CHAPTER 1

Preventing and Reducing Underage Drinking: An Overview

This document is excerpted from:
The 2013 Report to Congress on the Prevention and Reduction of Underage Drinking
submitted to Congress by The U.S. Department of Health and Human Services.

To obtain more information and a copy of the full Report to Congress go to:
https://www.stopalcoholabuse.gov

Introduction

Alcohol remains the most widely used substance of abuse among America's youth. According to the Substance Abuse and Mental Health Services Administration (SAMHSA) through a special analysis based on 2011 data, a higher percentage of youth who are 12 to 20 years old used alcohol in the past month (25.1 percent) than tobacco (19.6 percent) or illicit drugs (14.9 percent) (SAMHSA, 2012). The extent of alcohol consumption by those younger than the legal drinking age of 21 constitutes a serious threat to both public health and public safety. In response, governments at the federal, state, and local levels have sought to develop effective approaches to reduce underage drinking and its associated costs and consequences. The actions of government alone, however, cannot solve this serious problem. Only a broad, committed collaboration among governments, parents of underage youth, other adults, caregivers (people who provide services to youth, such as teachers, coaches, health and mental health care providers, human services workers, and juvenile justice workers), prevention professionals, youth, and private-sector organizations and institutions can reach an effective solution to this national challenge.

Underage drinking is a complex and challenging social problem that has defied an easy solution. Although selling alcohol to youth under age 21 is illegal in all 50 states and the District of Columbia, some states make it legal to provide (but not sell) alcohol to youth under special circumstances, such as at religious ceremonies, in private residences, or in the presence of a parent or guardian. Despite such broad restrictions, underage youth find it relatively easy to acquire alcohol, often from adults. Alcohol use often begins at a young age; the average age of first use for youths who initiated before age 21 is about 15.9 years old, and 10 percent of 9- to 10-year-olds have already started drinking (Donovan et al., 2004). Alcohol use increases with each additional year of age, and by age 20, more than half (55.3 percent) of youths report having had one or more drinks in the past 30 days (SAMHSA, 2012a). Underage drinkers are much more likely than adults to drink heavily and recklessly. Studies consistently indicate that about 80 percent of college students—of whom 48 percent are underage—drink alcohol, and about 40 percent of all college students engage in binge drinking (i.e., when men consume five or more drinks in a row and women consume four or more drinks in a row (National Institute on Alcohol Abuse and Alcoholism [NIAAA], 2002a)).[6]

Scientific research over the past decade has broadened our understanding of the ways and extent to which underage alcohol use threatens the immediate and long-term development, well-being, and future mental development of young people. Alcohol is a leading contributor to fatal injuries, a major cause of death for people younger than 21. The potential consequences of underage drinking include alcohol-related traffic crashes and fatalities, other unintentional injuries such as burns and drowning, increased risk of suicide and homicide, physical and sexual assault, academic and social problems, inappropriate and/or risky sexual activity, and adverse effects on the developing brain (NIAAA, 2005a). The consequences of underage alcohol use

[6] Binge drinking is the consumption of a large amount of alcohol over a relatively short period of time. No common terminology has been established to describe different drinking patterns. Based on National Survey on Drug Use and Health (NSDUH) data, SAMHSA defines "binge drinking" as five or more drinks on one occasion on at least 1 day in the past 30 days and "heavy drinking" as five or more drinks on at least 5 different days in the past 30 days. However, NSDUH can provide binge-drinking estimates based on the NIAAA gender-specific definition. Some studies, including Wechsler's (2002) survey of college students, define "binge drinking" as five or more drinks in a row for men and four or more for women. Other sources use "frequent heavy drinking" to refer to five or more drinks on at least five occasions in the last 30 days. Appendix A discusses these differences in more detail. See Courtney and Polich (2009) for further discussion of the definition issues.

extend beyond underage drinkers: society also pays. For example, in 2010, 50 percent of all deaths in traffic crashes involving a 15- to 20-year-old driver with a blood alcohol concentration (BAC) of .08 or higher were people other than the drinking driver (National Center for Statistics and Analysis, National Highway Traffic Safety Administration [NHTSA] Fatality Analysis Reporting System [FARS], 2010). In 2006, almost $27 billion (about 12 percent) of the total $223.5 billion economic costs of excessive alcohol consumption were related to underage drinking (Bouchery, Harwood, Sacks, Simon, & Brewer, 2011).

