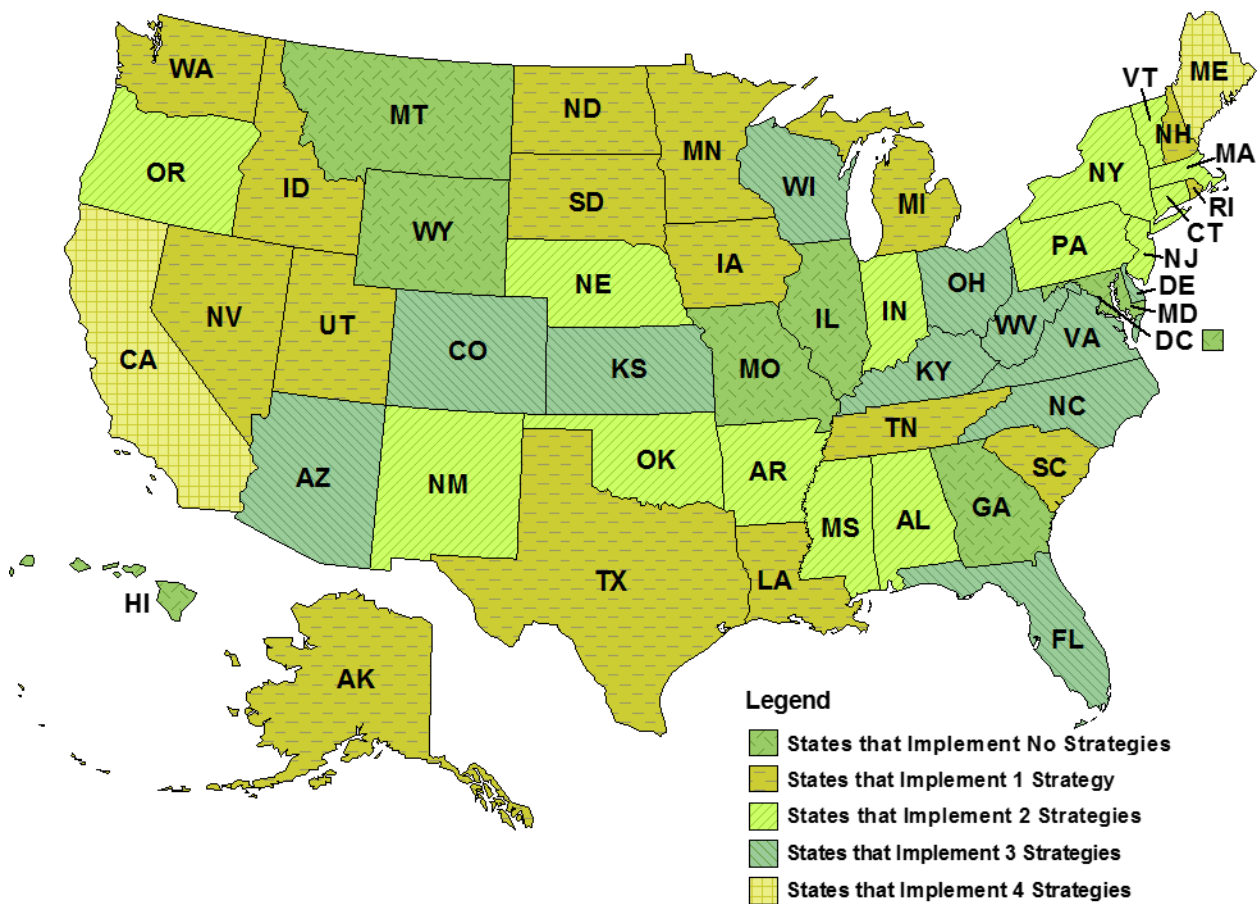


Given that much of the enforcement of laws pertaining to MIP occurs at the local level, it is not surprising that more states report implementation of related programs (Cops in Shops, shoulder tap and party patrol operations) by local law enforcement than at the state level.

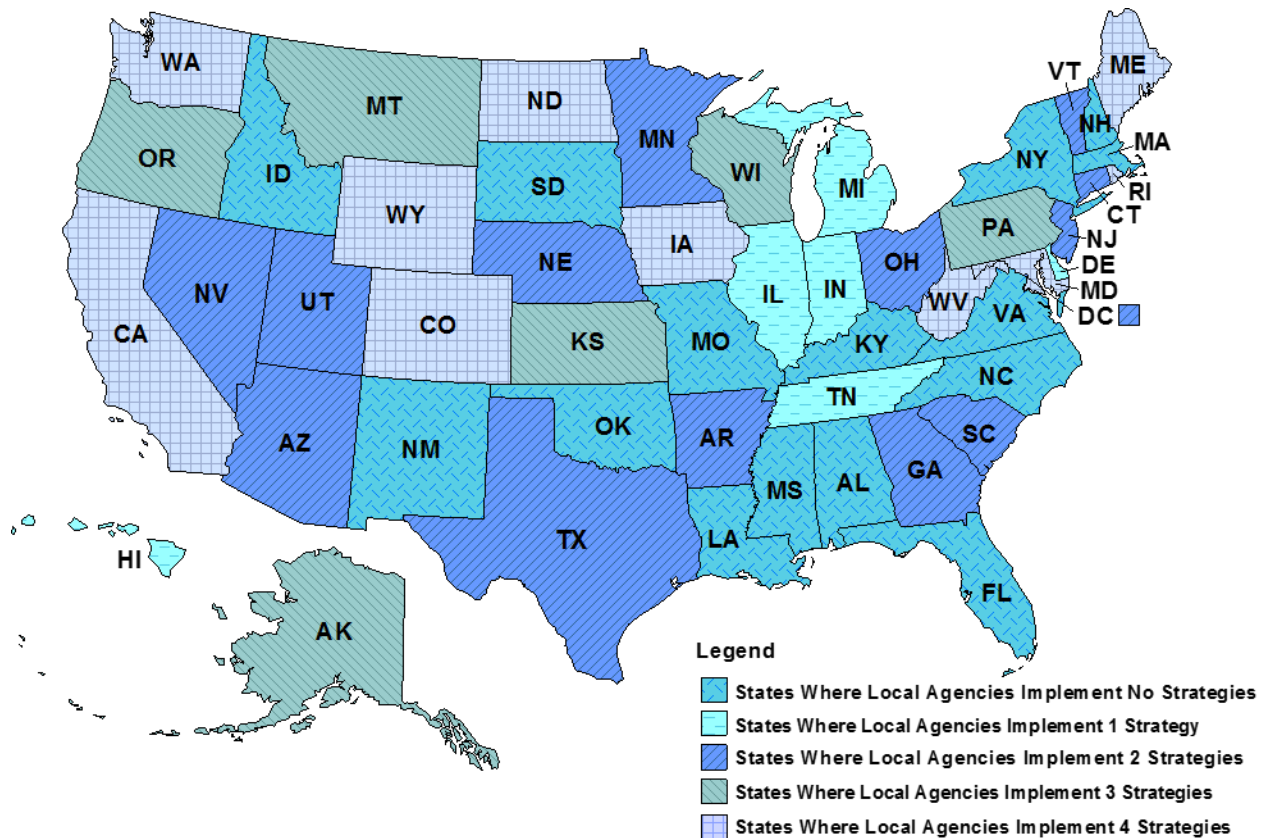
Exhibit 4.3.7 displays states that implement one, two, three, or all four of the strategies listed in Exhibit 4.3.6. Exhibit 4.3.8 displays states in which local law enforcement agencies implement one, two, three, or all four of the strategies.

