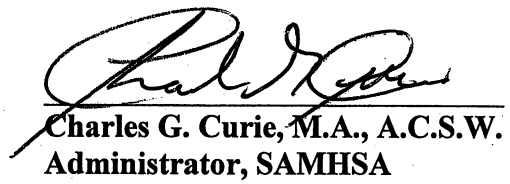
U. S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

Substance Abuse and Mental Health Services Administration

# A Comprehensive Plan for Preventing and Reducing Underage Drinking



Charles G. Curie, M.A., A.C.S.W.
Administrator, SAMHSA
January 2006

# MESSAGE FROM THE SECRETARY

The personal tragedies, social consequences, and economic costs associated with underage alcohol consumption in the United States are unacceptably high. Scientific research from the past few years indicates the potential for brain impairment in young adolescents, a discovery that adds to the long litany of adverse consequences of underage drinking that burden youth, their parents, and the Nation.

As this report to Congress makes clear, the Federal Government is deeply involved in the effort to prevent and reduce underage drinking. Nevertheless, underage drinking has remained a serious and persistent problem. We owe it to America's youth to mount a greater, more sustained effort to protect them from the consequences and potential consequences of alcohol consumption. By "we," I mean more than this Department or the Federal Government. A national commitment to preventing and reducing underage drinking will require the involvement of all of us in government, those in the private sector, parents of underage youth who still exercise significant influence over their adolescent's decisions to drink, and other adults who, in the final analysis, are the greatest source of alcohol for underage drinkers.

The Nation cannot afford to underestimate the seriousness of the problem of underage alcohol consumption and its consequences. This report to Congress provides an analysis of where we are on this critical issue and where we want to be. It takes advantage of the latest scientific data available and is based on input from some of the brightest minds in the country who have devoted their lives and service to preventing and reducing underage drinking. The report is both reassuring and alarming, a testament to what has been accomplished and a vision of what can be. The central themes that appear from all the research and all the analyses are these: underage drinking is dangerous for youth and society, and nothing short of a national commitment to preventing and reducing underage drinking through increasing public awareness; reducing youthful demand, availability, and access to alcohol; and rigorous research will succeed.

As Secretary of Health and Human Services, I applaud the Congress for its concern, and commit the Department and its agencies to the prevention and reduction of underage alcohol use. The targets we have set to monitor the Nation's progress in this area are realistic, but cannot be accomplished without the involvement of the public and private sectors and individuals throughout America who recognize the threat that underage drinking poses to America's youth as well as their own responsibility as adults and citizens to work with the young in preventing and reducing it.

Michael O. Leavitt
Secretary
Health and Human Services

## FOREWORD

No substance of abuse is more widely used in America by persons under the age of 21 than alcohol. The wide-spread prevalence of underage drinking and the negative consequences it creates for youth, their families, communities, and society as a whole remains a stubborn and destructive problem despite decades of efforts to combat it. This report to the Congress of the United States describes a comprehensive plan for preventing and reducing underage alcohol consumption and its associated human, social, and economic costs.

In response to Congressional concern about underage drinking and at the request of the Secretary of Health and Human Services, I was privileged to convene the Interagency Coordinating Committee on the Prevention of Underage Drinking (ICCPUD). The Committee is made up of representatives from the Office of the Surgeon General, the Centers for Disease Control and Prevention, the Administration for Children and Families, the Office of the Assistant Secretary for Planning and Evaluation, the National Institutes of Health/National Institute on Alcohol Abuse and Alcoholism, the Department of Justice/Office of Juvenile Justice and Delinquency Prevention, the Department of Education/Office of Safe and Drug Free Schools, the Department of Transportation/National Highway Traffic Safety Administration, the Office of National Drug Control Policy, the Department of the Treasury, the Department of Defense, and, *ex officio*, the Federal Trade Commission. Members of ICCPUD developed the comprehensive Plan for addressing underage drinking described in this report. That Plan represents the contributions of agencies across the government as well as input from distinguished experts and a variety of parties interested in this vital issue.

Much is being done to prevent and reduce underage drinking in America, as the Plan makes clear. However, more can be accomplished, as described in this report, the first of a series of annual reports on underage alcohol consumption and its adverse consequences. An enhanced leadership role at the Federal level and improved inter-agency collaboration and coordination are hallmarks of the Plan. By establishing national goals, providing specific recommendations, and setting targets, the Plan will make it possible to track America's progress in solving this serious, persistent, and challenging problem.

For America to succeed in preventing and reducing underage drinking, each of us must play a part. The ultimate responsibility for strengthening a national commitment to prevent and reduce underage drinking falls on all levels of government, on communities throughout America, and on parents, other adults, and, finally, on those under the age of 21 who make the decision to drink or not to drink. SAMHSA is dedicated to coordinating Federal leadership in the national collaborative effort envisioned in the comprehensive Plan to effectively address this threat to the public's health and safety.

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# A COMPREHENSIVE PLAN FOR PREVENTING AND REDUCING UNDERAGE DRINKING

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# EXECUTIVE SUMMARY

Alcohol is the most widely used substance of abuse among America's youth. A higher percentage of youth aged 12 to 20 use alcohol (29%) than use tobacco (24%) or illicit drugs (14%), making underage drinking a leading public health problem in the United States (SAMHSA, 2005). It is illegal in all fifty States to sell alcohol to youth under the age of 21; however, in some States it may be legally provided to youth in special circumstances such as religious ceremonies, in private residences, or in the presence of a parent or guardian. Nevertheless underage youth find it relatively easy to acquire alcohol, often from adults (Wagenaar et al., 1996). Underage drinking has proven to be a complex, persistent social problem that has resisted an easy solution even as new research over the past decade has increased our understanding of how underage alcohol use threatens the immediate and long-term well being of the individual and others.

## THE SCOPE OF THE PROBLEM OF UNDERAGE ALCOHOL USE IN AMERICA

The problem of underage alcohol use in America is extensive and daunting. Data from the major national surveys conducted by the Federal Government as well as from other sources reveal the following characteristics of underage drinking in America:

1. Underage Alcohol Use is Widespread
   Underage alcohol use in America is a widespread and serious problem as evidenced by the following data:
   - The 2004 National Survey on Drug Use and Health (NSDUH) reported that approximately 29% of Americans aged 12 through 20 (or about 10.8 million minors) reported drinking alcohol in the month prior to the survey.[1] These figures were essentially unchanged from the 2002 and 2003 survey.
   - Data from the 2005 Monitoring the Future (MTF) survey of U.S. youth show that 75.1% of 12$^{th}$ graders, 63.2% of 10$^{th}$ graders, and 41.0% of 8$^{th}$ graders have consumed alcohol at some point in their lives (Johnston et al., 2005a).
   - According to data from the 2004 NSDUH, 5.6% of 14-year-olds, 18.3% of 16-year-olds, 33.1% of 18-year-olds, and 40.3% of 20-year-olds had engaged in binge drinking within the past 30 days. (SAMHSA, 2004).[2]
   - Data from the 2004 NSDUH survey show that 4.5% of 16-year-olds, 11.0% of 18-year-olds, and 16.3% of 20-year-olds had engaged in heavy alcohol consumption within the past 30 days.[3]
   - According to 2005 data from the MTF survey, 57.5% of 12$^{th}$ graders, 42.1 % of 10$^{th}$ graders, and 19.5% of 8$^{th}$ graders reported having been drunk at least once in their lives (Johnston et al., 2005a).

[1] At least one drink in the past 30 days (includes binge and heavy use).
[2] Binge alcohol use is defined as drinking five or more drinks on the same occasion (i.e., at the same time or within a couple of hours of each other) on at least 1 day in the past 30 days.
[3] Heavy alcohol use is defined as drinking five or more drinks on the same occasion on each of 5 or more days in the past 30 days; all heavy alcohol users are also binge alcohol users.

- Data from the MTF survey for 2005 indicates that 30.2% of 12th graders, 17.6% of 10th graders, and 6.0% of 8th graders reported having been drunk in the past month. (Johnston et al., 2005a).

2. Youth Start Drinking at an Early Age
   Studies show that drinking often begins at very young ages.[4] Data from recent surveys indicate that approximately:

   - Ten percent of 9-10 year olds have already started drinking (Donovan et al., 2004).
   - Nearly one-third of underage drinkers begin before age 13 (Grunbaum, 2002).
   - The peak years of initiation are 7th through 11th grades, based on data from high school seniors (Johnston et al., 2005a).

   Youths who report drinking prior to the age of 15 are more likely to develop substance abuse problems, to engage in risky sexual behavior, and to experience other negative consequences in comparison to those who begin at a later time. The age of onset of drinking, therefore, is a marker for future problems, including heavier use of alcohol and other drugs during adolescence (e.g., Robins and Przybeck, 1985; Hawkins et *al*., 1997) and the development of an alcohol dependence diagnosis in adulthood (Grant & Dawson, 1998). Delaying the age of onset of first alcohol use as long as possible can ameliorate some of the negative consequences associated with underage alcohol consumption. Therefore, whether underage drinkers are starting at younger or older ages over a given period of years is a matter of concern.

3. Among Underage Drinkers, Alcohol Use and Binge Drinking Increase with Age
   The 2004 NSDUH reports that underage alcohol consumption increased in a steady progression from 2.3% at age 12 to 56.3% at age 20. Alcohol use peaks at 70% for 21-year-olds. Rates of binge alcohol use increased steadily from 1.1% at age 12 to 40.3% at age 20. The rate of binge drinking peaked at age 21 (48.2%) and then decreased beyond young adulthood (SAMHSA, 2005).

4. Youth Binge More and Drink More Than Adults When They Drink
   Young people who drink tend to drink less often than adults, but they drink more heavily when they do drink. Underage drinkers consume on average about 5 drinks per occasion, about 6 times a month (SAMHSA, 2003). By comparison, adult drinkers 21 and older consume on average about 3 drinks per occasion, about 9 times a month (SAMHSA, 2005). Studies consistently indicate that about 40% of all college students engage in episodic heavy consumption. In 2005, 10.5% of 8th graders, 21.0% of 10th graders, and 28.1% of 12th graders reported engaging in heavy episodic drinking (Johnston et al., 2005a).

[4] "Age of first use," means the age at which drinking begins. Drinking is defined as the consumption of at least one drink (e.g., a bottle of beer, glass of wine, shot of liquor, or mixed drink) rather than having had "a sip or two from a drink."

5. Underage Drinking is Different According to Gender, Race, and Ethnicity
   Underage males report more alcohol use during the past month than underage females. They also tend to start drinking at an earlier age, drink more frequently, and are more likely to binge drink than females. Whites aged 12 to 20 were more likely to report current use of alcohol in 2004 than any other racial or ethnic group. An estimated 32.6% of whites reported past month use, whereas the rates were 24.3% for American Indians and Alaska Natives, 26.6% for Hispanics, 16.4% for Asians, and 19.1% for blacks (SAMHSA, 2005). While fewer Hispanics and blacks report current drinking, data from the Youth Risk Behavior Survey (YRBS) also suggest that the prevalence of alcohol use before the age of 13 is greater among black (31.2%) and Hispanic (30.2%) students than among white (25.7%) students (YRBS, 2004).

6. Alcohol Use in College is Pervasive and Heavy
   Approximately 4 in 5 college students drink alcohol, about 2 in 5 engage in binge drinking (5 or more drinks in a row for men and 4 or more in a row for women within the past two weeks or 30 days, depending upon the survey), and about 1 in 5 engages in frequent binging (3 or more times in the past two weeks) (NIAAA, 2002a). Underage college students consume about 48% of the alcohol consumed by students attending 4-year colleges (Wechsler et al., 2002b).

7. Little Recent Progress Has Been Made in Reducing Underage Drinking
   Data available from 1975 to 2005 document that the prevalence of drinking among 12$^{th}$ graders peaked in 1979 for lifetime use and past-year use. Past-month use peaked in 1978, decreased throughout the 1980s, and held relatively steady throughout the 1990s, with 30-day prevalence rates of approximately 50%. The percentage of high school seniors who reported drinking within the last 30 days was the same in 1993 as in 2002 (48.6%). Rates of reported drinking within the past year were slightly lower for 2003 than for 1993. Although a modest reduction has occurred in the 30-day and annual usage rates over the past five years, current rates are not significantly different from 1993, and they remain high.

   Binge drinking peaked in 1981, held steady, and then declined from 41% in 1983 to a low of 28% in 1992. This drop of almost one-third in binge drinking was a significant improvement (Johnston et al., 2005). Between 1992 and 1998, binge drinking rose by about 4% among 12$^{th}$ graders. An upward drift in binge drinking among 8$^{th}$ graders occurred between 1991 (13%) and 1996 (16%) and among 10$^{th}$ graders between 1992 (21%) and 1999 (26%). After those peaks, a slight decline in use occurred in all three grades until 2002, when the rate dropped appreciably. Binge use declined again in 2003, but only slightly (Johnston et al., 2005). While the declines in underage drinking are encouraging, the current rates remain alarmingly high.

## CONSEQUENCES OF UNDERAGE DRINKING

The adverse consequences of underage drinking include alcohol-related motor vehicle crashes (the greatest single mortality risk for underage drinkers); increased risk for suicide and homicide; assault and rapes on college campuses, where it is estimated that

alcohol is involved in 90% of college rapes and 95% of all violent crime on college campuses (Commission on Substance Abuse at Colleges and Universities, 1994); unintentional injuries such as burns, falls, and drownings; potential brain impairment; an increased risk for developing an alcohol use disorder later in life; unwanted, unintended and unprotected sexual activity; academic problems; various social problems; and physical problems, such as alcohol poisoning or medical illnesses. Other consequences include increased risk for violence. Individuals under the age of 21 commit 45% of rapes, 44% of robberies, and 37% of other assaults (Levy et al., 1999). It is estimated that for the population as a whole, 50% of violent crime is related to alcohol use (Harwood et al., 1998). The degree to which violent crime committed by those under 21 is alcohol-related remains to be determined. The social costs of underage drinking are conservatively estimated at $53 billion, including $19 billion from traffic crashes and $29 billion from violent crime (Pacific Institute for Research and Evaluation, 1999).

## A COMPREHENSIVE PLAN TO PREVENT AND REDUCE UNDERAGE DRINKING

The Plan to prevent and reduce underage drinking developed through the Interagency Coordinating Committee on the Prevention of Underage Drinking (ICCPUD) and described in this report can be characterized as comprehensive, goal-driven, evidence-based, long-term, and coordinated. The Plan takes a multi-faceted, balanced approach to reducing both the demand for alcohol and its availability to the young. It involves all levels of government as well as individuals and private sector organizations and institutions, including faith-based organizations. Prevention, education, increasing public awareness of underage drinking and its consequences, treatment opportunities, school and workplace prevention programs, research, and legal enforcement are all components of the Plan. Verifiable data based on scientific investigation and developed through rigorous research is an essential part of the Plan, because underage alcohol consumption is a complex phenomenon that requires scientific research to confirm the effectiveness of proposed policies and interventions. NIAAA has undertaken a major effort to analyze the evidence base related to underage drinking, using a developmental approach. As NIAAA releases its findings and recommendations, the Plan will be updated to incorporate them as part of the annual report.

Underage drinking is deeply imbedded in the American culture. It is often viewed as a rite of passage, is frequently facilitated by adults (Wagenaar et al., 1996), and has proven stubbornly resistant to change. For these reasons, the Plan takes a long-term approach while concurrently implementing short- and medium-term initiatives that work together toward the achievement of the longer-term goals. Every agency in the Federal Government with an appropriate role to play has been included in order to strategically coordinate objectives and actions across agencies. The goal is to avoid or reduce unnecessary overlap, duplication, and wasted resources. The Federal Government will work with the States, local communities, individuals, and nongovernmental institutions and organizations as part of this collaborative effort. Specific numeric targets have been established so that progress can be measured from year-to-year through performance measurements developed specifically for that purpose.

## PLAN GOALS AND TARGETS

The Plan is built around the following three goals:

### Goal 1: Strengthen a national commitment to address the problem of underage drinking.

This goal will be achieved by increasing national awareness of the extent of underage drinking and its negative consequences, enhancing broad-based support for the prevention and reduction of underage drinking, and strengthening leadership at all levels of government and in all sectors of society aimed at addressing the problem; increasing cooperation, coordination, and collaboration among private entities, including faith-based organizations, and all levels of government; and encouraging public and private sector participation in, and providing support for, programs and projects that address the prevention and reduction of underage drinking.

### Goal 2: Reduce demand for, the availability of, and access to alcohol by persons under the age of 21.

This goal will be achieved by providing developmentally and culturally appropriate information to adults on underage drinking and its consequences, especially to parents and caregivers of those under the age of 21, emphasizing their responsibility to help prevent underage drinking; providing youth under the age of 21 in the workforce and in kindergarten through college with developmentally and culturally appropriate information and resistance skills training to enhance protective factors and to change attitudes toward underage drinking; informing States and local communities about effective policies and procedures for reducing access to alcohol by those under the age of 21; assisting States and local communities in enforcing underage drinking laws through compliance training in retail establishments and by crafting laws that prevent or reduce underage drinking; promoting partnerships at the State and local levels, including partnerships between enforcement agencies and other justice agencies as well as those interested in underage drinking prevention; supporting improvement of justice system responses to underage drinking and improved adjudication and programs that dissuade adults from providing alcohol to those under 21; and providing opportunities for early identification of alcohol abuse and brief interventions or treatment as appropriate.

### Goal 3: Utilize research, evaluation, and surveillance to improve the effectiveness of policies and programs designed to prevent and reduce underage drinking.

This goal will be achieved by analyzing the current knowledge base on preventing and reducing underage drinking and its consequences; supporting research to address gaps in knowledge; continually monitoring the extent of the problem, contributing factors, consequences, and trends through increased surveillance; expanding the use of evidence-based programs in prevention and reduction efforts; creating a Federal registry of effective programs for use by States and communities; encouraging and supporting the

rigorous evaluation of innovative and promising programs; implementing funding guidelines that require the use of evidence-based programs or rigorously evaluated programs that are innovative and promising; and requiring evaluation of all programs to correct problems in design and/or implementation.

The Plan establishes 5-year annual performance measures in the form of numeric targets that will be used to evaluate progress. These targets are as follows:

- Target 1: By 2009, reduce the prevalence of past month alcohol use by those aged 12 through 20 by 10% as measured against the 2004 baseline of 28.7 percent.

- Target 2: By 2009, reduce the prevalence of those aged 12 through 20 reporting binge alcohol use in the past 30 days by 10% as measured against the 2004 baseline of 19.6 percent.

- Target 3: By 2009, achieve an increase of average age of first use[5] among those who initiate before age 21 to 16.5 years of age as compared to the 2004 baseline.

## LOOKING FORWARD

Member agencies of the Interagency Coordinating Committee on the Prevention of Underage Drinking are committed to the comprehensive approach for preventing and reducing underage drinking described in this report. ICCPUD will serve as an ongoing mechanism for coordinating Federal efforts in this area. Future programming will be aligned with the Plan to ensure development and support of effective programs along with the elimination of duplication. In addition to their individual efforts, member agencies will continue to place a high priority on strengthening our Nation's commitment to address the underage drinking problem through a meeting of communities across the country in March 2006 and a national Ad Council campaign that will help increase the visibility of the issue and motivate parents to address it in their families and communities. In addition, the Surgeon General, as the Nation's leading medical spokesperson, will draw attention to underage drinking through a Call to Action that was announced at the national meeting and is expected this year. It is anticipated that this comprehensive Plan will reduce underage drinking and the associated costs and consequences that burden youth, their parents, and society as a whole**.** The Plan will be revised as needed, based on the Nation's progress in moving toward the performance goals described above, the findings and recommendations that emerge from NIAAA's underage drinking initiative, and data gathered from new research and other sources.

[5] The ultimate goal is to increase the age of initiation to the minimum legal drinking age of 21; however, underage drinking is so strongly embedded in the Nation's culture that the more realistic goal of increasing the average age of initiation to 16.5 by 2009 is being proposed.

# I. COMBATING UNDERAGE DRINKING: AN OVERVIEW

## INTRODUCTION

Alcohol is the most widely used substance of abuse among America's youth. A higher percentage of youth aged 12 to 20 use alcohol (29%) than use tobacco (24%) or illicit drugs (14%) (SAMHSA, 2005). One of the fundamental roles of government is the promotion of the public health and safety. Alcohol use by individuals under the legal drinking age of 21 constitutes a threat to both. Consequently, governments at the Federal, State, and local levels have sought to develop effective approaches to reduce underage drinking and the associated costs and consequences that burden society. Government alone, however, cannot solve the problem of underage drinking. An effective solution will require a broad and committed collaboration among the parents of underage youth, other adults, and organizations and institutions in the private sector.

It is illegal in all fifty States to sell alcohol to youth under the age of 21; however, in some States it may be legally provided to youth in special circumstances such as religious ceremonies, in private residences, or in the presence of a parent or guardian. Despite such restrictions, underage youth find it relatively easy to acquire alcohol, often from adults. Underage drinking has proven to be a complex, intractable social problem that has defied an easy solution. It often begins at a young age (10% of nine- to ten-year-olds have already started drinking), with the average age of first use now at about 16-years-old. Alcohol use increases each year of high school, and by the twelfth grade, more than half (55.9%) of the students surveyed reported having had one or more drinks within the past 30 days (YRBS, 2003). Underage drinkers are much more likely than adults to drink heavily and recklessly. Studies consistently indicate that about 80% of college students drink alcohol of which approximately 48% are underage, and about 40% of all college students engage in binge drinking, defined as consuming 5 or more drinks in a row for men and 4 or more drinks in a row for women (NIAAA, 2002a).

New research over the past decade has increased our understanding of how underage alcohol use threatens the immediate and long-term well being and future mental development of the young. The consequences of underage drinking include increased risk of suicide and homicide, alcohol-related crashes and fatalities, other unintentional injuries such as burns and drownings, physical and sexual assault, academic and social problems, unintended and unwanted sexual activity, and adverse effects on the developing brain (NIAAA, 2005a). Alcohol is a leading contributor to injuries that result in fatalities, the major cause of death of people under 21-years-old.

Beyond the personal cost to the individual, society as a whole also pays. Half of all persons who die in traffic crashes involving drinking drivers under the age of 21 are people other than the drinking driver (NHTSA, 2003). The social costs of underage drinking are estimated conservatively at $53 billion, including $19 billion from traffic

crashes and $29 billion from violent crime (Pacific Institute for Research and Evaluation, 1999).

## THE NATIONAL EFFORT TO REDUCE UNDERAGE DRINKING

After Prohibition ended in 1933, the States assumed authority for alcohol control, including the enactment of laws that restricted youth's access to alcohol. The majority of States designated 21 as the minimum legal drinking age (MLDA) for the "purchase or public possession" of alcohol. Between 1970 and 1976, 29 States lowered the MLDA to 18-, 19-, or 20-years-old, in part because the voting age had been lowered (Wagennar, 1981). However, studies conducted in the 1970s found that motor vehicle crashes increased significantly among teens, resulting in more traffic injuries and fatalities (Cucchiaro et al., 1974; Douglas et al., 1974; Wagenaar, 1983, 1993; Whitehead, 1977; Whitehead et al., 1975; Williams et al., 1974). As a result, 24 of the 29 States raised their MLDA's between 1976 and 1984 to different ages, sometimes with restrictions on the type of alcohol that could be consumed by persons under 21-years-old. Only 22 States had set the drinking age of 21, which prompted the Federal Government in 1984 to enact the National Minimum Drinking Age Act. That act mandated reduced Federal highway funds to States that did not raise the MLDA to 21.

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.

Other than establishing a minimum drinking age, alcohol problems were largely ignored through the 1960s (NIAAA, 2005b). However, on December 31, 1970, Congress established the National Institute of Alcohol Abuse and Alcoholism "to provide leadership in the national effort to reduce alcohol problems through research." 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."

As the national concern over underage drinking grew, in part because of advances in science that revealed increasingly adverse consequences, Congress appropriated funds for a study by The National Academies that would 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." That report was issued in 2004 by the National Research Council (NRC) and the Institute of Medicine (IOM).

A number of programs aimed at preventing and reducing underage drinking have been initiated at the Federal, State, and local levels. Appendix "A" (Inventory of Federal Programs by Agency) describes the major programs at the Federal level.

## DEVELOPMENT OF A COMPREHENSIVE PLAN

The conference report accompanying H.R. 2673, the "Consolidated Appropriations Act of 2004," directed the Secretary of Health and Human Services (HHS) to establish an 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. In response, ICCPUD developed a Comprehensive Plan to prevent and reduce underage drinking.

At the request of the Secretary of Health and Human Services, the Administrator of SAMHSA, Charles G. Curie, M.A., A.C.S.W., convened the Interagency Coordinating Committee on the Prevention of Underage Drinking (ICCPUD) in 2004. The Committee is made up of representatives from the Department of Health and Human Services' 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), National Institutes of Health/National Institute on Alcohol Abuse and Alcoholism (NIH/NIAAA); the Department of Justice/Office of Juvenile Justice and Delinquency Prevention (DOJ/OJJDP); the Department of Education/Office of Safe and Drug Free Schools (ED/OSDFS); the Department of Transportation/National Highway Traffic Safety Administration (DOT/NHTSA); the White House Office of National Drug Control Policy (ONDCP); the Department of the Treasury; the Department of Defense; and, *ex officio*, the Federal Trade Commission (FTC).

ICCPUD is intended to serve as a mechanism for coordinating Federal efforts aimed at reducing underage drinking and to serve as a resource for the development of a comprehensive Plan for combating underage drinking. HHS made ICCPUD a standing committee to provide ongoing, high-level leadership on this issue and to serve as a mechanism for coordinating Federal efforts aimed at preventing and reducing underage drinking.

## A COMPREHENSIVE PLAN

To guide development of the Plan, ICCPUD has received input from experts and organizations representing the views of a wide range of parties, including public health advocacy groups, the alcohol beverage industry, the ICCPUD member agencies, and the United States Congress. Finally, the most current and authoritative research was analyzed and incorporated into the Plan.

The resulting Plan to prevent and reduce underage drinking can be characterized as:

1. Comprehensive
2. Goal-Driven
3. Evidence-Based
4. Long-Term
5. Coordinated
6. Measurable

**1. Comprehensive:** Any successful plan to reduce the widespread prevalence of alcohol consumption by persons under 21 must be comprehensive, by which is meant a multi-faceted, balanced approach to reducing both the demand for alcohol and its availability to the young that includes the participation of all levels of government as well as individuals and private sector organizations and institutions, including faith-based organizations. Such an approach promotes integration of multiple interventions, creates synergy among them, and increases the likelihood of overall success. Prevention, education, increasing public awareness of underage drinking and its consequences, treatment opportunities, school and workplace prevention programs, research, and legal enforcement are all essential components of a comprehensive plan.

**2. Goal-Driven:** A broad strategic initiative must be directed by a clear set of goals that determine objectives and guide the actions to be taken in the pursuit of those goals and objectives. The Plan proposes three specific goals with related objectives and recommends interventions to protect young people from the immediate and long-term adverse consequences of alcohol use that threaten their health, safety, and development.

**3. Evidence-Based:** Underage alcohol consumption is a complex phenomenon that requires additional scientific research to address questions that cannot be answered from the current knowledge base and to confirm the efficacy of proposed policies and interventions. Without policies and interventions formulated on the basis of scientific evidence, there can be no assurance of their effectiveness. For example, root causes of underage alcohol use have to be identified and potential interventions developed; psychosocial factors that play an important role in moderating or exacerbating underage alcohol use must be investigated; epidemiological and natural-history studies should be conducted to shed light on understanding how and why alcohol-related problems develop among underage college students; and minority groups that appear to respond differently to alcohol than does the general population should be researched. In addition, since underage drinking encompasses an age range that spans childhood, through adolescence to early adulthood, it is essential to ensure that interventions are developmentally appropriate. Finally, programs, strategies, and interventions should be evaluated after implementation.

**4. Long-Term:** There is no quick fix for the problem of underage drinking in America. It is deeply imbedded in the American culture, is often viewed as a rite of passage, is frequently facilitated by adults, and has proven stubbornly resistant to change. A long-term effort will be required to solve it. The Plan provides a structure for planning over the long-term while implementing short- and medium-term initiatives that work together toward the achievement of the Plan's targets.

**5. Coordinated:** The Plan works to ensure that the national effort to reduce alcohol consumption by underage individuals is coordinated, by which is meant that each agency in the Federal Government with an appropriate role to play is both engaged in the effort and involved in the strategic coordination of agency activities. Furthermore, to the extent possible, the ICCPUD agencies will seek to avoid unnecessary overlap, duplication, or wasted resources. At the same time, the Federal Government will continue to work with

the States, local communities, individuals, and nongovernmental institutions and organizations in a collaborative effort to prevent and reduce underage drinking. Underage alcohol use is a national problem, but the ultimate implementation of prevention and reduction efforts must occur at the community and even family levels.

**6. Measurable:** The Plan will rely on data to evaluate its success in reducing underage drinking. Specific numeric targets will be established so that progress can be measured from year-to-year through performance measurements developed for that purpose.

## GOALS OF THE PLAN

The Plan consists of the following three goals:

- Goal 1: Strengthen a national commitment to address the problem of underage drinking.

- Goal 2: Reduce demand for, the availability of, and access to, alcohol by persons under the age of 21.

- Goal 3: Utilize research, evaluation, and scientific surveillance to improve the effectiveness of policies and programs designed to prevent and reduce underage drinking.

Nine objectives in support of the Plan goals and the actions to implement them are described in Chapter Three.

## TARGETS

The Plan proposes 5-year performance measures in the form of numeric targets that will be used to evaluate the Nation's progress in preventing and reducing underage drinking. These targets are national rather than Federal because they cannot be met without the committed involvement of government at all levels, as well as individuals, organizations, and institutions in the private sector. Progress in meeting the targets will be measured using data from the National Survey on Drug Use and Health (NSDUH).

- Target 1: By 2009, reduce the prevalence of past month alcohol use[6] by those aged 12 - 20 by 10%[7] as measured against the 2004 baseline[8] of 28.7 percent.

[6] For purposes of this target, "alcohol use" is defined as "other than a few sips."
[7] For example, if a 2003 baseline were to be used, the 10% target reduction would result in a prevalence change from 29.0% to 26.1%.
[8] The 2004 baseline figures will come from the NSDUH, which is scheduled to be published in September 2005.

- Target 2: By 2009, reduce the prevalence of those aged 12 - 20 reporting binge alcohol use[9] in the past 30 days by 10% as measured against the 2004 baseline of 19.6 percent.

- Target 3: By 2009, achieve an increase of average age of first use[10] among those who initiate before age 21 to 16.5[11] years of age as compared to the 2004 baseline.

[9] For purposes of this target, "binge alcohol use" is defined as "drinking five or more drinks on the same occasion (i.e., at the same time or within a couple of hours of each other) on at least 1 day in the past 30 days."

[10] The ultimate goal is to increase the age of initiation to the minimum legal drinking age of 21; however, underage drinking is so strongly embedded in the Nation's culture that the more realistic goal of increasing the average age of initiation to 16.5 by 2009 is being proposed.

[11] In 2004, the mean age of first use among those who initiate before age 21 was 15.6 years.

# II. THE SCOPE OF THE PROBLEM OF UNDERAGE ALCOHOL USE IN AMERICA

Despite laws against underage drinking in all fifty States and despite decades of Federal, State, and local efforts, as well as efforts by many private entities, to reduce underage drinking, alcohol is the most widely consumed substance of abuse among America's young, used more often than tobacco or marijuana. Underage alcohol use remains an intractable health and public safety problem with severe consequences for youth, their families, and communities. Alcohol accounts for more deaths than all other illicit drugs combined for adults and those under age 21. Yet a lack of public recognition of these consequences and their costs to individuals and society hampers implementation of a comprehensive prevention effort.

The Federal Government funds three major national surveys to gather information that includes data on underage drinking: the annual "National Survey on Drug Use and Health" (NSDUH), formerly called the "National Household Survey of Drug Abuse" (NHSDA), has a representative sample of 12- to 20-year-olds and is sponsored by the Substance Abuse and Mental Health Services Administration; "Monitoring the Future" (MTF) annually surveys 8th, 10th and 12th graders, is funded by the National Institute on Drug Abuse (NIDA) and conducted by the University of Michigan's Institute for Social Research; and the biannual "Youth Risk Behavior Surveillance System" (YRBSS) surveys 9th through 12th grade students[12] using a national school-based survey conducted by CDC as well as State and local school-based surveys conducted by education and health agencies. Other surveys used by the government include the National Epidemiologic Survey on Alcohol and Related Conditions (NESARC) conducted by the National Institute on Alcohol Abuse and Alcoholism (NIAAA) as well as the Worldwide Surveys of Substance Abuse and Health Behaviors Among Military Personnel conducted by the Department of Defense, both of which contain information on drinkers aged 18 and older. Data from these and other surveys and research efforts provide a disturbing picture of underage alcohol use in America.

## CHARACTERISTICS OF UNDERAGE ALCOHOL USE

Some of the principal findings of governmental surveys and other research related to underage alcohol use are described in the following paragraphs.

### 1. Underage Alcohol Use is Widespread

Underage alcohol use in America is a widespread and serious problem as evidenced by the following data:

[12] Because these surveys do not use common questions or methodologies, direct comparisons of underage alcohol consumption patterns across the three cannot be made.

- *Current Use:* The 2004 NSDUH reported that approximately 29% of Americans aged 12 through 20 (or about 10.8 million minors) reported having at least one drink in the 30 days prior to the survey. Of this age group, 19.6% (or nearly 7.4 million) were binge drinkers, meaning that they had drunk 5 or more drinks on the same occasion (i.e., at the same time or within a couple of hours of each other) on at least 1 day within the past 30 days. Of those in the 12 to 20 age group, 6.3% (or 2.4 million) were heavy drinkers, meaning that they had drunk 5 or more drinks on the same occasion on each of 5 or more days in the past 30 days. All heavy alcohol users are also binge alcohol users. These figures were essentially unchanged from the 2002 and 2003 surveys.

- *Lifetime Use*: Data from the 2004 MTF survey of U.S. youth show that 75.1% of 12th graders, 63.2% of 10th graders, and 41.0% of 8th graders have drunk alcohol at some point in their lives (Johnston et al., 2005a).

- *Binge Use*[13]*:* According to data from the 2004 NSDUH, 5.6% of 14-year-olds, 18.3% of 16-year-olds, 33.1% of 18-year-olds, and 40.3% of 20-year-olds had engaged in binge drinking within the past 30 days (SAMHSA, 2005).

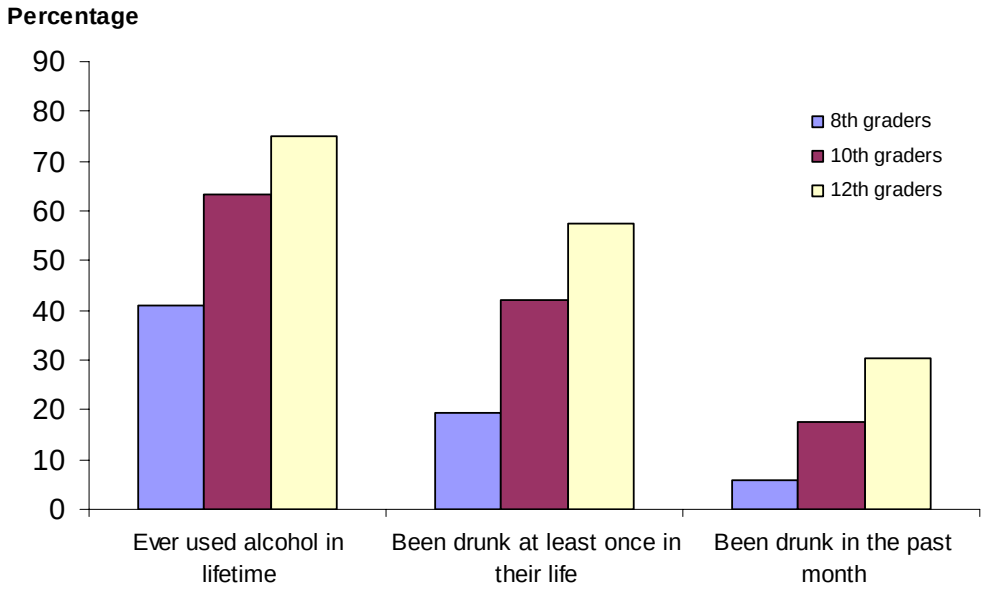
- *Heavy Use*[14]*:* Data from the 2004 NSDUH survey show that 4.5% of 16-year-olds, 11.0% of 18-year-olds, and 16.3% of 20-year-olds had engaged in heavy alcohol consumption within the past 30 days.

- *Use to Intoxication*: According to 2005 data from the 2004 MTF survey, 57.5% of 12th graders, 42.1% of 10th graders, and 19.5% of 8th graders reported having been drunk at least once in their lives (Johnston et al., 2005a).

- *Use to Intoxication Within the Last Month*: Data from the MTF survey for 2005 indicates that 30.2% of 12th graders, 17.6% of 10th graders, and 6.0% of 8th graders reported having been drunk in the past month. (Johnston et al., 2005a).

[13] Five or more drinks on the same occasion at least once in the past 30 days (includes heavy use)
[14] Five or more drinks on the same occasion on at least 5 different days in the past 30 days.

**Figure 2.1 Lifetime Alcohol Use, Use to Intoxication, and Use to Intoxication Within the Last Month Among 8th, 10th, and 12th Graders: 2005 Monitoring the Future**




## 2. Youth Start Drinking at an Early Age

Studies show that drinking often begins at very young ages.[15] Data from recent surveys indicate that approximately:

- Ten percent of 9-10 year olds have already started drinking (Donovan *et al*., 2004)
- Nearly one-third of underage drinkers begin before age 13 (Grunbaum, 2002).
- The peak years of initiation are 7th through 11th grades, based on data from high school seniors (Johnston et *al.*, 2005a)

Youths who report drinking prior to the age of 15 are more likely to develop substance abuse problems, to engage in risky sexual behavior, and to experience other negative consequences in comparison to those who begin at a later time. The age of onset of drinking, therefore, is a marker for future problems, including heavier use of alcohol and other drugs during adolescence (e.g., Robins and Przybeck, 1985; Hawkins et *al*., 1997) and the development of an alcohol dependence diagnosis in adulthood (Grant & Dawson, 1998). Delaying the age of onset of first alcohol use as long as possible can ameliorate some of the negative consequences associated with underage alcohol consumption. Therefore, whether underage drinkers are starting at younger or older ages over a given period of years is a matter of concern.

[15] "Age of first use," means the age at which drinking begins. Drinking is defined as the consumption of at least one drink (e.g., a bottle of beer, glass of wine, shot of liquor, or mixed drink) rather than having had "a sip or two from a drink."

Data from the NSDUH indicate that the average age of first-time users of alcohol decreased from 17.4 years to 16.2 years between 1965 and 1995. Data from the MTF study suggest no change in the average age at first use from 1995 to 2003, and declines in the proportion of 8th, 10th, and 12th graders who had ever used alcohol.

To improve the utility of these estimates, SAMHSA has developed a new methodology, which will provide estimates that are more timely and will more accurately assess trends in average age at first use and other measures of initiation such as incidence rates. The new method calculates the average age of first use based on those who initiated within the past 12 months. Using this new methodology, data from the NSDUH indicate that there was no difference in the average age of first use between 2002 and 2004, and that in 2004 the average age of first use for those who first used before age 21 was 15.6 and the average age of first use for all drinkers, including those who started drinking at 21 or over, was 17.5. See Appendix B for a discussion of methodological issues associated with measuring age at first use and other indicators of alcohol initiation.

## 3. Among Underage Drinkers, Alcohol Use and Binge Drinking Increase with Age

The 2004 NSDUH reports that underage alcohol consumption increased in a steady progression from 2.3% at age 12 to 56.3% at age 20. Alcohol use peaks at 70% for 21-year-olds (SAMHSA, 2005). Rates of binge alcohol use increased steadily between the ages of 12 and 20, as follows: 1.1% at age 12, 2.9% at age 13, 5.6% at age 14, 12.7% at age 15, 18.3% at age 16, 26.6% at age 17, 33.1% at age 18, 37.4% at age 19, and 40.3% at age 20. The rate of binge drinking peaked at age 21 (48.2%) and then decreased beyond young adulthood (SAMHSA, 2005).

**Figure 2.2 Current and Binge Alcohol Use among Persons Aged 12 to 20, by Age: 2004 National Survey on Drug Use and Health**

Underage drinking doubles between the ages of 14 (about 6%) and 15 (about 12%) and increases steadily thereafter to the age of 20 (Flewelling et al., 2004). Other researchers have also documented that drinking becomes increasingly common through the teenage years (e.g., O'Malley et al., 1998). Moreover, frequent, heavy use by underage drinkers also increases each year from the age of 12 to the age of 20 (Flewelling et al., 2004).