As noted below, the problems associated with college drinking include sexual assault or date rape, violent crime on college campuses, and academic consequences including missing class, falling behind, doing poorly on exams or papers, and receiving lower grades overall. Campus alcohol use also affects the academic performance of nondrinkers by contributing to a noisy and disruptive environment that is not conducive to studying.

The National Effort To Reduce Underage Drinking

Underage drinking has been recognized as a public health problem for many years. Recently, however, the national effort to prevent alcohol use by America's young people has intensified as the multifaceted consequences associated with underage drinking have become more apparent.

After Prohibition ended in 1933, states assumed authority for alcohol control, including the enactment of laws restricting youth access to alcohol. The majority of states designated 21 as the minimum legal drinking age (MLDA) for the "purchase or public possession" of alcohol. Beyond setting a minimum drinking age, the nation's alcohol problems were largely ignored through the 1960s (NIAAA, 2005b). However, 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 MLDAs 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 (Cucchiaro, Ferreira, & Sicherman, 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 MLDAs between 1976 and 1984, although to different minimum ages. Some placed restrictions on the types of alcohol that could be consumed by persons younger than 21. Only 22 states set an MLDA of 21 years old. In response, the federal government enacted the National Minimum Drinking Age Act of 1984, which mandated reduced federal highway funds to states that did not raise their MLDAs to 21. By 1987, all remaining states had raised their MLDAs to 21 in response to the federal legislation.

In 1992, Congress created 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' Office of Juvenile Justice and Delinquency Prevention (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 that report in 2004. Since then, a number of programs aimed at preventing and reducing underage drinking have been initiated at the federal, state, and local levels. Chapter 3 describes major programs at the federal level; Chapter 4 describes initiatives at the state level.

The conference report accompanying H.R. 2673, the "Consolidated Appropriations Act of 2004," directed the Secretary of the U.S. Department of Health and Human Services (HHS) to establish the Interagency Coordinating Committee on the Prevention of Underage Drinking (ICCPUD) 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 includes representatives from HHS's Office of the Surgeon General (OSG), Centers for Disease Control and Prevention (CDC), Administration for Children and Families (ACF), Office of the Assistant Secretary for Planning and Evaluation (ASPE), and National Institutes of Health (NIH), including NIAAA and NIDA; Department of Justice, Office of Juvenile Justice and Delinquency Prevention (OJJDP); Office of Safe and Healthy Students (OSHS); Department of Transportation, National Highway Traffic Safety Administration (NHTSA); White House Office of National Drug Control Policy (ONDCP); Department of the Treasury; Department of Defense; and Federal Trade Commission (FTC).

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*, which Congress called for 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.

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 STOP Act also calls for two annual reports:

1. A report to Congress from the HHS Secretary (the "Annual Report to Congress") that includes:
   - A description of all programs and policies of federal agencies 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 FTC.
- Surveillance data, including information about the onset and prevalence of underage drinking, consumption patterns, and the means of underage access, and certain other data included in the report.
- Such other information regarding underage drinking as the Secretary determines to be appropriate.

2. A report on state underage drinking-prevention and enforcement activities (the "State Report") that includes:
   - A set of measures to be used in preparing the report on best practices.
   - Categories of underage-drinking-prevention policies, enforcement practices, and programs (see Chapter 4 for list of specific categories).
   - Additional information on state efforts or programs not specifically included in the Act.

Chapters 1 through 3 of this document constitute the Annual Report to Congress; Chapter 4 constitutes the State Report. Together, they fulfill the STOP Act mandate and are designed to build on the efforts that precede it. For example, the State Report provides the second wave of data for a substantial new resource for state and local coalitions and policymakers. It reports on comprehensive assessments of state underage drinking laws, policies, and programs, including individual state reports. This is critical information for states as a foundation for enhancing their underage drinking prevention efforts.

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. In 2007, *The Surgeon General's Call to Action to Prevent and Reduce Underage Drinking* (HHS, 2007) (henceforth termed *Call to Action*), the first on that subject, was issued. Based on the latest and most authoritative research, particularly on underage drinking as a developmental issue, the *Call to Action* outlines a comprehensive national effort to prevent and reduce underage alcohol consumption. It includes six goals and describes the rationale, challenges, and strategies of each goal, including specific actions for parents and other caregivers, communities, schools, colleges and universities, the criminal and juvenile justice systems, law enforcement, the alcohol industry, and the entertainment and media industries.