In addition, all states regulate or prohibit direct sales and direct shipment of alcohol from producers to consumers, typically through internet orders and delivery by common carriers. (These laws do not address home delivery or internet sales by retailers.) States were asked whether they have a program to investigate and enforce direct-sales or direct-shipment laws and whether these laws are also enforced by local law enforcement agencies. As shown in Exhibit 4.3.9, 61 percent of the states report having direct-shipment enforcement programs, but only 12 percent report that local law enforcement enforce these laws.

**Exhibit 4.3.7: Number of Enforcement Strategies Implemented by States**



**Exhibit 4.3.8: Number of Enforcement Strategies Implemented by Local Law Enforcement Agencies**



**Exhibit 4.3.9: Enforcement of Direct-Shipment Laws**

State has a program to investigate and enforce direct-sales/shipment laws (%)		Laws are also enforced by local law enforcement agencies (%)
Yes	61%	12%
No	29%	31%
Don't know/No answer	10%	57%

**Sanctions Imposed on Retail Establishments for Violations**

The State Survey requested information on penalties imposed on retail establishments for furnishing to minors (see Exhibits 4.3.10–4.3.14; note that the “n” figures in these exhibits differ from the total number of states that answered “yes” to collecting data on fines, suspensions, and revocations, because some states provided incomplete data).

As would be expected, fines are the most common sanction, imposed about nine times as often as suspensions. However, revocations are rare. Of the states that collect data on revocations, 82 percent revoked one or no licenses. Eighty-eight percent of the states revoked fewer than six licenses.

**Exhibit 4.3.10: Fines Imposed on Retail Establishments for Furnishing to Minors**

Number of outlets fined for furnishing (n=34)		Total amount of fines in dollars across all licensees (n=33)
Median for those that collect data	175	\$144,350
Minimum	0	\$0
Maximum	2,326	\$6,522,525

**Exhibit 4.3.11: Lowest and Highest Fines Imposed on Retail Establishments for Furnishing to Minors**

Lowest fine imposed	Dollar amount of fines across all licenses
Median for those that collect data (n=34)	\$338
Minimum	\$0
Maximum	\$1,500
Highest fine imposed	Dollar amount of fines across all licenses
Median for those that collect data (n=33)	\$3,000
Minimum	\$500
Maximum	\$100,000

**Exhibit 4.3.12: License Suspensions Imposed on Retail Establishments for Furnishing to Minors**

Number of outlets suspended for furnishing (n=32)		Total days of suspension across all licensees (n=26)
Median for those that collect data	23	132
Minimum	0	0
Maximum	202	6,086

**Exhibit 4.3.13: Shortest and Longest License Suspensions Imposed on Retail Establishments for Furnishing to Minors**

Shortest suspension imposed	Number of days across all licenses
Median for those that collect data (n=30)	2
Minimum	0
Maximum	180
Longest suspension imposed	Number of days across all licenses
Median for those that collect data (n=28)	30
Minimum	0
Maximum	364

**Exhibit 4.3.14: License Revocations Imposed on Retail Establishments for Furnishing to Minors**

Number of outlets revoked for furnishing	
Median for those that collect data (n=33)	0*
Minimum	0
Maximum	46

\*The median will be zero if more than half the responses are zero.

The survey asked states to report the lowest and highest fine imposed, and the shortest and longest number of suspension days. Exhibits 4.3.11 and 4.3.13 illustrate great variation among the states in the amount of fines and the length of license suspensions imposed.

Sanctions for furnishing to minors can be put into perspective by considering rates per 100,000 drinking occasions among youth who are 16 to 20 years old. Exhibit 4.3.15 presents these rates for 26 states that collect complete sanctions data (fines, suspensions, and revocations).

**Minor in Possession Offenses**

States were also asked to provide statistics on MIP offenses. As noted earlier, arrest data for MIP offenses provide an index of the enforcement of laws designed to deter underage persons from drinking. Some states reported data that included arrests/citations issued by local law enforcement agencies; others did not.

The first three rows of Exhibit 4.3.16 present the number of arrests/citations reported by all states that collect such data. These data may not provide an accurate picture of MIP enforcement, because much of it is conducted at the local level and, therefore, is not represented in state data. The last three rows of Exhibit 4.3.16 present data only from those states that collect both state and local data. When only those states that collect local data are considered, the median number of arrests/citations increases by 56 percent, highlighting the importance of local enforcement efforts and data.

**Exhibit 4.3.15: Retailer Sanctions for Furnishing to Minors**

Sanctions per 100,000 drinking occasions	
Median for those that collect data (n=26)	7.22
Minimum	0.45
Maximum	24.02

**Exhibit 4.3.16: Number of Minors Found In Possession of (or Having Consumed or Purchased per State Statutes) Alcohol**

	Number of arrests/citations
Median for all states that collect data (n=34)	484
Minimum	7
Maximum	16,499
Median for states that collect both state and local data (n=14)	1,109
Minimum	63
Maximum	16,499

To explore the meaning of these data, two indices were calculated for states with both state and local MIP enforcement. The first index compares the rates of MIP arrests/citations with an estimate of yearly drinking occasions among 16- to 20-year-olds.<sup>35</sup> The second index reflects arrests per 100,000 youth in each state who are 16 to 20 years old. Results appear in Exhibit 4.3.17.

### Sanctions Against Youth vs. Sanctions Against Retailers

Comparing rates of MIP arrests and rates of retailer sanctions (totals of fines, suspensions, and revocations) highlights enforcement priorities. Nineteen states provided the complete dataset needed for this analysis (Exhibit 4.3.18).

In most states, MIP arrests greatly outnumber retailer sanctions, indicating that priority is given to individual arrests over enforcement at the retail level. The ratio of MIP arrests to retailer sanctions (indicating a priority on retailer enforcement) was less than one in seven states.

### Programs Targeted to Youth, Parents, and Caregivers

States were asked to list general prevention programs that have underage drinking as one objective and are funded or operated directly by the state. The survey provided space to provide detailed descriptions of up to 10 programs, plus additional space to briefly list any other programs that the states wanted to highlight.