## 4. Youth Binge[16] More and Drink More Than Adults When They Drink

Young people who drink tend to drink less often than adults, but they drink more heavily when they do drink. For example, 92% of the alcohol consumed by 12- to14-year-olds is consumed in 5 or more drinks on a single occasion (Pacific Institute for Research and Evaluation, 2002). Underage drinkers consume on average about 5 drinks per occasion, about 6 times a month (SAMHSA, 2005). By comparison, adult drinkers 21 and older consume on average about 3 drinks per occasion, about 9 times a month (SAMHSA, 2005).

A particularly worrisome aspect of underage drinking is the high prevalence of heavy episodic drinking, defined as drinking 5 or more drinks in a row in the past 2 weeks. In 2005, 10.5% of 8th graders, 21.0% of 10th graders, and 28.1% of 12th graders reported engaging in heavy episodic drinking (Johnston et al., 2005a). In 2004, about 2.4 million youth ages 12 through 20 (or 6.3% of this age group) drank 5 or more drinks on a single occasion[17], 5 or more times a month (SAMHSA, 2005).

Among 12th graders, the prevalence of drinking 5 or more drinks in a row in the past 2 weeks declined from 36.8% in 1975 to 29.2% in 2004, an absolute decrease of 7.6%. Analysis of data for the intervening years reveals that this behavior increased between 1975 and 1980, decreased between 1980 and 1987, decreased more steeply between 1987 and 1993, increased between 1993 and 1997, and decreased between 1997 and 2002 (Faden and Fay 2004). Information on the prevalence of this behavior among 8th and 10th graders first became available in 1991. In 1991 12.9% of 8th graders reported engaging in this behavior compared to 11.4% in 2004 with marked oscillation of rates in the intervening years. In 1991, 22.9% of 10th graders reported having 5 or more drinks in a row in the past 2 weeks compared with 22.0% in 2004. In the intervening years, rates of this behavior among 10th graders steadily increased peaking in 2000 and decreasing gradually since then (MTF Table 16 and Faden and Fay 2004).

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[16] No common terminology has been established to describe different drinking patterns. On the basis of NHSDA/NSDUH data, SAMHSA defines "binge drinking" as five or more drinks on one occasion and "heavy drinking" as five or more drinks on at least five different days in the past 30 days. Some studies, including Weschler's 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.

[17] If a typical 160 pound male drinks 5 standard drinks over a 2 hour period, he would reach a BAC of .08, making him legally intoxicated in all 50 States.

## 5. Underage Drinking is Different Between Genders

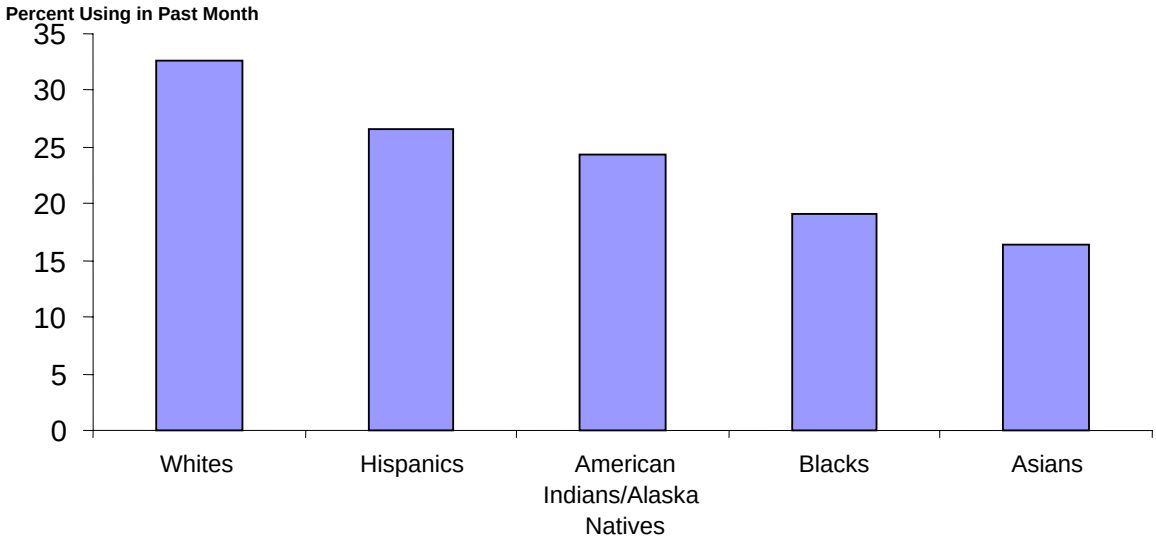
In general, underage males report more alcohol use during the past month than underage females. They also tend to start drinking at an earlier age, drink more frequently, and are more likely to binge drink than females. In the 2004 NSDUH, 56.9% of males aged 12 and older were current drinkers as compared to 44.0% of females. However, among underage drinkers, gender differences vary with age. Among individuals ages 12-13 rates of current drinking were similar—4.1% for males and 4.5% for females. Among 14 and 15-year-olds, females were more likely to be drinkers with 18.1% reporting past month use compared to 14.7% of males. Among those ages 16-17, the rates again even out with 33.2% of the males and 31.7% of the females being current drinkers. And by ages 18-20, males are more likely to be drinkers with 54.3% of the males and 47.8% of the females reported past month alcohol use (NSDUH 2004 data in tables 8-12).

The prevalence of binge drinking is the most significant gender difference. In 2004, 33.% of 12$^{th}$ grade males reported binge drinking (consumption of 5 or more drinks in a row) at least once in the prior two-week period whereas 23% of female 12$^{th}$ graders did. However, that gap is closing. In 1975, for example, there was a 23 percentage point spread between the rates. In 2005, that difference was 10 percentage points (Johnston, 2005a).

## 6. Underage Drinking By Race and Ethnicity

Whites aged 12 to 20 were more likely to report current use of alcohol in 2004 than any other racial or ethnic group. An estimated 32.6% of whites reported past month use, whereas the rates were 24.3% for American Indians and Alaska Natives, 26.6% for Hispanics, 16.4% for Asians, and 19.1% for blacks (SAMHSA, 2005). While fewer Hispanics and blacks report current drinking, data from the Youth Risk Behavior Survey also suggest that the prevalence of alcohol use before the age of 13 is greater among black (31.2%) and Hispanic (30.2%) students than among white (25.7%) students (YRBS, 2004). It is important to note that sample sizes from the MTF and the Youth Risk Behavior Survey do not allow estimates of alcohol consumption by Native Americans and Native Alaska youth. Whites aged 12 to 20 were also more likely to report binge alcohol use in the past month. An estimated 22.8% of whites reported having 5 or more drinks on the same occasion in the past month compared with 19.0% of American Indians and Alaska Natives, 19.3% of Hispanics, 8.0% of Asians and 9.9% of blacks (SAMHSA, 2005).

**Figure 2.3 Current Use of Alcohol Among Persons Aged 12-20 by Race/Ethnicity: 2004 National Survey on Drug Use and Health**




## 7. Types of Alcohol Consumed by Underage Drinkers

The following chart based on 2005 MTF data indicates the type of alcohol consumed by underage drinkers in the 8th, 10th, and 12th grades within the last 30 days. The four alcohol categories listed are beer, wine, spirits, and flavored malt beverages (FMB), which are sometimes called "alcopops" or "malternatives." "Alcopops" are ready-to-drink, flavored alcoholic beverages that tend to be sweet and have between 4-6% alcohol by volume (about the same as beer, which typically varies between 3 and 6%). An "n/c" notation indicates that no data were collected. In some cases, the same adolescents reported drinking more than one type of alcohol, which is why the percentage of adolescents for a given grade who have drunk alcohol may total more than 100 percent. For example, of the 12th graders who drank alcohol within the 30 days prior to the survey, some percent had consumed, for example, both beer and wine. 38.0% of the adolescents had consumed beer, 14.4% had consumed wine, 36.4% had consumed spirits, and 30.5% had consumed flavored malt beverages. Therefore, some of the adolescents must have consumed alcohol from more than one of these categories.

| UNDERAGE ALCOHOL USE WITHIN THE PAST 30 DAYS BY ALCOHOL CATEGORY | | | | |
|---|---|---|---|---|
| **Grade Level** | **Beer** | **Wine** | **Spirits** | **Flavored Malt Beverages** |
| 8th | 12.8% | n/c | n/c | 12.9% |
| 10th | 24.8% | n/c | n/c | 23.1% |
| 12th | 38.0% | 14.4% | 36.4% | 30.5% |
| Source: Johnston et al., 2006 | | | | |

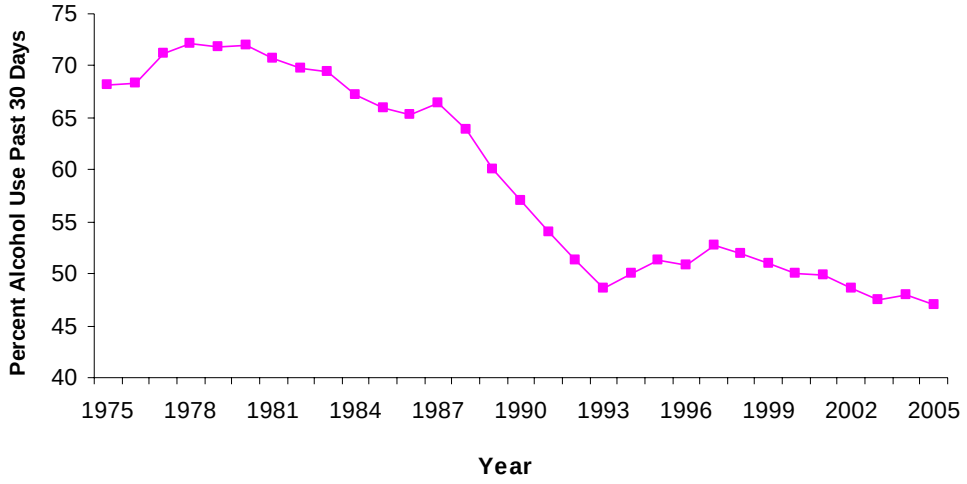
## 8. Alcohol Use in College is Pervasive and Heavy

Approximately 4 in 5 college students drink alcohol, about 2 in 5 engage in binge drinking (5 or more drinks in a row for men and 4 or more in a row for women within the past two weeks or 30 days, depending upon the survey), and about 1 in 5 engages in frequent binging (3 or more times in the past two weeks) (NIAAA, 2002a). Underage college students consume about 48% of the alcohol consumed by students attending 4-year colleges (Wechsler et al., 2002b). The consequences of underage drinking in college are widespread and serious and are discussed in a later subsection.

## 9. Little Recent Progress Has Been Made in Reducing Underage Drinking

Data available from 1975 to 2004 document that the prevalence of drinking among 12th graders peaked in 1978 for lifetime use and past-year use (Johnston et al., 2003, Johnston et al., 2005). Past month use among 12th graders increased between 1975 and 1979, decreased slightly between 1979 and 1988, decreased between 1988 and 1993, increased between 1993 and 1997, and decreased between 1997 and 2002 (Faden and Fay, 2004). The percentage of high school seniors who reported drinking within the last 30 days was the same in 1993 as in 2002 (48.6%). Although a modest reduction has occurred in the 30-day and annual usage rates over the past five years, current rates are not significantly different from 1993, and they remain high (Johnston et al., 2005).

**Figure 2.4 Trend in Thirty-Day Prevalence of Alcohol Use for Twelfth Graders 1975-2005; 2005 Monitoring the Future**




Binge drinking peaked in 1981, held steady, and then declined from 41% in 1983 to a low of 28% in 1992. This drop of almost one-third in binge drinking was a significant improvement (Johnston et al., 2005). Between 1992 and 1998, binge drinking rose by

about 4% among 12th graders. An upward drift in binge drinking among 8th graders occurred between 1991 (13%) and 1996 (16%) and among 10th graders between 1992 (21%) and 1999 (26%). After those peaks, a slight decline in use occurred in all three grades until 2002, when the rate dropped appreciably. Binge use declined again in 2003, but only slightly (Johnston et al., 2005).

Faden and Fay (2004) examined multiple years of similar data on underage drinking from the NSDUH, MTF, and YRBS surveys for the years 1990 to 2002. These trend analyses "show a pattern of relative stability or decreases in the late 1990s and early 2000s for all groups on all measures with the exception of daily drinking by 10th graders in MTF and drinking 5 or more drinks in a row by 10th graders in YRBS" (Faden and Fay, 2004). Faden and Fay write, "These results considered together offer stronger support for the finding of stability or decrease in youth drinking prevalence in the past 10 years or so than results from any one survey do by themselves." Yet the prevalence of alcohol consumption by persons under the age of 21 is unacceptably high.

## CONSEQUENCES AND ASSOCIATED RISKS OF UNDERAGE DRINKING

Underage drinking is both an individual and societal problem, a matter of public safety and of public health with profound consequences for the young, their families, and their communities. It is a complex problem that has plagued society for generations and results in a range of adverse short- and long-term consequences. Some of these adverse consequences are described in the following paragraphs. In addition to the negatives effects of underage drinking on the drinker, a number of consequences also result to those around him or her, which are referred to as secondary effects.

### 1. Alcohol-Related Motor Vehicle Crashes

The greatest single mortality risk for underage drinkers is motor vehicle crashes. In 2002, 6,788 persons aged 15 to 20 were involved in fatal crashes and 29% of the drivers in this age group who were killed had been drinking (NHTSA 2003). Relative to adults, young people who drink and drive have an increased risk of alcohol-related crashes because of their relative inexperience behind the wheel and their increased impairment from alcohol. According to survey data, about 5.9% of 16-year-olds, 12.6% of 17-year-olds, 16.4% of 18-year-olds, 21.1% of 19-year-olds, and 23.4% of 20-year-olds reported driving under the influence of alcohol in 2003 (NHTSA, 2003). The reported prevalence of driving under the influence of alcohol increases with age until 25, after which it declines. Over all, 30.2% of high school students reported that, within the past 30 days, they had ridden with a driver who had been drinking. For seniors, that figure rose to 33.3%.

## 2. Other Unintentional Injuries Such As Burns, Falls, and Drownings

In 2002, 2,569 individuals ages 16 to 20 died from unintentional injuries other than motor vehicle crashes, such as poisonings, drownings, falls, burns, etc. Research suggests that approximately 40% of these deaths were alcohol-related (Smith et al., 1999).

## 3. Suicide, Homicide, Violence

In 2002, 2,732 young people ages 12 to 20 died from homicide and 2,196 from suicide (CDC, 2005). At present, we do not know exactly how many of these deaths are alcohol related. One study (Smith et al., 1999) estimated that for all ages combined nearly half of the homicides and almost a third of the suicides were alcohol-related. Another study of deaths among those under 21 reported that over a third of the homicides were alcohol-related as were 12% of male suicides and 8% of female suicides (Levy et al., 1999).

Individuals under the age of 21 commit 45% of rapes, 44% of robberies, and 37% of other assaults (Levy et al., 1999). It is estimated that for the population as a whole, 50% of violent crime is related to alcohol use (Harwood et al., 1998). The degree to which violent crime committed by those under 21 is alcohol-related remains to be determined.

## 4. Assault and Rapes on College Campuses

It is estimated that 90% of college rapes involve the use of alcohol by the assailant, the victim, or both (Commission on Substance Abuse at Colleges and Universities, 1994). About 97,000 college students are victims of sexual assault or date rape related to alcohol use each year (Hingson et al., 2005). Alcohol use is involved in 95% of all violent crime on college campuses (Commission on Substance Abuse at Colleges and Universities, 1994).

More than 600,000 college students are assaulted by another student who has been drinking, and another 500,000 students were unintentionally injured while under the influence of alcohol (Hingson et al., 2005).

## 5. Other Risky Behaviors

A variety of other risky behaviors are associated with underage alcohol use. Some of these behaviors include riding with a driver who has been drinking, unplanned and unprotected sexual activity, and carrying a weapon to school (NIAAA, 2002b; YRBS, 2003). Although the data indicate that alcohol use is correlated with these risky behaviors, the data cannot prove causation between alcohol use and the behavior. Nevertheless, it is known that alcohol can impair an individual's decision making capacity and that it reduces inhibitions. Therefore, drinking may be related to the decision to engage in risky behavior, particularly in adolescents whose judgment and decision-making capabilities are still developing.

## 6. Potential Brain Impairment

Brain impairment is one of the potential long-term risks of underage alcohol consumption. Neurobiological research suggests that adolescence may be a period of unique vulnerability to the effects of alcohol. For example, early heavy alcohol use may have negative effects on the actual physical development of the brain structure of adolescents (Brown and Tapert, 2004) as well as on brain functioning. Negative effects indicated by neurological studies include decreased ability in planning, executive functioning, memory, spatial operations, and attention, all of which play an important role in academic performance and future levels of functioning (Giancola and Mezzich, 2000; Brown et al., 2000; Tapert and Brown, 1999; Tapert et al., 2001).

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

The early onset of alcohol use (at age 14 or younger) in combination with an escalation of drinking in adolescence have both been documented in a number of studies as risk factors for the development of alcohol-related problems in adulthood (e.g., Gruber et al., 1996; Grant & Dawson, 1997; Hawkins et al., 1997; Schulenberg et al., 1996; York et al., 2004). The onset of alcohol consumption in childhood or early adolescence is a marker for later alcohol-related problems, including heavier adolescent use of alcohol and other drugs (e.g., Robins and Przybeck, 1985; Hawkins et al., 1997) and the development of alcohol abuse or dependence in adulthood (Grant & Dawson, 1997, York et al 2004). Persons aged 21 or older who reported first use of alcohol before age 14 were more than 6 times as likely to report past year alcohol dependence or abuse than persons who first used alcohol at age 21 or older (SAMHSA, 2005).

## 8. Other Negative Consequences of Underage Drinking

Other consequences of underage drinking include death from alcohol poisoning, academic problems, various social problems, and physical problems such as medical illnesses.

The social costs of underage drinking are conservatively estimated at $53 billion, including $19 billion from traffic crashes and $29 billion from violent crime (Pacific Institute for Research and Evaluation, 1999).

The social, individual, and economic consequences of underage drinking make it a leading health problem in the United States, one that has remained stubbornly resistant to a variety of measures initiated to prevent and reduce it over the past three decades. Because adult alcohol use is an accepted part of American life, underage drinking must be addressed within that context. The primary preventive issue in underage drinking is to delay onset of alcohol use as long as possible—preferably until the age of 21. Yet that delay must be achieved within an environment in which alcohol is readily available to

most underage youth and is attractive to them. A comprehensive plan involving Federal, State, and local governments; organizations and institutions in the private sector; concerned individuals; and the parents of underage youth is critical if progress is to be made against this intractable health problem. Chapter Three describes such a plan.

# III. A COMPREHENSIVE PLAN FOR PREVENTING AND REDUCING UNDERAGE DRINKING

The comprehensive Plan to reduce underage drinking developed by ICCPUD in response to its Congressional mandate contains three goals and nine objectives. The three goals are:

- Goal 1: Strengthen a national commitment to address the problem of underage drinking.

- Goal 2: Reduce demand for, the availability of, and access to alcohol by persons under the age of 21.

- Goal 3: Utilize research, evaluation, and scientific surveillance to improve the effectiveness of policies and programs designed to prevent and reduce underage drinking.

A broad consensus exists that underage drinking is addressed most effectively when policies and interventions are informed by a developmental approach, i.e., one that takes into consideration the different ages and developmental stages of underage users. Age and developmentally specific interventions are more likely to be effective than general interventions and guard against a possible boomerang effect, where the intervention inadvertently stimulates alcohol use in a particular age or developmental group rather than reducing it. NIAAA has undertaken a major effort to analyze the evidence base related to underage drinking, using a developmental approach. As NIAAA releases its findings and recommendations, the Plan will be updated to incorporate them as part of the annual report.

## GOAL 1: STRENGTHEN A NATIONAL COMMITMENT TO ADDRESS THE PROBLEM OF UNDERAGE DRINKING.

*Rationale:* A national problem requires a national approach for its solution. The problem of underage drinking—intractable, widespread, and deeply embedded in the American culture—will require a broad national commitment by many different individuals and organizations at all levels of government and in the private sector if alcohol use by individuals under 21 and its associated negative consequences are to be prevented and reduced. This commitment will involve, out of necessity, the array of individuals and entities that influence a youth's decision to drink, including educational institutions, the military, alcohol producers, outlets where alcohol is sold, community organizations, parents, other adults, and youth themselves. The Federal Government is uniquely positioned to lead such an effort. Drawing on its varied resources, the Federal Government can fund, organize, develop, coordinate, evaluate, and direct the multiple initiatives required of an integrated and effective national plan for underage drinking prevention and reduction.

The Federal Government can also work with States and communities as well as with interested parties in the private sector to ensure that the collective efforts of the public and private sectors are programmatically and cost effective, eliminating unnecessary redundancy and obsolete or obsolescent approaches that are not supported by the latest research findings. Ultimately, all plans, strategies, and interventions aimed at reducing underage drinking must be coordinated, research based, and culturally and developmentally appropriate for the groups they are intended to reach if the overall effort is to succeed.

**Goal 1, Objective 1:** Increase awareness of underage drinking and its negative consequences, enhance broad-based support for preventing and reducing underage drinking, and strengthen leadership in all sectors of society aimed at addressing the problem.

*Rationale:* No problem can be solved until it has been recognized as a problem. In a diverse and democratic society, governmental action that addresses a health and public safety issue can only succeed if the public is made aware of the problem and is committed to preventing and reducing it. Broad-based support arises from public awareness—from knowledge of the latest data that confirm the problem and from realistic proposals for its solution. When the problem is complex and deeply embedded in the culture, leadership at all the levels of government and in the organizations and institutions of the private sector, including faith-based organizations, is necessary to address and resolve it.

1.1A. Federal Action: Exercise Federal leadership in promoting awareness of underage drinking and its negative consequences.

*Rationale*: The Federal Government is uniquely equipped for leadership in coordinating, evaluating, and promoting wide-ranging programs to increase public awareness of underage drinking and its adverse consequences.

1.1B. Federal Action: Use public Service Announcements (PSAs) targeting parents and other adults to increase awareness of underage drinking and its negative consequences.

*Rationale*: Preventing and reducing underage drinking is a collective responsibility of government at all levels, institutions and organizations in the private sector, and adult citizens, particularly parents. Adults play a major role in facilitating underage drinking as well as in preventing it. Minors obtain alcohol from multiple adult sources, including commercial outlets, their parents, parents of friends, and strangers (Harrison et al., 2000d). One way to reduce or eliminate access to these sources is to increase public awareness of the consequences of underage drinking and the role that parents and other adults play in its prevention and reduction. There is considerable evidence that parents are not aware of the full extent of underage drinking and that they are particularly naïve about their own children's use of alcohol, the potential of their influence in preventing it, or the significant risks associated with it. For example, 31% of youth 12- to 18-years-old who had consumed alcohol within the past year were described by their parents as nondrinkers, and 27% of those reporting 5 or more drinks within the

past month were similarly described by their parents (Roper Center, 2003a). The use of Public Service Announcements is one method of increasing public awareness of the prevalence and consequences of underage drinking.

1.1C. Federal Action: Support States, Tribes, and communities in providing leadership to address underage drinking.

*Rationale*: States, Tribes, and communities have distinct but collaborative leadership roles to play in preventing and reducing underage drinking. By supporting these communities and governmental entities in their unique roles, the Federal Government can help them coordinate and improve their existing efforts, encourage new initiatives, disseminate information on the most effective interventions and the latest research, increase public awareness of underage drinking and its consequences, and assist in developing broad-based support for addressing the problem of underage alcohol use in America.

1.1D. Federal Action: Engage and support youth and youth-service organizations in providing leadership to combat underage drinking.

*Rationale*: Studies have shown that peers and peer pressure have a greater effect on underage drinking than on adult alcohol use and may play a role in the adolescent decision to drink or not drink. By engaging youth and youth-service organizations in the effort to prevent and reduce underage drinking and by supporting them in playing a leadership role, the government can take advantage of the influence that peers exercise in adolescent life and harnesses peer pressure in the service of reducing underage alcohol consumption.

**Goal 1, Objective 2:** Increase cooperation, coordination, and collaboration among private entities, including faith-based organizations, and all levels of government; encourage their participation in, and provide support to, programs and projects that address the reduction of underage drinking.

*Rationale:* The persistent problem of underage drinking and its consequences requires a concerted and coordinated effort by the public and private sectors if the deeply embedded beliefs that feed it are to be changed and the social norms that nurture it are to be altered. Prevention and education efforts require widespread dissemination of information that is facilitated by multiple channels and by coordination and collaboration among those channels. By providing support to programs and projects that prevent and reduce underage drinking and by working with public and private sectors to implement such programs, the Federal Government can increase the effectiveness of all the prevention and reduction efforts planned or in progress across the country.

1.2A. Federal Action: Promote governmental cooperation, coordination, and collaboration at all levels.

*Rationale:* Cooperation, coordination, and collaboration at all levels of government can eliminate duplication of effort, address gaps in services, and

generate cross-agency initiatives and departmental activities that build on the unique talents and resources of each agency, department, and governmental level. Through such measures, cost-effective programs can be developed and implemented.

1.2B. Federal Action: Provide opportunities for increased cooperation, coordination, and collaboration between government and private entities, advocacy groups, community and faith-based organizations, and the alcohol beverage industry.

*Rationale:* Government has an important leadership role to play in preventing and reducing underage drinking, but government resources alone are not sufficient to solve such a complex and persistent problem. Private entities, including faith-based organizations, must be enlisted to carry the effort deep into American society—into its institutions, organizations, and homes—where significant progress can be made in changing public attitudes and behavior. Community and faith-based organizations, institutions in the private sector, advocacy groups, and the alcohol beverage industry can all contribute to preventing and reducing underage drinking.

1.2C. Federal Action: Create a Federal Web site dedicated to preventing and reducing underage drinking that is supported by all participating agencies.

*Rationale:* One of the functions that the Federal Government can serve is to disseminate the latest information, data, and research findings on effective programs and interventions as well as the extent and consequences of underage drinking. A Federal Web site is an efficient and effective way to provide such data to States, communities, organizations, and individuals through a searchable database of all Federal resources and programs related to the prevention of underage drinking. The proposed Web site will rely primarily on links to make the extensive information available from Federal agencies readily accessible to interested parties.

## GOAL 2: REDUCE DEMAND FOR, THE AVAILABILITY OF, AND ACCESS TO, ALCOHOL BY PERSONS UNDER THE AGE OF 21.

*Rationale:* Decades of research confirm that underage drinking has an adverse impact on youth, their families, their communities, and society as a whole. The damage that results from its consequences affects the public health and public safety and results in substantial financial, social, and emotional costs. Research indicates that limiting youth's access to alcohol is an effective way to reduce and prevent underage drinking and its related consequences. Therefore, prevention efforts must address underage demand for alcohol, and reduce its availability to youth while making opportunities to drink more difficult. Plans, strategies, and interventions aimed at preventing and reducing underage drinking, should be research based, and be culturally and developmentally appropriate to the groups they are intended to reach. There should also be a focus on prevention activities that begin prior to initiation of alcohol use.

**Goal 2, Objective 1:** Reduce use of alcohol by those under the age of 21 by increasing awareness of the negative consequences of underage drinking, by providing resistance skills training, and by reducing the social acceptance of underage drinking.

*Rationale:* In the last few decades, substantial new research and improvements in scientific and medical technology have expanded human knowledge about underage alcohol use and its adverse consequences. The general public, as well as those directly and indirectly affected by underage drinking, may not be aware of the new data and its importance in substantiating the seriousness of underage alcohol use. A program to make the public aware of the new findings and to educate the populace about the risks and costs of underage alcohol use can have a positive effect on underage alcohol consumption. Social norms affect underage alcohol use by influencing adolescent and adult attitudes and decisions about underage drinking. An effort to change those norms by reducing the acceptability of underage drinking should be part of a larger program aimed at prevention and reduction that includes resistance skills training.

2.1A. Federal Action: Provide developmentally and culturally appropriate information on underage drinking and its consequences to adults, emphasizing their responsibility to help prevent it, with specific information and recommendations for parents and caregivers of those under the age of 21.

*Rationale:* Since underage drinkers usually obtain alcohol from adults, either directly or indirectly, adults should be a primary target of prevention and reduction efforts. Developmentally and culturally appropriate interventions for adults deliver information on the adverse consequences of underage drinking and emphasize adult responsibility in preventing it. Parents, in particular, affect their children's decisions to use or not use alcohol through involving themselves in their lives and monitoring their activities. A parent's ability to affect that decision has been well documented and remains consistent across racial and ethnic groups. Parental influence is especially effective in the case of younger children. Yet there is considerable evidence that parents are not aware of the full extent of their own influence, their underage children's alcohol use, or the risky consequences associated with that use.

2.1B. Federal Action: Provide youth in kindergarten through high school with developmentally and culturally appropriate information and resistance skills training to enhance relevant protective factors and to help change their attitudes toward underage drinking.

*Rationale:* Because underage drinking often begins at very young ages and carries special risks (10% of 9- to 10-year-olds have already started), prevention and reduction efforts must begin early. Approaches that are developmentally and culturally appropriate are more effective than those that are not. Research on underage drinking indicates that school-based prevention programs, for example, are effective when they address social pressures to drink, teach resistance skills,

include developmentally appropriate information, are based on social influence, and include norm setting (NIAAA, 2005a).

2.1C. Federal Action: Provide college students with developmentally and culturally appropriate information and skills training to enhance relevant protective factors and to help change their attitudes toward underage drinking.

*Rationale:* The high prevalence of alcohol usage among underage college students and the adverse consequences that usage brings to the users and those around them mandate a concerted effort to prevent and reduce underage alcohol usage in this population. Developmentally and culturally appropriate approaches, including skills training to enhance relevant protective factors and information to change current campus attitudes toward underage drinking, should be made available to college students.

2.1D. Federal Action: Provide youth under the age of 21 in settings outside the educational system, including those in the workplace, with developmentally and culturally appropriate information and resistance skills training to enhance relevant protective factors and to help change their attitudes toward underage drinking.

*Rationale:* Underage drinkers pose a threat to themselves and others, regardless of whether they are in the educational system, the workforce, or somewhere else. Therefore, youth outside the educational system, including those in the workplace, constitute a group for whom developmentally and culturally appropriate interventions are needed. The Federal Government can take a leadership role in providing appropriate information and resistance skills training to this group.

**Goal 2, Objective 2:** Reduce access to alcohol by those under age 21 and strengthen accountability by enforcing underage drinking laws.

*Rationale:* Reducing underage access to alcohol is a critical element in preventing and reducing underage alcohol consumption. By more rigorously publicizing and enforcing underage drinking laws, authorities strengthen community responsibility and accountability for denying minors access to the alcohol they seek. These measures make alcohol more difficult to get by increasing the accountability of those who supply alcohol to underage youth. But the measures also serve to deter adolescent attempts to acquire alcohol because of the greater likelihood of their being caught and punished.

2.2A. Federal Action: Inform States and local communities about effective policies and procedures for reducing access to alcohol to those under age 21.

*Rationale:* The Federal Government gathers significant research data on underage alcohol use that can be used to help identify the most effective policies and procedures for use by States and communities in reducing underage access to alcohol. By providing routinely updated information on best practices to the

States and local communities, the Federal Government can increase the effectiveness of access reduction efforts.

2.2B. Federal Action: Assist States and local communities in enforcing underage drinking laws.

*Rationale:* Controlling access to alcohol is primarily a State responsibility under the 21st Amendment to the Constitution. However, communities may pass stricter laws than those required by the States. The Federal Government can assist States and local communities in crafting laws that prevent or reduce underage drinking as well as supporting the States and communities in the enforcement of these laws in such areas as compliance training in retail establishments.

> 2.2B.1. Action: Assist States and local communities in training local retail establishments about underage drinking laws and how to comply with those laws.
>
> *Rationale:* Local communities and their retail establishments will not enforce underage drinking laws unless they are aware of the laws, know how to enforce them, and are committed to that enforcement. The Federal Government can assist in compliance training for retail establishments within a State or community, including media campaigns concerning compliance check programs.
>
> 2.2B.2. Action: Assist States and local communities in enforcing retail establishment compliance with underage drinking laws.
> *Rationale:* Laws that prohibit providing alcohol to underage youth are only meaningful when they are enforced. The Federal Government can assist States and local communities in enforcing retail establishment compliance with underage drinking laws.
>
> 2.2B.3. Action: Assist States and local communities in using graduated sanctions in the enforcement of underage drinking laws.
>
> *Rationale:* Graduated, or accountability-based, sanctions hold individuals and retail establishments accountable for illegal behavior, providing swift and appropriate punishment based on the gravity of the offense followed by progressively tougher sanctions with each new occurrence. The Federal Government can assist States and local communities in the design and implementation of graduated sanctions in the enforcement of underage drinking laws, including fines and license suspension and revocation.
>
> 2.2B.4. Action: Provide information to States and communities on the range of available options for designing and passing laws that reduce or prevent underage drinking.
>
> *Rationale:* Some laws aimed at reducing or preventing underage drinking are more effective than others. A wide variety of options exists for States and local communities. The Federal Government can provide information

to States and communities about the design of the most effective laws and the options for aiding their passage.

2.2C. Federal Action: Promote partnerships to effectively address underage drinking at the State and local levels, including partnerships between enforcement agencies and those interested in underage drinking prevention, and partnerships between enforcement agencies and other justice agencies.

*Rationale:* Meaningful State and local involvement in the effort to reduce underage drinking develops from a partnership between governments, the private sector, organizations, and concerned individuals. Through such partnerships, the community itself is mobilized to respond in a broad-based, effective way to the underage drinking problem. An essential component of this partnership is involvement of the justice agencies, including the enforcement agencies. Curtailing underage access to alcohol and a commitment to enforcing the DWI (driving while intoxicated) laws requires a dedicated, coordinated effort between the community and its enforcement entities.

2.2D. Federal Action: Support improvement of justice system responses to underage drinking and improved adjudication by appropriately including the judiciary in underage drinking reduction efforts.

*Rationale:* When passed and enforced, laws aimed at reducing underage drinking serve as deterrents to adolescents and adults. The effectiveness of a deterrent depends upon the severity of its consequences, the likelihood of its imposition, and the speed with which it is applied. States and localities can reduce underage access to alcohol by improving adjudication and justice system responses to underage drinking. For example, States and communities can improve enforcement of laws that hold retailers responsible for sales to minors (e.g., through compliance checks), that keep adults from supplying alcohol to minors, that prohibit driving while intoxicated, and that prohibit underage possession of alcohol or attempts to purchase it.

2.2E. Federal Action: Support programs that dissuade adults from providing alcohol to those under 21.

*Rationale:* Third-party transactions in which adults purchase alcohol for minors are a common means by which adolescents, especially older teenagers, acquire alcohol. Laws designed to prevent these transactions are effective when they are known and understood by adults and are accompanied by a credible threat of enforcement. Media campaigns and other programs that publicize these laws, draw attention to their enforcement, and encourage community norms against providing alcohol to minors are an important part of a comprehensive effort to reduce underage access to alcohol.

**Goal 2, Objective 3:** Increase community support to prevent and reduce underage drinking through efforts to reduce risk factors and promote protective factors.

*Rationale:* Many different factors contribute to the drinking decisions of underage youth, and multiple approaches to reduce such drinking are possible. Two significant factors that are recognized to influence underage drinking decisions are parental attitudes and the norms and actions of the community in which they live. Case studies and community trials indicate that community coalitions have a positive effect on alcohol-related outcomes. Community involvement is an essential component of a comprehensive plan to prevent and reduce underage alcohol use. Such involvement can be used to help create the political will to implement strategies for reducing underage drinking, change community norms, produce greater awareness of the consequences of underage drinking, build support for better enforcement activities, complement Federal and State efforts, implement and support various interventions, and instill the idea that underage alcohol use is a problem that requires the community's participation to solve.

2.3A: Federal Action: Provide support for States and communities to address underage drinking in their prevention activities.

*Rationale:* While underage drinking has a negative impact on the public health and safety of the Nation as a whole, much of the work to prevent and reduce the problem must be accomplished at the community level. The success of school-based prevention programs, family-based prevention programs, attempts to enforce the minimum legal drinking age laws, and local public awareness campaigns to change community norms about the acceptability of underage alcohol use all depend, to some extent, upon community involvement. The Federal Government can provide support in all these areas to States and communities in their efforts to prevent and reduce underage drinking.

**Goal 2, Objective 4:** Provide opportunities for early identification of alcohol abuse and brief interventions or treatment as appropriate.

*Rationale:* Early identification of underage alcohol abuse makes it possible to intervene sooner rather than later to reduce or eliminate the negative consequences of alcohol use on the user and on society. Brief interventions or treatment, as appropriate, can be used to achieve this goal.

2.4A: Federal Action: Provide opportunities for early identification of alcohol abuse and brief interventions or treatment as appropriate.

*Rationale:* When underage alcohol use goes beyond experimentation to cause alcohol-related problems, such as driving while intoxicated, or becomes alcohol abuse, brief interventions can be an appropriate response. Others with more severe alcohol problems may require treatment.

## GOAL 3: UTILIZE RESEARCH, EVALUATION, AND SCIENTIFIC SURVEILLANCE TO IMPROVE THE EFFECTIVENESS OF POLICIES AND PROGRAMS DESIGNED TO PREVENT AND REDUCE UNDERAGE DRINKING.

*Rationale:* The effectiveness of any comprehensive plan for combating underage alcohol use will depend, in part, on the effectiveness of the policies, interventions, and recommendations it proposes to the involved parties. Rigorous scientific research, evaluation, and surveillance must be conducted to ensure that the most efficacious policies, interventions, and recommendations are made.

**Goal 3, Objective 1:** Increase knowledge of effective approaches to prevent and reduce underage drinking and its consequences, with an emphasis on developmentally and culturally appropriate strategies and interventions.

*Rationale:* Interventions have been developed to prevent and reduce underage drinking, but not all are equally effective. For example, a meta-analysis of school-based interventions (Gottfredson and Wilson, 2003) indicates that interventions vary widely in their ability to influence alcohol-related behavior. Similarly, the different approaches aimed at reducing drinking by underage college students are not equally effective. Unfortunately, the most effective programs are sometimes not used (Silvia & Throne, 1997) or implemented as designed (Dusenbury et al., 2003). The use of ineffective interventions wastes time, money, and opportunity.

Adolescents are a very diverse group developmentally. They differ physically, cognitively, and emotionally. Certainly a 12-year-old differs in many ways from a 16-year-old; however, there is also significant developmental variability within the population for any given age during adolescence. A single approach for preventing underage drinking is, therefore, less likely to be effective than multiple, developmentally-appropriate approaches. For example, individuals in pre-adolescence and at each stage of adolescence use alcohol with different expectations (Christiansen et al., 1982) and are subjected to different social forces and cultural influences. The most effective approaches to reducing underage drinking address the developmental stage and the culture specific to the individual.

3.1A. Federal Action: Analyze the current knowledge base on preventing and reducing underage drinking, with an emphasis on developmentally and culturally appropriate strategies and interventions.

*Rationale:* Although numerous interventions have been developed to prevent and reduce underage drinking, some have not been well evaluated; others have been proven to be ineffective, at least in a specific setting; and still others could be improved on the basis of additional research. An analysis of the current knowledge base on preventing and reducing underage drinking would identify the most effective programs, policies, and interventions and would expose gaps in knowledge that need to be filled.

3.1B. Federal Action: Support research to address gaps in the knowledge base identified in 3.1A.

*Rationale:* Many research questions still need to be answered about underage drinking and its prevention. These gaps in the knowledge base need to be filled in order to increase the effectiveness of efforts to prevent and reduce underage alcohol use. The Federal Government can support research that will address these unanswered questions and so increase the efficacy and cost effectiveness of prevention efforts.

**Goal 3, Objective 2:** Increase the use of evidence-based programs.

*Rationale:* Research-based evidence gathered from different interventions aimed at preventing and reducing underage alcohol use has established the superiority of some approaches and interventions over others. Programs that have been shown to work on the basis of causal, correlated, or other evidence should be implemented in place of programs that lack such evidence.

3.2A. Federal Action: Establish Federal registries of effective programs for reducing underage drinking for use by States and communities.

*Rationale:* To ensure cost effectiveness, avoid duplication of effort, and facilitate the widest possible dissemination of policies, programs, and interventions that are effective in preventing and reducing underage drinking, Federal registries should be developed for use by States and communities.