ICCPUD agencies collaborated to provide information and data for the *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 persons younger than 2 years
3. Using research, evaluation, and scientific surveillance to improve the effectiveness of policies and programs designed to prevent and reduce underage drinking

The six specific goals and associated strategies in the *Call to Action* for the nation build on these three general goals.

As the nation's leading medical spokesperson, the Surgeon General is in a unique position to call attention to national health problems. By issuing the *Call to Action,* the Surgeon General has sought to raise public awareness and foster changes in American society—goals similar to those described to Congress in the Comprehensive Plan. The *Call to Action* has incorporated—and, therefore, superseded—the Comprehensive Plan.

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

Principles and Goals of the *Call to Action*

The national effort to prevent and reduce underage drinking outlined in the *Call to Action* is based on the following principles from which its goals were derived:

- *Underage alcohol use is a phenomenon directly related to human development.* Because of the nature of adolescence, alcohol poses a powerful attraction to adolescents and can have unpredictable outcomes that put every child at risk.
- *Factors that protect adolescents from alcohol use, as well as put them at greater risk, change during the course of adolescence.* Individual characteristics, developmental issues, and shifting factors in adolescents' environments all play a role.
- *Protecting adolescents from alcohol use requires a comprehensive, developmentally based approach* that is initiated prior to puberty and continues throughout adolescence with support from families, schools, colleges, communities, the health care system, and government.
- *Prevention and reduction of underage drinking is the collective responsibility of the nation.* "Scaffolding the Nation's youth"[7] is the responsibility of all people in all of the social systems with which adolescents interact: family, schools, communities, health care systems, religious institutions, criminal and juvenile justice systems, all levels of government, and society as a whole. Each social system has a potential effect on the adolescent, and the active involvement of all systems is necessary to fully maximize existing resources to prevent underage drinking and its related problems. When all of the social systems work together toward the common goal of preventing and reducing underage drinking, they create a powerful synergy that is critical to realizing the vision.
- *Underage alcohol use is not inevitable, and parents and society are not helpless to prevent it.* The *Call to Action* proposes a vision for the future wherein each child is free to develop to his or her potential without the impairment of alcohol's negative consequences. The fulfillment of

[7] Scaffolding the nation's youth is the Surgeon General's term for a structured process through which parents and society facilitate positive adolescent development and minimize risk by protecting against adolescents' natural risk-taking, sensation-seeking tendencies. It is a fitting metaphor for the support and protection that parents and society provide children and youth to help them function in a more mature way until they are ready to function without that extra support. This external support system—or scaffold—around the adolescent promotes healthy development and protects against alcohol use and other risky behaviors by facilitating good decisionmaking, mitigating risk factors, and buffering potentially destructive outside influences that draw adolescents to use alcohol.

that vision rests on the achievement of six goals that the *Call to Action* sets for the nation, listed below.

Goal 1: Foster changes in American society that facilitate healthy adolescent development and help prevent and reduce underage drinking.

Goal 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.

Goal 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.

Goal 4: Conduct additional research on adolescent alcohol use and its relationship to development.

Goal 5: Work to improve public health surveillance on underage drinking and on population-based risk factors for this behavior.

Goal 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 health care system, juvenile justice and law enforcement, and the alcohol and entertainment industries are included in the full *Call to Action*, which is available at http://www.surgeongeneral.gov/topics/underagedrinking/calltoaction.pdf.

Best Practices for Prevention of Underage Drinking among College Students

Introduction: Extent of the Problem

As noted in Chapter 2, overall rates of college student drinking and binge drinking exceed those of their age peers who do not attend college (Johnston et al., 2012b). Of college students, 80.5 percent drink and 36.1 percent report drinking five or more drinks on an occasion in the past 2 weeks. Research indicates that some college students' drinking far exceeds the minimum binge criterion of five drinks per occasion (Wechsler et al., 1999; White, Kraus, & Swartzwelder, 2006). Underage college students consume about 48 percent of the alcohol consumed by students at 4-year colleges (Wechsler, Lee, Nelson, & Kuo, 2002; Wechsler & Nelson, 2008).