**Exhibit 4.3.17: State and Local Arrests/Citations for Minors in Possession: 16- to 20-Year-Olds**

	Number of arrests/citations	Arrests/Citations per 1,000 drinking occasions	Arrests/Citations per 100,000 population 16–20
Median for those that collect data (n=14)	1,109	1.14	1,227
Minimum	63	0.07	73
Maximum	16,499	2.06	2,225

**Exhibit 4.3.18: Ratio of State and Local MIP Arrests to Retailer Sanctions**

	MIP arrests per retailer sanctions
Median for those that collect data (n=19)	3
Minimum	0.23
Maximum	61

<sup>35</sup> This estimate is based on the calculations of Wagenaar and Wolfson (1994). Using *Monitoring the Future* data, they estimated a rate of 90 drinking occasions per 100 youth per month. To maintain consistency of analysis over the years, this formula is used in every Report to Congress.

States were also asked:

- The number of youth, parents, and caregivers served by each program (if the program was aimed at a specific, countable population)
- Whether the program has been evaluated
- Whether an evaluation report is available and where the report can be found

Specific populations served were defined as follows:

**Youth:** People younger than 21 years old

**Parents:** People who have primary responsibility for the well-being of a minor (e.g., biological and adoptive parents, grandparents, foster parents, extended family)

**Caregivers:** People who provide services to youth (e.g., teachers, coaches, health and mental healthcare providers, human services and juvenile justice workers)

In addition to program descriptions, states were asked whether they had programs to measure and reduce youth exposure to alcohol advertising and marketing, and best practice standards for selecting or approving underage-drinking programs.

### Program Content

States varied widely in the number of programs described, in part because some states provided detailed information on local variations of some program types (e.g., community coalitions), whereas others described umbrella programs. Many well-known programs were reported, including those focused on life skills, refusal skills, media advocacy, community organizing, and environmental change. Prevention initiatives developed by individual states were also well represented.

As a method for summarizing the types of programs states are implementing, all programs were coded into one of four categories:

- **Programs focused on individuals**—Programs designed to impart knowledge, change attitudes and beliefs, or teach skills. Although individual youths or adults (usually parents) are the focus of these programs, the programs are almost always conducted with groups (e.g., classrooms, Boys/Girls Clubs, PTAs, members of a congregation). Also in this category are programs for offenders (MIP, driving while intoxicated [DWI]). Certain kinds of education and skills development were considered part of the environment. These include training for alcohol sellers and servers, health care workers, public safety personnel, and others whose activities affect large numbers of people.
- **Programs focused on the environment**—Programs that seek to alter physical, economic, and social environments, which may be focused on entire populations (e.g., everyone in a state or community) or a subpopulation (e.g., underage people, youth who drive). The main mechanisms for environmental change include state laws and local ordinances and their enforcement; institutional policies (e.g., enforcement priorities or prosecutorial practice, how alcohol is to be served at public events, carding everyone who looks younger than 35 years old, alcohol screening of all ER injury admissions); and changing norms. These changes are generally designed to decrease physical availability of alcohol (e.g., home delivery bans, retailer compliance checks); raise economic costs (e.g., drink special restrictions, taxation); and limit social availability (e.g., policies that affect the extent to which alcohol and alcohol



users are visible in the community, such as banning alcohol in public places and at community events or banning outdoor alcohol advertising).

- **Mixed**—Cases where both individual and environmental approaches are a substantive part of the effort. So-called “comprehensive” prevention programs are a relevant example.
- **Media campaigns**

In total, 287 programs (90 percent of all programs) were described in sufficient detail to allow coding. The results are presented in Exhibit 4.3.19. As shown, programs focused on individuals were more than twice as common as programs focused on the environment. States tended to favor either individual or environmental approaches in the programs they described; and 42 percent of the states that reported any programs that could be coded focused exclusively on one or the other.

### Numbers Served

States were asked to estimate the numbers of youths, parents, and caregivers served by programs aimed at specific populations. These data were incomplete, with 57 percent of the states ( $n=29$ ) providing data for at least one program for youths served; 31 percent ( $n=16$ ) for parents served; and 16 percent ( $n=8$ ) for caregivers served. These data may be difficult for certain types of programs to estimate. In particular, the target populations for programs focused on the environment may be entire populations or subpopulations. Estimating the actual numbers reached is therefore problematic. Exhibit 4.3.20 gives the reported number of youths, parents, and caregivers served across all states that reported data.

### Evaluation Data

For each program, states were asked whether the program has been evaluated and whether an evaluation report is available. Summary data for these questions appear in Exhibit 4.3.21. Clearly, states vary widely in their emphasis on evaluation.

**Exhibit 4.3.19: Types of Programs Implemented by the States**

Program category	Percentage of programs implemented
Focused on individuals	52
Focused on the environment	22
Mixed focus	19
Media campaigns	6

**Exhibit 4.3.20: Reported Numbers of Youths, Parents, and Caregivers Served**

	Youths served	Parents served	Caregivers served
Median	1,551	0	0
Minimum	0	0	0
Maximum*	1,007,844	935,802	15,350

\*Maximum numbers served are high in those instances where states reported that a program served the entire state population, or in those instances in which individuals may be served by the program multiple times.

**Exhibit 4.3.21: Evaluation of Underage Drinking–Specific Programs**

	Percentage of state programs evaluated	Percentage of evaluated programs with reports available
Median	53	25
Minimum	0	0
Maximum	100	100

### Programs to Measure and Reduce Youth Exposure to Alcohol Advertising and Marketing

States were asked whether they have programs to measure or reduce youth exposure to alcohol advertising and marketing. Thirty-nine percent ( $n=20$ ) of the states reported they had such programs, which tend to implement four approaches:

1. Environmental scans to assess the degree of youth exposure to alcohol advertising
2. Counter-advertising initiatives
3. Eliminating environmental advertising aimed at youth
4. Social marketing

### Best Practice Standards

States were asked whether they have adopted or developed best practice standards for underage-drinking-prevention programs and, if so, the type of agency or organization that established the standards. Eighty-eight percent ( $n=45$ ) reported they had best practice standards. As shown in Exhibit 4.3.22, state agencies play a significant role in their establishment, followed by federal agencies. Sixty-seven percent of those states with best practice standards reported that more than one type of agency was responsible for their establishment. More than half (56 percent) included SAMHSA and CSAP in their list of agencies.

### Collaborations, Planning, and Reports

The STOP Act Survey included two questions about collaborations. The first question asked whether states collaborated on underage drinking issues with federally recognized tribal governments (if any). Fifty-four percent ( $n=27$ ) said they did collaborate, 22 percent said they did not collaborate, and the remainder reported no federally recognized tribes in their states.