3.2B. Federal Action: Through the provision of resources and expertise, encourage and support the rigorous evaluation of innovative and promising programs aimed at preventing reducing underage drinking.

*Rationale:* Current approaches and interventions designed to prevent underage alcohol use have not substantially reduced underage alcohol consumption in the past decade. Therefore, the Federal Government should encourage rigorous evaluation of promising new programs by providing expertise and resources.

3.2C. Federal Action: Implement funding guidelines that (1) require the use of evidence-based programs or rigorously evaluated programs that are innovative and promising and (2) require the use of evaluation in all programs as a mechanism for identifying and correcting problems in design and/or implementation.

*Rationale:* Programs to prevent and reduce underage alcohol use that have not been rigorously evaluated cannot be assumed to be effective. Therefore, with the exception of research projects, programs that are to be funded by the Federal Government should have evidence of effectiveness. Although the goal of requiring evidence-based programming will require a transition period to accomplish, it is nevertheless important for accomplishing the goals of the Plan.

**Goal 3, Objective 3:** Increase scientific surveillance of underage drinking, contributing factors, and consequences.

*Rationale:* In order to develop and implement effective policies, programs, and interventions aimed at reducing underage drinking, the extent of the problem and its contributing factors, consequences, and trends must be continually monitored. Strategies for preventing and reducing underage drinking can only be developed, analyzed, and understood when the data is current, accurate, and comprehensive.

3.3A. Federal Action: Review existing Federal data sets for opportunities to improve or refine analysis and reporting, and explore the need for expanding or refocusing data collection efforts to close gaps in existing knowledge.

*Rationale:* Additional analysis of existing data sets has the potential to increase our understanding of the problem of underage drinking at minimal cost. In addition, it may be desirable to expand existing data sets to further our understanding of the problem (e.g., by surveying younger children than are currently queried, expanding national surveys to include information about maximum levels of consumption and second-hand effects of alcohol use, monitoring alcohol-related incidents on college campuses, requiring the recording of alcohol-related emergency department visits, monitoring every unnatural death under age 21 for the presence of alcohol in the body, and examining the role of media messages in reinforcing cultural support for the prevention of underage drinking).

# IV. COMPONENTS OF A COMPREHENSIVE PLAN FOR PREVENTING AND REDUCING UNDERAGE DRINKING

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

Although the national responsibility for preventing and reducing underage drinking involves government at every level; the institutions, organizations, and agencies of the public and private sectors; and parents and other adults, the Plan described in this report focuses on the activities of the Federal Government and the unique role it has to play. 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 increases 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; lead the national effort; and support, coordinate, and monitor implementation of the various components of the Plan.

While all the ICCPUD agencies will contribute their leadership and vision to developing a national commitment to prevent and reduce underage alcohol use, the Surgeon General, as the Nation's medical spokesperson, will take a preeminent leadership role. Each participating agency also has a specific role to play according to its mission and mandate. NIAAA and CDC provide the research that helps people understand the serious nature of underage drinking and its consequences. SAMHSA, NHTSA, and the Department of Education conduct programs to reduce underage demand for alcohol, and the Department of Justice, through its Office of Juvenile Justice and Delinquency Prevention, works to reduce underage consumption of and access to alcohol, including its availability. SAMHSA, CDC, and NIAAA conduct the surveillance that gathers the latest data on underage alcohol use and the effectiveness of programs designed to prevent and reduce it. Thus, through the various agencies interacting with one another, the activities and expertise of each will inform and complement the others, creating a synergistic, integrated Federal program for addressing underage drinking in all its complexity.

While the Plan proposed to Congress in this report is built on three goals, five themes characterize it that provide a convenient means of understanding the solution that the

Plan offers and the role that the Federal Government plays in its development and implementation. The themes are:

- Strengthening the national commitment to prevent and reduce underage drinking
- Reducing underage demand for alcohol
- Reducing underage access to alcohol, including availability
- Conducting and supporting research to provide the necessary scientific data to create effective prevention and reduction programs and interventions, including the fostering of evidence-based practices
- Funding surveillance to gather data on underage alcohol usage and attitudes

All the member agencies of ICCPUD address some aspect of the Plan and so relate to one or more of these themes and to each other in supportive, integrated, or complementary ways. As these themes and existing programs indicate, the Federal Government has already taken a highly collaborative and coordinated approach to solving the problem of underage alcohol use, but more can be done. The Plan enhances current governmental efforts by increasing collaboration, coordination, and integration among agencies and programs.

The Plan measures progress by setting specific targets and by carefully monitoring a variety of survey and other data related to underage drinking and its consequences. Appendix B ("Household Data Survey Charts") contains a more detailed description of these measures and targets.

## FEDERAL AGENCIES INVOLVED IN PREVENTING AND REDUCING UNDERAGE DRINKING

Multiple Federal agencies are directly or indirectly involved in preventing and reducing underage drinking. Each of these agencies currently sponsors programs that address one or more aspect of underage alcohol consumption, and each has been included in the Interagency Coordinating Committee on the Prevention of Underage Drinking (ICCPUD) mandated by Congress. The agencies are listed below and their primary and specific roles related to underage drinking are summarized:

1. **Department of Health and Human Services/Administration for Children and Families (ACF):** The Administration for Children and Families (ACF), within the Department of Health and Human Services (HHS), 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.

2. **Department of Health and Human Services /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 conducts and supports research to improve knowledge about underage drinking and to develop effective prevention strategies. CDC assesses

the nature and extent of the problem and tracks progress in addressing it through surveillance activities and through epidemiological studies of underage drinking and its consequences. CDC also evaluates the effectiveness of prevention policies and programs and addresses underage drinking as a risk factor in programs designed to address specific health problems such as injury and violence, sexually transmitted diseases, and fetal alcohol syndrome. CDC also works to train new researchers in alcohol epidemiology and to build State research capacities.

3. **Department of Health and Human Services/National Institute on Alcohol Abuse and Alcoholism (NIAAA):** The mission of NIAAA is to "conduct research focused on improving the treatment and prevention of alcoholism and alcohol-related problems to reduce the enormous health, social, and economic consequences of this disease." NIAAA has expanded its focus on underage drinking based on recent research findings from several different disciplines, including the NIAAA epidemiological survey NESARC and studies on brain development during adolescence that suggest increased vulnerability to consequences of alcohol exposure.

4. **Department of Health and Human Services/Office of the Surgeon General (OSG):** Under the direction of the Surgeon General, OSG oversees the 6,000-member Commissioned Corps of the U.S. Public Health Service and provides support for the Surgeon General in the accomplishment of his other duties, which include, in part, educating the American public about health issues.

5. **Department of Health and Human Services/Substance Abuse and Mental Health Services Administration (SAMHSA):** SAMHSA's mission "is to build resilience and facilitate recovery for people with or at risk for substance abuse and mental illness." SAMHSA works to reduce underage drinking by supporting underage drinking prevention activities in States and communities, promoting the use of evidence-based practices, educating the public, and collaborating with other agencies and interested parties.

6. **Department of Defense (DoD):** DoD is charged with coordinating and supervising all agencies and functions of the government relating directly to national security and military affairs. Its alcohol-specific role in implementing the Plan involves programs to prevent and reduce alcohol consumption by underage military personnel and to improve the health of families of servicemen and women by strengthening protective factors and reducing risks factors in underage alcohol consumption.

7. **Department of Education/Office of Safe and Drug Free Schools (ED/OSDFS):** OSDFS supports programs that prevent violence in and around schools, prevent illegal use of alcohol, tobacco, and drugs, involve parents and communities and are coordinated with related Federal, State, school, and community efforts and resources to foster a safe and drug-free learning environment that support student academic achievement.

8. **Department of Justice/Office of Juvenile Justice and Delinquency Prevention (DOJ/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 and coordinated prevention and intervention programs and to improve the juvenile justice system so that it protects public safety, holds offenders accountable, and provides treatment and rehabilitative services tailored to the needs of juveniles and their families. Since 1998, OJJDP's central underage drinking prevention initiative, Enforcing the Underage Drinking Laws, is a nationwide State and community based, multi-disciplinary effort that seeks to prevent access to and consumption of alcohol by minors, with a special emphasis on enforcement of underage drinking laws and implementation of best and most promising practice programming.

9. **Department of the Treasury/Alcohol and Tobacco Tax and Trade Bureau (TTB):** TTB's mission "is to collect taxes owed, and to ensure that alcohol beverages are produced, labeled, advertised and marketed in accordance with Federal law."

10. **Department of Transportation/National Highway Traffic Safety Administration (DOT/NHTSA):** NHTSA's mission is to save lives, prevent injuries and reduce traffic-related health care and other economic costs. The Agency develops, promotes and implements effective educational, engineering, and enforcement programs to end preventable tragedies and reduce economic costs associated with vehicle use and highway travel, including underage drinking.

11. **Federal Trade Commission (FTC),** ***ex officio*****:** The FTC works to ensure that the Nation's markets are vigorous, efficient, and free of restrictions that harm consumers. The Commission has enforcement and administrative responsibilities under 46 laws relating to competition and consumer protection. As enforcer of Federal truth-in-advertising laws, the agency monitors alcohol advertising for unfair practices and deceptive claims and reports to Congress when appropriate.

12. **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.

The following section of the report highlights major initiatives currently being taken to prevent and reduce underage drinking and its consequences, categorized according to the five themes of the Plan. More detailed information about departmental and agency programs to prevent and reduce underage drinking appears in Appendix A ("Inventory of Federal Programs by Agency").

## HOW FEDERAL AGENCIES AND PROGRAMS WORK TOGETHER

One of the process goals of the comprehensive Plan is to increase coordination and collaboration in program development among the ICCPUD agencies so that resulting programs and interventions are complementary and synergistic. At the present time, numerous programs do support one another. For example, Project Northland, which was developed with funding from NIAAA, is a comprehensive universal prevention program that was tested in 22 school districts in northeastern Minnesota in a randomized trial. The intervention, delivered to a single cohort in grades 6 through 12, included innovative social behavioral school curricula, peer leadership, parental involvement programs, and community-wide task force activities to address community norms and alcohol availability. Significant differences were observed between intervention and comparison communities during each project period for "tendency to use alcohol" (a composite measure that combined items about intentions to use alcohol and actual use) and "five or more in a row." Growth rates in these measures were lower in the intervention communities during phase 1; higher during the interim period (suggesting a "catch-up" effect while intervention activities were minimal); and lower again during phase 2 when intervention activities resumed. Project Northland was most effective with youth who had not initiated alcohol use prior to the start of the program. Based on its success, Project Northland has been designated a model program by SAMHSA, and its materials have been adapted for a general audience and marketed by Hazelden.

## INITIATIVES FOR STRENGTHENING THE NATIONAL COMMITMENT TO PREVENT AND REDUCE UNDERAGE DRINKING

The initiatives described in this section highlight those from multiple agencies that are designed to strengthen the national commitment to prevent and reduce underage alcohol consumption.

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

Mandated by Congress, ICCPUD is both a mechanism for coordinating Federal efforts and a resource for the development and on-going refinement of a comprehensive plan for combating underage drinking. ICCPUD will coordinate the efforts that various governmental departments and agencies engage in to prevent and reduce underage drinking. It will encourage departments and agencies to align individual programs with the Plan, identify opportunities to address gaps in programming by objective and target age, and facilitate collaboration on projects that are more likely to succeed when supported by multiple agencies. To provide continuing, high-level leadership, HHS has made ICCPUD a standing committee.

A key element in strengthening the national commitment to address underage drinking is to ensure that all appropriate Federal agencies convey the same messages at the same

time and that they seek opportunities to do so. Therefore, ICCPUD agencies are increasing their efforts to:

- Highlight the need to prevent underage drinking and its negative consequences in speeches and meetings across the country
- Ensure that the Administration speaks with a common voice on underage drinking and its consequences
- Reinforce the messages that ICCPUD has developed
- Publicize programs, events, research data, and other information about underage drinking and its consequences

**National Meeting of the States on Underage Drinking**

In the fall of 2005, the ICCPUD agencies held a one-and-a-half-day national meeting in Washington, DC, on the prevention of underage drinking. The meeting included both State teams and Federal leaders. The purpose of the meeting was to highlight the Federal commitment to preventing underage drinking, raise public awareness of the extent of the problem and its negative consequences, inform the teams representing the States about the most recent scientific research related to underage drinking, and provide an opportunity for each State team to begin planning how to build a commitment to reducing underage drinking in its own State, and to maximize participation in a Web-based meeting of communities across the country scheduled for the spring of 2006.

**Role of the Surgeon General**

As the Nation's medical spokesperson, the Surgeon General will highlight the importance of preventing underage drinking to the health of the Nation by issuing a Call to Action. SAMHSA will work with the Office of the Surgeon General, NIAAA, and other Federal agencies to prepare this Call to Action, which was announced at the national meeting in the fall of 2005. The Surgeon General will also continue to address underage drinking in speeches and meetings across the country, presenting it as a public health problem. In declaring 2005 "The Year of the Healthy Child," he focused on improving the body, mind, and spirit of the growing child including the elimination of alcohol consumption and reduction of consequent vehicle crashes. In addition, the Surgeon General addresses childhood and adolescent drinking prevention on his "50 schools/50 States" tour and played a major role in the National Meeting of the States.

**Federal Web Site on Underage Drinking**

ICCPUD is supporting development of a Federal Web site dedicated to providing information about underage drinking. The Web site will include a searchable database of all Federal programs and resources related to the prevention of underage drinking. It will contain sections on core messaging, resources and materials, and college drinking as well as information for communities, parents, youth, and other interested groups.

## Leadership to Keep Children Alcohol Free

Founded by NIAAA and launched in March 2000, this nationwide initiative spearheaded by 52 spouses of current and former Governors (including two Governor's representatives) has been supported by seven public and private funding organizations. The initiative's four goals are: (1) make prevention of alcohol use among minors a national health priority; (2) focus State and national policymakers and opinion leaders on the seriousness of early-onset alcohol use; (3) educate the public about the incidence and impact of alcohol use by children 9- to 15-years of age; and (4) mobilize the public to address these issues in a sustained manner and work for change within their families, schools and communities. In addition, initiative members convene policy forums in their respective States, bringing together policymakers, law enforcement officials, substance abuse officials, educators and other stakeholders to discuss effective measures for reducing/preventing underage drinking, especially by 9- to 15-year-olds.

# INITIATIVES FOR REDUCING UNDERAGE DEMAND FOR ALCOHOL

The initiatives described in this section are designed to reduce the underage demand for alcohol. They may be specific to alcohol in their subject matter or they may relate to other factors that have a bearing on underage alcohol demand.

## Safe and Drug Free Schools Prevention Programs

The Office of Safe and Drug Free Schools in the Department of Education provides grants to local educational agencies (LEA's) to develop and implement effective, innovative alcohol abuse prevention programs for secondary school students. Under this grant program, LEA's develop prevention programs that include one or more proven SAMHSA strategies or model programs for reducing underage alcohol abuse. Since 2002, 57 school districts across 28 States have received grants to implement these programs.

## Strategic Prevention Framework State Incentive Grant Program (SPF SIG)

SPF SIG builds on the successful State Incentive Cooperative Agreements that have given the governors of 44 States and Territories the opportunity to enhance their States' substance abuse prevention systems and fill programmatic gaps with evidence-based services. SAMHSA's FY 2004 SPF SIG grants allow States and communities to focus resources on critical needs identified through an epidemiologically-based State needs assessment, allowing them subsequently to target populations and ages using evidence-based prevention and early-intervention policies, programs and practices. SPF SIGs also support States by providing prevention resources and facilitating systems improvement to help ensure successful transition from the Substance Abuse Prevention and Treatment Block Grant to State grants with National Outcome Measures (NOMs). The grants are

intended to fulfill SAMHSA's overall goal of increasing the capacity and effectiveness of States and communities in responding to critical problems and needs. State applicants must include the prevention of underage alcohol consumption in their SPF SIG Project and provide a comprehensive strategy that addresses this problem in addition to other SPF SIG priorities. All tasks, including needs assessment, consensus building, planning, funding allocations, implementation and evaluation must consider the issue of underage drinking. SPF SIG States are required to have representation from the State's lead agency on underage drinking on the grant's Governor's Advisory Committee and are required to report quarterly to SAMHSA on the status of underage drinking activities.

**Smashed: Toxic Tales of Teens and Alcohol**

NHTSA, SAMHSA and Safe & Drug Free Schools (Dept of Education) have collaborated to work with Recording Artists, Actors and Athletes Against Drunk Driving (RADD) and their partner, HBO Family to develop and disseminate an educational package including a documentary on underage drinking and alcohol-related driving to thousands of schools and communities across the country. HBO licensed RADD and the Federal partners with the use of its documentary "Smashed" and RADD collaborated with the Federal partners to develop a lesson plan for teachers, community guide, and pre- and post-tests for collection of data and evaluation. Two other major national youth organizations, Students Against Destructive Decisions (SADD) and Family Career and Community Leaders of America (FCCLA) provided an initial distribution network. Schools and youth and community groups using "Smashed" to initiate dialogue about underage drinking and alcohol-related driving are then directed to model programs that can be effectively implemented by individual communities to combat the problem in a way that fits their own community needs.

**Enforcing Underage Drinking Laws (EUDL)**

OJJDP's EUDL program encourages partnerships between law enforcement agencies and underage drinking prevention advocates in all 50 States and the District of Columbia for the purpose of reducing access to and consumption of alcohol by minors. One design element is the use of multidisciplinary coalitions, including representatives of the enforcement and prevention fields. An important element of the EUDL initiative is to reduce underage consumption of alcohol by establishing EUDL programs on select college and university campuses. EUDL has conducted campus-based programs in 33 States since 1998. Youth are encouraged to participate in the planning and implementation of EUDL initiatives. Another example of youth-focused programming is Mothers Against Drunk Driving's Youth in Action efforts.

**EUDL Annual Leadership Conference**

Since 1999, EUDL has conducted an Annual Leadership Conference focused solely on the prevention of underage drinking. The Conference attendees include State

Coordinators, enforcement officers and executives, youth, government officials such as ICCPUD members, staff of community-based organizations, and other individuals concerned with underage drinking. The goal of the Conference is to provide conference participants with detailed information about enforcement and other environmental initiatives aimed at reducing social availability of alcohol to youth. Attendance has grown from 250 in the first year to 1,200 in 2004, indicating the role of this program in strengthening the national commitment to reducing underage drinking. In 2005, the OJJDP-supported Underage Drinking Enforcement Training Center's 6th National Leadership Conference, Law Enforcement & Communities: Sustaining Progress, Blazing New Trails, will highlight underage drinking prevention efforts that have worked to ensure the sustainability of efforts. Plenary and workshop sessions will offer guidance on how to establish linkages between law enforcement agencies and community advocates, how to develop a strategic plan to guide your work, and how to document success at the local level. More than 900 attendees are expected to attend this year, including member agency representatives of ICCPUD.

**Higher Education Center for Alcohol and Other Drug Prevention**

The mission of the Department of Education's Higher Education Center for Alcohol and Other Drug Prevention is to help colleges and universities in their efforts to prevent alcohol, drug abuse, and violence on their campuses and in their surrounding communities using comprehensive prevention strategies. The Center achieves this goal by providing technical assistance; training; the publication and dissemination of prevention materials; and assessment, evaluation, and analysis activities.

**Substance Abuse Prevention and Treatment (SAPT) Block Grant**

This grant is a primary funding source for alcohol prevention and treatment in the United States. While there is no set-aside for youth treatment, States have the option of using this resource to prevent and treat alcohol use disorders among adolescents. SAMHSA's SAPT Block Grant contains a prevention set-aside that reserves a minimum of 20 percent of each State's block grant allocation for prevention activities. While the majority of programs are designed to prevent substance abuse in general, many will have an impact on underage drinking. The block grant application asks States to report voluntarily on underage drinking strategies such as implementation of public education and/or media campaigns; laws against alcohol consumption on college campuses; policies and enforcement of laws that reduce access to alcohol by minors, including event restrictions, product price increases and penalties for sales to minors; data for estimated age of drinking onset; and statutes restricting alcohol promotions to underage audiences.

**Reach Out Now Fifth and Sixth Grade *Scholastic, Inc.* Supplements**

SAMHSA and *Scholastic, Inc.* have developed special materials devoted to underage drinking that target 10- to12-year-olds and their parents. Known as *Reach Out Now*: *Talk*

*with Your Fifth Graders about Underage Drinking*, and *Reach Out Now: Prevent Underage Alcohol Use by Talking with Your Sixth Grader*, these materials have been focus-group tested with parents and teachers. They include a classroom discussion guide for teachers, activity sheet for students, and a take-home packet for parents. Reach Out Now is in its fourth year. In March 2005, the package was sent to every fifth and sixth grade class in America including those States participating in the *Leadership to Keep Children Alcohol Free* Initiative.

**Ad Council PSA Campaign**

This HHS project, with contributions from several ICCPUD agencies, supports the Ad Council in developing an underage drinking campaign targeting parents of youth 9- to 15-years-old. The resulting PSA's will reach a variety of audiences in addition to parents because of their broad distribution and so constitute one of the many initiatives to reduce the underage demand for alcohol use. In developing the campaign, the Ad Council is consulting with interested parties, including public health advocacy groups and the alcohol beverage industry.

**Too SMART to START (TSTS)**

This youth underage drinking prevention campaign, supported by SAMHSA, is a national community education program targeting children and youth 9- to 13-years-old. The campaign provides professionals, volunteers, and parents with tools and materials to help shape healthy behaviors regarding lifetime alcohol. TSTS includes a Web page, technical assistance, and a community action kit to help communities plan, develop, promote and support local underage alcohol use prevention. The program, which has been tested in nine communities nationwide, includes materials and strategies for use in communities of all sizes and actively involves entire communities in sending clear, consistent messages about why children should reject underage drinking.

**Drug Free Communities Program (DFC)**

This ONDCP program, which is administered by SAMHSA, provides resources to local coalitions though coalition and mentoring grants. The purposes of the program are to: (1) reduce substance abuse (including alcohol) among youth and, over time, among adults by addressing the factors in a community that increase the risk of substance abuse and by promoting factors that decrease the risk of substance abuse, and (2) establish and strengthen collaboration among communities; private non-profit agencies; and Federal, State, local, and tribal governments in support of community coalitions to prevent and reduce substance abuse among youth. With nearly 750 grants in separate communities, SAMHSA will begin to apply its Strategic Prevention Framework to these community-based grants in order to link local needs with programs and services that have proven effective in addressing substance abuse problems.

## Federal Trade Commission's (FTC) Monitoring of Alcohol Advertising

The Federal Trade Commission continues to monitor alcohol ads and marketing to ensure that they are not, through content or placement, directed to persons under the age of 21 in violation of the FTC Act. The FTC will conduct inquiries, as needed, to verify industry compliance with existing alcohol industry code provisions that limit the underage audience composition for alcohol advertising to 30% and that call for post-placement audits. The agency will persist in advocating improved industry self-regulation, including an industry-wide third-party review system as an external check on compliance with code standards, particularly as a means of addressing complaints about the underage appeal of alcohol advertising.

## INITIATIVES FOR REDUCING UNDERAGE ACCESS TO ALCOHOL, INCLUDING AVAILABILITY

These initiatives are designed to prevent and reduce underage access to alcohol, including availability.

## Enforcing Underage Drinking Laws (EUDL)

OJJDP's EUDL program encourages partnerships between law enforcement agencies and underage drinking prevention advocates in all 50 States and the District of Columbia for the purpose of reducing access to and consumption of alcohol by minors. Congress has directed OJJDP to develop task forces of State and local law enforcement and prosecutorial agencies, encourage innovative programming, and conduct public advertising programs that inform alcohol retailers about underage drinking laws and the consequences of violating them. One design element is the use of multidisciplinary coalitions, including enforcement and other representatives of the justice system.

The Underage Drinking Enforcement Training Center publishes documents to help States and local communities enforce retail establishment compliance with underage drinking laws. *The Guide to Responsible Alcohol Sales: Off Premise Clerk, Licensee & Manager Training* offers sales personnel training tools that stress support of management policies to prevent sales of alcohol to minors. *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, identifying program components and additional resources. *Strategies for Reducing Third-Party Transactions of Alcohol to Underage Youth* dissuades adults from providing alcohol to underage persons by discussing the problem of non-retail source availability of alcohol for underage drinkers, the essential elements of shoulder-tap operations, and other techniques designed to deter adults from buying or providing alcohol to underage drinkers.

Utilizing a community trials evaluation design, Wake Forest University is conducting an evaluation during 2003 through 2006 of EUDL discretionary programming in selected communities within five States: California, Connecticut, Florida, Missouri, and New York. This systematic and rigorous evaluation is studying the implementation of research-based "best" and "most promising" practices to enforce underage drinking laws and prevent and reduce underage drinking.

**Evaluation of the EUDL Program**

NIAAA is conducting an evaluation of OJJDP's EUDL program that targets youth under 21-years-old. The NIAAA supported evaluation is specifically focused on EUDL programs in rural communities of approximately 20,000 people or fewer. The EUDL program design encourages partnerships between enforcement and those interested in underage drinking prevention. One design element required in the discretionary program component is the utilization of multi-disciplinary coalitions to promote a comprehensive approach to underage drinking prevention at the local level. OJJDP is directed by Congress to focus on developing statewide task forces of State and local law enforcement and prosecutorial agencies, conducting public advertising programs that include informing alcohol retailers about laws pertaining to underage drinking and their consequences, and encouraging innovative programming. Currently, the NIAAA supported evaluation is underway in 4 States (New Mexico, Nevada, Pennsylvania and Illinois) and 3 more will be added shortly.

**Underage Drinking Enforcement**

NHTSA and the National Liquor Law Enforcement Association (NLLEA) are developing a best practices manual and training program to assist State and local alcohol beverage control and law enforcement agencies in enforcing underage drinking laws. This effort is targeted toward adults.

Additionally, NHTSA provides support for the International Association of Chiefs of Police (IACP) to encourage enforcement of underage drinking laws. The IACP developed a training program to help mid-level law enforcement managers address the youth impaired driving problem in their communities. IACP will form a cadre of course facilitators to deliver the Youth Enforcement Resource Kit.

**21 Drinking Age and Zero Tolerance Laws**

NHTSA implemented congressionally mandated programs to encourage States to enact 21 Minimum Drinking Age and Zero Tolerance Laws. Minimum Drinking Age laws make it unlawful for a person under age 21 to purchase or publicly possess alcohol. Zero Tolerance laws make it unlawful for persons under the age of 21 to drive with any detectable level of alcohol in their system. All 50 States and the District of Columbia

have enacted these laws, and NHTSA continues to monitor compliance. A failure to comply results in financial sanctions against the States.

**Techniques for Effective Alcohol Management (TEAM) Coalition**

NHTSA provides support to a coalition of public and private sector organizations that support the development of effective alcohol service training in public assembly facilities (primarily sports arenas) and promote responsible alcohol consumption (including deterrence of underage drinking) to reduce alcohol-related instances both in facilities and on surrounding roadways. This effort is targeted toward adults.

**Youth Courts**

OJJDP provides support to Youth Courts—which are also called teen, peer, and student courts—are programs through which youthful offenders are sentenced by their peers for minor delinquency and status offenses or problem behaviors. Currently, there are more than 1,019 youth courts operating in 48 States and the District of Columbia, and hundreds of jurisdictions are in various operational stages of establishing a youth court. A recent national survey indicated that 73% handle alcohol-related crimes and offenses. The age of offenders who appeared in youth court in 2003 averaged between 13- and 17-years-old. NHTSA also collaborates with OJJDP on some Youth Courts.

In May 2002, results from the first National Youth Court Evaluation contracted by OJJDP indicated that youth handled by Youth Court were less likely to re-offend. For example in Alaska, Youth Court participants were re-referred to the juvenile justice system in only 6% of the cases compared to 23% of those handled by the traditional judicial process. In Arizona, the outcome was 9% recidivism among Youth Court cases versus 15% in the comparison group. In Missouri, the results were 9% for teen court and 27% for the regular process.

**Rapid Response to College Drinking Problems**

The consequences of excessive and underage drinking affect virtually all college campuses and all college students, whether or not they choose to drink. Drunk driving, unsafe sex, and vandalism are among the serious alcohol-related problems that college campuses face. In December, 2002, the NIAAA issued a Request for Applications (RFA): "Research Partnership Awards for Rapid Response to College Drinking Problems." This RFA was aimed at established alcohol researchers who have expertise in research on drinking by college students and can serve as resources for college and university administrators. A companion solicitation, Program Announcement PAR-03-133, "Rapid Response to College Drinking Problems," was issued by NIAAA in June 2003. This PAR provides a rapid-funding mechanism for timely research on interventions to prevent or reduce alcohol-related problems among college students. It capitalizes on natural experiments (e.g., unanticipated adverse events, policy changes, new media campaigns, campus-community coalitions) to support rapidly-developed,

high-quality evaluations of services or interventions. Each awardee under the PAR is partnering with an awardee under the RFA and working with NIAAA to form individual steering committees to collaboratively develop study protocols. Thirty-six universities submitted applications to the PAR, thirteen of which were revised and resubmitted. To date, fifteen projects have been approved for funding. NHTSA also provided support for this effort.

## INITIATIVES FOR SCIENTIFIC RESEARCH TO CREATE MORE, AND THEN, DISSEMINATE, EFFECTIVE PREVENTION AND REDUCTION PROGRAMS AND INTERVENTIONS

These research initiatives are designed to provide the scientific data necessary to create more effective drinking prevention and reduction programs and interventions for underage youth and to foster evidence-based practices.

### NIAAA Research Studies to Examine the Effects of Adolescent Alcohol Abuse and Alcoholism on the Developing Brain

It is now understood that adolescence is a time of powerful developmental forces that go well beyond the traditional conceptualization of "raging hormones," and include significant changes to the brain and nervous system. These changes include increased myelination of neural cells and "pruning" of synapses and neural pathways that are infrequently used in specific regions of the brain. Animal studies suggest that the developing adolescent brain may be uniquely vulnerable to consequences from alcohol exposure. In animal studies: (1) heavy binge-like episodes of ethanol consumption produce damage in areas of the brain affecting cognition and memory; and (2) adolescent alcohol drinking in genetically predisposed rats has long-lasting effects into adulthood, potentially increasing alcohol-seeking behavior, making it more difficult to stop drinking, and increasing the probability of relapse. Preliminary studies in humans suggest that the studies in animals may have relevance to adolescents who are heavy drinkers.

### NIAAA Initiative on Underage Drinking

NIAAA has undertaken a major effort to analyze the evidence base related to underage drinking, using a developmental approach. The overarching goal of this broad interdisciplinary initiative is a more complete and integrated scientific understanding of the environmental, biobehavioral, and genetic factors that promote initiation, maintenance, and acceleration of alcohol use, along with those factors that influence the transition into harmful alcohol use/abuse and dependence. This understanding can only come by placing the determinants of drinking within a developmental context.

**Underage Drinking: Building Health Care System Responses**

The overarching goal of this NIAAA Request for Applications (RFA) is to stimulate the primary care health delivery system in rural and small urban areas in the United States to address the critical public health issue of underage drinking. To accomplish this goal, this RFA will solicit applications for cooperative agreements which will enable rural health care systems to engage in research on underage drinking. More specifically, NIAAA seeks to fund such systems: (1) to evaluate and upgrade their capacity to become platforms for research that assesses the extent of underage drinking in the areas they serve and to evaluate their capacity to intervene to reduce this underage drinking (Phase I); and (2) to prospectively study the development of alcohol use and alcohol-related problems among the youth in the areas they serve and to implement and evaluate interventions designed to address this underage drinking (Phase II).

**CDC/NIH Initiative on Research Designs for Complex, Multi-level Health Interventions and Programs**

The goals of this initiative, developed in cooperation with the National Institutes of Health (NIH), the Agency for Health Care Research and Quality (AHRQ), and the Robert Wood Johnson Foundation are to: (1) build a broad-based consensus on the strengths and limitations of experimental, quasi-experimental, and natural experiment research designs for studying complex interventions, programs, or policies implemented at the community level, and (2) encourage an enhanced understanding of the strengths and weaknesses of alternative designs for evaluating the effectiveness of community-based interventions. One of the specific topics addressed is the evaluation of interventions to prevent alcohol purchase and use among adolescents.

**Task Force on Community Preventive Services Systematic Reviews and Recommendations**

The HHS-chartered, Task Force on Community Preventive Services will oversee systematic reviews of the effectiveness of several programs and policies in reducing high-risk alcohol consumption and its consequences. These reviews will be conducted by CDC staff in conjunction with team members from several other Federal agencies and from academia. The systematic reviews will provide the basis for Task Force recommendations on implementing specific programs and policies or for conducting further outcome-oriented research. Several of the interventions to be evaluated will be specifically directed at underage drinking. Results and recommendations will be disseminated to key audiences through multiple channels.

**National Registry of Effective Programs and Practices (NREPP)**

SAMHSA's NREPP was developed in order to review and identify effective prevention programs and practices. The Registry is a voluntary rating and classification system for

mental health and substance abuse prevention and treatment interventions. The system is designed to categorize and disseminate information about programs and practices that meet established evidence rating criteria. SAMHSA has developed NREPP as a national resource for contemporary and reliable information on the scientific basis and practicality of interventions to prevent and/or treat addictive and mental disorders. ICCPUD agencies are currently evaluating whether NREPP can be used as a resource for their programs.

## INITIATIVES FOR SURVEILLANCE TO GATHER DATA ON UNDERAGE ALCOHOL USAGE AND ATTITUDES

The initiatives in the area of surveillance are designed to gather data on underage alcohol use and attitudes.

### Youth Risk Behavioral Survey

This CDC survey collects data about risk behaviors of high school students in grades 9 through 12. It provides information about their lifetime alcohol use, frequency of drinking, frequency of binge drinking, age of first drink, and alcohol use on school property. In addition, there is an optional list of questions for States to consider adding that includes the type of beverage usually consumed, the specific brand of beer usually consumed, the usual location where youth drink, and the source of the alcohol the youth obtained.

### Monitoring the Future Survey (MTF)

MTF is an ongoing NIDA-funded study of the behaviors, attitudes, and values of American secondary school students, college students, and young adults. Each year, a total of some 50,000 $8^{th}$, $10^{th}$ and $12^{th}$ grade students are surveyed ($12^{th}$ graders since 1975, and $8^{th}$ and $10^{th}$ graders since 1991). In addition, annual follow-up questionnaires are mailed to a sample of each graduating class for a number of years after their initial participation.

### National Survey on Drug Use and Health (NSDUH)

Conducted by SAMHSA's Office of Applied Studies (OAS), this survey is a primary source of information on the prevalence, patterns and consequences of alcohol, tobacco and illegal drug use and abuse in the non-institutionalized U.S. civilian population aged 12 and older. While the NSDUH is not alcohol-specific and includes adults as well as underage persons, it does track a variety of data on underage alcohol use and provides a database for studies on alcohol use and related disorders. In 2006, questions are being added to the survey related to the quantity and source of alcohol used by those under 21

and the locations they use it. The survey was formerly called the National Household Survey on Drug Abuse.

**The Drug and Alcohol Services Information System (DASIS)**

DASIS, conducted by SAMHSA, is the primary source of national data on substance abuse treatment. While not specific to youth, it does provide information on adolescent substance abuse treatment facilities as well as adolescent treatment in correctional facilities. DASIS has three components: (1) "The Inventory of Substance Abuse Treatment Services" (I-SATS), a listing of all known public and private substance abuse treatment facilities in the United States and its territories; (2) "The National Survey of Substance Abuse Treatment Services (N-SSATS)," an annual survey of all facilities in the I-SATS that collects information on location, characteristics, services offered and utilization; and (3) "The Treatment Episode Data Set" (TEDS), a compilation of data on the demographic and substance abuse characteristics of admissions to substance abuse treatment.

**NIAAA Funded Longitudinal and Genetic Epidemiology Studies and NIAAA's National Epidemiological Survey on Alcohol Related Conditions (NESARC)**

A number of longitudinal studies still following subjects ascertained when they were adolescents, genetic epidemiology studies, as well as, NIAAA's National Epidemiological Survey of Alcohol Related Conditions which includes people aged 18 to 21, are particularly pertinent to the question of underage drinking. These studies all have the potential to enhance our understanding of the etiology, extent and consequences of underage alcohol consumption. Analysis of data from the NESARC 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.

**National Roadside Survey of Impaired Driving**

NHTSA's Office of Research and Technology plans to undertake a National Roadside Survey of Impaired Driving. This groundbreaking research will provide crucial data on the incidence of impaired drivers, including much needed data on over-the-counter, prescription, and illegal drug use. Many previous roadside surveys have obtained blood alcohol concentrations (BAC) from drivers at roadside but this study will attempt to also obtain saliva samples as well - to determine whether drivers had used drugs. The roadside survey will be conducted in 60 sites across the country, with at least 6,000 subjects. These studies have provided critical information regarding the proportion of drivers on the road across years at various BACs. For example, the 1996 survey indicated that 17% of nighttime weekend drivers had a positive BAC, compared to 26% in 1986, and 36% in 1973. There was also a significant decrease in drivers under the age of 21 who had been drinking in 1996 compared to the previous surveys (.3% in 1996 compared to 4% in 1973). This type of information is needed to better determine the

extent of the drinking and driving problem, including underage drinkers, in order to develop and allocate appropriate countermeasures.

## LOOKING FORWARD

The ICCPUD agencies are committed to using a comprehensive approach to prevent and reduce underage drinking. This will be accomplished, in part, by continuing to use the interagency process as an ongoing mechanism for planning and coordinating Federal efforts. The Plan presented in Chapter 3 will inform and align the development of future programming. Supporting effective programs, eliminating duplication, and addressing gaps in programming will be priorities for the Committee.

The agencies will continue to place a high priority on strengthening our national commitment to addressing the problem. In addition to the agencies' individual efforts, the Committee expects that the Surgeon General's Call to Action and the meeting of communities across the country scheduled for March 2006 will raise the visibility of the problem and motivate individuals and communities to take action in addressing it. In addition, the Ad Council campaign will help increase the visibility of the issue nationally and is expected to motivate parents to address the issue in their families and communities. Efforts to reduce demand for, access to, and availability of alcohol by those under 21 will be improved by ongoing research and surveillance of the problem. It is anticipated that this comprehensive Plan will reduce underage drinking and the associated costs and consequences that burden both society and individuals. The Plan will be revised as needed, based on the Nation's progress in moving toward the performance goals described above, the findings and recommendations that emerge from NIAAA's underage drinking initiative, and data gathered from new research and other sources.

## APPENDIX A

## INVENTORY OF FEDERAL PROGRAMS FOR UNDERAGE DRINKING BY AGENCY

This section summarizes the major initiatives under way throughout the Federal Government to prevent and reduce underage alcohol use in America. This appendix is annotated to indicate the specific Plan goals and objectives that each program serves.