As further described in Chapter 2, the rates of alcohol consumption on college campuses constitute a significant public health problem. Abbey (2011) notes that approximately half of all reported and unreported college sexual assaults involve alcohol consumption by the perpetrator, victim, or both. Estimates of perpetrators' intoxication during the incident ranged from 30 to 75 percent. Alcohol use is also involved in a large percentage of violent crime on college campuses (Commission on Substance Abuse at Colleges and Universities, 1994). Approximately 25 percent of college students report academic consequences resulting from their drinking, including missing class, falling behind, doing poorly on exams or papers, and receiving lower

grades overall. Campus alcohol use also affects the academic performance of nondrinkers by contributing to a noisy and disruptive environment that is not conducive to study.

In its 2002 report, *A Call to Action: Changing the Culture of Drinking at U.S. Colleges*, NIAAA noted the following, which remains the case 10 years later:

> 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 alcohol is a necessary ingredient for social success. These beliefs and the expectations they engender exert a powerful influence over students' behavior toward alcohol.[8]

College Drinking Prevention Best Practices

In 1998, NIAAA convened its Task Force on College Drinking, composed of college presidents, students, and alcohol research experts on college drinking. During a 3-year research and outreach project, the Task Force produced a landmark report, *A Call to Action: Changing the Culture of Drinking at U.S. Colleges,* which highlighted the magnitude of the problem and made specific recommendations for addressing the problem based on existing research evidence.

The Task Force encouraged school administrators to address college drinking issues in a broad and comprehensive fashion. The report recommended that schools use a "3 in 1 Framework" to develop comprehensive programs that integrate multiple complementary strategies. Such programs focus simultaneously on (1) individuals, including at-risk or alcohol-dependent drinkers; (2) the student population as a whole; and (3) the college and surrounding community. Specific recommendations were grouped into four tiers based on the degree of research evidence to support or refute them. At the time, the strongest research evidence showing effectiveness among college students supported strategies that targeted individual students. A number of environmental strategies showed evidence of effectiveness with similar populations, whereas other strategies were listed as either promising or ineffective. Exhibit 1.1 outlines the strategies examined by the NIAAA Task Force, grouped according to the supporting evidence for them and the levels at which they operate.

Since the Task Force report was issued in 2002, research on college drinking has continued to yield important information about the potential effectiveness of these and additional intervention strategies. In 2007, after an updated review of the college intervention literature, NIAAA issued "What Colleges Need to Know Now: An Update on College Drinking Research." Current research confirms that interventions targeting individual students, including those at risk for alcohol problems, are effective. In addition, research now more clearly supports the use of environmental interventions, particularly campus–community partnerships, as part of a comprehensive program to address harmful college drinking.

[8] 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 et al., 1994, 1995, 1999; Presley et al., 1996a,b).

Exhibit 1.1: 3-in-1 Framework

3-IN-1 FRAMEWORK				
Tier	Strategy	Level of Operation		
		Individuals, including At-Risk and Dependent Drinkers	Student Population as Whole	Community
1: Effective among college students	Combining cognitive-behavioral skills with norms clarification & motivational enhancement intervention	Yes	No	No
	Offering brief motivational enhancement interventions in student health centers and emergency rooms	Yes	No	No
	Challenging alcohol expectancies	Yes	No	No
2: Effective with general populations	Increased enforcement of minimum drinking age laws	No	Yes	Yes
	Implementation, increased publicity, and enforcement of other laws to reduce alcohol-impaired driving	No	Yes	Yes
	Restrictions on alcohol retail density	No	No	Yes
	Increased price and excise taxes on alcoholic beverages	No	No	Yes
	Responsible beverage service policies in social & commercial settings	No	Yes	Yes
	The formation of a campus/community coalition	No	Yes	Yes
3: Promising	Adopting campus-based policies to reduce high-risk use (e.g., reinstating Friday classes, eliminating keg parties, establishing alcohol-free activities & dorms)	No	Yes	No
	Increasing enforcement at campus-based events that promote excessive drinking	No	Yes	No
	Increasing publicity about enforcement of underage drinking laws/eliminating "mixed" messages	No	Yes	Yes
	Consistently enforcing disciplinary actions associated with policy violations	No	Yes	No
	Conducting marketing campaigns to correct student misperceptions about alcohol use on campus	No	Yes	No
	Provision of "safe rides" programs	No	Yes	Yes
	Regulation of happy hours and sales	No	Yes	Yes
	Enhancing awareness of personal liability	Yes	Yes	No
	Informing new students and parents about alcohol policies and penalties	Yes	Yes	No
4: Ineffective	Informational, knowledge-based or values clarification interventions when used alone	N/A	N/A	N/A