**Exhibit 4.3.22: Agencies Establishing Best Standards**

Type of agency establishing best practice standards	Percentage of states adhering to best practice standards
Federal ( $n=33$ )	73
State ( $n=38$ )	84
Nongovernmental ( $n=5$ )	11
Other ( $n=6$ )	13

The second question asked whether the states had a state-level interagency body or committee to coordinate or address underage-drinking-prevention activities. Eighty-four percent of the states reported that such a committee exists, although the composition of the committee varied somewhat from state to state. Most states’ interagency committees included a variety of state agencies directly involved in underage-drinking-prevention policy implementation and enforcement, as well as educational- and treatment-program development and oversight. These include the states’ departments of health and human services and alcohol beverage control, their substance abuse agency, and their state police/highway patrol. Of interest is the extent to which the committees included representatives from the governor’s office, state legislature, and office of the attorney general, given that they are so critical in setting priorities, providing funding, and generating political and public support. As shown in Exhibit 4.3.23, 12 percent of the states with a committee included the governor, 12 percent included a legislative representative, and about one in three an attorney general.

Exhibit 4.3.24 shows the extent to which the interagency committee included relevant entities and constituencies outside of state government. Forty-four percent of the states with interagency committees included college/university administrations, campus life departments, or campus police, and 49 percent included community coalitions or concerned citizens. About one in four states included local law enforcement, and about one in six included youth.

States were asked whether they had prepared a plan for preventing underage drinking or issued a report on underage drinking in the past 3 years. Fifty-seven percent of the states had prepared a plan, and 57 percent had issued a report. The majority of states provided a source for obtaining the plans or reports (see individual state reports).

### State Expenditures on the Prevention of Underage Drinking

States were asked to estimate state expenditures for two categories of enforcement activities and five types of programs targeted to youths, parents, and caregivers. Exhibit 4.3.25 provides the data in \$1,000 units reported for the enforcement activities, program activities, and an “other” category. An entry of zero in the “Minimum reported” row means that at least one state that maintains data reported no expenditures in that category.

**Exhibit 4.3.23: Composition of the Interagency Group—State Government Entities**

	Office of the Governor	Legislature	Attorney General
Percentage of states with a committee (n=41)	12	12	29

**Exhibit 4.3.24: Composition of the Interagency Group—Other Entities**

	Local law enforcement	College/University administration, campus life department, campus police	Community coalitions/ Concerned citizens	Youth
Percentage of states with a committee (n=41)	24	44	49	17

**Exhibit 4.3.25: 12-Month Expenditures\* (in thousands) for Enforcement Activities; Programs Targeted to Youths, Parents, and Caregivers; and Other Programs†**

	Enforcement activities		Programs targeted to youths, parents, and caregivers					Other programs
	Compliance checks	Checkpoints and saturation patrols	Community-based programs	K-12 programs	College/University programs	Juvenile justice system programs	Child welfare system programs	
<b>Number of states providing data</b>	16	14	29	22	17	15	13	12
<b>Median expenditure*</b>	\$26	\$20	\$365	\$96	\$23	\$0	\$0	\$62
<b>Minimum reported</b>	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
<b>Maximum reported</b>	\$162	\$220	\$43,564	\$31,495	\$150	\$930	\$125	\$2,500
<b>Percentage of states providing data that invest in this category</b>	69	57	86	59	71	40	23	50

\*The median is zero if more than half the responses are zero.

†These data must be viewed cautiously. Response rates ranged from 23 percent to about 86 percent. Thus the extent to which some of these data reflect national trends is unclear.

The largest expenditure category is for community-based programs, followed by K-12 school programs. The median of expenditures for programs targeted to youth, parents, and caregivers (\$60,906) is nearly three times that for all enforcement activities (median = \$21,945), and the total dollar amount expended for these non-enforcement programs (approximately \$123.4 million) is 73 times the total dollar amount spent on enforcement (approximately \$1.7 million).

States were also asked whether funds dedicated to underage drinking are derived from taxes, fines, and fees. Eighty-four percent of the states provided data for these questions. The use of these funding sources for underage-drinking-prevention activities is limited (see Exhibit 4.3.26).

### Comparison of Enforcement Data: 2011 to 2016

The STOP Act State Survey is now in its sixth year of data collection. The following exhibits offer a snapshot of the results for 2011, 2012, 2013, 2014, 2015, and 2016 for several key components of the enforcement data. Caution should be used in interpreting these data.

**Exhibit 4.3.26: Sources of Funds Dedicated to Underage Drinking**

Source	Number of states providing data	Percentage reporting yes*
Taxes	43	19
Fines	43	19
Fees	43	19

\*Percentages reflect only those states that provided data for these questions.

Data collection and reporting vary greatly from year to year among the states, so it is not possible to compare all states over these 6 years. Fewer than half the states provided information in all 6 years for eight of the datasets.<sup>36</sup>

Twenty-two percent of the states provided MIP data over all 6 years. As shown in Exhibit 4.3.27, of these states, 27 percent reported a larger number of MIP arrests in 2016 than in 2011, and 73 percent reported a decrease in the number of arrests. Increases and decreases in the number of arrests were not continuous over the 6 years. For all of the states, there was some variation across the years.

Exhibit 4.3.28 shows that 57 percent of the states provided state compliance check data for all 6 years. Sixty-two percent of the states reported an increased number of compliance checks between 2011 and 2016, and 38 percent reporting a decreased number. As with MIP arrests, increases and decreases were not continuous across the years; 90 percent of the states reported some fluctuation.<sup>37</sup>

**Exhibit 4.3.27: Minors in Possession 2011–2016**

	Number	Percentage
<b>States reporting in all 6 years (n=11)</b>		
States showing increased arrests across all 6 years	0	0
States showing decreased arrests across all 6 years	0	0
States showing variation across all 6 years, but increased number of MIP arrests between 2011 and 2016	3	27
States showing variation across all 6 years, but decreased number of MIP arrests between 2011 and 2016	8	73
<b>States not reporting in all 6 years (n=40)</b>		

**Exhibit 4.3.28: State Compliance Checks 2011–2016**

	Number	Percentage
<b>States reporting in all 6 years (n=29)</b>		
States showing increasing number of compliance checks across all 6 years	2	7
States showing decreasing number of compliance checks across all 6 years	1	3
States showing variation across all 6 years, but increased number of compliance checks between 2011 and 2016	16	55
States showing variation across all 6 years, but decreased number of compliance checks between 2011 and 2016	10	34
<b>States not reporting in all 6 years (n=22)</b>		

<sup>36</sup> For detailed charts of all state enforcement data reported from 2011 to 2016, visit <http://www.stopalcoholabuse.gov> and go to Report to Congress, Supplemental Information, “2011-2016 Enforcement Data.”

<sup>37</sup> In previous reports, a comparison of local compliance check data was included. As only three states reported these data for all 6 years (2011 to 2016), a meaningful comparison is not possible. Similarly, a comparison of state expenditures for compliance checks is not included, as only two states have reported these data for all 6 years.

Exhibits 4.3.29–4.3.31 describe state reporting on penalties for retail establishments between 2011 and 2016. In most penalty categories, larger percentages of the states reported reduced use of these penalties than reported increased use. Given that revocations are relatively infrequent, it is not surprising that 45 percent of all states reporting showed no change between 2011 and 2016. Given the great variation in reporting rates for all 6 years (18 percent to 39 percent), these data should be viewed with caution.