# *ICCPUD ACTIVITIES*

### Activities Specific to Underage Drinking

- **Interagency Coordinating Committee on the Prevention of Underage Drinking (ICCPUD):** At the Secretary's request, the Administrator of SAMHSA, Charles G. Curie, M.A., A.C.S.W., convened an Interagency Coordinating Committee on the Prevention of Underage Drinking (ICCPUD). The Committee is made up of representatives from: DOJ/OJJDP, ED/Office of Safe and Drug Free Schools, DOT/NHTSA, ONDCP, HHS/OSG, CDC, ASPE, ACF, NIAAA, and SAMHSA. ICCPUD is intended to serve both as a mechanism for coordinating Federal efforts and as a resource for the development of a plan for combating underage drinking, which has been mandated by Congress. To provide ongoing, high-level leadership on this important issue, HHS intends that ICCPUD be a standing committee. (Goal 1, Objective 2A)

- **Messages:** To strengthen a national commitment to addressing the problem of underage drinking, it is important that Federal agencies seek opportunities to convey the same messages at the same time. Therefore, the leadership of these agencies will increase efforts to: 1) highlight the need to prevent underage drinking and its negative consequences in speeches and meetings across the country; 2) ensure that the Administration is speaking with a common voice on the issue; 3) reinforce the messages that ICCPUD has developed; and, 4) use a coordinated marketing plan to publicize programs/events, research results, etc. that address the underage drinking issue. (Goal 1, Objective 1A)

- **Support the Minimum Drinking Age:** Agency leadership will continue to develop and utilize messaging that supports a 21-year-old drinking age and will promote this in speeches and message points. (Goal 1, Objective 1A)

- **Website:** SAMHSA is creating a Federal web site dedicated to the issue of underage drinking supported by all participating agencies. The web site would

include a searchable database of all Federal programs/resources related to the prevention of underage drinking and contain sections on core messaging, information on resources and materials, college drinking, as well as information for groups such as parents, communities, and youth.
(Goal 1, Objective 2C)

- **National Meeting of the States on Underage Drinking:** In fall 2005, the ICCPUD agencies held a one and a half day national meeting in Washington, DC, on the prevention of underage drinking. The meeting included both State teams and Federal leaders. The meeting demonstrated a Federal commitment to preventing underage drinking; raised public awareness of the extent and negative consequences of the problem; informed State teams about the most recent research; and provided an opportunity for each State team to start planning how they might build a commitment to reducing underage drinking in their own State, and to maximize participation in a meeting of communities across the country to follow in March 2006.
(Goal 1, Objective 1A)

**Activities <u>Related to</u> Underage Drinking**

- **National Meeting:** On February 12, 2004, the NHTSA, NIAAA, SAMHSA and Office of the Surgeon General convened a meeting of national health organizations to promote alcohol screening and brief intervention as a part of routine medical practice.
(Goal 1, Objective 1A)

- **Uniform Accident & Sickness Policy Provision Law (UPPL) Working Group:** CDC chairs this ongoing working group of Federal (NHTSA, NIAAA, NIDA and SAMHSA) and non-Federal partners to evaluate the effects on screening of patients for alcohol problems of insurance regulations allowing denial of payment for medical services for alcohol-related conditions. The goal of this working group is to monitor the impact of current and changing insurance regulations on screening and interventions for substance use disorders in emergency departments and trauma centers, and to recommend improvements that reduce barriers to screening and brief interventions.
(Goal 2, Objective 4A)

- **EUDL Annual Leadership Conference:** The 2004 EUDL Annual Leadership Conference focused solely on the prevention of underage drinking. Held in San Diego, CA, the Conference drew a total attendance of 1,200, including State Coordinators, enforcement officers and executives, youth, government officials such as ICCPUD members, staff of community-based organizations, and other individuals concerned with underage drinking. The goal of the Conference was to provide conference participants with detailed

information about enforcement and other environmental initiatives aimed at reducing social availability of alcohol to youth.
(Goal 1, Objective 1A)

## *DEPARTMENT OF DEFENSE*

**Activities <u>Specific to</u> Underage Drinking:**

- **Youth Program:** Overseas Air Force youth may access the Adolescent Substance Abuse Counseling Service (ASACS) which is a comprehensive adolescent treatment program which provides treatment and rehabilitation, prevention education, identification and referral. Another Service-level program is Drug Education for Youth (DEFY), which is in place at 19 installations. DEFY provides a collaborative community program with summer camp and ongoing mentoring for youth ages 9-12.
(Goal 2, Objective 1D)

- **Law Enforcement:** Ensure installation-level enforcement of underage drinking laws on all Federal reservations. For Active Duty members who are underage, serious consequences (such as productivity loss or negative career impact) are tracked via the Triennial Health Related Behavior Survey.
(Goal 2, Objective 2B)

**Activities <u>Related to</u> Underage Drinking**

- **Web-based Alcohol Prevention Education Pilot Project:** Triennial Health Related Behavior Survey led to the development of a pilot web-based alcohol prevention education program to begin at eight DoD installations. The 2002 Survey indicated 18- to 21-year-olds accounted for 37% of all active duty binge drinkers. The web-based program will have a pre-program and post-program assessment of the active duty participants. The program will be 3-4 hours of training on affects and consequences of alcohol use.
(Goal 1, Objective 1A; Goal 3, Objective 1A)

- **Utilization of Federal Resources:** Uses many State and Federal marketing resources to conduct facility-level programs (such as the DARE programs at each base). Additionally the Services participate in many Federal alcohol prevention events such as the National Alcohol Screening Day every April and Recovery Month activities each September.
(Goal 1, Objective 2A)

- **Community Collaboration:** Air Force Installations have the Integrated Delivery System and Community Action Information Boards (IDS/CAIB) which provide structures and processes for leadership action. The CAIBs are attended by a multidisciplinary group of installation community members

such as behavioral health, substance abuse counselors, social workers, family advocacy members, law enforcement, facilities and morale recreation and welfare leaders. This group addresses community issues such as underage drinking prevention.
(Goal 2, Objective 2C)

- **Innovative Prevention Program:** One example of a DoD program is the 0-0-1-3 program at FE Warren Air Force Base in Cheyenne, WY. This installation worked with the local community to prevent sales of alcoholic beverages to underage members of the base population. The numbers stand for zero underage drinking, zero drinking and driving, one drink per hour if you are of age, and three drinks per occasion.
(Goal 2, Objective 2E)

- **Service-Level Prevention Programs:** Each Service has specific programs for new entry-level active duty personnel (18- to 26-year-olds) which emphasize healthy and safe lifestyle choices. For example, the Navy conducts the PREVENT (Personal Responsibility and Values: Education and Training) program for new entrants 18- to 26-years-old. This program was recognized in the 2004 National Academy of Science report "Reducing Underage Drinking" as a "promising program". The program trains in decision skills and personal responsibility regarding substance abuse prevention issues and choices made about substances, relationships, finances, and health.
(Goal 2, Objective 3A)

- **Innovative Early Identification Program:** The Air Force is pilot testing Teaching Responsible Alcohol Consumption (TRAC) at Sheppard Air Force Base. This program will provide population screening, identification of high risk individuals, universal and targeted prevention interventions.
(Goal 2, Objective 4A)

- **Research Alcohol Prevention Initiative:** The Naval Health Research Center conducted a pilot study of a web-based personalized alcohol assessment for Marines, gauging underage active duty member drinking habits, providing comparison data for age-appropriate cohorts and awareness education on associated risks.
(Goal 3, Objective 2B)

- **Active Duty Health Related Behaviors Survey:** The DoD conducts the Health Related Behavior Survey (HRBS) triennially, which maintains trended data on alcohol use among all active duty service members age 18 and above addressing age of first use, prevalence, binge use, and heavy use.
(Goal 3, Objective 3A)

## *DEPARTMENT OF EDUCATION*

**Activities Specific to Underage Drinking**

- **Interagency Agreements (in collaboration with NIAAA):** Since FY 1999, the ED provided funds to the NIAAA to support grants with activities that have the potential of preventing or reducing alcohol abuse and associated problems among college students.
  (Goal 1, Objective 2B)

- **School District Training & Technical Assistance (in collaboration with SAMHSA):** The Grants to Reduce Alcohol Abuse in Secondary Students, ED, through an Interagency Agreement with SAMHSA/CSAP's five regional Centers for the Application of Prevention Technologies, provide training and technical assistance to local school districts implementing SAMHSA model programs in preventing alcohol abuse by secondary school students.
  (Goal 2, Objective 1B)

- **Safe & Drug-Free Schools Prevention Programs:** In response to alcohol abuse and other related drug abuse and violence on college campuses and in their surrounding communities, OSDFS has supported campus and community-based prevention programs for more than a decade. Through a discretionary grant competition, OSDFS funds programs to individual institutions of higher education (IHEs), consortia thereof, public and private nonprofit organizations, including faith-based organizations, and individuals to develop or enhance, implement, and evaluate campus-and/or community-based prevention and early intervention strategies. Grantees focus attention on and develop solutions to prevent and reduce high-risk drinking or violent behavior among college students. In FY 2005, OSDFS awarded approximately 20 new awards under the Grant Competition to Prevent High-Risk Drinking or Violent Behavior Among College Students.

  In FY 2002 and 2004, the OSDFS provided 57 grants to local education agencies (LEAs) in 28 States to develop and implement effective, innovative alcohol abuse prevention programs for secondary school students. Programs supported under these grants required that LEAs develop prevention programs that included one or more proven SAMHSA strategies or evidenced-based model programs for reducing underage alcohol abuse. In 2005, 71 new grants were awarded to implement these programs. Technical assistance to these grantees is provided through an interagency agreement with SAMHSA's Center for Substance Abuse Prevention.
  (Goal 2, Objective 1B)

- **Higher Education Center for Alcohol & Other Drug Abuse & Violence Prevention:** The Center's mission is to help colleges and universities in their efforts to prevent alcohol and other drug abuse and violence on their campuses

and in their surrounding communities using comprehensive prevention strategies. The Center achieves this by providing technical assistance; training; publication and dissemination of prevention materials; and assessment, evaluation, and analysis activities. The target for this effort is college-age youths.
(Goal 2, Objective 1C)

- **Strategies for Grantees:** All ED grantees are required to implement, as part of their overall program, one or more of the proven strategies for reducing underage alcohol abuse as determined by the SAMHSA. Furthermore, they are required as part of the application process to explain how other activities to be carried out under the grant will be effective in reducing underage alcohol abuse, including references to the past effectiveness of the activities. In addition to the discretionary grants, ED uses an Interagency Agreement with SAMHSA, to provide alcohol abuse resources and start-up assistance to grantees through a technical assistance network operated by CSAP.
(Goal 2, Objective 3A)

**Activities <u>Related to</u> Underage Drinking**

- **Learning Education Agreements & Grants:** In FY 2004, the Office of Safe and Drug Free Schools Initiative Grants to Reduce Alcohol Abuse in Secondary Schools provided funding to 10 additional Learning Education Agreements (LEAs) and continued funding to 47 LEAs. The major goals of the program are to implement SAMHSA model programs to reduce underage drinking in secondary schools. Additionally, funds have been appropriated to support Grants to Reduce Alcohol Abuse, the Higher Education Grants (GRAAP) and, the Alcohol and Drug abuse Prevention Models in Higher Education. Performance reports for the Safe and Drug-Free Schools and Communities Act State Grants (SDFSCA) do not break down expenditures for alcohol-related programming. State and local educational agencies and community-based recipients under the SDFSCA State Grants Program may elect to use funds to address alcohol and other drug prevention as well as violence. Districts overwhelmingly used funds to address both alcohol and other drug use and violence. In FY 2002 and FY 2003, Education transferred funds to SAMHSA/CSAP under this Interagency Agreement to serve 47 GRAAP grantees implementing 21 Model programs, including multiple program implementations. In FY 2004, ED made an additional 10 new awards in the GRAAP initiative and transferred funds to support all 57 grants to Reduce Alcohol Abuse in Secondary Schools.
(Goal 1, Objective 2B)

- **Alcohol & Other Drug Prevention Models on College Campuses Grant Competition:** The goals of this funding opportunity are to identify models of innovative and effective alcohol and other drug abuse prevention programs at institutions of higher education, and disseminate information about these

programs to parents of prospective college students and to other colleges and universities where similar efforts may be adopted.
(Goal 2, Objective 3A)

- **Grant Competition to Prevent High-Risk Drinking or Violent Behavior Among College Students:** In FY 2001 and FY 2003, the goal of this grant competition was to provide funds to individual institutions of higher education, consortia thereof, as well as public and private nonprofit organizations (including faith-based organizations), or individuals to develop or enhance, implement, and evaluate campus- and/or community-based prevention strategies. Grantees focused attention on and developed solutions to reduce high-risk drinking or violent behavior among college students.
(Goal 2, Objective 3A)

- **National Meeting on Alcohol & Other Drug Abuse & Violence Prevention in Higher Education:** Each year, the Department sponsors the National Meeting to assist grantees and other campus communities and share information on effective strategies related to drug abuse and violence prevention in higher education.
(Goal 2, Objective 3A)

- **National College Alcohol, Drug & Violence Survey:** In August 1998, ED contracted with the Core Institute, part of Southern Illinois University, to conduct a national probability sample survey of alcohol and other drug use and violence on college campuses. The data obtained from this survey can be used to assess the level of alcohol and other drug use and violent behavior among college students, thereby helping to plan, set policy, and design programs to best meet the needs of college campuses and their communities.
(Goal 3, Objective 1B)

## *FEDERAL TRADE COMMISSION*

**Activities <u>Specific to</u> Underage Drinking**
None

**Activities <u>Related to</u> Underage Drinking**

- **Federal Trade Commission, Alcohol Advertising Program**. In 2005-06, the FTC will continue to advocate improved industry self-regulation and will conduct inquiries, as needed, to verify compliance with existing alcohol industry code provisions limiting underage audience composition to 30 percent. The FTC will also monitor alcohol ads and marketing to ensure that they are not, through content or placement, directed to persons under 21 in violation of the FTC Act.

- **Federal Trade Commission, Consumer Education Program.** In 2005-06, the FTC staff plans to coordinate a consumer education campaign promoting support of compliance with the legal drinking age.

## *DEPARTMENT OF HEALTH & HUMAN SERVICES*

**Activities Specific to Underage Drinking**

- **Public Health Strategy:** Department leadership will encourage the Regional Health Administrators and all relevant agencies to emphasize the prevention of underage drinking as a strategy for improving the public health.
  (Goal 1, Objective 1C)

***Administration for Children & Families (ACF)***
ACF is responsible for Federal programs that promote the economic and social well-being of families, children, individuals and communities.

**Activities Specific to Underage Drinking**
None

**Activities Related to Underage Drinking**

- **Mentoring Children of Prisoners:** Family and Youth Services Bureau (FYSB) supports the Mentoring Children of Prisoners Program. The living conditions, family configurations, and problems faced by incarcerated parents make it likely that significant numbers of children of prisoners will suffer emotional and behavioral difficulties. Data indicate that mentoring programs have reduced first time alcohol use by 33 percent. The target ages for this effort are 4- to 15-years-old.
  (Goal 1, Objective 1D)

- **National Youth Summit:** Each year, FYSB sponsors a National Youth Summit to promote leadership opportunities for youth ages 15 to 24 and provide them with alternatives to risky behavior. The Summit celebrates America's youth and their achievements, strengths, and leadership. In 2004, the Summit theme was Youth Leadership in America's Communities.
  (Goal 1, Objective 1D)

- **Runaway & Homeless Youth Program:** This program 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 (up to age 18) in need of immediate shelter. They provide family and youth counseling and refer them to services like substance abuse treatment. Through the Street Outreach Program, FYSB awards grants to private, nonprofit agencies to conduct outreach designed to build

relationships between grantee staff and street youth up to 21-years-old. The goal of these efforts is to help young people leave the streets. The Transitional Living Program (TLP) supports projects that provide longer-term residential services to homeless youth 16- to 21-years-old for up to 18 months. These services are designed to help youth who are homeless make a successful transition to self-sufficient living. TLPs enhance youths' abilities to make positive life choices through education and awareness programs and the support they provide youth; they include services such as substance abuse education and counseling. Alcohol is not allowed at any of the FYSB grantee sites and it is expected that after participating in these programs, youth will be prepared to make better choices regarding alcohol use.
(Goal 2, Objective 1D)

***Centers for Disease Control & Prevention (CDC)***
CDC's mission is to promote the health and quality of life by preventing and controlling disease, injury and disability.

**Activities <u>Specific to</u> Underage Drinking**
None

**Activities <u>Related to</u> Underage Drinking**

- **Youth Risk Behavioral Survey:** This survey collects data about risk behaviors of high school students in grades 9 through 12. It provides information about their lifetime alcohol use, frequency of drinking, frequency of binge drinking, age of first drink of alcohol, and alcohol use on school property. In addition, there is an optional list of questions for States to consider adding that includes questions about the type of beverage that youth usually consume, the specific brand of beer that youth usually consume, the usual location where youth drink, and the source of alcohol obtained by the youth.
(Goal 3, Objective 3A)

- **Recommendations & Conference Proceedings on Screening & Brief Intervention for Trauma Patients:** In May 2003, CDC organized a three-day conference to promote screening of hospitalized trauma patients for alcohol and drug problems and providing on-site brief interventions, referral, and treatment. The conference was co-sponsored by AHRQ, CMS, HRSA, NHTSA, NIAAA, NIDA, ONDCP, and SAMHSA as well as Join Together, the Robert Wood Johnson Foundation, and the American Association for the Surgery of Trauma. Representatives from government agencies, advocates, professional organizations, and leading trauma surgeons attended and presented at the conference, and devised a set of recommendations for research and practice in this area. In 2006, the final recommendations and the

complete proceedings of the conference were published as a special supplement of the *Journal of Trauma*.
(Goal 2, Objective 4A)

- **Project BALANCE (Birth Control & Alcohol Awareness: Negotiating Choices Effectively):** The program consists of (1) a brief epidemiological survey, (2) focus groups, and (3) a randomized controlled trial of a motivational intervention directed at Virginia Commonwealth University college students from 18- to 24-years-old. Project BALANCE's objectives are to identify the prevalence of risky drinking and contraceptive behaviors in this population, and to test the efficacy of an intervention in a randomized trial comparing a group receiving both assessment and one face-to-face session with a group receiving assessment only. The intervention focuses both on drinking and unprotected sex, allowing a woman to modify either or both behaviors.
(Goal 2, Objective 4A)

- **Alcohol-Related Disease Impact (ARDI):** In September 2004, the Alcohol Team in the National Center for Chronic Disease Prevention and Health Promotion at CDC released an updated version of ARDI software, which is accessible through the CDC's Alcohol and Public Health web site (www.cdc.gov/alcohol). The software provides national and State-level estimates of alcohol-attributable deaths (AADs) and years of potential life lost (YPLL) for excessive alcohol consumption. The software allows users to create custom data sets, so that they can generate sub-State (e.g., city or county level) estimates as well. For chronic conditions, AADs and YPLLs are calculated for decedents aged >20 years; for the majority of acute conditions, they are calculated for decedents aged >15 years. However, ARDI also provides estimates of AADs and YPLLs for persons aged <15 years who died from motor-vehicle crashes, child maltreatment, and low birth weight. Consistent with World Health Organization recommendations, the harmful and beneficial effects of alcohol use are reported separately. The Alcohol Team is expanding the functionality of ARDI so that users can calculate alcohol-related economic impacts as well.
(Goal 3, Objective 1A)

- **Initiative on Research Designs for Complex, Multilevel Health Interventions & Programs:** The goals of this initiative, developed in cooperation with the National Institutes of Health (NIH), AHRQ, and the Robert Wood Johnson Foundation are to: 1) build a broad-based consensus as to the strengths and limitations of experimental, quasi-experimental, and natural experiment research designs for studying complex interventions, programs, or policies implemented at the community level, and to 2) encourage an enhanced understanding of the strengths and weaknesses of alternative designs for evaluating the effectiveness of community-based

interventions. One of the specific topics addressed is the evaluation of interventions to prevent alcohol purchase and use among adolescents. (Goal 3, Objective 1A)

- **Task Force on Community Preventive Services Systematic Reviews & Recommendations:** The HHS-chartered Task Force on Community Preventive Services will oversee systematic reviews of the effectiveness of several programs and policies to reduce high-risk alcohol consumption and its consequences. These reviews will be conducted by CDC staff in conjunction with team members from several other Federal agencies and from academia. The systematic reviews will provide the basis for Task Force recommendations for or against implementation of these programs and policies, or indicating the need for further outcome-oriented research. Results and recommendations will be disseminated to key audiences through several channels. Several of the interventions to be evaluated will be specifically directed at underage drinking.
  (Goal 3, Objective 1A)

- **Behavioral Risk Factor Surveillance System (BRFSS):** BRFSS collects data on number of drinking days in the past 30 days, average number of drinks per occasion, and frequency of binge drinking. Although the system does not specifically cover the underage population, it does include persons 18- to 21-years-old. BRFSS currently has a binge drinking module collecting more detailed information on a person's most recent binge drinking episode, including beverage type, location of drinking, and source of alcohol.
  (Goal 3, Objective 3A)

- **Pregnancy Risk Assessment Monitoring System (PRAMS):** PRAMS collects information on women 13-years or older who recently had a live birth. The survey asks about weekly alcohol consumption in the pre-conception period and during pregnancy.
  (Goal 3, Objective 3A)

***Indian Health Service (IHS)***

IHS is the primary Federal agency responsible for healthcare for American Indian/Alaskan Native (AI/AN) beneficiaries nationally. The IHS Division of Behavioral Health, Alcohol and Substance Abuse Program (ASAP) funds tribally administered programs through contracts and compacts in accordance with P.L. 93-638. Fully 97% of the budget goes directly to tribally administered programs. These programs provide holistic and culturally-based alcohol and substance abuse treatment and prevention services to rural and urban communities. The ASAP exists as a part of an integrated Behavioral Health Team that works collaboratively to reduce the incidence of alcoholism and other drug dependencies in American Indian and Alaska Native communities. The ASAP is designed to provide support and resources to American Indian and Alaska Native communities to achieve better practices in alcohol and other drug dependency

treatments, rehabilitation, and prevention services. ASAP program staffs support the social, cultural, and spiritual values of communities in order to promote overall health.

**Activities Related to Underage Drinking**

Alcohol abuse in Indian Country is a problem beginning with prenatal exposure and continuing through the life cycle. Programs are primarily community based and reflect the needs of the individual Tribes and communities in which they operate. As virtually all of the ASAP programs are tribally managed and operated, IHS shifted from a focus on direct care to now supporting those tribal programs and professionals in three principle areas:

1. Support for 12 Youth Regional Treatment Centers which provide residential substance abuse treatment for youth aged 12-18. They offer residential and outpatient programs, including prevention activities, in each of the 12 IHS Areas, and are used to support the locally based outpatient programs in those Areas.
2. Support for technology development and infrastructure for clinical programs as well as trending and data analysis capabilities to drive treatment programs in accordance with requirements and recommendations of accrediting agencies both public and private. IHS has undertaken a large scale technology initiative which now provides a comprehensive treatment documentation, data analysis, and national reporting platform free to all ASAP programs nationally.
3. Support for ongoing training of ASAP personnel including support for ASAP certification training for alcohol an substance abuse counselors; Primary Care Provider training for medical staffs; Fetal Alcohol Spectrum Disorders (FASD) identification and treatment training with the University of Washington; and continuing education programs to maintain certification for all alcohol and substance abuse professionals.

***National Institute on Alcohol Abuse & Alcoholism (NIAAA)***

NIAAA provides leadership in the effort to reduce alcohol-related problems by conducting and supporting alcohol-related research; collaborating with international, national, State and local institutions, organizations, agencies and programs; and translating and disseminating research findings to health care providers, researchers, policymakers and the public.

**Activities Specific to Underage Drinking**

- **Leadership to Keep Children Alcohol Free:** Launched in March 2000, this nationwide initiative spearheaded by 52 spouses of current and former Governors (including two Governor's representatives) has been supported by seven public and private funding organizations. The initiative's four goals are: (1) make prevention of alcohol use among minors a national health priority; (2) focus State and national policymakers and opinion leaders on the seriousness of early-onset alcohol use; (3) educate the public about the

incidence and impact of alcohol use by children 9- to 15-years of age; and (4) mobilize the public to address these issues in a sustained manner and work for change within their families, schools and communities. Initiative members produce television PSAs directed at parents and other adults in their respective States and support youth-centered events (e.g., Ohio's Smart & Sober Youth Conference and Alaska's statewide poster contest). Leadership members also deliver keynote addresses at national meetings (e.g., 2004 Pride Youth conference). In addition, initiative members convene policy forums in their respective States, bringing together policymakers, law enforcement officials, substance abuse officials, educators and other stakeholders to discuss effective measures for reducing/preventing underage drinking, especially by 9- to 15-year-olds.

To educate and raise awareness, this initiative disseminates information for adults about prevention of childhood drinking through such publications as *How Does Alcohol Affect the World of a Child* (also available in Spanish), *Keep Kids Alcohol Free: Strategies for Action* (also available in Spanish) and *Science, Kids & Alcohol Research Briefs*. In 2002 and 2003, more than a million copies of these materials were distributed. Additionally, the initiative placed 207 dioramas on childhood drinking in 41 airports nationwide. It also distributes weekly electronic updates to 360 recipients, including governors' spouses, national organizations, State officials, members of the prevention community and other stakeholders in the underage drinking prevention effort. The initiative's website (www.alcoholfreechildren.org) also provides information for adults, from parents to policymakers.

Supporting the initiative through an interagency agreement with NIAAA, SAMHSA also funds an effort to link this initiative with prevention programs funded by State-level SAPT Block Grants, as well as with such SAMHSA programs as Too Smart to Start and the Reach Out Now Teach-Ins.
(Goal 1, Objective 1B, 1C, 1D, 2A, 2B; Goal 2, Objective 1A, 2C, 3A)

- **Television Public Service Announcements (PSAs) for Youth:** NIAAA's TV PSAs were redistributed to an additional 205 markets in December 2004. The TV PSA, *The Party's Over*, has won the following awards: Award of Excellence -- 2003 National Association of Government Communicators Gold Screen Competition in the PSA category, received May 2004; Platinum, Best of Show -- 2004 Aurora Award; NIAAA's entry received the highest possible award for overall quality; Bronze -- 2004 Telly Award; Copper -- 2004 AXIEM Award; Emmy -- 2003 Mid-America Emmy Awards.
(Goal 1, Objective 1B)

- **Radio Public Service Announcements (PSAs) for Parents:** NIAAA developed two underage drinking prevention PSAs for parents. The focus group–tested PSAs are 30 seconds each and were released in late fall 2004. They were included in ONDCP's pro bono media match program. The five

NIAAA radio PSAs (three for teens and two for parents) were disseminated to 4,500 radio stations throughout the U.S. in November 2004.
(Goal 1, Objective 1B)

- **Radio PSAs for Youths:** NIAAA developed three underage drinking prevention PSAs directed toward youths under age 21. The focus group-tested PSAs are 30 seconds each and were released in late fall 2004. They were included in ONDCP's pro bono media match program. The five NIAAA radio PSAs (three for teens and two for parents) were disseminated to 4,500 radio stations throughout the U.S. in November 2004.
(Goal 1, Objective 1B)

- **Project Northland:** Project Northland, completed prior to 2004, is a comprehensive universal prevention program tested in 22 school districts in northeastern Minnesota in a randomized trial. The intervention, delivered to a single cohort in grades six through twelve, included: innovative social behavioral school curricula; peer leadership; parental involvement programs; and community-wide task force activities to address community norms and alcohol availability. Significant differences were observed between intervention and comparison communities during each project period for "tendency to use alcohol" (a composite measure that combined items about intentions to use alcohol and actual use) and "five or more in a row." Growth rates were lower in the intervention communities during phase 1; higher during the interim period (suggesting a "catch-up" effect while intervention activities were minimal); and lower again during phase 2 when intervention activities resumed. Northland was most effective with youth who had not initiated alcohol use prior to the start of the program. Based on its success, Project Northland is designated as a model program by SAMHSA, and its materials have been adapted for a general audience and marketed by Hazelden. This model is targeted to youths in grades 6 through 12.
(Goal 2, Objective 1A, 1B)

- **Project Northland for Urban Youth:** Project Northland is now being replicated in ethnically diverse urban neighborhoods. Similarly to the original Northland, this project includes parental involvement programs and community-wide task force activities. The purpose is to adapt, enhance, implement, and evaluate Project Northland in racially diverse and economically disadvantaged urban neighborhoods of Chicago. Beyond using the Project Northland plan, the design of the intervention builds on recent results from other large-scale randomized trials on youth alcohol, tobacco, and other drug use. In addition to the cultural adaptations, the original strategies are enhanced, particularly those outside of the classroom setting.

  The design is a randomized community trial that will evaluate an adapted and enhanced Project Northland in 10 intervention and 12 control units (schools and surrounding neighborhoods) with sizable African American and Hispanic

populations. Approximately 4,400 students and their families will be involved. A supplement was received from Office of Behavioral and Social Sciences Research (NIH) to support an additional component to analyze the effects of alcohol marketing in the participating neighborhoods. This effort targets youth in grades 6-12.
(Goal 2, Objective 1A, 1B; Goal 3, Objective 2C)

- **Iowa Strengthening Families Program (ISFP):** NIAAA supported this program as part of its research portfolio. Participants were given instruction on various communication, problem-solving, and perspective-taking skills. The first hour of each program session consisted of separate parent and adolescent training. Among other issues, parents were taught limit-setting, communication, encouraging good behavior, and using community resources; adolescents received training on goal-setting, appreciating parents, dealing with stress, and how to deal with peer pressure. The subsequent hour of joint training focused on appreciating others, understanding family values, conflict resolution, and various communication skills.

  Delivered when students were in grade six, ISFP has shown long-lasting preventive effects on alcohol use, suggesting that the intervention succeeded in changing the normative environment of schools in which the program was offered since even students whose families did not participate benefited. In addition, the increase in effect size over time and the duration of effects into high school compares favorably with school-based interventions. This effort is targeted toward families with a sixth grade student.
  (Goal 2, Objective 1A, 1B)

- **Publications:** NIAAA disseminates information for adults about the prevention of underage drinking through a variety of publications including the NIAAA parent booklet, *Make a Difference – Talk to Your Child About Alcohol – Parents' Booklet, Alcohol Alert* including issues entitled "Underage Drinking: A Major Public Health Challenge" (2003) and "Changing the Culture of Campus Drinking" (2002), as well as the widely cited report from the college drinking task force, *A Call to Action: Changing the Culture of Drinking at U.S. Colleges (2002).*
  (Goal 2, Objective 1A)

- **NIAAA Website:** The NIAAA website (www.niaaa.nih.gov) provides adults with information about the science and prevention of underage drinking and includes links to NIAAA's college website (www.collegedrinkingprevention .gov) and the website targeted to youth (www.thecoolspot.gov).
  (Goal 2, Objective 1A)

- **Coolspot Website for Kids:** Targeted to youth ages 11- to 13-years-old, the NIAAA website www.thecoolspot.gov provides information on underage drinking, including effective refusal skills.
  (Goal 2, Objective 1B)

- **College Drinking Prevention Website:** NIAAA's website www.college drinkingprevention.gov addresses alcohol use among college students.
  (Goal 2, Objective 1A)

- **Deliberations of the Task Force on College Drinking, a Task Force of the National Advisory Council on Alcohol Abuse and Alcoholism** -- These deliberations resulted in the seminal report *A Call to Action: Changing the Culture of Drinking At U.S. Colleges* released in 2002. NIAAA continues to disseminate this report as well as other information related to alcohol consumption by college students through its college web site. This effort targets college-age youths.
  (Goal 2, Objective 1C)

- **Environmental Prevention of College Alcohol Problems (in collaboration with SAMHSA):** CSAP and NIAAA provided joint funding from FY 1999 to FY 2003, to support a comprehensive environmental prevention strategy aimed at reducing binge drinking and resulting alcohol problems among college students at San Diego State University. The research design provided for a quasi-experimental study employing New Mexico State University as a comparison site.
  (Goal 2, Objective 1C)

- **National Alcohol Screening Day (in collaboration with SAMHSA):** The goal of National Alcohol Screening Day (NASD) is to create public awareness of and provide education about alcohol problems and provide the opportunity to screen and refer, when indicated, for further assessment and treatment (if indicated). NASD screening programs are held on college campuses, in community settings, and in private and public primary care practices to reach college students, adults, and older adults. When the results of the screening test indicate, participants are referred to local alcohol treatment through the Treatment Referral Locator program funded by SAMHSA. Since its inception in 1999, nearly 100,000 people from 50 States have participated in the educational component of NASD. Of the 100,000 participants over 55,000 persons have been screened. Of those persons screened more that 13,000 have been referred for further assessment and diagnosis. In 2003, approximately 750 people were trained on "How to Conduct a NASD Event" in various cities across the country. In 2003, screening occurred on almost 900 college campuses; nearly 1000 colleges and universities have signed up for 2004. In 2004, over 5,300 colleges, community, and primary care settings registered to conduct NASD screening program. Of the 112,241 participants over 70,821

persons have been screened. The major vehicle for assessment and treatment diagnosis referral is the SAMHSA locator web site at: www.samhsa.gov.
(Goal 2, Objective 1C and 1D)

- **College Drinking Prevention Initiative:** Undertaken in FYs 2000-2002, this initiative continues to support and stimulate studies of the epidemiology and natural history of college student drinking and related problems with the ultimate goal of designing and testing interventions to prevent or reduce alcohol-related problems among college students. Currently NIAAA's portfolio in this area includes more than 30 projects. This effort targets college-age youths.
(Goal 2, Objective 1C; Goal 3, Objective 2C)

- **Research Studies:** NIAAA supports research studies on programs that decrease youth access to alcohol. Programs may target parents, retailers, community members and others to decrease access.
(Goal 2, Objective 2E)

- **Brief Intervention Research:** This research is providing the evidence base for effective brief interventions with adolescents. Targeted toward youth in the Emergency Room following an alcohol-related event, health care providers take advantage of a 'teachable moment' to deliver a brief intervention aimed at reducing problem drinking and associated problems. This approach complements other programs that rely on school-based primary prevention programs and which therefore do not address cessation/reduction issues for adolescents who are already drinking, rarely address motivational issues related to use and abuse, and cannot target school dropouts.
(Goal 2, Objective 4A)

- **Underage Drinking: Building Health Care System Responses:** The overarching goal of this NIAAA Request for Applications (RFA) is to stimulate the primary care health delivery system in rural and small urban areas in the United States to address the critical public health issue of underage drinking. To accomplish this goal, this RFA will solicit applications for cooperative agreements which will enable rural health care systems to engage in research on underage drinking. More specifically, NIAAA seeks to fund such systems: (1) to evaluate and upgrade their capacity to become platforms for research that assesses the extent of underage drinking in the areas they serve and to evaluate their capacity to intervene to reduce this underage drinking (Phase I); and (2) to prospectively study the development of alcohol use and alcohol-related problems among the youth in the areas they serve and to implement and evaluate interventions designed to address underage drinking (Phase II).
(Goal 3, Objectives 1A and 1B)

- **Rapid Response to College Drinking Problems:** The consequences of excessive and underage drinking affect virtually all college campuses and all college students, whether or not they choose to drink. Drunk driving, unsafe sex, and vandalism are among the serious alcohol-related problems that college campuses face. In December, 2002, the NIAAA issued a Request for Applications (RFA): "Research Partnership Awards for Rapid Response to College Drinking Problems." This RFA was aimed at established alcohol researchers who have expertise in research on drinking by college students and can serve as resources for college and university administrators. A companion solicitation, Program Announcement PAR-03-133, "Rapid Response to College Drinking Problems," was issued by NIAAA in June 2003. This PAR provides a rapid-funding mechanism for timely research on interventions to prevent or reduce alcohol-related problems among college students. It capitalizes on natural experiments (e.g., unanticipated adverse events, policy changes, new media campaigns, campus-community coalitions) to support rapidly-developed, high-quality evaluations of services or interventions. Each awardee under the PAR is partnering with an awardee under the RFA and working with NIAAA to form individual steering committees to collaboratively develop study protocols. Thirty-six universities submitted applications to the PAR, thirteen of which were revised and resubmitted. To date, fifteen projects have been approved for funding. NHTSA also provided support for this effort.
  (Goal 3, Objective 1A)

- **NIAAA Research Studies to Examine the Effects of Adolescent Alcohol Abuse and Alcoholism on the Developing Brain:** It is now understood that adolescence is a time of powerful developmental forces that go well beyond the traditional conceptualization of "raging hormones," and include significant changes to the brain and nervous system. These changes include increased myelination of neural cells and "pruning" of synapses and neural pathways that are infrequently used in specific regions of the brain. Animal studies suggest that the developing adolescent brain may be uniquely vulnerable to consequences from alcohol exposure. In animal studies: (1) heavy binge-like episodes of ethanol consumption produce damage in areas of the brain affecting cognition and memory; and (2) adolescent alcohol drinking in genetically predisposed rats has long-lasting effects into adulthood, potentially increasing alcohol-seeking behavior, making it more difficult to stop drinking, and increasing the probability of relapse. Preliminary studies in humans suggest that the studies in animals may have relevance to adolescents who are heavy drinkers.
  (Goal 3, Objective 1A)

- **NIAAA Initiative on Underage Drinking:** NIAAA has undertaken a major effort to analyze the evidence base related to underage drinking, using a developmental approach. The overarching goal of this broad interdisciplinary initiative is a more complete and integrated scientific understanding of the

environmental, biobehavioral, and genetic factors that promote initiation, maintenance, and acceleration of alcohol use, along with those factors that influence the transition into harmful alcohol use/abuse and dependence. This understanding can only come by placing the determinants of drinking within a developmental context.
(Goal 3, Objective 1A and 1B)

- **Adolescent Treatment Research Program:** NIAAA initiated an adolescent treatment research program in 1998. Since then, 18 clinical projects have been funded, most of which are clinical trials. Fifteen are behavioral projects and three are pharmacotherapy trials. The objective of this initial wave of studies is to design and test innovative, developmentally tailored interventions that provide evidence-based knowledge to improve alcohol treatment outcomes in adolescents. Results for many of these projects will be forthcoming over the next few years, and will yield a broad perspective on the potential efficacy of family-based, cognitive behavioral, brief motivational, and guided self-change interventions in a range of settings.
(Goal 3, Objective 2B)

- **Evaluation of the EUDL Program:** NIAAA is conducting an evaluation of OJJDP's EUDL program that targets youth under 21-years-old. The NIAAA supported evaluation is specifically focused on EUDL programs in rural communities of approximately 20,000 people or fewer. The EUDL program design encourages partnerships between enforcement and those interested in underage drinking prevention. One design element required in the discretionary program component is the utilization of multi-disciplinary coalitions to promote a comprehensive approach to underage drinking prevention at the local level. OJJDP is directed by Congress to focus on developing statewide task forces of State and local law enforcement and prosecutorial agencies, conducting public advertising programs that include informing alcohol retailers about laws pertaining to underage drinking and their consequences, and encouraging innovative programming. Currently, the NIAAA supported evaluation is underway in 4 States (New Mexico, Nevada, Pennsylvania and Illinois) and 3 more will be added shortly.
(Goal 3, Objective 2B)

***National Institute on Alcohol Abuse & Alcoholism (NIAAA)*** **Activities <u>Related to</u> Underage Drinking**

- **Alcohol Policy Information System (APIS):** APIS is an electronic resource that provides authoritative, detailed, and comparable information on alcohol-related policies in the United States, at both State and Federal levels. Designed primarily as a tool for researchers, APIS is intended to encourage and facilitate research on the effects and effectiveness of alcohol-related policies. Although not dedicated to underage drinking policies, APIS does provide information on all policies relevant to underage drinking, for example policies

and procedures in retail alcohol outlets for preventing alcohol sales and service to minors.
(Goal 2, Objective 3A)

- **NIAAA Funded Longitudinal and Genetic Epidemiology Studies and NIAAA's National Epidemiological Survey on Alcohol Related Conditions (NESARC):** A number of longitudinal studies still following subjects ascertained when they were adolescents, genetic epidemiology studies, as well as, NIAAA's National Epidemiological Survey of Alcohol Related Conditions which includes people aged 18 to 21, are particularly pertinent to the question of underage drinking. These studies all have the potential to enhance our understanding of the etiology, extent and consequences of underage alcohol consumption. Analysis of data from the NESARC 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.
(Goal 3, Objective 3A)

***Substance Abuse & Mental Health Services Administration (SAMHSA)***
SAMHSA's mission is to build resilience and facilitate recovery for people with or at risk for substance abuse and mental illness.