The *Call to Action* also provided best practices recommendations for college drinking prevention, including fostering a culture in which alcohol does not play a central role in college life or the college experience. About a quarter of the recommendations of the *Call to Action* specifically overlap the 3-in-1 framework. The *Call to Action* also recommends:

- Providing frequent alcohol-free late-night events, extending hours of student centers and athletics facilities, and increasing public service opportunities.
- Offering alcohol-free dormitories that promote healthy lifestyles.
- Restricting or eliminating alcohol sales at concerts and at athletic and other campus events.
- Reinstating Friday classes to shorten the extended weekend.

The Community Preventive Services Task Force (2010) and the Institute of Medicine (*Reducing Underage Drinking: A Collective Responsibility*, 2004), although not specifically focused on college drinking, both support the 3-in-1 framework strategies of aggressive enforcement of underage drinking laws, increasing alcohol prices, and excise tax. Exhibit 4.1.1, "Underage Drinking Prevention Policies – Best Practices," presented in Chapter 4.1 lists additional policies that may contribute to a reduction in college drinking, especially drinking that occurs in the surrounding community. The policies include dram shop and social host liability, bans on direct sales (internet/mail order); keg registration; minimum age for servers, sellers, and bartenders; internal possession laws; and restrictions on alcohol advertising. Much of this information is still very helpful today.

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. A few recent highlights follow:

1. At the individual level, screening and brief intervention in the college student health center can be effective in reducing high-risk drinking and alcohol-related consequences (Schaus et al., 2009; Fleming et al., 2010).
2. At the environmental level, a large-scale trial showed the effectiveness of community–college partnerships in reducing alcohol problems in off-campus settings through heavily publicized and highly visible alcohol policy and enforcement activities (Saltz, Paschall, McGaffigan, & Nygaard, 2010).
3. An online alcohol education course for incoming freshmen showed benefits through the first semester in reducing binge drinking and alcohol-related problems (Paschall, Antin, Ringwalt, & Saltz, 2011).

These results reinforce the findings in the 2002 *Call to Action* and the 2007 Update of College Drinking Research, that intervening with problem drinking and its associated consequences can occur at different levels and times during college, and that implementing a combination of interventions may be especially helpful.

Moving Forward—The NIAAA Matrix Tool

NIAAA-supported research has resulted in evidence-based practices that can be used to address harmful drinking and related consequences on college campuses, several of which are mentioned above. To foster the implementation of these strategies, NIAAA convened a new College Presidents Working Group in 2011. Its goals are to bring renewed, vigorous national attention to college drinking; encourage the translation of college prevention research findings into practice; and provide a platform for sharing and disseminating evidence-based information. In FY 2012, NIAAA continued to work with the group of 11 college presidents first convened in FY 2011. Among the many practical recommendations the presidents made to NIAAA, one stood out: the need for a clear, easy-to-understand tool to help them evaluate and select interventions that are effective, best fit their schools, and feasible to implement. In response, NIAAA is developing a matrix-based decision tool that organizes what is known about college drinking interventions by important parameters such as the strength of the research evidence and ease of implementation. NIAAA enlisted a team of six college drinking research experts to develop the matrix. Next, 10 additional scientific experts reviewed the draft matrix. Their comments were collated and shared

with the developers, who have revised the matrix in response. The matrix will form the centerpiece of a guide for college administrators on intervening to prevent harmful drinking on campus. A searchable online decision tool is envisioned as well.

College Learning Collaborative on High-Risk Drinking

The National College Health Improvement Project (NCHIP) was founded in 2010 by Dr. Jim Yong Kim, then President of Dartmouth College. Its mission is to improve the health of college students through the application of population health solutions coupled with a quality improvement framework in bringing evidence into practice and measuring outcomes.