**Exhibit 4.3.29: Fines on Retail Establishments 2011–2016**

	Fines: Total number	Fines: Total dollar amount
	<i>States reporting in all 6 years (n=12)</i>	<i>States reporting in all 6 years (n=11)</i>
States showing consistent increases over all 6 years	0% (n=0)	0% (n=0)
States showing consistent decreases over all 6 years	0% (n=0)	0% (n=0)
States showing variation across all 6 years, but increases between 2011 and 2016	42% (n=5)	45% (n=5)
States showing variation across all 6 years, but decreases between 2011 and 2016	58% (n=7)	55% (n=6)

**Exhibit 4.3.30: License Suspensions of Retail Establishments 2011–2016**

	Suspensions: Total number	Suspensions: Total number of days
	<i>States reporting in all 6 years (n=18)</i>	<i>States reporting in all 6 years (n=9)</i>
States showing consistent increases over all 6 years	6% (n=1)	0% (n=0)
States showing consistent decreases over all 6 years	0% (n=0)	0% (n=0)
States showing variation across all 6 years, but increases between 2011 and 2016	22% (n=4)	11% (n=1)
States showing variation across all 6 years, but decreases between 2011 and 2016	72% (n=13)	89% (n=8)

**Exhibit 4.3.31: Revocations of Retail Establishment Licenses 2011–2016**

	Revocations: Total number
	<i>States reporting in all 6 years (n=20)</i>
States showing consistent increases over all 6 years	0% (n=0)
States showing consistent decreases over all 6 years	0% (n=0)
States showing variation across all 6 years, but 2011 and 2016 were equal	45% (n=9)
States showing variation across all 6 years, but increases between 2011 and 2016	10% (n=2)
States showing variation across all 6 years, but decreases between 2011 and 2016	45% (n=9)



## Discussion

A key conclusion to be drawn from the STOP Act State Survey is that the states have demonstrated a commitment to the reduction of underage drinking and its consequences. This commitment is evident in the fact that all states completed the survey, reported numerous program activities, and in many cases provided substantial detail about those activities (see individual state summaries). Completion of the lengthy survey required the cooperation of multiple state agencies, including those charged with enforcement of underage drinking laws and policies and those involved in prevention of underage consumption. The fact that the survey has had a 100 percent response rate over its 6-year existence is evidence of the seriousness with which the task of preventing underage drinking is taken by the states.

Although data provided by the state survey is informative and useful, it should be noted that enforcement activities appear highly variable across the states. Compliance checks and other enforcement activities related to furnishing (Cops in Shops, shoulder tap operations, underage alcohol-related fatality investigations, and enforcement of direct-shipment laws) are fairly widely implemented, although not necessarily at both the state and local levels. However, the total number of checks is modest. Sixty-one percent of those states conducting checks test 20 percent or fewer of their licensees. Sanctions for furnishing are predominantly fines, which are about nine times more common than suspensions. Revocations are extremely rare; 82 percent of the states revoked one or no licenses.

Some of the variability found in the enforcement data may be due as much to data unavailability as to whether the activities were actually conducted. As discussed in the enforcement results section, the number of states that collect data on local enforcement efforts is limited. Given that much of the enforcement of laws on furnishing minors and minors in possession occurs at the local level, it is likely that the enforcement statistics reported here actually underestimate the total amount of underage drinking enforcement occurring in the states. Regular and complete collection of both state and local enforcement data is critical to building an accurate picture of the national effort to prevent underage drinking.

Availability of funding for both enforcement and prevention program activities may also play a role in the types of activities conducted and data reported. For example, the termination of discretionary state grants from the Enforcing Underage Drinking Laws (EUDL) program through the Office of Juvenile Justice and Delinquency Prevention after FY 2011 is cited by some states as having an impact on their efforts to prevent underage drinking. The longer-term impact of this loss of funding remains to be seen.



# **CHAPTER 5**

## **Evaluation of the National Media Campaign: “Talk. They Hear You.”**

## Background

“Talk. They Hear You.” (TTHY) is the Underage Drinking Prevention National Media Campaign of the Substance Abuse and Mental Health Services Administration’s (SAMHSA’s) Center for Substance Abuse Prevention (CSAP). The campaign is currently in its fourth year and has evolved to become as much an ongoing communication initiative as a well-recognized brand. In 2016, to bolster the credibility and consistency of the campaign, the U.S. Department of Health and Human Services (HHS) established a trademark for the campaign logo.

Underage drinking remains a national public health issue with serious implications, especially among adolescents. SAMHSA is responsible for leading public health efforts to reduce the impact of substance abuse and mental illness on American communities. TTHY responds to directives set forth in Section 2(d) of the STOP Act, requiring the Secretary of the U.S. Department of Health and Human Services to fund and oversee a national adult-oriented media public service campaign and to report annually on the production, broadcasting, and evaluation of this campaign. The goal of the national media campaign is to reduce underage drinking by providing parents and caregivers of children ages 9 to 15 with information and resources to discuss the issue of alcohol with their children.

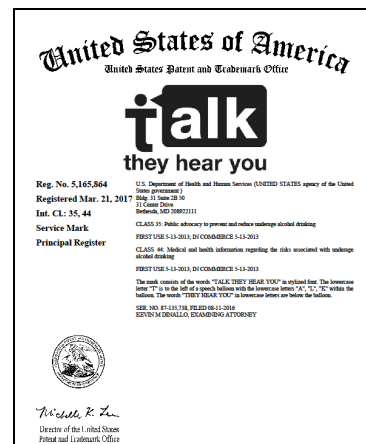
Although most of the “Talk. They Hear You” campaign’s product placement is achieved through earned media, it competes successfully against commercial brands that have significant media budgets. TTHY’s annual budget totals about \$1 million (the cumulative since its 2013 inception equals \$5 million), but the campaign has reached nearly 6 billion impressions with \$59 million in free ad space.

As referenced in more detail later in this chapter, the literature on underage drinking (UAD) prevention suggests that parental interaction with youth regarding underage drinking may provide a unique opportunity for early intervention and prevention. TTHY was designed to capitalize on this theory and add to the current knowledge base about underage drinking prevention. It also empowers parents to address the issue by increasing their level of comfort with the topic and encouraging open communication with their children.

Officially launched in May 2013, the TTHY campaign objectives include:

1. Increasing parents’ *awareness of the prevalence and risk* of underage drinking
2. Equipping parents with the *knowledge, skills, and confidence* to prevent underage drinking
3. Increasing parents’ *actions to prevent underage drinking*

During campaign development, parents, youth, and stakeholders provided feedback on all aspects of concept and message development. In 2012, SAMHSA conducted a national pilot program to test and refine the campaign’s creative materials and objectives, the details of which can be found in the 2016 version of the Report to Congress. Feedback received during this market testing was incorporated into final campaign materials prior to launch.