**Activities <u>Specific to</u> Underage Drinking**

- **Development of an Underage Drinking Public Service Campaign Directed at Parents:** This project supports the Ad Council in the development of an underage drinking campaign directed at parents. In developing the campaign, the Ad Council is consulting with interested parties, including advocates and the industry. This effort targets parents of youth 9- to 15-years-old.
(Goal 1, Objective 1B)

- **Governors' Spouses Initiative:** In addition to supporting the *Leadership to Keep Children Alcohol Free* initiative through an Interagency Agreement with NIAAA, SAMHSA funds an effort to link this initiative with prevention programs funded by the SAPT Block Grant in the States and with other SAMHSA programs, such as Too Smart to Start and the Reach Out Now Teach-Ins. This initiative targets youth 9- to 15-year-olds.
(Goal 1, Objective 2A)

- **Underage Drinking Prevention Campaign - Too Smart to Start (TSTS):** This effort is a national community education program targeting children and youth 9- to 13-years-old. The campaign has been tried and tested in twelve communities nationwide and provides professionals, volunteers, and parents with tools and materials that can help shape healthy behaviors regarding alcohol use for a lifetime. TSTS includes a web page, technical assistance, and

a community action kit to help plan, develop, promote and support local underage alcohol use prevention. The program includes materials and strategies that are flexible for use in communities of all sizes and actively involves entire communities in sending clear, consistent messages about why children should reject underage drinking.
(Goal 1, Objective 2B)

- **Health Communication Initiative for Preventing Underage Alcohol Use (new in FY 2004):** This new SAMHSA/CSAP effort will provide resources, message development, and public education for preventing underage alcohol use for ages 0- to 21-years-old. This project will provide ongoing support for the Too Smart Too Start initiative and Reach Out Now Teach Ins. In addition, it will provide multi-faceted evidence-based approaches that communities in the Nation can use to build resiliency and enhance protective factors and reduce the risk factors associated with underage alcohol use. The new effort will develop a cadre of trainers and facilitators to assist communities in providing evidence-based strategies for preventing underage alcohol use.
(Goal 2, Objective 1A)

- **Reach Out Now Fifth & Sixth Grade *Scholastic, Inc.* Supplements:** SAMHSA and *Scholastic, Inc.* have developed special materials devoted to underage drinking that target 10- to 12-years-olds and their parents. Known as *Reach Out Now*: *Talk with Your Fifth Graders about Underage Drinking*, and *Reach Out Now: Prevent Underage Alcohol Use by Talking with Your Sixth Grader*, these materials have been focus-group tested with parents and teachers. They include a classroom discussion guide for teachers, activity sheet for students, and a take-home packet for parents. Reach Out Now is in its fourth year. In March 2005, the package was sent to every fifth and sixth grade class in America including those States participating in the *Leadership to Keep Children Alcohol Free* Initiative.
(Goal 2, Objective 1A)

- **Strategic Prevention Framework (SPF) State Incentive Grant (SIG) Program (new in FY 2004):** The SPF SIG Grants build on the successful State Incentive Cooperative Agreements, which have given the governors of 44 States and Territories the opportunity to enhance their States' substance abuse prevention systems and fill gaps in programs with evidence-based services to address the widespread problems related to substance abuse. SAMHSA's FY 2004 SPF SIG grants will give States and communities the opportunity to focus resources on critical needs identified through an epidemiologically based State Needs Assessment, and they will subsequently target populations and ages across the life span with evidence-based prevention and early intervention policies, programs and practices. To date, 26 SPF SIG grants have been awarded to States and territories. SPF SIGs will also support States by providing prevention resources and facilitating systems improvement to help ensure successful transition from the SAPT Block Grant

to Performance Partnerships. The grants will receive support for up to five years, subject to availability of funding. As such, they are intended to fulfill SAMHSA's overall goal of increasing the capacity and effectiveness of States and communities as they respond to critical problems and needs by implementing SAMHSA's SPF. The SPF SIG grant offers an excellent vehicle for supporting the goals of this underage drinking initiative. State applicants must therefore include the prevention of underage alcohol consumption in their SPF SIG Project and provide a comprehensive strategy that addresses this problem, in addition to other SPF SIG priorities. All tasks, including needs assessment, consensus building, planning, funding allocations, implementation and evaluation must be carried out with a consideration for the issue of underage drinking.
(Goal 1, Objective 1C; Goal 2, Objective 3A)

- **Potential Interventions for Underage Drinkers in Emergency Rooms:** A white paper about the interventions that could be used with underage drinkers admitted to emergency rooms has been developed. The paper includes next steps/recommendations, the barriers to recruiting underage drinkers into adolescent emergency room brief intervention programs, variables that increase participation rates in these interventions, whether or how these interventions impact adolescents' movement through the continuum of the stages of change, and the role of significant others.
(Goal 2, Objective 4A)

- **Treatment of Adolescent Alcohol Abuse & Alcoholism Replication of Effective Alcohol Treatment Interventions for Youth:** In FY 2003, CSAT developed the Adopt/Expand Effective Adolescent Alcohol and Drug Abuse Treatment program. This grant program builds on effective interventions for youth experiencing alcohol or other drug problems. Twenty-two sites were funded to provide training and certification on using Motivational Enhancement Therapy/Cognitive Behavioral Therapy, a proven effective intervention. This program will increase the availability and effectiveness of treatment for youth with alcohol and drug problems and will treat approximately 2,000 teens and their families per year. This initiative targets youth under 21-years-old.
(Goal 2, Objective 4A)

***Substance Abuse & Mental Health Services Administration (SAMHSA)* Activities <u>Related to</u> Underage Drinking**

- **Substance Abuse Prevention & Treatment** (**SAPT) Block Grant:** This grant is a primary funding source for alcohol prevention and treatment. While there is no set-aside for youth treatment, States have the option of using this resource to treat alcohol use disorders among adolescents. The SAPT Block Grant also contains a prevention set-aside that reserves a minimum of 20 percent of each State's block grant allocation for prevention activities. While

the majority of programs supported by these funds are designed to prevent substance abuse in general, many will have an impact on underage drinking. The block grant application asks States to report voluntarily on underage drinking strategies, such as: implementation of public education and/or media campaigns; laws against alcohol consumption on college campuses; policies or enforcement of laws that reduce access to alcohol by minors, including event restrictions, product price increases and penalties for sales to minors; data for estimated age of drinking onset; and statutes restricting alcohol promotions to underage audiences. The responses to these requests are in CSAP's "e-prevention" block grant database.
(Goal 1, Objective 2A; Goal 2, Objective 4A)

- **Mothers Against Drunk Driving (MADD):** In FY 2004 CSAP is providing support for one year to MADD to assist them in building a partnership with three American Indian reservations. In 2002, these Tribes were awarded funding to implement Protecting You/Protecting Me (PYPM), a MADD alcohol-use prevention curriculum for elementary students that is a CSAP Model Program. The project entails observation, analysis and documentation of the transcultural process leading to modifications of the curriculum. The target age for this effort is elementary school children.
(Goal 2, Objective 1A)

- **Outreach to Children of Parents in Treatment (OCPT):** In collaboration with the National Association for Children of Alcoholics (NACoA), the OCPT project has developed a kit that includes prevention materials that target the children of parents in substance abuse treatment and covers school-age youth under 18-years-old. The materials are being disseminated to substance abuse treatment centers to use for staff in-services and for children of parents in treatment. The kit includes a promising practices program list which identifies existing prevention and support services to children of substance abusing parents in various settings (e.g., treatment centers, faith/community settings, private voluntary organizations); a practice manual and resource packet; videos; and colorful announcement posters. Additionally, in August 2004, a three-day training was provided for trainers on the use of SAMHSA/CSAP's Children's Program Kit -- Supportive Education for Children of Addicted Parents. Representatives from CSAP's Center for the Application of Prevention Technologies (CAPTs), One Sky Center, and CSAT's Addiction Technology Transfer Centers (ATTCs) attended and learned the structure, philosophy, and goals of a children's supportive education program; program implementation strategies, how to train group facilitators to run educational support groups for children of parents who are alcohol or drug dependent using the Children's Program Kit; and how to engage treatment providers, schools, and community-based prevention programs to partner in providing groups.
(Goal 2, Objective 1B)

- **National Alcohol Screening Day (in collaboration with NIAAA):** Since NASD's inception in 1999, over 100,000 people from 50 States have participated in its educational component. Of the 100,000 participants, more than 55,000 have been screened. Of those persons screened more that 13,000 have been referred for further assessment and diagnosis. In 2003, about 750 people nationwide attended training on "How to Conduct a NASD Event". In 2003, nearly 900 college campuses offered screening programs. In 2004, more than 5,300 colleges, communities and primary care facilities registered to conduct NASD screening programs. If the tests indicate, participants are referred to local treatment programs through the SAMHSA-funded online substance abuse treatment facility locator (http://dasis3.samhsa.gov).
  (Goal 2, Objective 1C)

- **Environmental Prevention of College Alcohol Problems (in collaboration with NIAAA):** CSAP and NIAAA provided joint funding from FY 1999 to FY 2003, to support a comprehensive environmental prevention strategy aimed at reducing binge drinking and resulting alcohol problems among college students at San Diego State University. The research design provided for a quasi-experimental study employing New Mexico State University as a comparison site.
  (Goal 2, Objective 1C)

- **Building Blocks for a Healthy Future:** Building Blocks for a Healthy Future is an early childhood substance abuse prevention program that educates parents and caregivers about the basics of risk and protective factors, ways to reduce risk factors, and how to reinforce skills that will enable caregivers to better nurture and protect their children and promote healthy lifestyles. Designed for parents and caregivers of children 3- to 6-years-old, Building Blocks is designed to help open up the lines of communication with young children and make it easier to keep those lines of communication open as they grow older. Building Blocks collaborates with the National Head Start Association, the National Association for Elementary School Principals, the National League of Cities, and the American Medical Association Alliance to facilitate the training and dissemination efforts of the materials and products.
  (Goal 2, Objective 1A)

- **Partnership for Drug-Free America (PDFA):** In conjunction with PDFA, CSAT is working on the development of a consumer-related interactive web site. The site, an interactive online treatment resource, will be targeted to friends, family and other caring influencers of dependent youth and young adults. Using SAMHSA resources, attention will be paid to culturally appropriate information and culturally specific links and resources. The site will seek to assist the influencer to find encouragement, access to general expertise on substance use disorders and information to help them navigate their way towards additional help and resources.
  (Goal 2, Objective 4A)

- **National Helpline (1-800-662-HELP):** Individuals in need of treatment for alcohol or illicit drug problems can call the SAMHSA National Helpline for referral to appropriate treatment services. In addition individuals seeking treatment can go to the SAMHSA web site www.samhsa.gov to locate treatment services in their area.
  (Goal 2, Objective 4A)

- **Targeted Capacity Expansion (TCE) Program:** CSAT's TCE program addresses emerging substance abuse trends and the disparity in some areas between the demand for and the availability of appropriate treatment. It is designed to address gaps in treatment capacity by supporting rapid and strategic responses to demands for both alcohol and drug treatment services in communities with serious, emerging drug problems as well as communities with innovative solutions to unmet needs. Adolescents are one of the target populations for the TCE grants. In 2003, the TCE programs served approximately 300 adolescents, of which approximately one-third were alcohol involved.
  (Goal 2, Objective 4A)

- **Screening, Brief Intervention, Referral & Treatment (SBIRT) Grants:** SBIRT involves implementation of a system within 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 within the generalist setting, when appropriate, or motivates and refers the individual with a high level of problems and probable diagnosis of a substance dependence disorder to the specialist setting for assessment and diagnosis and either brief or long-term treatment. This includes training in self-management and involvement in mutual help groups, as appropriate. (Workgroup on Substance Abuse Self-Help Organizations, 2003) Several SBIRT grantees have developed programs that are available to individuals under 21-years of age.
  (Goal 2, Objective 4A)

- **Young Offender Reentry Program (YORP):** This program addresses the needs of sentenced substance-abusing juveniles and young adult offenders from the ages of 14 to 21 who are returning to their families and community from adult of juvenile incarceration in facilities including prisons, jails, or juvenile detention centers. YORP is designed to form partnerships that will plan, develop and provide community-based substance abuse treatment and related reentry services for the targeted population.
  (Goal 2, Objective 4A)

- **Program to Provide Treatment Services for Family, Juvenile & Adult Treatment Drug Courts:** Drug Courts are designed to combine the sanctioning power of courts with effective treatment services to break the

cycle of child abuse/neglect or criminal behavior, alcohol and/or drug use, and incarceration or other penalties. Motivational strategies are developed and utilized to help adolescents deal with often powerful negative influences of peers, gangs, and family members.
(Goal 2, Objective 4A)

- **Programs for Improving Addiction Treatment:** CSAT supports a variety of programs to improve transfer of science to services and improve addiction treatment nationally. For example, the Addiction Technology Transfer Center (ATTC) Network is dedicated to identifying and advancing opportunities for improving addiction treatment. The Network is designed to upgrade the skills of existing practitioners and other health professionals and to disseminate the latest science to the treatment community. The ATTC Network provides both academic (pre-service) and continuing education opportunities as well as technical assistance to multiple disciplines working in the addictions field. In addition several Treatment Improvement Protocols (TIPS) address these concerns (e.g., 16: *Alcohol and Drug Screening of Hospitalized Trauma Patients*, 24: *A Guide to Substance Abuse Services for Primary Care, 26: Substance Abuse Among Older Adults, 31: Screening and Assessing Adolescents for Substance Use Disorders, 32: Treatment of Adolescents With Substance Use Disorders,* 34: *Brief Interventions and Brief Therapies for Substance Abuse*.)
(Goal 2, Objective 4A)

- **National Association of Insurance Commissioners Effort:** CSAT provided experts to educate State legislators who also serve as State insurance commissioners about the repeal of a model insurance law that does not support reimbursement for medical care following an alcohol-related traffic crash resulting in injury. The existing and now repealed Model Law was based on the 1950's premise that alcohol problems were due to a moral failing rather than the current disease model of alcohol problems. With the repeal of this Model, State insurance laws will provide for reimbursement of alcohol-related events and the opportunity for the attending emergency room provider to conduct a brief intervention surrounding the person's injury and drinking pattern.
(Goal 2, Objective 4A)

- **Fetal Alcohol Spectrum Disorders (FASD):** SAMHSA's FASD Center for Excellence, the largest alcohol prevention initiative within SAMHSA, addresses innovative techniques and effective strategies to prevent alcohol use among women of childbearing age and persons and families affected by FASD. Communities, States and juvenile justice systems are improving existing service delivery systems, their policies and procedures to screen at intake and refer for diagnosis, and surveillance to create sustainable evidence-based responses to FASD among children, youth, and adults. While this initiative does not specifically target underage drinkers, it is expected that children,

youth, and adults will be reached, educated, and/or trained on co-occurring issues (substance use/abuse) across the lifespan among individuals affected by FASD.
(Goal 2, Objective 4A)

- **Access to Recovery (ATR):** ATR is a Presidential initiative to provide consumer choice among substance abuse clinical treatment and recovery support service providers, expand access to a comprehensive array of clinical treatment and recovery support options (including faith-based programmatic options), and increase substance abuse treatment capacity. States and Tribal Organizations may implement the program statewide or may target geographic areas of greatest need, specific populations in need, or where there is a high degree of readiness to implement a voucher program. Through the ATR grants, these entities will have flexibility in designing and implementing voucher programs to meet the needs of consumers in the State/tribal community. They are encouraged to support any mixture of traditional clinical treatment and recovery support services that can be expected to achieve the program's goal of achieving successful outcomes for the largest number of people at the lowest available cost.
(Goal 2, Objective 4A)

- **Drug & Alcohol Services Information System (DASIS):** The primary source of national data on substance abuse treatment. The Office of Applied Studies (OAS), SAMHSA, conducts DASIS. While not specific to youth, it does provide information on adolescent substance abuse treatment facilities as well as adolescent treatment in correctional facilities. DASIS has three components:

    - The Inventory of Substance Abuse Treatment Services (I-SATS) is a listing of all known public and private substance abuse treatment facilities in the United States and its territories. Before 2000, the I-SATS was known as the National Master Facility Inventory.

    - The National Survey of Substance Abuse Treatment Services (N-SSATS) is an annual survey of all facilities in the I-SATS that collects information on location, characteristics, services offered and utilization. Information from the N-SSATS is used to compile and update the National Directory of Drug and Alcohol Abuse Treatment Programs and the online Substance Abuse Treatment Facility Locator. The N-SSATS includes a periodic survey of substance abuse treatment in adult and juvenile correctional facilities. Before 2000, the N-SSATS was known as the Uniform Facility Data Set (UFDS).

    - The Treatment Episode Data Set (TEDS) is a compilation of data on the demographic and substance abuse characteristics of admissions to substance abuse treatment. Information on treatment admissions are

routinely collected by State administrative systems and then submitted to SAMHSA in a standard format.
(Goal 3, Objective 1A)

- **National Registry of Effective Programs & Practices (NREPP):** NREPP was developed in order to review and identify effective substance abuse programs and practices. This effort seeks candidates from the practice community and the scientific literature and includes three categories of programs: Effective Programs, Promising Programs, and Model Programs. Programs defined as Effective have the option of becoming Model Programs if their developers choose to take part in SAMHSA dissemination efforts. The target ages for this effort are across the lifespan.
(Goal 3, Objective 2A)

- **National Survey on Drug Use & Health (NSDUH):** Conducted by SAMHSA/OAS, this survey (formerly the National Household Survey on Drug Abuse) is a primary source of information on the prevalence, patterns and consequences of alcohol, tobacco and illegal drug use and abuse in the noninstitutionalized U.S. civilian population (age 12 and older). While the NSDUH is not alcohol-specific, it does track a variety of information on underage alcohol use and provides a database for studies on alcohol use and related disorders.
(Goal 3, Objective 3A)

- **Service to Science:** In FY 2004, SAMHSA/CSAP funded logistics and technical assistance efforts to support its Service to Science Initiative, the goal of which is to enhance the capacity of community-based and local programs to strategically plan, implement, and evaluate prevention interventions and build stronger evidence of effectiveness. Through this Initiative, CSAP will direct fixed-price "mini" subcontracts to a small number of selected underage drinking programs to assist them in enhancing program capacity for rigorous evaluation design, implementation and outcomes measurement, and data collection and analysis. The goal of these modest capacity-enhancement subcontracts is to assist locally-developed innovative programs that demonstrate readiness to move up the scale of evidence and show promise of achieving recognition in SAMHSA's National Registry of Evidence-Based Programs and Practices (NREPP).
(Goal 3, Objective 2C)

***Office of the Surgeon General (OSG)***

The Surgeon General is America's chief health educator, giving Americans the best available scientific information on how to improve their health and reduce the risk of illness and injury. OSG oversees the 6,000-member Commissioned Corps of the U.S. Public Health Service and assists the Surgeon General with his other duties.

**Activities Specific to Underage Drinking**

- **50 Schools in 50 States:** As the Nation's leading doctor, the Surgeon General addresses prevention of childhood and adolescent alcohol use in his 50 Schools in 50 States tour, and he will continue to address underage drinking as a public health problem in speeches and meetings nationwide.
  (Goal 1, Objective 1A)

- **Year of the Healthy Child:** In declaring 2005 "The Year of the Healthy Child," the Surgeon General has focused on improving the body, mind, and spirit of the growing child including the elimination of alcohol consumption and reduction of consequent auto accidents.
  (Goal 1, Objective 1A)

***National Institute on Drug Abuse (NIDA)***
NIDA's mission is to lead the Nation in bringing the power of science to bear on drug abuse and addiction.

**Activities Specific to Underage Drinking**
None

**Activities Related to Underage Drinking**

- **Monitoring the Future (MTF):** MTF is an ongoing study of the behaviors, attitudes, and values of American secondary school students, college students, and young adults. Each year, a total of some 50,000 8th, 10th and 12th grade students are surveyed (12th graders since 1975, and 8th and 10th graders since 1991). In addition, annual follow-up questionnaires are mailed to a sample of each graduating class for a number of years after their initial participation. This survey targets youths in grades 8 through 12.
  (Goal 3, Objective 3A)

## *DEPARTMENT OF THE INTERIOR*

***Bureau of Indian Affairs (BIA)***
BIA supports alcohol and drug prevention activities that target American Indian and Alaska Native school age children. These activities occur within the Office of Indian Education Programs (OIEP) as well as under the BIA's Law Enforcement Services (LES) and Tribal Services (TS) components. The BIA's activities do not specifically or solely focus on underage drinking, but address the full range of alcohol and drug use issues that impact tribal communities and the residents of those communities.

**Activities Specific to Underage Drinking**
None

**Activities Related to Underage Drinking**

- The Division of Alcohol and Substance Abuse Prevention (DASAP), in BIA's Tribal Services, is the primary BIA component with an alcohol and drug prevention mission. The DASAP provides culturally appropriate technical assistance to Tribes in strategic planning and implementing tribal community alcohol and drug abuse prevention activities, programs and services; prepares culturally appropriate technical assistance materials for Tribes to use in tribal community planning and in implementing alcohol and drug abuse prevention activities, programs and services; provides liaison to and coordination with other Federal, State, and private organizations that have Indian programs or non-Indian programs which Tribes are eligible to apply for funding or services; identifies exemplary programs with culturally appropriate components and provides information to Tribes on these programs; gathers, compiles, and analyses data and provides policy analysis reports and programmatic recommendations to Tribes and BIA staff; consults with Tribes through the Nation Indian Task Force on Alcohol and Substance Abuse and incorporates tribal recommendations into programs and activities; and provides guidance to other Federal, State and private organizations based on these tribal consultations and recommendations. OIEP, which funds BIA operated schools as well as grants and contracts for tribal operated schools, supports educational activities on drug and alcohol use. Other BIA programs, such as those under LES and TS, include activities that focus on the consequences of alcohol and drug abuse. Examples are juvenile delinquency, youth emergency centers, child protection, and poor student progress or performance.

## *DEPARTMENT OF JUSTICE*

***Office of Juvenile Justice& Delinquency Prevention (OJJDP)***
The OJJDP provides national leadership, coordination and resources to prevent and respond to juvenile delinquency and victimization.

**Activities Specific to Underage Drinking**

- **Enforcing the Underage Drinking Laws (EUDL):** A governor-designated agency and agency coordinator in each State and the District of Columbia implement the EUDL initiative. Agency contacts are listed on the Underage Drinking Enforcement Training Center website (www.udetc.org).
  (Goal 1, Objective 1C)

  State agencies that implement OJJDP supported EUDL programs include justice agencies, highway safety offices, health and human services agencies, and offices of the governor.

(Goal 1, Objective 2A)

Congress directs OJJDP to develop task forces of State and local law enforcement and prosecutorial agencies, encourage innovating programming and conduct public advertising programs that inform alcohol retailers about underage drinking and its consequences.
(Goal 2, Objective 2C)

The EUDL program encourages partnerships between law enforcement and underage drinking prevention advocates. One design element required in the discretionary program is use of multidisciplinary coalitions that utilize a comprehensive local approach.
(Goal 2, Objective 2C)

A standard component of local EUDL discretionary programming is development and utilization of youth leadership to plan and implement the community EUDL program. Designated youth assist law enforcement with compliance checks, utilize media to promote underage drinking prevention, hold alcohol-free events and participate in training events to learn about underage drinking issues.
(Goal 1, Objective 1D)

A major component of the EUDL program is training and technical assistance provided to adults and youth by the Underage Drinking Enforcement Training Center (UDETC). The Center identifies science-based strategies, publishes supporting documents, delivers training and provides technical assistance. These resources are accessible at www.udetc.org.
(Goal 2, Objective 1A)

The UDETC published the following documents to help States and local communities enforce retail establishment compliance with underage drinking laws: *The Guide to Responsible Alcohol Sales: Off Premise Clerk, Licensee & Manager Training* offers sales personnel training tools that stress support of management policies to prevent sales of alcohol to minors. *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, identifying necessary components and resources for more information. Additionally, the document, *Strategies for Reducing Third-Party Transactions of Alcohol to Underage Youth*, dissuades adults from providing alcohol to underage persons. The publication discusses the problem of non-retail 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.
(Goal 2, Objective 2B, 2E)

The UDETC publishes the following document about effective policies and procedures for reducing underage alcohol use: Published in both English and Spanish, *Strategies to Reduce Underage Alcohol Use: Typology & Brief Overview* summarizes common strategies to reduce underage drinking and their effectiveness based on existing research and evaluation.
(Goal 2, Objective 2A, 2B.4)

The UDETC maintains a small library of radio and TV public service announcements (PSAs) aimed at increasing awareness among parents and other adults of underage drinking and its consequences. EUDL State coordinators and EUDL-funded communities voluntarily forward PSAs to the Center, which shares the collection with State coordinators and others seeking guidance or assistance with their own PSAs. The Center instructs recipients to contact the producer of a PSA if they would like to use or edit the recording.
(Goal 1, Objective 1B)

Through the UDETC, OJJDP conducts an annual National Leadership Conference that provides training opportunities and promotes cooperation, coordination and collaboration among such partners as highway safety offices, health agencies, justice agencies, enforcement, schools, youth advocacy groups, health care professionals and alcohol prevention service providers. Monthly web-enhanced audio conferences tackle a wide range of underage drinking issues and science-based approaches that address such issues.
(Goal 1, Objective 2B)

As part of OJJDP's efforts to address underage drinking, EUDL grantees routinely partner with a number of other private and public organizations. For example, a total of 26 States work closely with State alcohol beverage control agencies or other State-level enforcement agencies that specialize in alcohol enforcement; 33 States have incorporated college communities into EUDL funding priorities; a total of 10 States engage members of the Leadership to Keep Children Alcohol Free in their State EUDL programs; and five States have established linkages to U.S. military bases in order to address underage and hazardous drinking behavior by troops.
(Goal 1, Objective 2A; Goal 2, Objectives 1A, 3A, 1B, 2B, 1C, 2C)

- **National Institute on Alcohol Abuse and Alcoholism (NIAAA) Studies, through the Prevention Research Center, of EUDL Discretionary Programming in Rural Sites:** In FY 2004, the EUDL discretionary program partnered with NIAAA to address underage drinking in rural communities. OJJDP is funding four States' efforts to conduct best and most promising EUDL program activities in up to five rural sites in each of the four States. NIAAA is funding and managing an evaluation of the rural sites being conducted by the Prevention Research Center. This effort establishes community coalitions to reduce/prevent underage drinking in rural areas.

(Goal1, Objective 2A; Goal 3, Objective 2B)

- **Youth Courts:** Youth courts, also called teen, peer, and student courts, are programs in which youthful offenders are sentenced for minor delinquent and status offenses or problem behaviors by their peers. Over the past ten years, as a result of a Federal initiative by the DOJ/OJJDP there has been over a 1000 percent increase in the number of youth court programs. In 1994, there were approximately 78 youth courts operating in the United States. Currently, there are 1,019 youth courts operating in 48 States and the District of Columbia and hundreds of jurisdictions are in various operational stages of establishing a youth court. A recent national data collection survey indicated of these 1,019 communities with operational youth courts, 73 percent now handle alcohol related crimes and offenses by minors. The average age of youthful offenders who appeared in youth court in 2003 was between 13- and 17-years-old. NHTSA also collaborates with OJJDP on some youth courts.

  OJJDP contracted with the Urban Institute to conduct the Evaluation of Youth Courts Project that investigated how teen courts respond to young offenders and measured the effect of teen court sanctions and services on recidivism. In May 2002, the results from the first National Youth Court Evaluation were released by the Urban Institute. The results indicated youth handled by Youth Court were less likely to re-offend. In Alaska, Youth Court participants were re-referred to the juvenile justice system in only six percent of the cases, compared with 23 percent of those handled by the traditional process. In Arizona, the outcome was 9 percent recidivism among Youth Court cases versus 15 percent in the comparison group. In Missouri, the results were 9 percent for teen court and 27 percent for the regular process. This evaluation is available at www.urban.org and www.youthcourt.net.
  (Goal 2, Objective 2C)

- **Juvenile & Family Drug Courts:** In 2004, OJJDP assumed management of the juvenile and family drug court program for OJP. Though drug courts were initially implemented to address adult drug offenders, the approach has been modified over time to operate within the juvenile justice system to address the unique needs of juvenile substance abusers and within the civil justice system to address the substance abuse of parents who are charged with abuse and neglect of their children. Youth who participate in juvenile drug courts generally are between 14- and 17-years-old. A high percentage of these youth are multi-substance abusers with the vast majority having engaged in alcohol abuse. The drug court program uses the coercive power of the judicial branch to foster abstinence and helps alter destructive behavior through a combination of escalating sanctions, mandatory drug testing, treatment, and effective aftercare.

  OJJDP manages approximately 135 juvenile and family drug court grants. In addition, OJJDP will sponsor training to courts that are planning to initiate

either a juvenile or family drug court program. There were 80 courts that participated in these training sessions during 2005. It is estimated that approximately 60 courts will participate in these training sessions during 2006.
(Goal 2, Objective 2C)

- ***Beyond the Bench*:** OJJDP in partnership with NHTSA funded a video produced by the Police Executive Research Forum titled *Beyond the Bench.* This video, featuring two judges who have exercised leadership on the underage drinking issue, highlights appropriate judicial leadership activity in developing a community response to preventing underage drinking. The video may be accessed through NHTSA.
(Goal 2, Objective 2D)

- **Wake Forest University School of Medicine Studies of the Utilization of Best Practices in EUDL Discretionary Programming:** Utilizing a community trials evaluation design, Wake Forest University is conducting an evaluation during 2003 through 2005 of EUDL discretionary programming in selected communities within five States: California, Connecticut, Florida, Missouri, and New York. This systematic and rigorous evaluation is studying the implementation of research-based "best" and "most promising" practices to enforce underage drinking laws and prevent and reduce underage drinking.
(Goal 3, Objectives 1A, 2C)

## *DEPARTMENT OF LABOR*

***Occupational Safety & Health Administration (OSHA)***
OSHA's mission is to assure the safety and health of America's workers by setting and enforcing standards; providing training, outreach and education; establishing partnerships; and encouraging continual improvement in workplace safety and health.

**Activities <u>Specific to</u> Underage Drinking**
None

**Activities <u>Related to</u> Underage Drinking**

- **Teen Worker Initiative:** Now a part of OSHA's strategic plan, this initiative seeks to reduce the risk of injuries and illnesses among 14- to 24-year-old workers. The initiative sparked development of an innovative Teen Worker website that targets teens and their employers, educators and parents with age- and audience-appropriate information about potential workplace hazards and how to reduce such occupational risks.

  A new addition to the website incorporates text that recognizes alcohol and drug use as a workplace hazard, reminding teens that in order to work, they

must be alcohol and drug-free. Embedded links access other government websites, directing employers to DOL's Working Partners for an Alcohol- and Drug-Free Workplace website, teens to ONDCP's National Youth Anti-Drug Media Campaign Freevibe website, and educators and parents to ONDCP's TheAntidrug website, respectively.
(Goal 1, Objective 1A)

- **Federal Network for Young Worker Safety & Health:** In 2003, OSHA convened the Federal Network for Young Worker Safety & Health (FedNet). The main goal of this group is to reduce redundancies and maximize Federal resources to address occupational safety and health issues facing young workers. Eight Federal departments (Labor, Transportation, Health & Human Services, Commerce, Agriculture, Education, Environmental Protection Agency, and Housing & Urban Development) attend quarterly network meetings.

  One means toward FedNet's goal is to identify and evaluate existing tools and resources that promote young worker occupational safety and health. Early meetings were used to explore available resources. FedNet participants strive not so much to create new materials as to identify existing materials on similar topics, create mechanisms to hold these resources together and disseminate them to the appropriate target audience.

  A FedNet participant from the DOT's National Highway Traffic Safety Administration will act as a liaison to the Interagency Committee on the Prevention of Underage Drinking to ensure that FedNet members are informed about new initiatives from this committee and to encourage the Federal agency members to incorporate these into their respective agency activities.
  (Goal 1, Objective 2A)

***Employment Training Administration (ETA)***
ETA's mission is to advance the U.S. labor market by providing high quality job training, employment, labor market information and income maintenance services primarily through State and local workforce development systems.

**Activities <u>Specific to</u> Underage Drinking**
None

**Activities <u>Related to</u> Underage Drinking**

- **Youth Opportunity Grants (YOGs):** These grants represent a major commitment on the part of the DOL to serve youth growing up in high-poverty urban and rural communities. They provide both in-school and out-of-school youth 14- to 21-years-old with a variety of employment, education,

and youth development services. Currently, there are 36 grants in the United States with a combined enrollment of close to 90,000 youth.

YOGs differ from traditional formula-funded youth programs in two fundamental ways: (1) rather than distribute a relatively small amount of money across the entire U.S., they concentrate a large amount of funds in specific high-poverty communities; and (2) rather than restricting eligibility based on family income, they are open to all youth residing in the target area. These grants serve some of the poorest communities in the United States, including Watts in Los Angeles, Philadelphia's West Side, Detroit's Central Corridor, the Hough section of Cleveland, the Westside of Baltimore, the Third and Fifth Wards of Houston, the Navajo and Pine Ridge Indian Reservations, a rural section of California near the Mexican border, Southeastern Arkansas, and a rural area of Louisiana in the Mississippi Delta that has been called by *Time Magazine* the poorest place in America.

Various YOG sites work with local partnering agencies that utilize assessment tools to indicate whether youth are engaging in underage drinking or drug use or at risk of engaging in such behavior and refer these youth to contracted counseling services. As well, sites provide information on the connection between employment problems and underage drinking (i.e. the inability to be hired due to citations for underage drinking, problems with obtaining or keeping a driver's license for the same reasons, etc.). Sites also contract services with certified addictions counselors and set-aside dollars to treat substance abuse.

YOG sites utilize support groups and team building methods to create a positive atmosphere and promote healthy living as well as mentoring activities that emphasize increasing self-esteem and providing safe adult role models. Workshops are held to support healthy lifestyles and family values in a culturally sensitive manner. Other activities also include educational classes on alcohol awareness sponsored by local non-profits, focus groups to allow youth the chance to express frustrations positively, surveillance of local liquor stores to crack down on the selling of alcohol to minors, and the use of "party patrols" in which sites work with local police to step up their neighborhood presence on weekends and holidays when alcohol is more likely to be consumed. YOG is targeted to both in-school and out-of-school youth 14- to 21-years-old.
(Goal 2, Objective 1D)

- **Youth Offender Demonstration Project (YODP):** Since 1999, DOL/ETA has funded 52 youth offender pilot projects designed to provide comprehensive services to youth between the ages of 14 and 24 who are offenders, gang members, or at-risk of criminal involvement that will assist them with their transition into long-term employment at wage levels that are likely to break the cycle of crime and juvenile delinquency. The youth

offender initiative was originally funded through the Office of Policy Development, Evaluation, and Research as a demonstration project and by design, collected limited, quantifiable local or national program outcomes. In July 2002, ETA began Round III of YODP, which consists of 29 grantees that are funded to deliver alternatives to incarceration and re-entry transition options through such vehicles as aftercare, route counseling, and/or gang suppression/prevention services to court-involved and at-risk youth.

Sites have begun utilizing "youth courts" in which youth are held accountable to each other for minor infractions, including underage drinking. This helps to create a positive peer environment to potentially cut down on some of the peer pressure to engage in risk behaviors such as underage drinking. As well, probation officers come to schools in the local communities and teach underage drinking prevention classes to the youth offenders in the YODP program. YODP Career Preparation classes have a component about alcohol/drug use on-the-job and what constitutes a drug-free workplace. For example, the DeKalb County YODP works with the DeKalb County Taskforce to Reduce Underage Drinking to promote alcohol abstinence among the program's youth. Further, the DeKalb County school system has an in-house prevention department that conducts in-school activities with youth around underage drinking.

Many sites provide alternative activities for youth at times when they are most likely to consume alcohol – on weekends and evenings. These include community service activities, social outings, picnics and even youth conferences. As well, there are traditional counseling and intervention services provided for youth who feel they may have a problem with substance abuse. Many youth engaged in YODP are required to provide some manner of restitution as part of their adjudication. Sites coordinate community service activities in part to serve as the restitution and also use the time to emphasize the value of the efforts to the community being served as well as the positive self-esteem that comes from a job well done. YODP sites also offer traditional case management and assessment services for youth that focus on the mental health needs of the youth and provide referrals when appropriate. (Goal 2, Objective 1D, 2C)

## *OFFICE OF NATIONAL DRUG CONTROL POLICY*

**Activities <u>Specific to</u> Underage Drinking**

- ***Challenges in Higher Education*** **Booklet:** In June 2004, ONDCP released this booklet that is focused on college-aged drug and alcohol use. The booklet on campus substance abuse issues will contain information on underage drinking and policy/program directions to address binge drinking on campus. Outreach activities continue to find venues to bring ONDCP's perspective on

youth alcohol and drug use to college health professionals, BACCHUS-GAMMA and the Inter-Association Task Force, who together represent over 35 national organizations with members from colleges representing the areas of student personnel, student activities, campus health centers, college presidents, college administrators, and college students.
(Goal 2, Objective 1C)

**Activities Related to Underage Drinking**

- **The National Youth Anti-Drug Media Campaign:** This Campaign addresses underage drinking prevention in the context of illicit drug use through web sites (www.theantidrug.com, www.freevibe.com, www.laantidroga.com) and brochures, including the popular booklet titled "Keeping Your Kids Drug Free—A How To Guide for Parents and Caregivers." Paid advertising for parents includes messages aimed at building monitoring skills and parent efficacy. These skills can positively affect a host of youth behavioral issues. In addition, ad time and space has been donated for underage drinking-related advertising as part of the Campaign's media match program, which has benefited such groups as Mother's Against Drunk Driving (MADD), the National Council on Alcoholism and Drug Dependence, Alateen and Al Anon. With the start of the Early Intervention Initiative in February 2004, the Campaign addresses underage drinking along with illicit drug use. This effort targets youth 12- to 18-years-old, as well as the parents of this age group.
(Goal 1, Objective 1B)

- **Drug-Free Communities (DFC) Grant Program:** In October 2004, SAMHSA assumed responsibility for administering the Drug-Free Communities grant program. This program, which is made up of two types of grants—coalitions and mentoring—provides resources to local coalitions. The purpose of the program is to: 1) reduce substance abuse (including alcohol) among youth and, over time, among adults by addressing the factors in a community that increase the risk of substance abuse and promoting the factors that minimize the risk of substance abuse; and 2) establish and strengthen collaboration among communities, private non-profit agencies, and Federal, State, local and tribal governments to support the efforts of community coalitions to prevent and reduce substance abuse among youth. With nearly 750 grants in separate and distinct communities, SAMHSA will begin working to apply its Strategic Prevention Framework to the community-based process within these grants, in order to link local needs with programs and services that have proven effective at addressing substance abuse problems. The target age varies with each coalition.
(Goal 1, Objective 1C)

## *DEPARTMENT OF TRANSPORTATION*

***National Highway & Traffic Safety Administration (NHTSA)***
The NHTSA develops, promotes and implements effective educational, engineering and enforcement programs to end preventable tragedies and reduce economic costs associated with vehicle use and highway travel.