In February 2011, NCHIP convened a panel of experts on drinking to discuss the current evidence on how to best address the problem, along with the measurement strategies that could be used to track outcomes and effectiveness of campus efforts. Two months later, NCHIP formally launched the Learning Collaborative on High-Risk Drinking.

Membership in the initiative totals 32 institutions. Each participating school has a campus improvement team with multidisciplinary representation, including students, administrators, health services and health promotion professionals, student affairs staff members, faculty members, and other key stakeholders. The collaborative is a 24-month-long process devoted to implementing policies and programs to reduce college high-risk drinking and its associated harms using measurement-based improvement. The goal is to discover what works well, how, and why, and to broadly disseminate these findings so that others can adapt and replicate them on their campuses.

The collaborative used the Institute for Healthcare Improvement's Breakthrough Series framework as the foundation for testing and implementing harm prevention strategies across participating institutions. The framework relies on rapid-cycle tests of change in adapting and implementing existing evidence across multiple settings to accomplish a common aim. Developed in the early 1990s, the Breakthrough Series has been shown effective in many clinical and public health settings.

The following infrastructure supports the work of the 32 schools and universities involved in the collaborative.

- ***Learning sessions:*** Three face-to-face learning sessions were held (June 2011, January 2012, and July 2012). Each focused on a specific domain: individual drinker, campus environment, and the larger system. Prior to the sessions, teams collected and analyzed data relative to these domains, and prepared storyboards on initiatives targeting these areas on their individual campuses. The sessions enabled participants to share their knowledge and work results on reducing high-risk drinking and its associated harms.
- ***Action periods:*** Between each learning session, teams tested and implemented new initiatives and interventions while concurrently measuring outcomes and relevant processes. The NCHIP Leadership Team, composed of measurement and quality improvement experts and nationally recognized experts on high-risk drinking, facilitated this process through virtual meetings, monthly conference calls, and review and analysis of team online reporting of progress and measures.

- ***Summative Congress and Dissemination:*** A Summative Congress held in June 2013 synthesized and summarized results of the 2-year collaborative, and discussed sustainability of gains over the long term and possible research opportunities emanating from this work. The collaborative expects to publish its findings and add to the body of knowledge about high-risk drinking on college campuses.

Conclusion

Research on college drinking prevention is ongoing, as is innovation on campuses across the country. Evidence supporting college-specific best practices is growing, and practices known to be effective with the general population of youth are being tested in college settings. The College Learning Collaborative on High-Risk Drinking may represent a step forward in the commitment of colleges and universities to address underage drinking on their campuses. It also suggests a new effort to develop effective collaboration among college campuses, federal agencies, and researchers. If so, there is reason for optimism.

Federal and State Actions Regarding Caffeinated Alcoholic Beverages

Caffeinated alcoholic beverages (CABs) are premixed beverages that combine alcohol, caffeine, and other stimulants. Research suggests that including caffeine in such beverages poses public health and safety risks because the caffeine can mask the depressant effects of alcohol without changing alcohol's intoxicating properties (http://www.cdc.gov/alcohol/fact-sheets/cab.htm). This could lead some to believe they are more capable of operating a vehicle and presents other risks such as encouraging binge drinking, particularly among young drinkers.

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 in 2007. In 2008, those companies agreed to remove caffeine and other stimulants from their products. In 2009, the Federal Drug Administration (FDA) initiated an investigation into the marketing and distribution of other caffeinated malt-based alcoholic beverages and, on November 17, 2010, issued warning letters to four companies that the caffeine added to their alcoholic malt beverages is an "unsafe food additive." The letters stated that further action, including seizure of their products, was possible under federal law.[9] In response, the four companies ceased using added caffeine in their products, and, by summer 2011, it appeared that, with few if any exceptions, malt-based beverages with added caffeine were no longer available in the United States.[10]

In parallel with the federal actions against caffeinated alcoholic beverages, 9 states enacted statutory or administrative bans on such beverages, and 21 states considered such bans.

[9] See http://www.fda.gov/ForConsumers/ConsumerUpdates/ucm233987.htm#2. The FDA investigation and warning letters involved companies that produce 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).

[10] 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 (http://www.stopalcoholabuse.gov/media/ReportToCongress/2012/report_main/report_to_congress_2012.pdf), Appendix E.