“Talk. They Hear You.” service mark certificate

SAMHSA continues to invigorate the campaign by incorporating findings from ongoing research. For instance, to further inform the development of the national survey (scheduled to launch late 2017), which was designed to investigate whether a correlation exists between campaign exposure and desired UAD-related behavioral outcomes among parents/caregivers of children ages 9 to 15, a pilot test of this instrument was completed in January 2016. Findings from this research indicate that a national survey effort is feasible. Early in 2016, SAMHSA also submitted a full OMB package to conduct the focus group research needed for additional short-term campaign evaluation. The five groups commenced in September 2016 and were completed that November. A topline of research findings and recommendations for how to further refine both the national survey and the TTHY campaign materials and approach are detailed in the Campaign Evaluation Strategy section below.

An additional package is currently in the OMB queue for clearance to conduct a pilot case study (scheduled for launch in mid-2017). This pilot program will launch as a forced campaign exposure within one or more school settings and will be evaluated using a pre-post-evaluation design. The effort will include both a parent and a student survey in order to draw conclusions about the impact of parental knowledge, attitudes, beliefs, and behaviors (KABBs) on student alcohol consumption behaviors. There will also be a qualitative component of the research post-program among participating parents. Findings will further inform development of the TTHY campaign materials and dissemination approach.

A final OMB package is currently being developed to conduct the large-scale national survey that will evaluate the national reach and impact of the campaign. This research is slated for launch year-end 2017.

## Target Audience

Alcohol use by those younger than the legal age of 21 remains a serious public health and safety problem, undermining the well-being of America's youth. Although recent data on drinking behavior among 9- to 10-year-olds is not available, 10 percent of 9- to 10-year-olds had already started drinking, according to a 2004 analysis of multiple studies conducted in the 1990s (Donovan et al., 2004). Almost 20 percent of underage drinkers begin drinking before age 13 (CDC, 2012). More than 7 percent of 14- to 15-year-olds used alcohol in the last month (CBHSQ, 2016c).

As noted, SAMHSA's TTHY campaign focuses on encouraging parents to begin conversations about alcohol with children at an early age, when the likelihood of influencing children's decisions about drinking is greatest (Office of the Surgeon General, 2007). The campaign draws from social marketing and health education behavior theories, feedback from audiences across the country, and the latest scientific research.



**After a visit with a friend.**  
A perfect moment to talk about alcohol.

Alarming numbers of pre-teens are drinking alcohol—which makes it urgent to find every opportunity to talk to your kids about the dangers of underage drinking. For tips on how—and when—to begin the conversation, visit:  
[www.underagedrinking.samhsa.gov](http://www.underagedrinking.samhsa.gov)

**talk**  
they hear you




Parents have a significant influence on young people’s decisions about alcohol consumption. Parental attitudes toward drinking, as well as parental communication, can have a substantial impact on adolescent alcohol use, particularly among younger adolescents (Ennett et al., 2001; Wood et al., 2004). Although most adults support public policy aimed at reducing youth access to alcohol, there is evidence to suggest that parents are unaware of the pervasiveness and risk of underage drinking (NRC and IOM, 2004).

Parents who know about underage alcohol use can take action to protect their children from many of the high-risk behaviors associated with it. Through a direct association with adolescent perceptions and cognition, parental beliefs and communication about the acceptability of underage drinking may positively impact use of alcohol in youth (Sieving, Maruyama, Williams, & Perry, 2000), suggesting that parental interaction with youth regarding underage drinking may provide a unique opportunity for early intervention and prevention.

## Campaign Components

TTHY messages and materials are disseminated through radio, television, and print public service announcements (PSAs); social media; the campaign website; partner networks; and direct outreach. Campaign messages:

- Emphasize the importance of parents talking to their kids about underage drinking before they reach the age range when alcohol use typically begins (before age 15)
- Offer advice to parents about preparing children to deal with peer pressure issues that may lead to alcohol abuse
- Highlight underage drinking statistics that are likely to catch parents’ attention
- Focus on helping parents address the issue of underage drinking in a manner that emphasizes their children’s ability to make autonomous decisions
- Model behaviors and situations when parents can begin the conversation about the dangers of alcohol with their children

## Public Service Announcements

TTHY PSAs show parents using everyday opportunities to talk with their children about alcohol and reinforce the importance of starting these conversations at an early age. PSAs direct viewers/listeners to the campaign website (<http://www.samhsa.gov/underage-drinking>) for additional information and tools, as well as downloadable versions of video, radio, and print PSAs. A select number of these materials are currently available in both English and Spanish, with several new Spanish-language versions having been developed and released in 2016. A series of print PSAs directed at Native American audiences has also been distributed to markets in Alaska, Arizona, and Oklahoma. In February 2017, the TTHY Campaign released a new set of PSAs, which includes an extended-time English-language video PSA. This discussion-starter video, approximately 4 minutes long, illustrates the concerns and questions parents have about underage drinking, how to talk with their children about it, and how to model a meaningful and effective conversation. It is intended for use by community organizations, schools, healthcare providers, policymakers, and others concerned about underage drinking prevention. Since the campaign launched in 2013, “Talk. They Hear You.” television and print PSAs have collectively garnered more than 5.8 billion impressions. Distribution has generated an estimated \$59 million in free air time and ad space.



## Partner Networks

The media campaign works with more than 100 local, state, and national partners to support outreach and dissemination of campaign materials across the United States. Partners include other government agencies as well as prevention, retail, healthcare, community, and school-based organizations.

In addition to PSAs, promotional materials include infographics, web banners, buttons, and a scannable Quick Response (QR) code for promoting the campaign on partner websites. These materials were created and provided to partners for display and distribution to parents and community members, along with talking points, fact sheets, infographics, draft social media messages, and email templates to ensure consistent outreach to parents and community members.

## Website

The TTHY website provides a centralized resource for all campaign information and products. Materials and information are organized by visitor category: parent/caregiver, partner, or media. Educational and informational documents provide facts and statistics on the problems and consequences of underage drinking, risk factors, warning signs, and suggestions for actions parents and educators can take to help protect children and strengthen decision-making skills.

A Spanish version of the site (<http://www.samhsa.gov/hable-ellos-escuchan>) launched in March 2016.

Parents can use an interactive “create your own” action plan to generate tips on when and how to talk to their children about alcohol that are tailored to a child’s gender and age, and download a family agreement template that enables parents and children to pledge their commitment to avoid underage drinking together. Other tools include answers to children’s frequently asked questions about alcohol and five primary conversational goals for parents emphasizing the importance of:

- Indicating disapproval of underage drinking
- Demonstrating concern for their child’s happiness and well-being
- Establishing themselves as a trustworthy source of information
- Showing their child they are paying attention and will notice alcohol use
- Building their child’s skills and strategies for avoiding underage drinking



**CADCA is an example of a partner organization that is leveraging the campaign to benefit communities across the country.**

Collective promotional activities from January 1, 2016, through December 31, 2016, helped drive 57,425 visits to the website—an 80 percent increase from the prior year. Social media promotion has been especially effective in driving traffic to the site, with Facebook leading as a top referring website for 8 of the 12 months in 2016. In 2015, SAMHSA ran a Thunderclap campaign and in 2016 ran a Facebook ad campaign (see details below).