**Activities <u>Specific to</u> Underage Drinking**

- **Programs to Encourage States to Enact Minimum Drinking Age & Zero Tolerance Laws:** NHTSA implemented congressionally mandated programs to encourage States to enact 21 Minimum Drinking Age and Zero Tolerance Laws (Zero Tolerance laws make it unlawful for a person under the age of 21 to drive with any detectable alcohol in their system. Minimum Drinking Age laws make it unlawful for a person under age 21 to purchase or publicly possess alcohol). Currently all 50 States and the District of Columbia have enacted both of these laws. NHTSA continues to monitor State compliance with these Federal mandates. Failure to comply results in financial sanctions to the States.
  (Goal 1, Objective 1A)

- **Support for Students Against Destructive Decisions (SADD):** This effort reaches youth organizations in local communities and schools with peer-to-peer messages and activities to help prevent underage drinking and driving. This program targets high school age youths.
  (Goal 1, Objective 1D)

- **Smashed: Toxic Tales of Teens and Alcohol**: NHTSA, SAMHSA and Safe & Drug Free Schools (Dept of Education) have collaborated to work with Recording Artists, Actors and Athletes Against Drunk Driving (RADD) and their partner, HBO Family to develop and disseminate an educational package including a documentary on underage drinking and alcohol-related driving to thousands of schools and communities across the country. HBO licensed RADD and the Federal partners with the use of its documentary "Smashed" and RADD collaborated with the Federal partners to develop a lesson plan for teachers, community guide, and pre- and post-tests for collection of data and evaluation. Two other major national youth organizations, Students Against Destructive Decisions (SADD) and Family Career and Community Leaders of America (FCCLA) provided an initial distribution network. Schools and youth and community groups using “Smashed” to initiate dialogue about underage drinking and alcohol-related driving are then directed to model programs that can be effectively implemented by individual communities to combat the problem in a way that fits their own community needs. (Goal 1, Objective 2B; Goal 2, Objective2A)

- **Latino Strategies:** NHTSA and ASPIRA will utilize the ASPIRANTE (Youth) program around the country to research, develop, test, and promote specific Latino youth underage drinking and impaired driving information. ASPIRA, with NHTSA's support, produces a quarterly newsletter in both English and Spanish for parents and another for students, each addressing multiple traffic safety issues, including guidance for preventing underage drinking and driving. The target ages for this effort are 15- to 20-year-olds. (Goal 2, Objective 1B)

- **Traffic Safety Curriculum for School Resource Officers:** NHTSA and National Association of School Resource Officers (NASRO) are developing a traffic safety school curriculum for 15- to 18-year-olds for delivery by School Resource Offices. The curriculum emphasizes impaired driving and occupant protection issues. The target for this effort is adult training for all school ages. (Goal 2, Objective 1A)

- **BACCHUS & GAMMA Peer Education Network:** This network will demonstrate combined strategies to combat high-risk and underage drinking among the 18- to 24-year-old population. Launched in the fall of 2004, the 18-month project focuses on enforcement, local policy, and peer education strategies at the University of California at Riverside, University of Tampa, and Texas A&M University. This effort targets youth who are college age. (Goal 1, Objective 1D; Goal 2, Objective 1C)

- **Support for the International Association of Chiefs of Police (IACP):** NHTSA provides support for the International Association of Chiefs of Police (IACP) to encourage enforcement of underage drinking laws. This effort targets youth 15- to 20-years-old.
(Goal 1, Objective 2B)

- **Underage Drinking Enforcement:** NHTSA and the National Liquor Law Enforcement Association (NLLEA) are developing a best practices manual and training program to assist State and local alcohol beverage control and law enforcement agencies in enforcing underage drinking laws. This effort is targeted toward adults.
(Goal 1, Objective 2B)

- **Youth Data Compendium:** DOT will compile a compendium of data relevant to determining appropriate youth programming directions. The report will address a comprehensive range of data for traffic safety issues among youth and young adults ages 8 to 24 (i.e. belt use, alcohol-related driving, etc.). The data will be published online for other public and private sector entities to take into account when planning their national, State and local efforts. This could encompass local advocacy groups, employers of young people, youth organizations, and government.
(Goal 1, Objective 2B)

- **Techniques for Effective Alcohol Management (TEAM) Coalition:** NHTSA provides support to a coalition of public and private sector organizations that support the development of effective alcohol service training in public assembly facilities (primarily sports arenas) and promote responsible alcohol consumption (including deterrence of underage drinking) to reduce alcohol-related instances both in facilities and on surrounding roadways. This effort is targeted toward adults.
  (Goal 2, Objectives 1A, 1C, 1D)

- **Information for Employers:** NHTSA, through a partnership with Network for Employers of Traffic Safety (NETS) and additional input from OSHA, developed and distributed materials for employers to use with underage workers regarding the issues of drinking and driving. One educational resource under development is designed for employees who are parents of teens, "Teens at Risk: A Parent's Guide to Underage Drinking," and provides guidance to employees and their families on how to deal with this issue. This effort targets employers and parents of youth who are in high school and college.
  (Goal 2, Objective 1A)

- **Skills Training for Youth Leaders:** NHTSA, through the National Organizations for Youth Safety (NOYS) provides skills training for national youth leaders to use to train peers in how to help prevent underage drinking and driving; provides additional leadership materials on the NOYS web site; and developed the first component of an online program, "Project U-Turn; Turn a Tragic Event into a Teachable Moment" which enhances protective factors to help change attitudes regarding underage drinking and driving. This effort targets youth 8- to 24-years-old.
  (Goal 1, Objective 1D)

- **Peer-to-Peer Strategies:** NHTSA and Students Against Destructive Decisions (SADD) support the Think About It campaign, a peer-to-peer student awareness program focused on underage drinking and impaired driving. The SADD & the Law campaign encourages student support of underage drinking enforcement mobilizations. SADD is also establishing a cadre of youth student leaders to initiate local anti-drinking and driving activities. This effort targets high school aged youth.
  (Goal 1, Objective 1D; Goal 2, Objective 1B)

- **Drug Impairment Training for Educational Professionals:** NHTSA and the International Association of Chiefs of Police (IACP) developed an educational training program designed to recognize drug abuse among students and provide appropriate intervention. The program offers school administrators and nurses a systematic approach to recognizing and evaluating drug abuse. This effort targets adult training.
  (Goal 2, Objective 1A, 2C)

- **Youth Court Program & Training:** Youth Courts (see full description under OJJDP) are programs in which peers sentence juvenile offenders. NHTSA is developing National Youth Court Guidelines in conjunction with the ED, Office of Elementary and Secondary Education, the DOJ/OJJDP, and the American Probation and Parole Association. The national guidelines were designed to help elevate the standard of youth court program operations and practices. OJJDP took the lead in continued support for teen/youth court programs. This initiative focuses on youth under age 21.
  (Goal 2, Objective 1B, 2D)

- **Alcohol Prevention Guidebook for Colleges and Universities:** DOT's NHTSA and Education's Office of Safe and Drug-Free Schools, through its Higher Education Center for Alcohol and Other Drug Prevention, released NHTSA Alcohol Prevention Handbook for Colleges and Universities: the *Safe Lanes on Campus: A Guide for Preventing Impaired Driving and Underage Drinking*. Grounded in research literature, the 60-page guidebook describes strategies for combating underage drinking and impaired driving. This effort targets youth who are college age.
  (Goal 2, Objective 1C)

- **College Binge Drinking Prevention Initiative:** NHTSA is working with the North American Interfraternity Conference to develop programs focused on reducing high-risk and underage drinking on campuses. Alcohol summits have been conducted on college 18 campuses. As a result, various programs, activities, events and policies were developed and implemented. The results and experiences of the participating fraternities and sororities are featured in a new publication, *The Alcohol Summit: A Roadmap for Fraternities and Sororities*, released in 2004. This effort targets youth who are college age.
  (Goal 1, Objective 2B; Goal 2, Objective 1C)

- **Interagency Agreement to Reduce Alcohol-Related Traffic Fatalities:** In FY 2004, an underage drinking and impaired driving prevention manual titled *Safe Lanes on Campus*, which was the result of this partnership, was made available to help college campuses and their surrounding communities to implement effective impaired driving and underage drinking prevention programs. This effort targets college-age youths.
  (Goal 2, Objective 1C)

- **Zoning & Ordinance Plans to Prevent Underage Drinking & Impaired Driving:** NHTSA and the Responsible Hospitality Institute will develop a web-based resource guide and recommendations on local community policies and processes to address underage drinking and impaired driving. Demonstrations of these strategies will be conducted in selected sites.
  (Goal 2, Objective 2B)

***National Highway & Traffic Safety Administration (NHTSA)***
**Activities Related to Underage Drinking**

- **Impaired Driving Communications:** The Ad Council and NHTSA will consolidate impaired driving prevention communications into a coordinated and effective social marketing campaign. The campaign's aim is to influence behavior in high-risk populations, including underage drinkers. Messages will be delivered primarily through three complementary campaigns: "You Drink and Drive. You Lose" (addresses general deterrence); "Friends Don't Let Friends Drive Drunk" (addresses personal responsibility); and "Zero Tolerance Means Zero Chances." This effort targets youth 15- to 20-years-old.
  (Goal 1, Objective 1B)

- **State Highway Safety Funding:** This initiative provides Federal funding to States and local communities through State Highway Safety Offices. Funds may be used for activities related to underage drinking and driving under the following programs: 402 (State and community programs); 410 (impaired driving incentive grants); 154 (open container transfers); 157 (occupant protection incentive grants); 164 (repeat offender transfer); and 163 (.08 BAC incentive grants).
  (Goal 1, Objective 1C)

- **Support for National Association of School Resource Officers (NASRO):** NHTSA supports the development and training of School Resource Officers to more effectively reach students in their assigned schools with safety messages, including underage drinking and driving. This effort targets adult training for all school ages.
  (Goal 1, Objective 1C)

- **Support of National Organizations for Youth Safety (in collaboration with HHS & ED):** This Federal collaboration supports a national coalition of youth-serving organizations to address youth-related health and safety issues, including underage drinking. The coalition, National Organizations for Youth Safety (NOYS), which has a membership of more than 30 active national organizations and Federal agencies; engages youth leaders in reaching other youth through positive youth development actions to promote safe and healthy lifestyles. Member organizations represent culturally, ethnically, and geographically diverse youth through groups such as United National Indian Tribal Youth, National Asian Pacific Americans Against Substance Abuse, Farm Safety 4 Just Kids, 100 percent Drug-Free Clubs, National 4-H, and ASPIRA. These coalitions target youth from middle school through college ages.
  (Goal 1, Objective 1D)

- **American Indian Strategies:** NHTSA and the National Indian Education Association are developing leadership training for American Indians. Training for *Road Warriors: Indian Youth for Traffic Safety* will be provided at several key conferences in 2002-2004. Mini grants will facilitate dissemination efforts. This strategy targets high school age youths. (Goal 1, Objective 1D)

- **Stop Impaired Driving Website:** NHTSA provides public information and education to the public, including parents and other caregivers and adults who interact with youth, through its www.stopimpaireddriving.org web site. The web site also provides direct links with other Federal agencies and national organizations that have additional information. (Goal 2, Objective 1A)

- **Parents Guide:** In partnership with Network of Employers for Traffic Safety (NETS), NHTSA developed "Teens at Risk: A Parent's Guide to Prevent Underage Drinking" to deliver underage drinking and driving information to parents at work. This effort is targeted toward adults. (Goal 2, Objective 1D)

- **Project U-Turn:** Project U-Turn: Turning a Tragedy into a Teachable Moment, is a web-based campaign developed by National Organizations for Youth Safety (NOYS). The campaign focuses on teaching local media, school and community officials, and other volunteers to turn a tragic event into a teachable moment. The online package provides youth ready-to-use templates and information on how to communicate their positive safety message to other teens, the media, government officials, and community groups. NOYS will demonstrate the project in at least two communities. This effort targets high school and college-age youths. (Goal 2, Objective 2B)

- **Underage Drinking Enforcement:** The International Association of Chiefs of Police (IACP) developed a training program to assist mid-level law enforcement managers address youth impaired driving problem in their community. IACP will form a cadre of course facilitators to deliver the Youth Enforcement Resource Kit. This initiative targets youth under 21-years-old. (Goal 2, Objective 2C)

- **Training for Judges:** NHTSA, in partnership with the National Judicial College, supports the "Courage to Live" program that trains judges to provide Education and information to youth in their community about underage drinking and driving and its negative consequences. This effort targets high school age youth. (Goal 2, Objective 2C)

- **Juvenile Holdover Program:** NHTSA is working with the Community Anti-Drug Coalitions of America (CADCA) to promote the Juvenile Holdover Program as an alternative to the use of traditional juvenile detention, jails, or lockups when such facilities are inappropriate, unnecessary, or unavailable. CADCA provides training to its member coalitions on how to implement the program in their communities. This program is targeted toward adults.
  (Goal 2, Objective 2D)

- **Screening & Brief Intervention:** DOT partnered with the American College of Emergency Physicians, Emergency Nurses Association, American Academy of Family Physicians and the National Hispanic medical Association to conduct screening and brief intervention activities, including providing intervention for underage youth. This effort is targeted toward adults.
  (Goal 2, Objective 4A)

- **National Roadside Survey of Impaired Driving:** NHTSA's Office of Research and Technology plans to undertake a National Roadside Survey of Impaired Driving. This groundbreaking research will provide crucial data on the incidence of impaired drivers, including much needed data on over-the-counter, prescription, and illegal drug use. Many previous roadside surveys have obtained blood alcohol concentrations (BAC) from drivers at roadside but this study will attempt to also obtain saliva samples as well - to determine whether drivers had used drugs. The roadside survey will be conducted in 60 sites across the country, with at least 6,000 subjects. These studies have provided critical information regarding the proportion of drivers on the road across years at various BACs. For example, the 1996 survey indicated that 17% of nighttime weekend drivers had a positive BAC, compared to 26% in 1986, and 36% in 1973. There was also a significant decrease in drivers under the age of 21 who had been drinking in 1996 compared to the previous surveys (.3% in 1996 compared to 4% in 1973). This type of information is needed to better determine the extent of the drinking and driving problem, including underage drinkers, in order to develop and allocate appropriate countermeasures.
  (Goal 3, Objective 3A)

**ICCPUD Agency Funding for Programs Specific to Underage Drinking**

| ICCPUD Agency | Underage Drinking Funding Amount | |
|---|---|---|
| | **2004 Actual:** | **2005 Estimated:** |
| **Department of Defense*** | $2,820,000 | $4,320,000 |
| **Department of Education** | $29,823,000 | $32,736,000 |
| **National Institute on Alcohol Abuse & Alcoholism** | $54,200,000 | $55,800,000 |
| **Substance Abuse & Mental Health Services Administration**** | $39,905,000 | $40,396,000 |
| **Office of Juvenile Justice & Delinquency Prevention** | $25,000,000 | $25,000,000 |
| **National Highway & Traffic Safety Administration** | $697,500 | $968,000 |
| **TOTAL:** | | |

*These figures are estimates of the cost of alcohol and drug abuse reduction program expenditures that are dedicated to underage drinking prevention.

**Includes SAMHSA's target for underage drinking expenditures in the SPF SIG program.

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# Preface

Federal funding supports a wide variety of surveys. Information about underage alcohol use, abuse, and consequences primarily comes from three federally funded surveys—the National Survey on Drug Use and Health (NSDUH), Monitoring the Future (MTF), and the national Youth Risk Behavior Survey (YRBS). Briefly, each of the three surveys highlighted here makes a unique contribution to our understanding of the nature of youth alcohol use. The NSDUH assesses use of drugs, alcohol, and tobacco among noninstitutionalized individuals age 12 and older and serves as the major Federal source of nationally representative data on adult substance use in the United States. The MTF examines attitudes and behaviors of 8th, 10th, and 12th graders with regard to alcohol, drug, and tobacco use and provides important data on both substance use and the attitudes and beliefs that may contribute to such behaviors. The YRBS examines various risk behaviors among high school students and provides vital information on specific behaviors that cause the most important health problems among youth in the United States today.

When viewing the results from these surveys, readers may encounter differences in results for some findings. In order to address questions related to differences in youth substance use prevalence estimates generated by these surveys and to improve the understanding of Federal policy makers regarding the influence of methodological differences on youth prevalence estimates, the Office of the Assistant Secretary for Planning and Evaluation within the Department of Health and Human Services, commissioned a group of recognized experts in the area of survey design, sampling techniques, and statistical analysis to write papers examining and comparing the methodologies in each survey. The commissioned papers and accompanying Federal commentaries can be found in a special issue of *Journal of Drug Issues* (Volume 31, Number 3, Spring 2001). These experts agreed that the overall methodology for each survey is strong and that observed differences are not the result of flaws or serious weaknesses in survey design. In fact, some differences are to be expected such as those resulting from home- vs. school-based setting. From a policy perspective, serious and complex issues such as youth alcohol use and related behavior often require examination and analysis from multiple perspectives. Because no one survey is absolute or 100 percent precise, input from multiple sources is not only valuable but also necessary.

**National Survey of Drug Use and Health (NSDUH)**

NSDUH, the primary source of statistical information on the use of illegal drugs by the U.S. population age 12 and older, also collects information on use of alcohol; use of tobacco products; trends in initiation of substance use; prevention-related issues; substance dependence, abuse, and treatment; and mental health. Conducted since 1971, this annual survey collects data by administering questionnaires to a representative sample of the population through face-to-face interviews at their places of residence. The survey is sponsored by the Substance Abuse and Mental Health Services Administration (SAMHSA) and is planned and managed by SAMHSA's Office of Applied Studies (OAS). Data collection is conducted under contract with RTI International. NSDUH collects information from residents of households, noninstitutional group quarters (e.g., shelters, rooming houses, dormitories), and civilians living on military bases. Since 1999, the NSDUH has been carried out using computer-assisted interviewing. Most of the questions are administered with audio computer-assisted self-interviewing (ACASI). ACASI is designed to provide respondents with a highly private and confidential means of responding to questions to increase the level of honest reporting of illicit drug use and other sensitive behaviors. Less sensitive items are administered using computer-assisted personal interviewing (CAPI). The NSDUH is designed to be able to provide estimates for all 50 States

and the District of Columbia as well as national estimates. The design also oversamples youth ages 12–17 and young adults ages 18–25. For the 2003 survey, 67,784 interviews were completed for a weighted response rate for interviewing of 77.39 percent. Prior to 2002, NSDUH was called the National Household Survey on Drug Abuse (NHSDA). Because of improvements to the survey in 2002, the 2002 data constitute a new baseline for tracking trends in substance use. Therefore SAMHSA recommends that estimates from 2002 forward not be compared with estimates from 2001 and earlier years of NHSDA.

**Monitoring the Future (MTF)**

MTF measures alcohol, tobacco, and illicit drug use as well as perceived risk, personal disapproval, and perceived availability associated with each substance among nationally representative samples of students in public and private secondary schools throughout the conterminous United States. The National Institute on Drug Abuse supports MTF through a series of investigator-initiated grants to the University of Michigan's Institute for Social Research. Every year since 1975, a national sample of 12$^{th}$ graders has been surveyed. Beginning in 1991, the survey was expanded to include comparable numbers of 8$^{th}$ and 10$^{th}$ graders each year. The study also includes representative samples of adults through age 45 from previous high school graduating classes, who are administered follow-up surveys by mail and representative samples of college students one to four years past high school, who are part of these follow-up samples. The 2005 numbers are 16,800 for 8th graders, 16,200 for 10th and 14,700 for 12th graders. University of Michigan staff members administer the questionnaires to students, usually in their classrooms during a regular class period. Questionnaires are self completed and formatted for optical scanning. In 8$^{th}$ and 10$^{th}$ grades, the questionnaires are completely anonymous. In the 12$^{th}$ grade, they are confidential (to permit the longitudinal follow-up of a random subsample of participants. Extensive procedures are followed to protect the confidentiality of both the subjects and their data.

**Youth Risk Behavior Survey (YRBS)**

In the United States in the late 1980s, only a limited number of health-related school-based surveys such as MTF existed. Therefore the Centers for Disease Control and Prevention (CDC) developed the Youth Risk Behavior Surveillance System (YRBSS) to monitor six categories of priority health risk behaviors that contribute substantially to the leading causes of death, disability, and social problems among youth and young adults. YRBSS includes biennial national, State, and local school-based surveys of representative samples of students in grades 9–12 as well as other national and special population surveys. The national survey is conducted by CDC. The target population of the national survey comprises all public and private high school students in the 50 States and the District of Columbia. The State and local surveys are conducted by education and health agencies. The national sample is not an aggregation of the State and local surveys, and State and local estimates cannot be obtained from the national sample. In 2003, 15,214 students completed the national YRBS with an overall response rate of 67 percent.

**Additional Surveys**

Two additional federally supported surveys collect information on alcohol consumption and related information of a segment of the underage population—those 18- to 20-years of age. The first is the National Epidemiologic Survey of Alcohol and Related Conditions (NESARC). The second is the Worldwide Surveys of Substance Abuse and Health Behaviors Among Military Personnel. The NESARC, a large nationwide household survey sponsored by the National Institute on Alcohol Abuse and Alcoholism (NIAAA) and fielded by the Census Bureau, is designed to assess the prevalence of alcohol use disorders and their associated disabilities in the

general population age 18 and older. NESARC is designed to be a longitudinal survey with the first wave fielded in 2001–2002. Begun in the early 1980s, the Worldwide Survey is designed to measure prevalence of substance use and health behaviors among active-duty military personnel on U.S. military bases worldwide. The Worldwide Survey is fielded every 2- to 4-years, most recently in 2002. Information from these two surveys related to underage drinkers ages 18–20 would be a valuable addition to the report; however, current data from both surveys are not as recent as those for NSDUH, MTF, and YRBS. The next wave of NESARC data will be collected in 2004–2005. Similarly, the next Worldwide Survey will be conducted this year. It is anticipated that data from both surveys will be available in 2006. Consideration of the addition of information from these surveys in the annual report will be made at that time.

**Purpose of the Data Appendix**

Extensive information on underage alcohol use can be found in a variety of sources. The purpose of this data appendix is to provide the reader with one convenient location in which to find the latest statistics on underage drinking. Topics covered in the appendix include age of initiation of drinking and related information; alcohol use, binge use, and heavy alcohol use; alcohol abuse and dependence; drinking and driving; perceptions and attitudes related to alcohol; and other risky behaviors. Many of the tables presented here were created specifically for this report. Others, such as detailed tables from NSDUH data, are routinely produced and posted on the SAMHSA website but are not routinely published in printed reports. In order to keep this appendix to a manageable size, most of the statistics are presented in the form of percentages. To provide the reader with a frame of reference for appreciating the magnitude of underage alcohol use, Table 7, Alcohol Use, Binge Alcohol Use, and Heavy Alcohol Use in the Past Month Among Persons Ages 12–20, by Demographic Characteristics: Numbers in Thousands, National Survey on Drug Use and Health, 2002 and 2003 has been included. Table 8 presents the same information as percentages. For the majority of the other tables, information is presented as percentages only. The tables containing the corresponding numbers can be found at [link to the website for the annual report – under development] as can tables reporting standard error and P-values.

**Association vs. Causation**

In the section on other risky behaviors, data related to a number of risky behaviors are displayed by categories of alcohol use. When viewing this data, it is important for readers to keep in mind that association does not prove causation. Just because alcohol use is associated with other risky behaviors, it does not prove that alcohol use causes these other risky behaviors. Additional research needs to be done to establish whether alcohol is a causative factor.

**Additional Methodological Caveats**

The age of initiation of alcohol use is an important topic. When reviewing studies in this area, it is important to recognize that different researchers have used different methods to describe initiation of drinking and to estimate the average age at first use of alcohol. In some cases, large differences in estimates have resulted, primarily due to differences in how age groups and time periods are specified in the calculations. To help readers understand the impact of these different calculation methods, a few examples are discussed here. A popular method for computing the average age involves restricting the age group of estimation to persons ages 12 to 17 or 12 to 20, with no restriction on the time period. This method provides an estimate of the average age of first use among persons in the age group who have ever used alcohol in their lifetime, and typically this results in a younger estimated average age of first use than other methods. This is because initiation occurring in older age groups is excluded from the calculation, and also because the calculation gives too much weight to very early initiation. For

example, 15-year-olds who will first use at age 17 are excluded since they have not yet ever used alcohol at the time of data collection. Thus, based on the 2003 NSDUH, the average age of first use among lifetime alcohol users age 12–20 is 14.0, the average age of first use among 20-year-olds is 15.4, and the average age of first use among all lifetime drinkers is 16.8.

The above method has limited utility for assessing trends, because estimates do not reflect a well-defined recent time period. A 20-year-old may have first used alcohol at age 10, so an average age of first use among 12- to 20-year-olds would span a period covering as much as 10 years. Besides not reflecting the most current patterns, year-to-year change in this average is typically negligible due to the substantial overlap in the covered time periods. Trends in average age of initiation are best measured by estimating the average age among those who initiated alcohol use during a specific time period, such as a calendar year or within the 12 months prior to interview, in a repeated cross-sectional survey. These estimates also can be made with or without age restrictions. For example, the average age of first use among persons in 2003 who initiated within the past 12 months was 16.5, but restricting the calculation to just those who initiated before age 21 results in an average age of 15.6. Based on the 2003 NSDUH, an estimated 11 percent of recent initiates were age 21 or older when they first used. Finally, it should also be mentioned that estimates of average age of first use among recent initiates based on the NSDUH sample of persons 12 and older is biased upward because it does not capture all of the initiation occurring prior to age 12. An estimated 6.6 percent of alcohol initiates during 1990–1999 were age 11 or younger, based on the 2003 NSDUH. Exclusion of these early initiates from the calculation inflates the estimates of average age by approximately a half year. Using NSDUH, this bias can be diminished by making estimates only for time periods at least 2 years prior (e.g., from 2003 NSDUH, estimate average age at first use for 2001, but not 2002), an approach used in prior NSDUH reports. While providing interesting historical data, it does not give timely information on emerging patterns of alcohol initiation. Furthermore, there are serious bias concerns with historical estimates of the number of initiates and their average age at first use constructed from retrospectively reported age at first use. Memory errors are more likely to occur for the older respondents—they may not remember when an event occurred. An event may be remembered as having occurred more recently than it actually did—a kind of "forward telescoping" of the recalled timing of events. Evidence of "telescoping," where respondents report a more recent time of first use than is true, suggests that trend estimates based on reported age at first use may be misleading.

For example, in the 2003 MTF, alcohol use by the end of 6$^{th}$ grade is reported by 23.7 percent of the 2003 8$^{th}$ graders but by only 7.2 percent of the 2003 12$^{th}$ graders. In addition to the above-mentioned telescoping, several other factors also probably contribute to this difference. One is that eventual dropouts are more likely than average to drink at an early age. Thus, they will be captured as 8$^{th}$ graders but not as 12$^{th}$ graders. The lower grades also have lower absentee rates. Another is related to the issue of what is meant by first use of an alcoholic beverage. Those in 12$^{th}$ grade are more inclined to report only use that is not adult-approved and do not count having less than a glass with parents or for religious purposes. Younger students may be more likely to report first use of a limited amount of alcohol. Thus 8$^{th}$ and 9$^{th}$ grade data probably exaggerate drinking while 11$^{th}$ and 12$^{th}$ grade data may understate it.

# AGE OF INITIATION OF DRINKING

# Table 1. Past Year Initiation of Alcohol Use among Persons Ages 12 or Older, Persons Ages 12 or Older At Risk for Initiation of Alcohol Use, and Past Year Alcohol Users Ages 12 or Older, by Demographic Characteristics: Numbers in Thousands and Percentages, National Survey on Drug Use and Health, 2002, 2003, and 2004

| Demographic Characteristic | Number of Past Year Initiates (1,000s)[1] | | | Percentage of Past Year Initiates[1] | | | Percentage of Past Year Initiates Among Persons At Risk for Initiation[1,2] | | | Percentage of Past Year Initiates Among Past Year Users[1] | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | 2002 | 2003 | 2004 | 2002 | 2003 | 2004 | 2002 | 2003 | 2004 | 2002 | 2003 | 2004 |
| **Total** | 3,942[b] | 4,082[a] | 4,396 | 1.7[a] | 1.7 | 1.8 | 9.0 | 9.2 | 9.4 | 2.5[a] | 2.6 | 2.8 |
| **Age** | | | | | | | | | | | | |
| 12–17 | 2,588 | 2,593 | 2,743 | 10.5 | 10.4 | 10.9 | 15.6 | 15.4 | 15.8 | 30.2 | 30.2 | 32.1 |
| 12–13 | 462 | 451 | 472 | 5.6 | 5.3 | 5.6 | 6.4 | 6.1 | 6.4 | 46.0 | 43.9[a] | 49.9 |
| 14–15 | 1,082[a] | 1,125 | 1,222 | 12.8 | 13.6 | 14.1 | 18.9 | 19.6 | 20.0 | 36.5[a] | 39.0 | 40.4 |
| 16–17 | 1,045 | 1,017 | 1,049 | 13.1 | 12.3 | 12.8 | 28.9 | 27.0 | 27.5 | 22.7 | 21.8 | 23.0 |
| 18–25 | 1,230[b] | 1,430 | 1,484 | 4.0[a] | 4.5 | 4.6 | 22.9 | 25.8 | 25.0 | 5.1[a] | 5.8 | 5.9 |
| 18–20 | 834[a] | 961 | 1,004 | 6.7[a] | 7.7 | 8.0 | 26.8 | 29.5 | 29.4 | 9.3[a] | 10.7 | 11.1 |
| 21–25 | 396 | 468 | 481 | 2.1 | 2.4 | 2.4 | 17.6 | 20.6 | 19.1 | 2.6 | 3.0 | 3.0 |
| 26 or Older | 124 | 60 | 169 | 0.1 | 0.0 | 0.1 | 0.6 | 0.3 | 0.7 | 0.1 | 0.0 | 0.1 |
| **Gender** | | | | | | | | | | | | |
| Male | 1,756[a] | 1,827 | 1,985 | 1.5 | 1.6 | 1.7 | 10.2 | 10.4 | 10.8 | 2.2 | 2.3 | 2.4 |
| Female | 2,186 | 2,255 | 2,411 | 1.8 | 1.8 | 1.9 | 8.3 | 8.4 | 8.5 | 2.9 | 3.0 | 3.2 |
| **Gender/Age** | | | | | | | | | | | | |
| Male 12–17 | 1,160 | 1,156 | 1,285 | 9.2 | 9.1 | 10.0 | 13.9 | 13.5 | 14.6 | 27.5[a] | 28.1 | 30.6 |
| Female 12–17 | 1,429 | 1,436 | 1,458 | 11.8 | 11.7 | 11.8 | 17.3 | 17.3 | 17.1 | 32.8 | 32.2 | 33.7 |

Low precision, no estimate reported.
– Not available.

[a] Difference between estimate and 2004 estimate is statistically significant at the 0.05 level.
[b] Difference between estimate and 2004 estimate is statistically significant at the 0.01 level.

[1] Past Year Initiates are defined as persons who used the substance(s) for the first time in the 12 months prior to date of interview.
[2] At Risk for Initiation is defined as persons who did not use the substance(s) in their lifetime or used the substance(s) for the first time in the past year.

Source: SAMHSA, Office of Applied Studies, National Survey on Drug Use and Health, 2002, 2003 and 2004.

# Table 2. Mean Age at First Use among Past Year Initiates of Substance Use Ages 12 or Older, by Gender: National Survey on Drug Use and Health, 2002, 2003, and 2004

| | Mean Age | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | Total | | | Male | | | Female | | |
| **Substance** | **2002** | **2003** | **2004** | **2002** | **2003** | **2004** | **2002** | **2003** | **2004** |
| **Alcohol** | 16.7 | 16.5 | 17.5 | 16.3 | 16.3 | 16.6 | 17.1 | 16.6 | 18.3 |
| Initiated under age 21* | 15.6 | 15.6 | 15.6 | 15.2 | 15.2 | 15.3 | 16.0 | 16.0 | 16.0 |
| **Illicit Drug**[1] | 18.1[a] | 19.7 | 20.1 | 17.2 | 17.7 | 18.5 | 19.0 | 21.2 | 21.2 |
| Marijuana and Hashish | 17.0 | 17.5 | 18.0 | 16.8 | 17.8 | 16.7 | 17.1 | 17.2 | 19.0 |
| Cocaine | 19.8 | 19.8 | 20.0 | 19.8 | 20.0 | 20.0 | 19.7 | 19.7 | 20.2 |
| Crack | 27.1[a] | 22.9 | 21.9 | 27.8[b] | 23.8 | 20.5 | 26.2 | 21.9 | 23.1 |
| Heroin | 21.0 | 20.9 | 24.4 | 22.9 | 21.5 | 22.7 | 17.3[a] | 19.8 | 26.4 |
| Hallucinogens | 18.7 | 17.9 | 18.7 | 19.1 | 18.6 | 18.7 | 18.4 | 17.2 | 18.7 |
| LSD | 17.4 | 17.2 | 18.4 | 17.0 | 17.9 | 18.2 | 17.8 | 16.2 | 18.6 |
| PCP | 16.0[a] | 17.4 | 18.9 | 15.9[a] | 17.4 | 17.7 | 16.1 | 17.4 | 20.3 |
| Ecstasy | 21.6[a] | 19.7 | 19.5 | 22.6 | 20.2 | 20.5 | 20.7 | 19.2 | 18.3 |
| Inhalants | 15.9 | 16.0 | 16.0 | 16.2 | 16.5 | 15.7 | 15.4 | 15.5 | 16.3 |
| Nonmedical Use of Psychotherapeutics[2] | 21.5[b] | 23.9 | 24.7 | 20.5 | 19.8 | 24.1 | 22.3[a] | 26.4 | 25.1 |
| Pain Relievers | 21.0[a] | 24.0 | 23.3 | 20.6 | 20.0[a] | 22.9 | 21.5 | 26.8 | 23.8 |
| OxyContin® | -- | -- | 24.5 | -- | -- | 25.2 | -- | -- | 23.6 |
| Tranquilizers | 25.2 | 22.9[a] | 25.2 | 23.0 | 21.1 | 23.1 | 26.5 | 24.0 | 26.5 |
| Stimulants | 19.2 | 22.1 | 24.1 | 18.8 | 19.3 | 27.2 | 19.7 | 23.8 | 21.7 |
| Methamphetamine | 18.9 | 20.4 | 22.1 | 19.0 | 19.9 | 20.8 | 18.8 | 20.8 | 23.1 |
| Sedatives | 28.4 | 31.1 | 29.3 | 22.0 | 19.1 | 21.6 | 30.8 | 37.3 | 33.1 |
| **Illicit Drug Other Than Marijuana**[1] | 20.0[a] | 21.7 | 21.7 | 18.6[a] | 18.3[a] | 20.5 | 21.1 | 24.2 | 22.7 |
| **Cigarettes** | 16.9 | 16.9 | 16.7 | 16.9 | 16.6 | 16.6 | 17.0 | 17.1 | 16.8 |
| Daily Cigarettes[3] | 19.9 | 19.8 | 18.8 | 20.0 | 18.1 | 19.0 | 19.8 | 21.2[a] | 18.6 |

* Mean age of first use among past year initiates of alcohol use who were age 20 or younger.
** Low precision, no estimate reported.
– Not available.
NOTE: Past Year Initiates are defined as persons who used the substance(s) for the first time in the 12 months prior to date of interview.

[a] Difference between estimate and 2004 estimate is statistically significant at the 0.05 level.
[b] Difference between estimate and 2004 estimate is statistically significant at the 0.01 level.

[1] Illicit Drugs include marijuana/hashish, cocaine (including crack), heroin, hallucinogens, inhalants, or prescription-type psychotherapeutics used nonmedically. Illicit Drugs Other Than Marijuana include cocaine (including crack), heroin, hallucinogens, inhalants, or prescription-type psychotherapeutics used nonmedically.
[2] Nonmedical use of prescription-type pain relievers, tranquilizers, stimulants, or sedatives; does not include over-the-counter drugs.
[3] Daily Cigarette Use is defined as ever smoking every day for at least 30 days.

Source: SAMHSA, Office of Applied Studies, National Survey on Drug Use and Health, 2002, 2003, and 2004.

# Table 3. Numbers (in Thousands) of Persons Who Initiated Alcohol Use in the United States, Their Mean Age at First Use, and Rates of First Use (Per 1,000 Person-Years of Exposure): 1965–2003, Based on National Survey on Drug Use and Health, 2002–2004

| YEAR | NUMBER OF INITIATES (1,000s) | | | MEAN AGE | AGE-SPECIFIC RATES[1] | |
|---|---|---|---|---|---|---|
| | All Ages | Under 18 | 18 or Older | | 12–17 | 18–25 |
| **1965** | 3,261 | 1,817 | 1,444 | 17.4 | 96.1 | 223.0 |
| **1966** | 2,968 | 1,638 | 1,330 | 17.1 | 86.6 | 213.3 |
| **1967** | 3,604 | 1,959 | 1,645 | 17.2 | 104.4 | 246.2 |
| **1968** | 3,552 | 2,059 | 1,493 | 17.2 | 108.2 | 216.3 |
| **1969** | 3,893 | 2,213 | 1,679 | 17.1 | 115.3 | 259.3 |
| **1970** | 4,003 | 2,390 | 1,613 | 16.9 | 122.2 | 261.0 |
| **1971** | 3,922 | 2,441 | 1,481 | 16.8 | 125.4 | 239.0 |
| **1972** | 4,272 | 2,703 | 1,569 | 16.9 | 141.9 | 260.1 |
| **1973** | 4,072 | 2,685 | 1,387 | 16.5 | 142.7 | 234.9 |
| **1974** | 4,211 | 2,845 | 1,366 | 16.7 | 153.4 | 233.1 |
| **1975** | 3,919 | 2,597 | 1,322 | 16.6 | 140.9 | 226.0 |
| **1976** | 3,930 | 2,600 | 1,330 | 16.6 | 142.6 | 229.0 |
| **1977** | 4,130 | 2,811 | 1,319 | 16.4 | 158.8 | 242.3 |
| **1978** | 3,852 | 2,702 | 1,150 | 16.3 | 159.2 | 209.8 |
| **1979** | 3,993 | 2,721 | 1,273 | 16.5 | 167.1 | 235.4 |
| **1980** | 3,626 | 2,453 | 1,173 | 16.6 | 155.1 | 220.8 |
| **1981** | 3,606 | 2,461 | 1,145 | 16.7 | 158.9 | 214.7 |
| **1982** | 3,466 | 2,403 | 1,063 | 16.6 | 152.9 | 202.9 |
| **1983** | 3,289 | 2,199 | 1,090 | 16.5 | 141.4 | 217.7 |
| **1984** | 3,365 | 2,367 | 998 | 16.5 | 156.6 | 198.4 |
| **1985** | 3,263 | 2,237 | 1,026 | 16.7 | 149.6 | 212.7 |
| **1986** | 3,316 | 2,404 | 912 | 16.1 | 165.0 | 192.6 |
| **1987** | 3,119 | 2,063 | 1,057 | 16.7 | 144.7 | 218.4 |
| **1988** | 2,909 | 1,971 | 938 | 16.4 | 138.9 | 194.7 |
| **1989** | 3,195 | 2,140 | 1,055 | 16.7 | 152.3 | 210.2 |
| **1990** | 2,933 | 1,941 | 993 | 16.8 | 135.3 | 198.0 |
| **1991** | 2,890 | 1,875 | 1,015 | 16.6 | 125.7 | 211.1 |
| **1992** | 3,059 | 2,009 | 1,050 | 16.8 | 128.9 | 207.5 |
| **1993** | 3,190 | 2,192 | 998 | 16.4 | 138.4 | 198.0 |
| **1994** | 3,311 | 2,260 | 1,051 | 16.2 | 137.5 | 206.5 |
| **1995** | 3,299 | 2,218 | 1,081 | 16.5 | 132.4 | 209.1 |
| **1996** | 3,473 | 2,338 | 1,136 | 16.6 | 134.5 | 221.3 |
| **1997** | 3,668 | 2,538 | 1,130 | 16.3 | 141.8 | 220.4 |
| **1998** | 3,882 | 2,633 | 1,248 | 16.4 | 145.8 | 238.8 |
| **1999** | 4,072 | 2,832 | 1,240 | 16.5 | 155.6 | 233.2 |
| **2000** | 4,764 | 3,358 | 1,407 | 16.3 | 191.6 | 273.3 |
| **2001**[2] | 4,906 | 3,500 | 1,406 | 16.3 | 200.7 | 277.4 |
| **2002**[3] | 5,240 | 3,748 | 1,492 | 16.2 | 216.6 | 290.0 |
| **2003**[3] | -- | -- | 1,442 | -- | 228.2 | 284.1 |

*Low precision; no estimate reported.
-- Not available.
NOTE: Comparisons between years, particularly between recent estimates and those from 10 or more years prior, should be made with caution due to potential bias from reporting and other sources.

[1] The numerator of each rate is the number of persons in the age group who initiated use of the drug in the specified year, while the denominator is the person-time exposure of persons in the age group measured in thousands of years.
[2] Estimated using 2003 and 2004 data only.
[3] Estimated using 2004 data only.

Source: SAMHSA, Office of Applied Studies, National Survey on Drug Use and Health, 2002, 2003, and 2004.

## Table 4. Percentage of High School Students who Drank Alcohol* for the First Time Before Age 13 Years, by Sex, Race/Ethnicity, and Grade—United States, Youth Risk Behavior Survey, 2003

| Category | Female | | Male | | Total | |
|---|---|---|---|---|---|---|
| | % | CI† | % | CI† | % | CI† |
| **Race/Ethnicity** | | | | | | |
| White, non-Hispanic | 21.2 | ±2.9 | 30.0 | ±3.0 | 25.7 | ±2.5 |
| Black, non-Hispanic | 26.8 | ±3.5 | 35.7 | ±4.0 | 31.2 | ±2.8 |
| Other,‡ non-Hispanic | 27.4 | ±6.3 | 39.1 | ±7.7 | 33.6 | ±5.4 |
| Hispanic | 26.3 | ±3.5 | 34.1 | ±4.4 | 30.2 | ±3.2 |
| **Grade** | | | | | | |
| 9 | 33.3 | ±5.2 | 39.4 | ±3.6 | 36.4 | ±4.0 |
| 10 | 23.5 | ±3.4 | 33.3 | ±4.1 | 28.5 | ±3.0 |
| 11 | 18.2 | ±2.7 | 27.6 | ±4.0 | 23.0 | ±2.8 |
| 12 | 15.2 | ±1.9 | 25.1 | ±3.1 | 20.3 | ±1.7 |
| **Total** | 23.3 | ±2.4 | 32.0 | ±2.5 | 27.8 | ±2.1 |

* Other than a few sips.

† 95% Confidence Interval.

‡ Other includes Asian, Native Hawaiian, Pacific Islander, American Indian, Alaska Native, and multiple races.

Source: Youth Risk Behavior Survey, 2003

## Table 5. Mean Age of First Drink of Alcohol Among High School Students, by Sex, Race/Ethnicity, and Grade—United States, Youth Risk Behavior Survey, 2003

| Category | Years | | |
|---|---|---|---|
| | Female | Male | Total |
| **Race/Ethnicity** | | | |
| White, non-Hispanic | 13.3 | 12.7 | 13.0 |
| Black, non-Hispanic | 12.9 | 11.9 | 12.4 |
| Other*, non-Hispanic | 12.6 | 11.9 | 12.2 |
| Hispanic | 13.1 | 12.5 | 12.8 |
| **Grade** | | | |
| 9 | 11.9 | 11.5 | 11.7 |
| 10 | 13.0 | 12.3 | 12.6 |
| 11 | 13.6 | 12.9 | 13.3 |
| 12 | 14.1 | 13.4 | 13.7 |
| **Total** | 13.1 | 12.5 | 12.8 |

* Other includes Asian, Native Hawaiian, Pacific Islander, American Indian, Alaska Native, and multiple races.