Extent of Progress

The STOP Act requires the HHS Secretary to report to Congress on "the extent of progress in preventing and reducing underage drinking nationally." An examination of trend data reported in federally sponsored surveys suggests that meaningful progress is being made in reducing the extent of underage drinking. It is generally inadvisable to draw conclusions based on changes from one year to the next because of natural fluctuations. Examining trends over a multiyear period is much more informative. The following exhibits provide estimates of past-year alcohol use from 2004 through 2011 based on NSDUH data.[11] All age groups showed a statistically significant decline in both past-month alcohol use and binge alcohol use in 2011 compared with 2004.

As shown in the last column in Exhibits 1.2 and 1.3, 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 percent change among 12- to 20-year-olds compared with 12- to 17-year olds. As shown in Exhibit 1.4, there was a statistically significant increase in average age at first use over the same time period (SAMHSA, CBHSQ, NSDUH, Special Data Analysis, 2012).

Exhibit 1.2: Past-Month Alcohol Use for 12- to 20-Year-Olds, 2004–2011

Age	2004	2005	2006	2007	2008	2009	2010	2011	% Change 2004 to 2011
12-13	4.3%	4.2%	3.9%	3.5%*	3.4%*	3.5%*	3.2%*	2.5%*	-41.9%
14-15	16.4%	15.1%	15.6%	14.7%*	13.3%*	13.1%*	12.4%*	11.3%*	-31.1%
16-17	32.5%	30.1%*	29.8%*	29.2%*	26.3%*	26.5%*	24.6%*	25.3%*	-22.2%
18-20	51.1%	51.1%	51.6%	50.8%	48.6%*	49.5%	48.5%*	46.8%*	-8.4%
12-17	17.6%	16.5%*	16.7%*	16.0%*	14.7%*	14.8%*	13.6%*	13.3%*	-24.4%
12-20	28.7%	28.2%	28.4%	28.0%	26.5%*	27.2%*	26.2%*	25.1%*	-12.5%

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

Exhibit 1.3: Past-Month Binge Alcohol Use for 12- to 20-Year-Olds, 2004–2011

Age	2004	2005	2006	2007	2008	2009	2010	2011	% Change 2004 - 2011
12-13	2.0%	2.0%	1.5%	1.5%	1.5%	1.6%	1.0%*	1.1%*	-45.0%
14-15	9.1%	8.0%	9.0%	7.8%*	7.0%*	7.0%*	6.7%*	5.7%*	-37.4%
16-17	22.4%	19.7%*	20.1%*	19.5%*	17.2%*	17.1%*	15.3%*	15.0%*	-33.0%
18-20	36.8%	36.1%	36.2%	35.9%	33.9%*	34.9%	33.1%*	31.2%*	-15.2%
12-17	11.1%	9.9%*	10.3%	9.7%*	8.9%*	8.9%*	7.9%*	7.4%*	-33.3%
12-20	19.6%	18.8%	19.0%	18.7%	17.5%*	18.2%*	16.9%*	15.8%* †	-19.4%

*Difference between 2004 estimate and this estimate is statistically significant at the 0.05 level.
†Difference between 2010 and 2011 estimate is statistically significant at the 0.05 level.

[11] The 2006–2010 estimates are based on data files revised in March 2012.

Exhibit 1.4: Average Age at First Use among Past-Year Initiates of Alcohol Use Who Initiated Before Age 21, 2004–2011

Year	2004	2005	2006	2007	2008	2009	2010	2011
Average Age at First Use	15.6	15.6	15.8*	15.8*	15.8*	15.9*	16.0*	15.9*

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

Data from the Monitoring the Future (MTF) survey and Youth Risk Behavior Survey (YRBS) also suggest positive movement.[12] This alignment within and across surveys, even without statistical significance across all three surveys, is a good sign.

These data demonstrate that meaningful progress has been made in reducing underage drinking prevalence. The factors that have contributed to this progress are varied and complex. However, one clear factor 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.

Nevertheless, the 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, comprehensive approach to preventing and reducing underage drinking. This report, with its yearly updates to the State Report and survey responses, is part of that sustained effort to reduce underage drinking in America.

[12] Please note for comparability with the 2011 NSDUH and 2011 YRBS data, the latest MTF data included in the report are also from 2011. The 2012 MTF data, which became available in December 2012, will be included in the next report.