### Mobile Application

Available to parents since July 2015, the mobile application (“Talk. They Hear You.”) is available through Google Play™, the Windows® Store, and the App Store®. The app features an interactive simulation using avatars to help parents practice bringing up the topic of alcohol, asking relevant questions, and keeping the conversation going in a role-play environment. The app was downloaded 5,723 times as of December 2016.

In coordination with Prevention Week and Alcohol Awareness Month (May 15–21, 2016) the TTHY mobile app was promoted through paid advertising on Facebook.

In late 2015, the TTHY campaign launched the #WeTalked campaign on Thunderclap, a platform that helps amplify social cause messages in social media. The campaign encouraged parents, caregivers, and organizations to pledge to talk to children about underage drinking and to encourage others to do the same. The campaign amassed more than 20,000 likes, comments, shares, and retweets, and reached more than 2.3 million social media users across the country.

In 2016, the TTHY campaign launched a 30-day Facebook ad campaign to help further promote the mobile app and campaign website. The Facebook campaign generated 3,500 likes and shares, and 4 million impressions, which drove more than 9,000 clicks to the app download page at SAMHSA.gov. The mobile app saw 551 downloads in this 30-day period, a 116 percent increase compared with the previous 30 days.



TTHY materials are available on the SAMHSA website.



“Talk. They Hear You.” mobile app.

## Campaign Evaluation Strategy

Evaluation of the effectiveness of the “Talk. They Hear You.” media campaign relies on the establishment of a correlation between parent/caregiver exposure to campaign materials and a change in knowledge, attitudes, and behavior to affect the prevention of underage drinking.

As described earlier in the Background section, SAMHSA plans to conduct a large-scale national survey of parents/caregivers of children ages 9 to 15—in addition to conducting a series of forced-exposure case studies—to investigate whether such a correlation exists. To determine the feasibility of a large-scale national survey, SAMHSA recently conducted a pilot survey and a series of focus groups. The pilot survey and focus group findings helped to:

- Determine whether campaign materials are being seen, retained, and applied by sufficient numbers of the target population to make a national survey sampling practical
- Determine, within the limited frame of the pilot study, whether the questions elicit differences in responses between parents and caregivers who have and have not been exposed to the campaign
- Refine data collection procedures and survey questions

SAMHSA has completed the pilot survey and focus groups with both English- and Spanish-speaking parents/caregivers of children ages 9 to 15. Research findings are being used to inform and finalize the national survey, which will be administered in both English and Spanish.

### Pilot Study Research Results

Questions included in the pilot survey were designed to (1) quantify parent and caregiver awareness of the campaign and retention of campaign messages and (2) determine whether parents and caregivers have used the campaign materials in talking to their children. SAMHSA administered the 28-item pilot survey online through the Qualtrics<sup>®</sup> Survey Suite to a panel of parents and caregivers of children ages 9 to 15 living in six geographic locations targeted for intensive campaign outreach: Atlanta, GA; Los Angeles, CA; Manhasset, NY; Oklahoma City, OK; Phoenix, AZ; and Washington, DC.

Because the survey was intended to provide both preliminary information about campaign reach and retention as well as information addressing the quality of the survey itself, the panel purchased from Qualtrics<sup>®</sup> included a requirement that approximately one third of respondents had been exposed to campaign materials. A total of 227 people responded to the online survey in order to obtain 48 qualified respondents (approximately 23 percent) who had been exposed to the campaign in the six geographic regions. Of those 227 respondents, 16 were disqualified because they were not parents of children currently ages 9 to 15, and 58 were eliminated because they did not fulfill the quota regarding exposure to the campaign. Complete responses were provided from a total of 153 parents and caregivers with children ages 9 to 15.

The pilot survey provided important findings about the feasibility of conducting a national survey. For example, the pilot survey provided information on campaign exposure—approximately 23 percent of parents and caregivers of children ages 9 to 15 in the six geographic regions who were part of the panel had heard of the campaign. This finding suggests it will be possible to develop a nationally representative sample of enough respondents who have heard of

the campaign to measure any possible correlations between exposure to the campaign and knowledge, skills, or behaviors regarding talking to children about underage drinking.

In addition to the feasibility of developing a nationally representative sample, the pilot survey also provided information about the potential of the survey to detect differences in responses between parents and caregivers who had been exposed to the campaign and those who had not. For example, of those parents who had heard of the campaign, 69 percent said they were “somewhat” or “very much” concerned about their child/children drinking alcohol, compared with 44 percent who had not heard of the campaign ( $p < 0.05$ ).<sup>38,39</sup>

Because the pilot survey was distributed to a small, targeted sample that was not selected to be representative of the general population, this finding is not generalizable to the overall population and should not be interpreted as an evaluation of the campaign as a whole.

Together with the focus group discussion findings, detailed below, the pilot survey results will be used to further refine the survey instrument and the data collection procedures for the national survey.

## Focus Group Research Results

Five focus groups were conducted in fall 2016 among a diverse group of participants from several regions across the United States. Focus group findings corroborate much of what has already been discovered both in the general literature on underage drinking and in the past research conducted specifically for this initiative, such as the pilot survey detailed above. The primary takeaway supports that the challenge for the TTHY campaign remains: parents do not consider underage drinking as a top of mind problem. In relation to other pressing issues, concern about underage drinking could best be described as moderate, eliciting more fear and apprehension when imagined in the extreme (e.g., excessive drinking). This finding suggests a pervasive tolerance for experimentation with alcohol among youth, and an understanding of this behavior as acceptable, if not harmless.

Many are already discussing the issue of underage drinking with their children, particularly those with children in the upper range of the 9- to 15-year-old campaign target. Even among those not yet engaging their young children in this conversation, there was agreement that starting the conversation earlier than later could only be a benefit. The great majority of research participants, however, also expressed their beliefs that peer and societal pressures are significant, and while leaving the door open for discussion about underage drinking would hopefully delay onset of underage drinking, or the degree to which it occurs, this practice would not lead to complete immunity from this behavior.

Most reported a reliance on personal experience and ad hoc Google searches to inform the conversations they are having with their children. This further corroborates the notion of drinking as something “everyone does” and thus does not necessarily warrant outside expertise or special knowledge about how to address it. Nearly all caretakers reported confidence in

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<sup>38</sup> This bivariate relationship was tested using a standard Pearson’s Chi-Square test of significance.