Source: Youth Risk Behavior Survey, 2003.

# ALCOHOL USE, BINGE, AND HEAVY DRINKING

# Table 6. Percent of 8th, 10th, and 12th Graders Who Have Ever Used Alcohol and Percent of Alcohol Users in these Grades who First Used Before Grade 7: Monitoring the Future, Odd Years, 1995—2005

| | 1995 | 1997 | 1999 | 2001 | 2003 | 2005 |
|---|---|---|---|---|---|---|
| **8th Graders** | | | | | | |
| Percent who ever used | 54.5 | 53.8 | 52.1 | 50.5 | 45.6 | 41.0 |
| Percent of ever users who first used before grade 7 | 54.3 | 51.9 | 52.6 | 52.3 | 52.0 | 49.0 |
| **10th Graders** | | | | | | |
| Percent who ever used | 70.5 | 72.0 | 70.6 | 70.1 | 66.0 | 63.2 |
| Percent of ever users who first used before grade 7 | 22.8 | 21.4 | 22.4 | 20.8 | 22.3 | 19.0 |
| **12th Graders** | | | | | | |
| Percent who ever used | 80.7 | 81.7 | 80.0 | 79.7 | 76.6 | 75.1 |
| Percent of ever users who first used before grade 7 | 12.1 | 11.8 | 9.8 | 10.8 | 9.4 | 7.7 |

Source: SAMHSA/OAS, based on data from University of Michigan, Monitoring the Future

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# Table 7. Alcohol Use, Binge Alcohol Use, and Heavy Alcohol Use in the Past Month among Persons Ages 12 to 20, by Demographic Characteristics: Numbers in Thousands, National Survey on Drug Use and Health, 2002, 2003, and 2004

| Demographic Characteristic | Type of Alcohol Use | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | Any Alcohol Use | | | Binge Alcohol Use | | | Heavy Alcohol Use | | |
| | 2002 | 2003 | 2004 | 2002 | 2003 | 2004 | 2002 | 2003 | 2004 |
| **Total** | 10,713 | 10,876 | 10,838 | 7,175 | 7,190 | 7,397 | 2,301 | 2,297 | 2,375 |
| **Gender** | | | | | | | | | |
| Male | 5,619 | 5,720 | 5,723 | 4,140 | 4,162 | 4,271 | 1,544 | 1,506 | 1,582 |
| Female | 5,094 | 5,156 | 5,115 | 3,035 | 3,027 | 3,127 | 756 | 791 | 793 |
| **Hispanic Origin and Race** | | | | | | | | | |
| Not Hispanic or Latino | 9,217 | 9,292 | 9,152 | 6,168 | 6,146 | 6,170 | 2,044 | 2,044 | 2,076 |
| White | 7,681 | 7,749 | 7,590 | 5,326 | 5,316 | 5,320 | 1,857 | 1,874 | 1,889 |
| Black or African American | 1,020 | 1,005 | 1,065 | 518 | 502 | 556 | 103 | 89 | 113 |
| American Indian or Alaska Native | 87 | 65 | 56 | 61 | 52 | 44 | 8 | 10 | 11 |
| Native Hawaiian or Other Pacific Islander | * | * | * | * | * | * | 2 | 8 | 1 |
| Asian | 234 | 278 | 255 | 129 | 146 | 125 | 28 | 48 | 25 |
| Two or More Races | 156 | 149 | 155 | 110 | 89 | 106 | 45 | 15[a] | 36 |
| Hispanic or Latino | 1,496 | 1,584 | 1,686 | 1,006[b] | 1,044[a] | 1,227 | 257 | 253 | 299 |
| **Gender/Race/Hispanic Origin** | | | | | | | | | |
| Male, White, Not Hispanic | 3,976 | 4,022 | 4,015 | 3,029 | 3,025 | 3,074 | 1,231 | 1,209 | 1,241 |
| Female, White, Not Hispanic | 3,704 | 3,728 | 3,574 | 2,298 | 2,292 | 2,246 | 626 | 665 | 649 |
| Male, Black, Not Hispanic | 538 | 542 | 582 | 295 | 307 | 335 | 73 | 69 | 97 |
| Female, Black, Not Hispanic | 482 | 463 | 483 | 223 | 195 | 221 | 31 | 20 | 17 |
| Male, Hispanic | 853 | 898 | 884 | 634 | 655 | 692 | 177 | 183 | 204 |
| Female, Hispanic | 643[a] | 686 | 802 | 373[b] | 388[b] | 535 | 80 | 69 | 95 |

*Low precision; no estimate reported.

NOTE: Binge Alcohol Use is defined as drinking five or more drinks on the same occasion (i.e., at the same time or within a couple of hours of each other) on at least 1 day in the past 30 days. Heavy Alcohol Use is defined as drinking five or more drinks on the same occasion on each of 5 or more days in the past 30 days; all heavy alcohol users are also binge alcohol users.

[a] Difference between estimate and 2004 estimate is statistically significant at the 0.05 level.
[b] Difference between estimate and 2004 estimate is statistically significant at the 0.01 level.

Source: SAMHSA, Office of Applied Studies, National Survey on Drug Use and Health, 2002, 2003, and 2004.

# Table 8. Alcohol Use, Binge Alcohol Use, and Heavy Alcohol Use in the Past Month among Persons Ages 12 to 20, by Demographic Characteristics: Percentages, National Survey on Drug Use and Health, 2002, 2003, and 2004

| Demographic Characteristic | Type of Alcohol Use | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | Any Alcohol Use | | | Binge Alcohol Use | | | Heavy Alcohol Use | | |
| | 2002 | 2003 | 2004 | 2002 | 2003 | 2004 | 2002 | 2003 | 2004 |
| **Total** | 28.8 | 29.0 | 28.7 | 19.3 | 19.2 | 19.6 | 6.2 | 6.1 | 6.3 |
| **Gender** | | | | | | | | | |
| Male | 29.6 | 29.9 | 29.6 | 21.8 | 21.7 | 22.1 | 8.1 | 7.9 | 8.2 |
| Female | 28.0 | 28.1 | 27.8 | 16.7 | 16.5 | 17.0 | 4.2 | 4.3 | 4.3 |
| **Hispanic Origin and Race** | | | | | | | | | |
| Not Hispanic or Latino | 29.5 | 29.7 | 29.2 | 19.8 | 19.6 | 19.7 | 6.5 | 6.5 | 6.6 |
| White | 32.8 | 33.2 | 32.6 | 22.7 | 22.8 | 22.8 | 7.9 | 8.0 | 8.1 |
| Black or African American | 19.3 | 18.2 | 19.1 | 9.8 | 9.1 | 9.9 | 2.0 | 1.6 | 2.0 |
| American Indian or Alaska Native | 32.4 | 26.0 | 24.3 | 22.6 | 20.8 | 19.0 | 3.1 | 4.0 | 4.7 |
| Native Hawaiian or Other Pacific Islander | * | * | * | * | * | * | 1.5 | 5.7 | 1.1 |
| Asian | 15.5 | 18.2 | 16.4 | 8.6 | 9.6 | 8.0 | 1.8 | 3.1 | 1.6 |
| Two or More Races | 28.1 | 27.7 | 26.4 | 19.8 | 16.5 | 18.0 | 8.2 | 2.9[a] | 6.2 |
| Hispanic or Latino | 25.0 | 25.6 | 26.6 | 16.8[a] | 16.9[a] | 19.3 | 4.3 | 4.1 | 4.7 |
| **Gender/Race/Hispanic Origin** | | | | | | | | | |
| Male, White, Not Hispanic | 33.3 | 33.8 | 33.5 | 25.4 | 25.4 | 25.7 | 10.3 | 10.1 | 10.4 |
| Female, White, Not Hispanic | 32.2 | 32.6 | 31.6 | 19.9 | 20.0 | 19.8 | 5.4 | 5.8 | 5.7 |
| Male, Black, Not Hispanic | 20.1 | 19.5 | 20.3 | 11.0 | 11.0 | 11.7 | 2.7 | 2.5 | 3.4 |
| Female, Black, Not Hispanic | 18.4 | 17.0 | 17.7 | 8.5 | 7.2 | 8.1 | 1.2 | 0.7 | 0.6 |
| Male, Hispanic | 27.1 | 27.8 | 26.9 | 20.1 | 20.3 | 21.1 | 5.6 | 5.7 | 6.2 |
| Female, Hispanic | 22.6 | 23.2 | 26.2 | 13.1[b] | 13.1[b] | 17.5 | 2.8 | 2.3 | 3.1 |

*Low precision; no estimate reported.

NOTE: Binge Alcohol Use is defined as drinking five or more drinks on the same occasion (i.e., at the same time or within a couple of hours of each other) on at least 1 day in the past 30 days. Heavy Alcohol Use is defined as drinking five or more drinks on the same occasion on each of 5 or more days in the past 30 days; all heavy alcohol users are also binge alcohol users.

[a] Difference between estimate and 2004 estimate is statistically significant at the 0.05 level.
[b] Difference between estimate and 2004 estimate is statistically significant at the 0.01 level.

Source: SAMHSA, Office of Applied Studies, National Survey on Drug Use and Health, 2002, 2003, and 2004.

**Table 9. Past Month Alcohol and Binge Alcohol Use among Persons Ages 12 to 20, by State: Percentages and Confidence Intervals, Annual Averages Based on National Survey on Drug Use and Health, 2002, 2003, and 2004**

| State | Past Month Alcohol Use | | Past Month Binge Alcohol Use[1] | |
|---|---|---|---|---|
| | Percentage | 95% Confidence Interval | Percentage | 95% Confidence Interval |
| **Total** | 28.8 | (28.4 – 29.3) | 19.4 | (18.9 – 19.8) |
| Alabama | 25.6 | (22.3 – 29.2) | 17.4 | (14.3 – 20.9) |
| Alaska | 26.3 | (24.3 – 28.4) | 18.3 | (16.5 – 20.1) |
| Arizona | 28.3 | (24.7 – 32.1) | 19.3 | (16.4 – 22.5) |
| Arkansas | 25.0 | (20.8 – 29.6) | 18.3 | (14.2 – 23.2) |
| California | 25.2 | (23.8 – 26.6) | 16.1 | (14.8 – 17.5) |
| Colorado | 33.1 | (29.8 – 36.6) | 21.3 | (18.9 – 23.8) |
| Connecticut | 33.8 | (30.8 – 36.9) | 22.3 | (19.1 – 25.9) |
| Delaware | 29.8 | (25.7 – 34.3) | 19.3 | (15.7 – 23.4) |
| District of Columbia | 31.1 | (27.3 – 35.1) | 17.5 | (14.3 – 21.3) |
| Florida | 27.7 | (25.6 – 29.9) | 17.3 | (15.6 – 19.2) |
| Georgia | 23.0 | (20.0 – 26.2) | 15.2 | (13.4 – 17.2) |
| Hawaii | 28.2 | (25.7 – 30.8) | 20.1 | (18.1 – 22.3) |
| Idaho | 26.5 | (22.3 – 31.2) | 18.9 | (15.6 – 22.8) |
| Illinois | 30.6 | (28.5 – 32.8) | 21.6 | (19.7 – 23.6) |
| Indiana | 26.9 | (23.9 – 30.1) | 18.8 | (16.4 – 21.5) |
| Iowa | 34.1 | (27.4 – 41.6) | 26.0 | (19.8 – 33.3) |
| Kansas | 32.7 | (28.4 – 37.3) | 23.9 | (19.8 – 28.5) |
| Kentucky | 29.9 | (27.5 – 32.4) | 20.8 | (18.7 – 23.1) |
| Louisiana | 31.5 | (28.6 – 34.6) | 20.3 | (18.4 – 22.2) |
| Maine | 29.2 | (26.4 – 32.1) | 21.0 | (18.6 – 23.7) |
| Maryland | 28.6 | (24.1 – 33.5) | 16.9 | (14.1 – 20.0) |
| Massachusetts | 35.1 | (29.1 – 41.5) | 25.0 | (20.0 – 30.7) |
| Michigan | 30.7 | (28.4 – 33.0) | 20.9 | (18.8 – 23.1) |
| Minnesota | 31.9 | (27.8 – 36.3) | 22.6 | (19.1 – 26.5) |
| Mississippi | 24.3 | (21.0 – 27.9) | 15.6 | (13.3 – 18.1) |
| Missouri | 32.6 | (28.7 – 36.8) | 22.5 | (19.2 – 26.1) |
| Montana | 39.9 | (37.3 – 42.6) | 30.4 | (27.1 – 33.9) |
| Nebraska | 33.6 | (29.8 – 37.7) | 23.5 | (21.1 – 26.1) |
| Nevada | 25.9 | (23.7 – 28.2) | 16.2 | (14.6 – 17.8) |
| New Hampshire | 36.2 | (33.1 – 39.5) | 25.7 | (23.0 – 28.7) |
| New Jersey | 28.9 | (26.2 – 31.8) | 16.9 | (14.3 – 20.0) |
| New Mexico | 32.9 | (29.2 – 36.9) | 23.2 | (19.4 – 27.5) |
| New York | 32.1 | (30.3 – 34.0) | 21.1 | (19.4 – 22.8) |
| North Carolina | 25.9 | (22.2 – 29.9) | 17.3 | (14.2 – 21.0) |
| North Dakota | 42.7 | (38.8 – 46.7) | 32.9 | (30.1 – 35.9) |
| Ohio | 29.4 | (27.5 – 31.3) | 20.8 | (19.1 – 22.5) |
| Oklahoma | 29.1 | (25.0 – 33.7) | 20.3 | (17.2 – 23.9) |
| Oregon | 28.3 | (25.4 – 31.3) | 19.3 | (16.2 – 22.8) |
| Pennsylvania | 30.9 | (29.1 – 32.9) | 21.6 | (20.0 – 23.3) |
| Rhode Island | 38.4 | (34.0 – 42.9) | 28.0 | (23.3 – 33.2) |
| South Carolina | 24.9 | (20.3 – 30.1) | 17.0 | (12.9 – 22.1) |
| South Dakota | 39.3 | (36.1 – 42.7) | 30.8 | (27.8 – 34.0) |
| Tennessee | 22.8 | (19.8 – 26.1) | 14.4 | (11.6 – 17.8) |
| Texas | 26.7 | (25.3 – 28.2) | 16.9 | (15.6 – 18.3) |
| Utah | 18.8 | (15.1 – 23.1) | 13.2 | (10.4 – 16.6) |
| Vermont | 35.2 | (29.3 – 41.5) | 24.5 | (19.0 – 31.0) |
| Virginia | 29.7 | (26.2 – 33.5) | 20.6 | (16.7 – 25.3) |
| Washington | 29.8 | (26.7 – 33.1) | 20.6 | (18.1 – 23.3) |
| West Virginia | 28.9 | (24.6 – 33.7) | 22.2 | (18.7 – 26.2) |
| Wisconsin | 37.5 | (34.3 – 40.9) | 26.5 | (22.4 – 31.1) |
| Wyoming | 33.2 | (27.5 – 39.5) | 24.2 | (20.0 – 28.9) |

* Low Precision; no estimate reported.

[1] Binge Alcohol Use is defined as drinking five or more drinks on the same occasion (i.e., at the same time or within a couple of hours of each other) on at least 1 day in the past 30 days.

Source: SAMHSA, Office of Applied Studies, National Survey on Drug Use and Health, 2002, 2003, and 2004

# Table 10. Alcohol Use, Binge Alcohol Use, and Heavy Alcohol Use in the Past Month among Persons Ages 12 to 13, by Demographic Characteristics: Percentages, National Survey on Drug Use and Health, 2002, 2003, and 2004

| | Type of Alcohol Use | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | Any Alcohol Use | | | Binge Alcohol Use | | | Heavy Alcohol Use | | |
| **Demographic Characteristic** | **2002** | **2003** | **2004** | **2002** | **2003** | **2004** | **2002** | **2003** | **2004** |
| **Total** | 4.3 | 4.5 | 4.3 | 1.8 | 1.6 | 2.0 | 0.3 | 0.1 | 0.2 |
| **Gender** | | | | | | | | | |
| Male | 4.0 | 4.4 | 4.1 | 1.7 | 1.7 | 2.2 | 0.3 | 0.3 | 0.2 |
| Female | 4.6 | 4.6 | 4.5 | 1.9 | 1.4 | 1.9 | 0.2 | 0.0[a] | 0.3 |
| **Hispanic Origin and Race** | | | | | | | | | |
| Not Hispanic or Latino | 4.1 | 4.7 | 4.1 | 1.7 | 1.6 | 1.7 | 0.2 | 0.2 | 0.2 |
| White | 4.3 | 5.1 | 4.5 | 1.7 | 1.6 | 1.8 | 0.3 | 0.2 | 0.2 |
| Black or African American | 4.1 | 3.8 | 2.7 | 1.4 | 1.9 | 0.8 | 0.1 | 0.1 | * |
| American Indian or Alaska Native | * | * | 10.5 | * | * | 9.2 | 0.2 | * | * |
| Native Hawaiian or Other Pacific Islander | * | * | * | * | * | * | * | * | * |
| Asian | * | * | * | * | * | * | * | * | 0.2 |
| Two or More Races | 4.5 | 8.3 | 4.2 | 0.7 | 3.6 | 0.8 | * | * | * |
| Hispanic or Latino | 5.1 | 3.8 | 5.3 | 2.5 | 1.2[a] | 3.6 | 0.5 | 0.1 | 0.5 |
| **Gender/Race/Hispanic Origin** | | | | | | | | | |
| Male, White, Not Hispanic | 4.2 | 5.0 | 4.4 | 1.8 | 1.7 | 2.0 | 0.4 | 0.3 | 0.1 |
| Female, White, Not Hispanic | 4.4 | 5.2 | 4.5 | 1.7 | 1.5 | 1.6 | 0.1 | 0.1 | 0.3 |
| Male, Black, Not Hispanic | 3.2 | 4.0 | 2.5 | 1.4 | 2.0[a] | 0.5 | 0.2 | 0.1 | * |
| Female, Black, Not Hispanic | 5.0 | 3.6 | 2.9 | 1.5 | 1.7 | 1.1 | * | * | * |
| Male, Hispanic | 5.3 | 3.6 | 4.5 | 2.4 | 1.6 | 3.7 | 0.4 | 0.1 | 0.5 |
| Female, Hispanic | 4.8 | 4.0 | 6.3 | 2.7 | 0.7[a] | 3.4 | 0.7 | 0.0 | 0.6 |

*Low precision; no estimate reported.

NOTE: Binge Alcohol Use is defined as drinking five or more drinks on the same occasion (i.e., at the same time or within a couple of hours of each other) on at least 1 day in the past 30 days. Heavy Alcohol Use is defined as drinking five or more drinks on the same occasion on each of 5 or more days in the past 30 days; all heavy alcohol users are also binge alcohol users.

[a]Difference between estimate and 2004 estimate is statistically significant at the 0.05 level.
[b]Difference between estimate and 2004 estimate is statistically significant at the 0.01 level.

Source: SAMHSA, Office of Applied Studies, National Survey on Drug Use and Health, 2002, 2003, and 2004.

# Table 11. Alcohol Use, Binge Alcohol Use, and Heavy Alcohol Use in the Past Month among Persons Ages 14 to 15, by Demographic Characteristics: Percentages, National Survey on Drug Use and Health, 2002, 2003, and 2004

| | Type of Alcohol Use | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | Any Alcohol Use | | | Binge Alcohol Use | | | Heavy Alcohol Use | | |
| **Demographic Characteristic** | **2002** | **2003** | **2004** | **2002** | **2003** | **2004** | **2002** | **2003** | **2004** |
| **Total** | 16.6 | 17.0 | 16.4 | 9.2 | 9.4 | 9.1 | 1.9 | 2.2[a] | 1.6 |
| **Gender** | | | | | | | | | |
| Male | 16.6 | 14.9 | 14.7 | 9.2 | 8.5 | 8.5 | 1.9 | 2.0 | 1.6 |
| Female | 16.5 | 19.3 | 18.1 | 9.3 | 10.2 | 9.7 | 1.9 | 2.4[a] | 1.5 |
| **Hispanic Origin and Race** | | | | | | | | | |
| Not Hispanic or Latino | 16.4 | 16.9 | 16.3 | 9.0 | 9.3 | 8.8 | 1.8 | 2.2[a] | 1.5 |
| White | 18.4 | 19.3 | 18.6 | 10.5 | 10.8 | 10.1 | 2.1 | 2.7[a] | 1.8 |
| Black or African American | 10.4 | 10.0 | 9.3 | 3.8 | 4.5 | 5.2 | 0.4 | 0.4 | 0.7 |
| American Indian or Alaska Native | * | 16.1 | * | * | 12.7 | * | * | 1.2 | * |
| Native Hawaiian or Other Pacific Islander | * | * | * | * | * | * | * | * | * |
| Asian | 5.9 | 7.4 | 7.3 | 4.0 | 2.6 | 1.7 | 0.2 | 2.2 | * |
| Two or More Races | * | 13.2 | 10.9 | * | 6.0 | 9.0 | * | 0.2 | 1.7 |
| Hispanic or Latino | 17.4 | 17.4 | 16.6 | 10.4 | 9.8 | 10.4 | 2.5 | 1.9 | 1.8 |
| **Gender/Race/Hispanic Origin** | | | | | | | | | |
| Male, White, Not Hispanic | 18.4 | 17.0 | 17.0 | 10.4 | 10.0 | 9.7 | 1.9 | 2.3 | 1.8 |
| Female, White, Not Hispanic | 18.4 | 21.6 | 20.4 | 10.5 | 11.7 | 10.5 | 2.2 | 3.1[a] | 1.8 |
| Male, Black, Not Hispanic | 10.0 | 8.5 | 9.2 | 3.2 | 3.1 | 4.9 | * | 0.3 | 1.2 |
| Female, Black, Not Hispanic | 10.8 | 11.4 | 9.3 | 4.3 | 5.9 | 5.4 | 0.5 | 0.6 | 0.0 |
| Male, Hispanic | 17.5 | 16.2 | 14.3 | 10.9 | 9.4 | 9.3 | 3.3 | 2.4 | 1.4 |
| Female, Hispanic | 17.2 | 18.7 | 18.9 | 10.0 | 10.1 | 11.5 | 1.7 | 1.4 | 2.3 |

*Low precision; no estimate reported.

NOTE: Binge Alcohol Use is defined as drinking five or more drinks on the same occasion (i.e., at the same time or within a couple of hours of each other) on at least 1 day in the past 30 days. Heavy Alcohol Use is defined as drinking five or more drinks on the same occasion on each of 5 or more days in the past 30 days; all heavy alcohol users are also binge alcohol users.

[a]Difference between estimate and 2004 estimate is statistically significant at the 0.05 level.
[b]Difference between estimate and 2004 estimate is statistically significant at the 0.01 level.

Source: SAMHSA, Office of Applied Studies, National Survey on Drug Use and Health, 2002, 2003, and 2004.

# Table 12. Alcohol Use, Binge Alcohol Use, and Heavy Alcohol Use in the Past Month among Persons Ages 16 to 17, by Demographic Characteristics: Percentages, National Survey on Drug Use and Health, 2002, 2003, and 2004

| Demographic Characteristic | Type of Alcohol Use | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | Any Alcohol Use | | | Binge Alcohol Use | | | Heavy Alcohol Use | | |
| | 2002 | 2003 | 2004 | 2002 | 2003 | 2004 | 2002 | 2003 | 2004 |
| **Total** | 32.6 | 31.8 | 32.5 | 21.4 | 21.2 | 22.4 | 5.6 | 5.5 | 6.3 |
| **Gender** | | | | | | | | | |
| Male | 32.5 | 32.6 | 33.2 | 24.1 | 23.6 | 24.5 | 7.4 | 6.7 | 7.8 |
| Female | 32.6 | 31.1 | 31.7 | 18.6 | 18.7 | 20.3 | 3.8 | 4.4 | 4.7 |
| **Hispanic Origin and Race** | | | | | | | | | |
| Not Hispanic or Latino | 33.4 | 32.5 | 32.3 | 21.8 | 21.8 | 22.1 | 6.0 | 6.0 | 6.3 |
| White | 37.4 | 37.1 | 36.2 | 25.3 | 26.0 | 25.7 | 7.4 | 7.5 | 7.8 |
| Black or African American | 19.6 | 17.3 | 18.2 | 10.3 | 7.7 | 9.2 | 1.4 | 1.2 | 1.1 |
| American Indian or Alaska Native | * | * | 24.0 | * | * | 15.6 | * | 1.7 | 5.1 |
| Native Hawaiian or Other Pacific Islander | * | * | * | * | * | * | * | * | * |
| Asian | 15.2 | 17.7 | 18.6 | 4.5 | 6.5 | 11.2 | 0.2 | 1.4 | * |
| Two or More Races | 31.4 | * | 43.0 | * | * | * | 5.5 | 2.6 | * |
| Hispanic or Latino | 28.2 | 28.3 | 33.5 | 19.1 | 17.8[a] | 23.9 | 3.6 | 3.3[a] | 6.0 |
| **Gender/Race/Hispanic Origin** | | | | | | | | | |
| Male, White, Not Hispanic | 36.9 | 38.0 | 35.8 | 28.8 | 28.1 | 27.7 | 9.7 | 8.8 | 9.2 |
| Female, White, Not Hispanic | 37.9 | 36.1 | 36.6 | 21.6 | 23.8 | 23.5 | 4.9 | 6.1 | 6.2 |
| Male, Black, Not Hispanic | 21.6 | 17.8 | 18.9 | 11.9 | 10.5 | 9.7 | 1.9 | 2.2 | 1.5 |
| Female, Black, Not Hispanic | 17.6 | 16.6 | 17.4 | 8.7 | 4.8[a] | 8.7 | 0.9 | 0.2 | 0.7 |
| Male, Hispanic | 29.6 | 28.8 | 35.1 | 21.6 | 20.5 | 25.0 | 4.3 | 4.0[a] | 8.5 |
| Female, Hispanic | 26.8 | 27.8 | 31.9 | 16.5 | 15.1[a] | 22.8 | 2.9 | 2.5 | 3.4 |

*Low precision; no estimate reported.

NOTE: Binge Alcohol Use is defined as drinking five or more drinks on the same occasion (i.e., at the same time or within a couple of hours of each other) on at least 1 day in the past 30 days. Heavy Alcohol Use is defined as drinking five or more drinks on the same occasion on each of 5 or more days in the past 30 days; all heavy alcohol users are also binge alcohol users.

[a]Difference between estimate and 2004 estimate is statistically significant at the 0.05 level.
[b]Difference between estimate and 2004 estimate is statistically significant at the 0.01 level.

Source: SAMHSA, Office of Applied Studies, National Survey on Drug Use and Health, 2002, 2003, and 2004.

# Table 13. Alcohol Use, Binge Alcohol Use, and Heavy Alcohol Use in the Past Month among Persons Ages 18 to 20, by Demographic Characteristics: Percentages, National Survey on Drug Use and Health, 2002, 2003, and 2004

| | Type of Alcohol Use | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | Any Alcohol Use | | | Binge Alcohol Use | | | Heavy Alcohol Use | | |
| **Demographic Characteristic** | **2002** | **2003** | **2004** | **2002** | **2003** | **2004** | **2002** | **2003** | **2004** |
| **Total** | 51.0 | 51.5 | 51.1 | 36.4 | 36.2 | 36.8 | 13.4 | 13.1 | 13.6 |
| **Gender** | | | | | | | | | |
| Male | 53.9 | 55.3 | 54.3 | 42.6 | 42.9 | 42.9 | 18.1 | 17.7 | 18.2 |
| Female | 48.0 | 47.5 | 47.8 | 30.0 | 29.2 | 30.2 | 8.5 | 8.4 | 8.7 |
| **Hispanic Origin and Race** | | | | | | | | | |
| Not Hispanic or Latino | 53.0 | 53.1 | 52.6 | 37.9 | 37.2 | 37.4 | 14.4 | 14.0 | 14.6 |
| White | 57.6 | 58.4 | 57.7 | 42.7 | 42.6 | 43.1 | 17.1 | 17.1 | 17.7 |
| Black or African American | 37.2 | 35.4 | 38.9 | 20.3 | 18.6 | 20.7 | 4.9 | 3.9 | 5.1 |
| American Indian or Alaska Native | * | * | * | * | * | * | 3.5 | 9.4 | * |
| Native Hawaiian or Other Pacific Islander | * | * | * | * | * | * | * | * | * |
| Asian | 32.2 | 34.5 | 29.2 | 19.7 | 20.7 | 13.6 | 5.3 | 6.5 | 3.8 |
| Two or More Races | 59.1 | 58.8 | 51.0 | 46.7 | 33.0 | 36.7 | 20.8 | 9.0 | 14.9 |
| Hispanic or Latino | 40.9 | 43.6 | 43.7 | 28.9 | 31.2 | 33.4 | 8.3 | 8.7 | 8.7 |
| **Gender/Race/Hispanic Origin** | | | | | | | | | |
| Male, White, Not Hispanic | 60.6 | 61.8 | 61.2 | 49.2 | 50.1 | 49.8 | 23.1 | 23.0 | 23.2 |
| Female, White, Not Hispanic | 54.6 | 55.0 | 53.9 | 36.3 | 34.9 | 35.9 | 11.1 | 11.1 | 11.7 |
| Male, Black, Not Hispanic | 39.0 | 39.6 | 42.7 | 23.3 | 23.4 | 26.3 | 6.8 | 6.0 | 8.6 |
| Female, Black, Not Hispanic | 35.2 | 31.1 | 34.8 | 17.0 | 13.7 | 14.8 | 2.8 | 1.8 | 1.4 |
| Male, Hispanic | 45.2 | 49.6 | 45.3 | 36.0 | 38.5 | 38.0 | 11.0 | 12.2 | 11.7 |
| Female, Hispanic | 35.6 | 36.6 | 41.8 | 20.0[a] | 22.6 | 28.2 | 5.0 | 4.5 | 5.3 |

*Low precision; no estimate reported.

NOTE: Binge Alcohol Use is defined as drinking five or more drinks on the same occasion (i.e., at the same time or within a couple of hours of each other) on at least 1 day in the past 30 days. Heavy Alcohol Use is defined as drinking five or more drinks on the same occasion on each of 5 or more days in the past 30 days; all heavy alcohol users are also binge alcohol users.

[a]Difference between estimate and 2004 estimate is statistically significant at the 0.05 level.
[b]Difference between estimate and 2004 estimate is statistically significant at the 0.01 level.

Source: SAMHSA, Office of Applied Studies, National Survey on Drug Use and Health, 2002, 2003, and 2004.

# Table 14. Alcohol Use, Binge Alcohol Use, and Heavy Alcohol Use in the Past Month, by Detailed Age Category: Percentages, National Survey on Drug Use and Health, 2002, 2003, and 2004

| | Type of Alcohol Use | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | Any Alcohol Use | | | Binge Alcohol Use | | | Heavy Alcohol Use | | |
| Age Category | 2002 | 2003 | 2004 | 2002 | 2003 | 2004 | 2002 | 2003 | 2004 |
| **TOTAL** | 28.8 | 29.0 | 28.7 | 19.3 | 19.2 | 19.6 | 6.2 | 6.1 | 6.3 |
| 12 | 2.0 | 2.9 | 2.3 | 0.8 | 0.9 | 1.1 | 0.0 | 0.1 | 0.1 |
| 13 | 6.5 | 6.1 | 6.1 | 2.8 | 2.2 | 2.9 | 0.5 | 0.2 | 0.4 |
| 14 | 13.4 | 13.1 | 12.3 | 7.0 | 7.1[a] | 5.6 | 1.4 | 1.3 | 1.0 |
| 15 | 19.9 | 20.9 | 20.4 | 11.6 | 11.7 | 12.7 | 2.4 | 3.1[a] | 2.2 |
| 16 | 29.0 | 28.5 | 27.7 | 17.9 | 18.0 | 18.3 | 4.0 | 4.3 | 4.5 |
| 17 | 36.2 | 35.3 | 37.3 | 25.0 | 24.5 | 26.6 | 7.2 | 6.8 | 8.1 |
| 18 | 46.3 | 43.7 | 46.3 | 32.6 | 31.5 | 33.1 | 11.2 | 10.1 | 11.0 |
| 19 | 51.6 | 52.4 | 51.5 | 38.3 | 36.3 | 37.4 | 14.1 | 13.8 | 13.9 |
| 20 | 55.5 | 59.6 | 56.3 | 38.7 | 41.4 | 40.3 | 15.1 | 16.1 | 16.3 |

*Low precision; no estimate reported.

NOTE: Binge Alcohol Use is defined as drinking five or more drinks on the same occasion (i.e., at the same time or within a couple of hours of each other) on at least 1 day in the past 30 days. Heavy Alcohol Use is defined as drinking five or more drinks on the same occasion on each of 5 or more days in the past 30 days; all heavy alcohol users are also binge alcohol users.

[a] Difference between estimate and 2004 estimate is statistically significant at the 0.05 level.
[b] Difference between estimate and 2004 estimate is statistically significant at the 0.01 level.

Source: SAMHSA, Office of Applied Studies, National Survey on Drug Use and Health, 2002, 2003, and 2004.

# Table 15. Alcohol Use in the Past Month among Females Ages 15 to 20, by Pregnancy Status and Age Group: Percentages, Annual Averages Based on National Survey on Drug Use and Health, 2002, 2003, and 2004

| Level of Alcohol Use/Age Group | Total[1] | Pregnancy Status | |
|---|---|---|---|
| | | Pregnant | Not Pregnant |
| **Alcohol** | | | |
| Total | 38.1 | 11.6 | 39.0 |
| 15–17 | 28.4 | 13.7 | 28.6 |
| 18–20 | 47.8 | 11.0 | 49.7 |
| **Binge Alcohol Use**[2] | | | |
| Total | 23.4 | 5.9 | 24.0 |
| 15–17 | 17.0 | 7.7 | 17.0 |
| 18–20 | 29.8 | 5.3 | 31.1 |
| **Heavy Alcohol Use**[2] | | | |
| Total | 6.1 | 0.9 | 6.3 |
| 15–17 | 3.7 | * | 3.7 |
| 18–20 | 8.5 | 0.9 | 8.9 |

*Low precision; no estimate reported.

[1] Estimates in the Total column are for all females ages 15 to 20, including those with unknown pregnancy status.

[2] Binge Alcohol Use is defined as drinking five or more drinks on the same occasion (i.e., at the same time or within a couple of hours of each other) on at least 1 day in the past 30 days. Heavy Alcohol Use is defined as drinking five or more drinks on the same occasion on each of 5 or more days in the past 30 days; all heavy alcohol users are also binge alcohol users.

Source: SAMHSA, Office of Applied Studies, National Survey on Drug Use and Health, 2002, 2003, and 2004.

## Table 16. Percentage of High School Students who Drank Alcohol* in the Past 30 Days, by Sex, Race/Ethnicity, and Grade—United States, Youth Risk Behavior Survey, 2003

| | Female | | Male | | Total | |
|---|---|---|---|---|---|---|
| **Category** | % | CI[†] | % | CI[†] | % | CI[†] |
| **Race/Ethnicity** | | | | | | |
| White, non-Hispanic | 48.4 | ±3.7 | 45.9 | ±3.0 | 47.1 | ±3.0 |
| Black, non-Hispanic | 37.0 | ±3.3 | 37.5 | ±4.3 | 37.4 | ±3.3 |
| Other,[‡] non-Hispanic | 37.0 | ±5.2 | 40.4 | ±8.3 | 38.8 | ±4.8 |
| Hispanic | 48.4 | ±2.8 | 42.7 | ±4.0 | 45.6 | ±2.7 |
| **Grade** | | | | | | |
| 9 | 38.5 | ±3.3 | 33.9 | ±3.6 | 36.2 | ±2.8 |
| 10 | 44.9 | ±3.5 | 42.2 | ±3.8 | 43.5 | ±3.2 |
| 11 | 46.8 | ±4.6 | 47.3 | ±4.2 | 47.0 | ±4.1 |
| 12 | 55.5 | ±3.9 | 56.0 | ±3.8 | 55.9 | ±3.2 |
| **Total** | 45.8 | ±2.5 | 43.8 | ±2.6 | 44.9 | ±2.4 |

*One or more drinks of alcohol on one or more of the 30 days preceding the survey.

[†]95% Confidence Interval.

[‡]Other includes Asian, Native Hawaiian, Pacific Islander, American Indian, Alaska Native, and multiple races.

Source: Youth Risk Behavior Survey, 2003

## Table 17. Percentage of High School Students who Drank Five or More Drinks of Alcohol in a Row on One or More of the Past 30 Days, by Sex, Race/Ethnicity, and Grade—United States, Youth Risk Behavior Survey, 2003

| | Female | | Male | | Total | |
|---|---|---|---|---|---|---|
| **Category** | % | CI* | % | CI* | % | CI* |
| **Race/Ethnicity** | | | | | | |
| White, non-Hispanic | 31.5 | ±2.4 | 32.1 | ±2.5 | 31.8 | ±2.0 |
| Black, non-Hispanic | 12.7 | ±2.7 | 17.9 | ±3.5 | 15.3 | ±2.6 |
| Other,[†] non-Hispanic | 19.7 | ±4.8 | 25.7 | ±7.3 | 22.9 | ±4.6 |
| Hispanic | 29.8 | ±2.6 | 27.9 | ±3.7 | 28.9 | ±2.7 |
| **Grade** | | | | | | |
| 9 | 20.9 | ±3.3 | 18.8 | ±2.8 | 19.8 | ±2.4 |
| 10 | 27.2 | ±3.6 | 27.7 | ±3.6 | 27.4 | ±2.9 |
| 11 | 29.4 | ±3.2 | 34.1 | ±3.9 | 31.8 | ±3.0 |
| 12 | 34.5 | ±3.5 | 39.5 | ±3.7 | 37.2 | ±2.3 |
| **Total** | 27.5 | ±2.1 | 29.0 | ±2.1 | 28.3 | ±2.0 |

*95% Confidence Interval.

[†]Other includes Asian, Native Hawaiian, Pacific Islander, American Indian, Alaska Native, and multiple races.