<sup>39</sup> It should be noted that selective exposure may have been a factor in this finding, as parents who were concerned about their children drinking alcohol may have been more likely to pay attention to the campaign materials than parents who were not concerned about their children drinking alcohol.



seizing the “teachable moment” when speaking to their children about underage drinking. Still, the majority were amenable, and even eager, to receiving additional information about underage drinking, and how to best persuade their children to avoid underage drinking, if it were made available to them.

Upon exposure, the TTHY campaign resonated across the broad swath of U.S. culture sampled for the focus groups, from lower to higher socioeconomic status and among the major ethnicities. While some took exception to individual executions for various reasons, there was general consensus that the tone, approach, and main messages of the campaign are salient and empowering to parents of tweens and teens. The campaign messages rang true and were motivational for the majority of caretakers in inspiring deeper consideration of and discussion about underage drinking with their tweens and teens. Finally, while exposure to the test materials was clearly influential, so was the mere activity of coming together as a group to discuss underage drinking and “compare notes.”

The research conducted for this report was qualitative in nature, and dependent upon a convenience sample that is not representative of the entire US population. While SAMHSA cannot generalize findings to the entire population, the findings do yield strong guidance on which components of the TTHY work well and which areas could be improved or should be further researched.

## **National Survey and Forced-Exposure Case Studies**

To establish a correlation between parent/caregiver exposure to campaign materials and a change in knowledge, attitudes, and behavior to affect the prevention of underage drinking, the national survey will:

- Examine campaign reach and exposure to determine whether enough adults with children in the targeted age range have been exposed to campaign messaging and materials
- Evaluate whether parents exposed to campaign messaging and materials report increased knowledge and skills and/or changes in behavior regarding talking to their children about alcohol after seeing the materials

As with the pilot survey, SAMHSA will administer the nationally representative survey online in both English and Spanish using the Qualtrics<sup>®</sup> Survey Suite.

To supplement findings from the national survey, SAMHSA will conduct the forced-exposure case study within one or more school sites situated in an area that has limited campaign outreach. The case study(ies) will include baseline surveys of parents and children ages 9 to 15, followed by intensive exposure to campaign materials, and post-exposure surveys of parents and children. SAMHSA also will conduct focus groups and interviews with parents to identify details on specific campaign content and its usefulness for discussing underage drinking with children.

Whereas national survey data will provide an evaluation of overall campaign information exposure and retention across the United States, case studies will explore details of *how* exposure to the “Talk. They Hear You.” campaign affects parent and student attitudes and behaviors at the target sites. Inclusion of student pre- and post-exposure surveys will also allow SAMHSA to identify trends in correlations between changes in parent behavior and changes in youth

behavior. Together, these sources of information will allow an estimation of overall campaign impact.

## Campaign Refinement

Both the pilot survey and the focus group research findings are being used to develop a more robust national survey of parents and caregivers, and to refine data collection procedures and data collection instruments used in the forced-exposure case studies. To these ends, specific recommendations are provided in the full report of the focus group research report, “Advancing the Evaluation of the “Talk. They Hear You.” Initiative: A Formative Research Project Assessing the National Survey Effort to Determine Reach and Impact of SAMHSA’s Underage Drinking Prevention National Media Campaign.”

Topline recommendations include survey question refinements for the national and case study surveys, such as: (1) an expansion and specification of response options; (2) rewording base questions to elicit more nuanced information around parents’ confidence and locus of control in influencing underage drinking behaviors among their children; (3) collecting additional open-ended responses to allow for deeper discovery around current content of parent/child communications around underage drinking; and (4) probing around gender bias and alcohol use trends that, according to the findings from our recent TTHY primary data collection efforts and corroborated in the social science and medicine literature, appear unique to the Hispanic community.<sup>40</sup> A recommendation was also made to collect data separately for children by more narrow age ranges (9–10; 11–13; 14–15) to gain a more complete understanding of the role age plays not only in current practices but also in desired behaviors targeted by the TTHY campaign.

Additional, initiativewide recommendations include:

- Counter the cultural norm of tolerance around underage drinking
- Dial up the level of concern around underage drinking
- Model additional parent/child communication scenarios
  - Develop scenarios that model how to best deal with “alcohol-lenient” parents
- Investigate (and address) gender bias regarding alcohol consumption
- Create executions that are more broadly salient in select markets of relevance
- Alter the Spanish-language “Pajama Party” PSA (this apparently is not a culturally relevant concept and is reportedly forbidden within many Hispanic households)
- Heighten TTHY campaign promotions to fill the information gap
- Optimize brand/message placement
- Expand the scope of the campaign

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<sup>40</sup> While much of the evidence for gender disparities specific to alcohol consumption norms is based on the study of Mexican Americans, the literature supports that a culture of “machismo” and other sociocultural and economic factors underpins the gender differences found between less acculturated Latino men and women in the United States (Collins & McNair, 2003; Wahl & Eitle, 2010; Alaniz, Treno, & Saltz., 1999; Alaniz, 1994; Panitz, McConchie, Sauber, & Fonseca, 1983). These studies suggest higher levels of abstinence among Hispanic women and moderately higher consumption rates among Hispanic men compared with other ethnicities. Level of acculturation has been identified as a primary mechanism of behavior, with second- and third-generation Latinas eventually approximating mainstream trends in alcohol consumption (Collins & McNair, 2003; Wahl & Eitle, 2010; Zamboanga et al., 2006; Alaniz et al., 1999; Panitz et al., 1983). These findings suggest that a more targeted TTHY messaging approach illuminating this reality among the Spanish-speaking parent population may be more effective in preventing UAD than the current TTHY messaging.



- Communicate a combined message of drug and alcohol prevention
- Widen execution of the TTHY communication initiative beyond dissemination of PSAs, based on focus group discussions that gave rise to deeper consideration and concern about early alcohol use
- Incorporate more factual information about alcohol use, parental influence, and the potential detriment to mental/physical health and social outcomes

A full explanation of these recommendations can be found in the “Formative Research Project” report described above.

## Conclusions

To determine whether a relationship exists between parent/caregiver exposure to TTHY campaign materials and a change in knowledge, attitudes, and behavior regarding prevention of underage drinking, SAMHSA will conduct a large-scale national survey of parents and caregivers of children ages 9 to 15 and a forced-exposure case study. Meaningful assessment of the effect of exposure to campaign messages and materials on parents requires sufficient time for the media campaign to reach a significant number of parents with children in the targeted age range across the United States. Currently, SAMHSA is completing preliminary evaluation of both the reach and the effectiveness of campaign materials through use of both English- and Spanish-language versions of the pilot survey and focus groups. Findings from the English- and Spanish-language pilot survey suggest that campaign reach is sufficient to make deployment of the national survey feasible in 2017. These data will inform the sampling plan for the national survey.

Combined results from both the English- and Spanish-language versions of the pilot survey and focus groups will also be used to develop a more robust national survey of parents and caregivers and to refine data collection procedures and data collection instruments used in the forced-exposure case studies. Together, national survey data and the forced-exposure case study data will be used to estimate overall campaign impact.