Source: Youth Risk Behavior Survey, 2003

# Table 18. Alcohol: Trends in Various Measures of Use, Percent, Monitoring the Future, 1975–2005

| | Class of: | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | **1975** | **1976** | **1977** | **1978** | **1979** | **1980** | **1981** | **1982** | **1983** | **1984** | **1985** | **1986** | **1987** | **1988** | **1989** | **1990** |
| **Alcohol (never used in lifetime):** | | | | | | | | | | | | | | | | |
| 12th Grade | 9.6 | 8.1 | 7.5 | 6.9 | 7.0 | 6.8 | 7.4 | 7.2 | 7.4 | 7.4 | 7.8 | 8.7 | 7.8 | 8.0 | 9.3 | 10.5 |
| **Alcohol (30-day use):** | | | | | | | | | | | | | | | | |
| 8th Grade | | | | | | | | | | | | | | | | |
| 10th Grade | | | | | | | | | | | | | | | | |
| 12th Grade | 68.2 | 68.3 | 71.2 | 72.1 | 71.8 | 72.0 | 70.7 | 69.7 | 69.4 | 67.2 | 65.9 | 65.3 | 66.4 | 63.9 | 60.0 | 57.1 |
| **Beer (30-day use):** | | | | | | | | | | | | | | | | |
| 8th Grade[a] | | | | | | | | | | | | | | | | |
| 10th Grade[a] | | | | | | | | | | | | | | | | |
| 12th Grade[b] | | 59.8 | 62.1 | 62.3 | 63.7 | 62.9 | 62.7 | 60.3 | 61.7 | 59.5 | 56.7 | 55.5 | 56.2 | 53.3 | 51.4 | 47.2 |
| **Liquor (30-day use):** | | | | | | | | | | | | | | | | |
| 12th Grade[b] | | 44.1 | 45.0 | 48.2 | 47.3 | 47.9 | 44.6 | 45.2 | 46.4 | 42.3 | 40.0 | 41.0 | 39.0 | 35.6 | 35.7 | 30.8 |
| **Alcohol (5+ drinks in a row in past 2 weeks):** | | | | | | | | | | | | | | | | |
| 8th Grade | | | | | | | | | | | | | | | | |
| 10th Grade | | | | | | | | | | | | | | | | |
| 12th Grade | 36.8 | 37.1 | 39.4 | 40.3 | 41.2 | 41.2 | 41.4 | 40.5 | 40.8 | 38.7 | 36.7 | 36.8 | 37.5 | 34.7 | 33.0 | 32.2 |
| College Students | | | | | | 43.9 | 43.6 | 44.0 | 43.1 | 45.4 | 44.6 | 45.0 | 42.8 | 43.2 | 41.7 | 41.0 |
| **Approx. Wtd. N's:** | | | | | | | | | | | | | | | | |
| 8th Grade | | | | | | | | | | | | | | | | |
| 10th Grade | | | | | | | | | | | | | | | | |
| 12th Grade | 9,400 | 15,400 | 17,100 | 17,800 | 15,500 | 15,900 | 17,500 | 17,700 | 16,300 | 15,900 | 16,000 | 15,200 | 16,300 | 16,300 | 16,700 | 15,200 |

(Continued on next page)

# Table 18. Alcohol: Trends in Various Measures of Use, Percent, Monitoring the Future, 1975–2005 (continued)

| | Class of: | | | | | | | | | | | | | | | '04–'05 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | 1991 | 1992 | 1993 | 1994 | 1995 | 1996 | 1997 | 1998 | 1999 | 2000 | 2001 | 2002 | 2003 | 2004 | 2005 | change |
| **Alcohol (never used in lifetime):** | | | | | | | | | | | | | | | | |
| 12th Grade | 12.0 | 12.5‡ | 20.0 | 19.6 | 19.3 | 20.8 | 18.3 | 18.6 | 20.0 | 19.7 | 20.3 | 21.6 | 23.4 | 23.2 | 24.9 | +1.7 |
| **Alcohol (30-day use):** | | | | | | | | | | | | | | | | |
| 8th Grade | 25.1 | 26.1‡ | 24.3 | 25.5 | 24.6 | 26.2 | 24.5 | 23.0 | 24.0 | 22.4 | 21.5 | 19.6 | 19.7 | 18.6 | 17.1 | -1.5 |
| 10th Grade | 42.8 | 39.9‡ | 38.2 | 39.2 | 38.8 | 40.4 | 40.1 | 38.8 | 40.0 | 41.0 | 39.0 | 35.4 | 35.4 | 35.2 | 33.2 | -2.0 s |
| 12th Grade | 54.0 | 51.3‡ | 48.6 | 50.1 | 51.3 | 50.8 | 52.7 | 52.0 | 51.0 | 50.0 | 49.8 | 48.6 | 47.5 | 48.0 | 47.0 | -1.0 |
| **Beer (30-day use):** | | | | | | | | | | | | | | | | |
| 8th Grade[a] | 16.2 | 16.9 | 17.4 | 18.3 | 18.8 | 18.4 | 16.7 | 16.2 | 16.6 | 15.2 | 15.0 | 12.3 | 12.0 | 14.4 | 12.8 | -1.6 |
| 10th Grade[a] | 31.1 | 28.9 | 28.7 | 30.2 | 29.9 | 30.5 | 30.4 | 28.3 | 29.5 | 30.6 | 28.0 | 24.6 | 23.2 | 26.5 | 24.8 | -1.7 |
| 12th Grade[b] | 47.2 | 42.0 | 43.4 | 42.6 | 44.9 | 46.9 | 44.4 | 45.6 | 42.7 | 42.7 | 41.5 | 39.7 | 37.8 | 38.3 | 38.0 | -0.3 |
| **Liquor (30-day use):** | | | | | | | | | | | | | | | | |
| 12th Grade[b] | 31.3 | 28.6 | 31.4 | 28.0 | 34.3 | 34.7 | 34.6 | 37.3 | 34.3 | 36.0 | 35.1 | 36.0 | 34.3 | 35.6 | 36.4 | +0.8 |
| **Alcohol (5+ drinks in a row in past 2 weeks):** | | | | | | | | | | | | | | | | |
| 8th Grade | 12.9 | 13.4 | 13.5 | 14.5 | 14.5 | 15.6 | 14.5 | 13.7 | 15.2 | 14.1 | 13.2 | 12.4 | 11.9 | 11.4 | 10.5 | -1.0 |
| 10th Grade | 22.9 | 21.1 | 23.0 | 23.6 | 24.0 | 24.8 | 25.1 | 24.3 | 25.6 | 26.2 | 24.9 | 22.4 | 22.2 | 22.0 | 21.0 | -1.0 |
| 12th Grade | 29.8 | 27.9 | 27.5 | 28.2 | 29.8 | 30.2 | 31.3 | 31.5 | 30.8 | 30.0 | 29.7 | 28.6 | 27.9 | 29.2 | 28.1 | -1.1 |
| College Students | 42.8 | 41.4 | 40.2 | 40.2 | 38.6 | 38.3 | 40.7 | 38.9 | 40.0 | 39.3 | 40.9 | 40.1 | 38.5 | | | |
| **Approx. Wtd. N's:** | | | | | | | | | | | | | | | | |
| 8th Grade | 17,500 | 18,600 | 18,300 | 17,300 | 17,500 | 17,800 | 18,600 | 18,100 | 16,700 | 16,700 | 16,200 | 15,100 | 16,500 | 17,000 | 16,800 | |
| 10th Grade | 14,800 | 14,800 | 15,300 | 15,800 | 17,000 | 15,600 | 15,500 | 15,000 | 13,600 | 14,300 | 14,000 | 14,300 | 15,800 | 16,400 | 16,200 | |
| 12th Grade | 15,000 | 15,800 | 16,300 | 15,400 | 15,400 | 14,300 | 15,400 | 15,200 | 13,600 | 12,800 | 12,800 | 12,900 | 14,600 | 14,600 | 14,700 | |

‡ In 1993, the question text was changed slightly in half of the forms to indicate that a "drink" meant "more than just a few sips." The 1993 data are based on the changed forms only; N is one-half of N indicated. In 1994, the question text was changed in the remaining forms. Beginning in 1994, the data are based on all forms.

NOTES: Level of significance of difference between the two most recent classes: s = .05, ss = .01, sss = .001. '—' indicates data not available. Any apparent inconsistency between the change estimate and the prevalence of use estimate for the two most recent classes is due to rounding error.

[a] Data based on one of two forms in 1991-96; N is one-half of N indicated. Data based on one of four forms beginning in 1997. N is one-third of N indicated.

[b] Data based on one of five forms in 1976-88; N is one-fifth of N indicated. Data based on one of six forms beginning in 1989. N is one-sixth of N indicated.

SOURCE: The Monitoring the Future Study, the University of Michigan.

# Table 19. Alcohol, Marijuana, and Cigarettes: 30-Day Use for Eighth, Tenth, and Twelfth Graders, Percent Who Used in 30 Days, Monitoring the Future, 1991–2005

| | Class of: | | | | | | | | | | | | | | | '04–'05 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | 1991 | 1992 | 1993 | 1994 | 1995 | 1996 | 1997 | 1998 | 1999 | 2000 | 2001 | 2002 | 2003 | 2004 | 2005 | change |
| **8th Grade:** | | | | | | | | | | | | | | | | |
| Alcohol | 25.1 | 26.1‡ | 24.3 | 25.5 | 24.6 | 26.2 | 24.5 | 23.0 | 24.0 | 22.4 | 21.5 | 19.6 | 19.7 | 18.6 | 17.1 | -1.5 |
| Marijuana | 3.2 | 3.7 | 5.1 | 7.8 | 9.1 | 11.3 | 10.2 | 9.7 | 9.7 | 9.1 | 9.2 | 8.3 | 7.5 | 6.4 | 6.6 | +0.2 |
| Cigarettes | 14.3 | 15.5 | 16.7 | 18.6 | 19.1 | 21.0 | 19.4 | 19.1 | 17.5 | 14.6 | 12.2 | 10.7 | 10.2 | 9.2 | 9.3 | +0.1 |
| **10th Grade:** | | | | | | | | | | | | | | | | |
| Alcohol | 42.8 | 39.9‡ | 38.2 | 39.2 | 38.8 | 40.4 | 40.1 | 38.8 | 40.0 | 41.0 | 39.0 | 35.4 | 35.4 | 35.2 | 33.2 | -2.0 |
| Marijuana | 8.7 | 8.1 | 10.9 | 15.8 | 17.2 | 20.4 | 20.5 | 18.7 | 19.4 | 19.7 | 19.8 | 17.8 | 17.0 | 15.9 | 15.2 | -0.7 |
| Cigarettes | 20.8 | 21.5 | 24.7 | 25.4 | 27.9 | 30.4 | 29.8 | 27.6 | 25.7 | 23.9 | 21.3 | 17.7 | 16.7 | 16.0 | 14.9 | -1.1 |
| **12th Grade:** | | | | | | | | | | | | | | | | |
| Alcohol | 54.0 | 51.3‡ | 48.6 | 50.1 | 51.3 | 50.8 | 52.7 | 52.0 | 51.0 | 50.0 | 49.8 | 48.6 | 47.5 | 48.0 | 47.0 | -1.0 |
| Marijuana | 13.8 | 11.9 | 15.5 | 19.0 | 21.2 | 21.9 | 23.7 | 22.8 | 23.1 | 21.6 | 22.4 | 21.5 | 21.2 | 19.9 | 19.8 | -0.1 |
| Cigarettes | 28.3 | 27.8 | 29.9 | 31.2 | 33.5 | 34.0 | 36.5 | 35.1 | 34.6 | 31.4 | 29.5 | 26.7 | 24.4 | 25.0 | 23.4 | -1.6 |
| **Approx. Wtd. N's:** | | | | | | | | | | | | | | | | |
| 8th Grade | 17,500 | 18,600 | 18,300 | 17,300 | 17,500 | 17,800 | 18,600 | 18,100 | 16,700 | 16,700 | 16,200 | 15,100 | 16,500 | 17,000 | 16,800 | |
| 10th Grade | 14,800 | 14,800 | 15,300 | 15,800 | 17,000 | 15,600 | 15,500 | 15,000 | 13,600 | 14,300 | 14,000 | 14,300 | 15,800 | 16,400 | 16,200 | |
| 12th Grade | 15,000 | 15,800 | 16,300 | 15,400 | 15,400 | 14,300 | 15,400 | 15,200 | 13,600 | 12,800 | 12,800 | 12,900 | 14,600 | 14,600 | 14,700 | |

NOTES: Level of significance of difference between the two most recent classes: s = .05, ss = .01, sss = .001. '—' indicates data not available. Any apparent inconsistency between the change estimate and the prevalence of use estimate for the two most recent classes is due to rounding error.

SOURCE: The Monitoring the Future Study, the University of Michigan.

‡ In 1993, the question text was changed slightly in half of the forms to indicate that a "drink" meant "more than just a few sips." The 1993 data are based on the changed forms only; N is one-half of N indicated. In 1994, the question text was changed in the remaining forms. Beginning in 1994, the data are based on all forms.

# ALCOHOL ABUSE AND DEPENDENCE

# Table 20. Alcohol Dependence or Abuse in the Past Year among Persons Ages 12 to 20, by Demographic Characteristics: Percentages, National Survey on Drug Use and Health, 2002, 2003, and 2004

| | Past Year Dependence or Abuse | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | Dependence | | | Abuse | | | Dependence or Abuse | | |
| **Demographic Characteristic** | **2002** | **2003** | **2004** | **2002** | **2003** | **2004** | **2002** | **2003** | **2004** |
| **Total** | 3.5 | 3.5 | 3.7 | 6.1 | 5.8 | 5.9 | 9.6 | 9.2 | 9.6 |
| **Gender** | | | | | | | | | |
| Male | 3.8 | 3.7 | 3.9 | 7.1 | 6.3 | 6.9 | 10.9 | 9.9 | 10.8 |
| Female | 3.1 | 3.3 | 3.4 | 5.1 | 5.2 | 4.9 | 8.2 | 8.5 | 8.3 |
| **Hispanic Origin and Race** | | | | | | | | | |
| Not Hispanic or Latino | 3.4 | 3.5 | 3.5 | 6.4 | 6.0 | 6.0 | 9.8 | 9.5 | 9.6 |
| White | 3.9 | 3.9 | 4.0 | 7.3 | 6.7 | 6.9 | 11.2 | 10.6 | 10.9 |
| Black or African American | 1.5 | 1.8 | 2.0 | 3.1 | 2.8 | 3.2 | 4.6 | 4.7 | 5.2 |
| American Indian or Alaska Native | 7.2 | 6.7 | 10.2 | 8.6 | 9.5 | 7.8 | 15.8 | 16.2 | 18.0 |
| Native Hawaiian or Other Pacific Islander | 2.0 | * | 1.6 | * | 4.4 | * | * | * | * |
| Asian | 1.4 | 2.3[a] | 0.5 | 3.3 | 4.6[a] | 2.2 | 4.7 | 7.0[b] | 2.7 |
| Two or More Races | 6.2 | 4.5 | 6.2 | 4.9 | 7.4 | 6.7 | 11.2 | 11.9 | 12.8 |
| Hispanic or Latino | 3.7 | 3.3 | 4.3 | 4.7 | 4.7 | 5.4 | 8.4 | 8.1 | 9.7 |
| **Gender/Race/Hispanic Origin** | | | | | | | | | |
| Male, White, Not Hispanic | 4.2 | 4.0 | 4.0 | 8.3 | 7.1 | 8.0 | 12.5 | 11.1 | 12.0 |
| Female, White, Not Hispanic | 3.6 | 3.8 | 3.9 | 6.3 | 6.3 | 5.8 | 9.9 | 10.1 | 9.7 |
| Male, Black, Not Hispanic | 1.4[a] | 2.3 | 2.5 | 4.0 | 3.5 | 4.1 | 5.4 | 5.8 | 6.6 |
| Female, Black, Not Hispanic | 1.6 | 1.4 | 1.5 | 2.3 | 2.1 | 2.2 | 3.9 | 3.5 | 3.7 |
| Male, Hispanic | 4.7 | 3.9 | 5.4 | 5.8 | 5.3 | 6.1 | 10.6 | 9.2 | 11.5 |
| Female, Hispanic | 2.6 | 2.6 | 3.2 | 3.4 | 4.2 | 4.6 | 6.0 | 6.8 | 7.8 |

*Low precision; no estimate reported.
NOTE: Dependence or abuse is based on definitions found in the 4th edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV).

[a] Difference between estimate and 2004 estimate is statistically significant at the 0.05 level.
[b] Difference between estimate and 2004 estimate is statistically significant at the 0.01 level.

Source: SAMHSA, Office of Applied Studies, National Survey on Drug Use and Health, 2002, 2003, and 2004.

# Table 21. Alcohol Dependence or Abuse in the Past Year and Alcohol Dependence/Abuse Criteria Met in the Past Year among Persons Ages 12 to 20, by Gender: Percentages, National Survey on Drug Use and Health, 2002, 2003, and 2004

| Past Year Alcohol Dependence or Abuse/Criteria Met | Total | | | Gender | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | | | | Male | | | Female | | |
| | 2002 | 2003 | 2004 | 2002 | 2003 | 2004 | 2002 | 2003 | 2004 |
| **Dependence or Abuse** | 9.6 | 9.2 | 9.6 | 10.9 | 9.9 | 10.8 | 8.2 | 8.5 | 8.3 |
| **Dependence** | 3.5 | 3.5 | 3.7 | 3.8 | 3.7 | 3.9 | 3.1 | 3.3 | 3.4 |
| **Dependence Criteria** | | | | | | | | | |
| Spent Time Getting, Using, or Getting Over Effects | 10.4 | 10.3 | 10.7 | 11.3 | 10.8 | 11.4 | 9.5 | 9.7 | 10.0 |
| Unable to Set Limits/Used More Than Intended | 1.8 | 1.7[a] | 2.0 | 1.8 | 1.8 | 2.1 | 1.7 | 1.5[a] | 1.9 |
| Needed to Use More Than Before for Desired Effects | 12.3 | 12.3 | 12.6 | 14.3 | 13.8 | 14.0 | 10.3 | 10.8 | 11.2 |
| Unable to Cut Down or Stop Using | 1.5 | 1.3[a] | 1.6 | 1.6 | 1.5 | 1.8 | 1.3 | 1.0 | 1.3 |
| Continued to Use Despite Problems with Emotions, Nerves, Mental Health, or Physical Problems | 2.2 | 2.3 | 2.3 | 2.1 | 2.1 | 2.1 | 2.4 | 2.6 | 2.6 |
| Reduced or Gave Up Important Activities Due to Use | 2.6 | 2.8 | 2.6 | 2.9 | 2.9 | 2.7 | 2.2 | 2.7 | 2.6 |
| Experienced Withdrawal Symptoms Lasting Longer Than a Day | 1.5 | 1.4 | 1.4 | 1.7 | 1.5 | 1.4 | 1.3 | 1.4 | 1.4 |
| **Abuse** | 6.1 | 5.8 | 5.9 | 7.1 | 6.3 | 6.9 | 5.1 | 5.2 | 4.9 |
| **Abuse Criteria** | | | | | | | | | |
| Serious Problems at Home/Work/School Due to Use | 2.7[a] | 2.4 | 2.3 | 2.9[a] | 2.3 | 2.4 | 2.5 | 2.5 | 2.3 |
| Physical Danger Due to Regular Use | 6.5 | 6.2 | 6.5 | 7.6 | 6.9 | 7.5 | 5.4 | 5.5 | 5.5 |
| Use Caused Illegal Actions | 1.6 | 1.4 | 1.4 | 2.1 | 2.0 | 2.1 | 1.0 | 0.8 | 0.8 |
| Continued Use Despite Problems with Family/Friends | 2.1 | 1.9 | 2.1 | 2.1 | 1.9 | 2.2 | 2.1 | 2.0 | 2.0 |

*Low precision; no estimate reported.

NOTE: Dependence or abuse is based on definitions found in the 4th edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV). Respondents were defined as having alcohol dependence if they reported a positive response to three or more of the seven dependence criteria. Respondents were defined as having alcohol abuse if they were not classified as having alcohol dependence and reported a positive response to one or more of the four abuse criteria.

[a] Difference between estimate and 2004 estimate is statistically significant at the 0.05 level.
[b] Difference between estimate and 2004 estimate is statistically significant at the 0.01 level.

Source: SAMHSA, Office of Applied Studies, National Survey on Drug Use and Health, 2002, 2003 and 2004.

# DRINKING AND DRIVING

## Table 22. Fatalities in Motor Vehicle Traffic Crashes When at Least One Driver or Non-Occupant Ages 20 and Under Was Involved, by Highest Driver or Non-Occupant BAC in the Crash, Fatality Analysis Reporting System, 2002 Final and 2003 Annual Repost File

| | No Alcohol | | BAC=0.01-0.07 | | BAC=0.08+ | | BAC=.01+ | | Total | |
|---|---|---|---|---|---|---|---|---|---|---|
| Year | Number | Percent | Number | Percent | Number | Percent | Number | Percent | Number | Percent |
| **2002** | 7,816 | 76.1 | 581 | 5.7 | 1,869 | 18.2 | 2,450 | 23.9 | 10,266 | 100.0 |
| **2003** | 7,375 | 75.7 | 494 | 5.1 | 1,868 | 19.2 | 2,361 | 24.3 | 9,736 | 100.0 |

Source: Report generated by the Information Services Branch, NCSA. CMS# 2004.00816; 00816.SAS; PL

## Table 23. 16- to 20-Year-Old Drivers Involved in Alcohol-Related Fatal Crashes, Licensed Drivers and Involvement Rate* in Alcohol-Related Fatal Crashes, Fatality Analysis Reporting System, 1994–2002 Final and 2003 Annual Repost File

| | Number of Drivers | Any Alcohol (BAC .01+) | | 16–20 Licensed | |
|---|---|---|---|---|---|
| Year | Involved | Number | Percent | Drivers | Alcohol Involvement Rate* |
| **1994** | 7,723 | 1,831 | 24 | 11,728,563 | 15.61 |
| **1995** | 7,725 | 1,620 | 21 | 11,945,516 | 13.56 |
| **1996** | 7,824 | 1,772 | 23 | 12,089,294 | 14.66 |
| **1997** | 7,719 | 1,700 | 22 | 12,587,060 | 13.51 |
| **1998** | 7,767 | 1,721 | 22 | 12,660,903 | 13.59 |
| **1999** | 7,985 | 1,741 | 22 | 12,618,644 | 13.80 |
| **2000** | 8,024 | 1,904 | 24 | 12,857,375 | 14.81 |
| **2001** | 7,992 | 1,855 | 23 | 12,567,965 | 14.76 |
| **2002** | 8,128 | 1,887 | 23 | 12,512,204 | 15.08 |
| **2003** | 7,693 | 1,834 | 24 | 12,404,230 | 14.79 |

*Per 100,000 Licensed Drivers
Source: FARS 1994–2002 (FINAL) 2003 (ARF), Licensed Drivers—FHWA

## Table 24. 16-Year-Old Drivers Involved in Alcohol-Related Fatal Crashes, Licensed Drivers and Involvement Rate* in Alcohol-Related Fatal Crashes, Fatality Analysis Reporting System, 2002 Final and 2003 Annual Repost File

| | Number of Drivers | Any Alcohol (BAC .01+) | | 16-Year-Old | |
|---|---|---|---|---|---|
| Year | Involved | Number | Percent | Licensed Drivers | Alcohol Involvement Rate |
| **1994** | 1,162 | 142 | 12 | 1,470,521 | 9.66 |
| **1995** | 1,311 | 153 | 12 | 1,563,571 | 9.79 |
| **1996** | 1,304 | 180 | 14 | 1,550,375 | 11.61 |
| **1997** | 1,220 | 153 | 13 | 1,651,823 | 9.26 |
| **1998** | 1,174 | 126 | 11 | 1,626,819 | 7.75 |
| **1999** | 1,142 | 129 | 11 | 1,458,257 | 8.85 |
| **2000** | 1,079 | 133 | 12 | 1,470,141 | 9.05 |
| **2001** | 1,011 | 123 | 12 | 1,362,670 | 9.03 |
| **2002** | 1,156 | 131 | 11 | 1,318,404 | 9.94 |
| **2003** | 972 | 135 | 14 | 1,262,899 | 10.69 |

* Per 100,000 Licensed Drivers
Source: FARS 1994–2002 (FINAL) 2003 (ARF), Licensed Drivers—FHWA

## Table 25. 17-Year-Old Drivers Involved in Alcohol-Related Fatal Crashes, Licensed Drivers and Involvement Rate* in Alcohol-Related Fatal Crashes, Fatality Analysis Reporting System, 2002 Final and 2003 Annual Repost File

| Year | Number of Drivers Involved | Any Alcohol (BAC .01+) | | 17-Year-Old Licensed Drivers | Alcohol Involvement Rate |
|---|---|---|---|---|---|
| | | Number | Percent | | |
| **1994** | 1,503 | 283 | 19 | 2,200,842 | 12.86 |
| **1995** | 1,425 | 205 | 14 | 2,250,594 | 9.11 |
| **1996** | 1,488 | 261 | 18 | 2,312,978 | 11.28 |
| **1997** | 1,499 | 255 | 17 | 2,411,717 | 10.57 |
| **1998** | 1,468 | 258 | 18 | 2,387,259 | 10.81 |
| **1999** | 1,520 | 263 | 17 | 2,330,449 | 11.29 |
| **2000** | 1,431 | 244 | 17 | 2,330,769 | 10.47 |
| **2001** | 1,442 | 247 | 17 | 2,191,469 | 11.27 |
| **2002** | 1,479 | 238 | 16 | 2,197,874 | 10.83 |
| **2003** | 1,400 | 256 | 18 | 2,178,432 | 11.75 |

* Per 100,000 Licensed Drivers

Source: FARS 1994–2002 (FINAL) 2003 (ARF), Licensed Drivers—FHWA

## Table 26. 18-Year-Old Drivers Involved in Alcohol-Related Fatal Crashes, Licensed Drivers and Involvement Rate* in Alcohol-Related Fatal Crashes, Fatality Analysis Reporting System, 2002 Final and 2003 Annual Repost File

| Year | Number of Drivers Involved | Any Alcohol (BAC .01+) | | 18-Year-Old Licensed Drivers | Alcohol Involvement Rate |
|---|---|---|---|---|---|
| | | Number | Percent | | |
| **1994** | 1,666 | 371 | 22 | 2,493,137 | 14.88 |
| **1995** | 1,738 | 374 | 22 | 2,563,026 | 14.59 |
| **1996** | 1,767 | 388 | 22 | 2,554,163 | 15.19 |
| **1997** | 1,703 | 370 | 22 | 2,702,477 | 13.69 |
| **1998** | 1,869 | 441 | 24 | 2,774,824 | 15.89 |
| **1999** | 1,853 | 372 | 20 | 2,767,520 | 13.44 |
| **2000** | 1,896 | 437 | 23 | 2,838,762 | 15.39 |
| **2001** | 1,843 | 407 | 22 | 2,754,846 | 14.77 |
| **2002** | 1,813 | 431 | 24 | 2,726,939 | 15.81 |
| **2003** | 1,861 | 459 | 25 | 2,765,798 | 16.60 |

* Per 100,000 Licensed Drivers

Source: FARS 1994–2002 (FINAL) 2003 (ARF), Licensed Drivers—FHWA

## Table 27. 19-Year-Old Drivers Involved in Alcohol-Related Fatal Crashes, Licensed Drivers and Involvement Rate* in Alcohol-Related Fatal Crashes, Fatality Analysis Reporting System, 2002 Final and 2003 Annual Repost File

| Year | Number of Drivers Involved | Any Alcohol (BAC .01+) | | 19-Year-Old Licensed Drivers | Alcohol Involvement Rate |
|---|---|---|---|---|---|
| | | Number | Percent | | |
| **1994** | 1,733 | 502 | 29 | 2,727,972 | 18.40 |
| **1995** | 1,623 | 409 | 25 | 2,688,274 | 15.21 |
| **1996** | 1,710 | 462 | 27 | 2,787,489 | 16.57 |
| **1997** | 1,728 | 456 | 26 | 2,828,354 | 16.12 |
| **1998** | 1,675 | 439 | 26 | 2,920,331 | 15.03 |
| **1999** | 1,853 | 509 | 27 | 3,020,668 | 16.85 |
| **2000** | 1,878 | 543 | 29 | 3,077,319 | 17.65 |
| **2001** | 1,937 | 518 | 27 | 3,086,268 | 16.78 |
| **2002** | 1,911 | 536 | 28 | 3,061,537 | 17.51 |
| **2003** | 1,752 | 492 | 28 | 3,018,679 | 16.30 |

* Per 100,000 Licensed Drivers

Source: FARS 1994–2002 (FINAL) 2003 (ARF), Licensed Drivers—FHWA

## Table 28. 20-Year-Old Drivers Involved in Alcohol-Related Fatal Crashes, Licensed Drivers and Involvement Rate* in Alcohol-Related Fatal Crashes, Fatality Analysis Reporting System, 2002 Final and 2003 Annual Repost File

| Year | Number of Drivers Involved | Any Alcohol (BAC .01+) | | 20-Year-Old Licensed Drivers | Alcohol Involvement Rate |
|---|---|---|---|---|---|
| | | Number | Percent | | |
| **1994** | 1,659 | 534 | 32 | 2,836,091 | 18.83 |
| **1995** | 1,628 | 480 | 29 | 2,880,051 | 16.67 |
| **1996** | 1,555 | 481 | 31 | 2,884,289 | 16.68 |
| **1997** | 1,569 | 466 | 30 | 2,992,689 | 15.57 |
| **1998** | 1,581 | 457 | 29 | 2,951,670 | 15.48 |
| **1999** | 1,617 | 468 | 29 | 3,041,750 | 15.39 |
| **2000** | 1,740 | 547 | 31 | 3,140,384 | 17.42 |
| **2001** | 1,759 | 560 | 32 | 3,172,712 | 17.65 |
| **2002** | 1,769 | 551 | 31 | 3,207,450 | 17.18 |
| **2003** | 1,708 | 493 | 29 | 3,178,422 | 15.51 |

* Per 100,000 Licensed Drivers

Source: FARS 1994–2002 (FINAL) 2003 (ARF), Licensed Drivers—FHWA

## Table 29. Drove Under the Influence of Alcohol in the Past Year among Persons Ages 16 to 20, by Demographic Characteristics: Percentages, National Survey on Drug Use and Health, 2002, 2003, and 2004

| Demographic Characteristic | Drove Under the Influence in Past Year Alcohol | | |
|---|---|---|---|
| | 2002 | 2003 | 2004 |
| **Total** | 17.4[a] | 16.0 | 16.2 |
| **Age** | | | |
| 16 | 7.8 | 6.9 | 6.8 |
| 17 | 13.8 | 12.6 | 13.7 |
| 18 | 18.5[a] | 16.4 | 16.1 |
| 19 | 22.7 | 21.1 | 21.8 |
| 20 | 24.3 | 23.4 | 23.3 |
| **Gender** | | | |
| Male | 19.6 | 17.9 | 18.7 |
| Female | 15.2[a] | 14.0 | 13.6 |
| **Hispanic Origin and Race** | | | |
| Not Hispanic or Latino | 18.7[b] | 17.0 | 16.7 |
| White | 21.6[b] | 19.7 | 19.3 |
| Black or African American | 7.3 | 7.5 | 8.3 |
| American Indian or Alaska Native | * | 16.2 | 16.1 |
| Native Hawaiian or Other Pacific Islander | * | * | * |
| Asian | 11.7[a] | 9.2 | 6.3 |
| Two or More Races | 18.6 | 19.0 | 16.8 |
| Hispanic or Latino | 11.1[a] | 10.7[a] | 14.0 |

*Low precision; no estimate reported.

[a] Difference between estimate and 2004 estimate is statistically significant at the 0.05 level.
[b] Difference between estimate and 2004 estimate is statistically significant at the 0.01 level.
Source: SAMHSA, Office of Applied Studies, National Survey on Drug Use and Health, 2002, 2003, and 2004.

## Table 30. Percentage of High School Students who Drove After Drinking Alcohol* in the Past 30 Days, by Sex, Race/Ethnicity, and Grade—United States, Youth Risk Behavior Survey, 2003

| Category | Female | | Male | | Total | |
|---|---|---|---|---|---|---|
| | % | CI[†] | % | CI[†] | % | CI[†] |
| **Race/Ethnicity** | | | | | | |
| White, non-Hispanic | 10.3 | ±1.3 | 15.2 | ±2.0 | 12.9 | ±1.5 |
| Black, non-Hispanic | 4.6 | ±1.6 | 13.4 | ±4.1 | 9.1 | ±2.6 |
| Other,[‡] non-Hispanic | 6.6 | ±3.2 | 16.9 | ±6.0 | 12.1 | ±4.1 |
| Hispanic | 8.6 | ±1.9 | 14.9 | ±2.4 | 11.7 | ±1.8 |
| **Grade** | | | | | | |
| 9 | 5.1 | ±1.4 | 7.2 | ±1.7 | 6.2 | ±1.2 |
| 10 | 6.9 | ±1.9 | 11.3 | ±1.9 | 9.2 | ±1.3 |
| 11 | 11.1 | ±2.6 | 19.5 | ±3.8 | 15.3 | ±2.7 |
| 12 | 13.6 | ±2.5 | 25.6 | ±3.0 | 19.8 | ±2.1 |
| **Total** | 8.9 | ±1.1 | 15.0 | ±1.6 | 12.1 | ±1.2 |

* In a car or other vehicle one or more times during the 30 days preceding the survey.
[†] 95% Confidence Interval.
[‡] Other includes Asian, Native Hawaiian, Pacific Islander, American Indian, Alaska Native, and multiple races.
Source: Youth Risk Behavior Survey, 2003

# Table 31. Percentage of High School Students Who Rode With a Driver who Had Been Drinking Alcohol* in the Past 30 Days, by Sex, Race/Ethnicity, and Grade—United States, Youth Risk Behavior Survey, 2003

| | Female | | Male | | Total | |
|---|---|---|---|---|---|---|
| **Category** | % | CI[†] | % | CI[†] | % | CI[†] |
| **Race/Ethnicity** | | | | | | |
| White, non-Hispanic | 29.8 | ±2.6 | 27.3 | ±3.0 | 28.5 | ±2.5 |
| Black, non-Hispanic | 29.8 | ±3.3 | 31.8 | ±4.1 | 30.9 | ±3.1 |
| Other,[‡] non-Hispanic | 24.7 | ±5.3 | 32.6 | ±7.2 | 29.0 | ±4.9 |
| Hispanic | 40.0 | ±4.2 | 32.8 | ±5.6 | 36.4 | ±4.2 |
| **Grade** | | | | | | |
| 9 | 30.2 | ±4.1 | 26.4 | ±3.0 | 28.2 | ±3.0 |
| 10 | 31.0 | ±3.6 | 27.6 | ±3.5 | 29.3 | ±3.1 |
| 11 | 30.7 | ±4.1 | 30.3 | ±3.7 | 30.5 | ±3.1 |
| 12 | 32.6 | ±3.8 | 34.0 | ±3.8 | 33.3 | ±3.2 |
| **Total** | 31.1 | ±2.0 | 29.2 | ±2.6 | 30.2 | ±2.1 |

*In a car or other vehicle one or more times during the 30 days preceding the survey.

[†]95% Confidence Interval

[‡]Other includes Asian, Native Hawaiian, Pacific Islander, American Indian, Alaska Native, and multiple races.

Source: Youth Risk Behavior Survey, 2003.

# PERCEPTIONS AND ATTITUDES

# Table 32. Alcohol: Trends in Various Attitudinal Measures for Eighth, Tenth, and Twelfth Graders, Percent, Monitoring the Future, 1975–2005

| | Class of: | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | **1975** | **1976** | **1977** | **1978** | **1979** | **1980** | **1981** | **1982** | **1983** | **1984** | **1985** | **1986** | **1987** | **1988** | **1989** | **1990** |
| **Percent reporting "great risk" in having 5 or more drinks in a row once or twice each weekend:** | | | | | | | | | | | | | | | | |
| 8th Grade | | | | | | | | | | | | | | | | |
| 10th Grade | | | | | | | | | | | | | | | | |
| 12th Grade[a] | 37.8 | 37.0 | 34.7 | 34.5 | 34.9 | 35.9 | 36.3 | 36.0 | 38.6 | 41.7 | 43.0 | 39.1 | 41.9 | 42.6 | 44.0 | 47.1 |
| **Percent who disapprove of having 5 or more drinks in a row once or twice each weekend:** | | | | | | | | | | | | | | | | |
| 8th Grade | | | | | | | | | | | | | | | | |
| 10th Grade | | | | | | | | | | | | | | | | |
| 12th Grade[a] | 60.3 | 58.6 | 57.4 | 56.2 | 56.7 | 55.6 | 55.5 | 58.8 | 56.6 | 59.6 | 60.4 | 62.4 | 62.0 | 65.3 | 66.5 | 68.9 |
| **Percent who disapprove of having 1-2 drinks nearly every day:** | | | | | | | | | | | | | | | | |
| 8th Grade | | | | | | | | | | | | | | | | |
| 10th Grade | | | | | | | | | | | | | | | | |
| 12th Grade[a] | 67.6 | 68.9 | 66.8 | 67.7 | 68.3 | 69.0 | 69.1 | 69.9 | 68.9 | 72.9 | 70.9 | 72.8 | 74.2 | 75.0 | 76.5 | 77.9 |
| **Percent reporting that it is "fairly easy" or "very easy" to get alcohol:** | | | | | | | | | | | | | | | | |
| 8th Grade | | | | | | | | | | | | | | | | |
| 10th Grade | | | | | | | | | | | | | | | | |
| 12th Grade[a] | | | | | | | | | | | | | | | | |
| **Approx. Wtd. N's:** | | | | | | | | | | | | | | | | |
| 8th Grade | | | | | | | | | | | | | | | | |
| 10th Grade | | | | | | | | | | | | | | | | |
| 12th Grade | 9,400 | 15,400 | 17,100 | 17,800 | 15,500 | 15,900 | 17,500 | 17,700 | 16,300 | 15,900 | 16,000 | 15,200 | 16,300 | 16,300 | 16,700 | 15200 |

(Continued on next page)

# Table 32. Alcohol: Trends in Various Attitudinal Measures for Eighth, Tenth, and Twelfth Graders, Percent , Monitoring the Future, 1975–2005 (*continued*)

| | Class of: | | | | | | | | | | | | | | | '04–'05 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | 1991 | 1992 | 1993 | 1994 | 1995 | 1996 | 1997 | 1998 | 1999 | 2000 | 2001 | 2002 | 2003 | 2004 | 2005 | change |
| **Percent reporting "great risk" in having 5 or more drinks in a row once or twice each weekend:** | | | | | | | | | | | | | | | | |
| 8th Grade | 59.1 | 58.0 | 57.7 | 54.7 | 54.1 | 51.8 | 55.6 | 56.0 | 55.3 | 55.9 | 56.1 | 56.4 | 56.5 | 56.9 | 57.2 | +0.3 |
| 10th Grade | 54.7 | 55.9 | 54.9 | 52.9 | 52.0 | 50.9 | 51.8 | 52.5 | 51.9 | 51.0 | 50.7 | 51.7 | 51.6 | 51.7 | 53.3 | +1.6 |
| 12th Grade[a] | 48.6 | 49.0 | 48.3 | 46.5 | 45.2 | 49.5 | 43.0 | 42.8 | 43.1 | 42.7 | 43.6 | 42.2 | 43.5 | 43.6 | 45.0 | +1.4 |
| **Percent who disapprove of having 5 or more drinks in a row once or twice each weekend:** | | | | | | | | | | | | | | | | |
| 8th Grade | 85.2 | 83.9 | 83.3 | 80.7 | 80.7 | 79.1 | 81.3 | 81.0 | 80.3 | 81.2 | 81.6 | 81.9 | 81.9 | 82.3 | 82.9 | +0.6 |
| 10th Grade | 76.7 | 77.6 | 74.7 | 72.3 | 72.2 | 70.7 | 70.2 | 70.5 | 69.9 | 68.2 | 69.2 | 71.5 | 71.6 | 71.8 | 73.7 | +1.9 |
| 12th Grade[a] | 67.4 | 70.7 | 70.1 | 65.1 | 66.7 | 64.7 | 65.0 | 63.8 | 62.7 | 65.2 | 62.9 | 64.7 | 64.2 | 65.7 | 66.5 | +0.8 |
| **Percent who disapprove of having 1-2 drinks nearly every day:** | | | | | | | | | | | | | | | | |
| 8th Grade | 82.2 | 81.0 | 79.6 | 76.7 | 75.9 | 74.1 | 76.6 | 76.9 | 77.0 | 77.8 | 77.4 | 78.3 | 77.1 | 78.6 | 78.7 | +0.1 |
| 10th Grade | 81.7 | 81.7 | 78.6 | 75.2 | 75.4 | 73.8 | 75.4 | 74.6 | 75.4 | 73.8 | 73.8 | 74.9 | 74.2 | 75.1 | 76.9 | +1.8 |
| 12th Grade[a] | 76.5 | 75.9 | 77.8 | 73.1 | 73.3 | 70.8 | 70.0 | 69.4 | 67.2 | 70.0 | 69.2 | 69.1 | 68.9 | 69.5 | 70.8 | +1.3 |
| **Percent reporting that it is "fairly easy" or "very easy" to get alcohol:** | | | | | | | | | | | | | | | | |
| 8th Grade | | 76.2 | 73.9 | 74.5 | 74.9 | 75.3 | 74.9 | 73.1 | 72.3 | 70.6 | 70.6 | 67.9 | 67.0 | 64.9 | 64.2 | -0.7 |
| 10th Grade | | 88.6 | 88.9 | 89.8 | 89.7 | 90.4 | 89.0 | 88.0 | 88.2 | 87.7 | 87.7 | 84.8 | 83.4 | 84.3 | 83.7 | -0.6 |
| 12th Grade[a] | | | | | | | | | 95.0 | 94.8 | 94.3 | 94.7 | 94.2 | 94.2 | 93.0 | -1.2 |
| **Approx. Wtd. N's:** | | | | | | | | | | | | | | | | |
| 8th Grade | 17,500 | 18,600 | 18,300 | 17,300 | 17,500 | 17,800 | 18,600 | 18,100 | 16,700 | 16,700 | 16,200 | 15,100 | 16,500 | 17,000 | 16,800 | |
| 10th Grade | 14,800 | 14,800 | 15,300 | 15,800 | 17,000 | 15,600 | 15,500 | 15,000 | 13,600 | 14,300 | 14,000 | 14,300 | 15,800 | 16,400 | 16,200 | |
| 12th Grade | 15,000 | 15,800 | 16,300 | 15,400 | 15,400 | 14,300 | 15,400 | 15,200 | 13,600 | 12,800 | 12,800 | 12,900 | 14,600 | 14,600 | 14,700 | |

NOTES: Level of significance of difference between the two most recent classes: s = .05, ss = .01, sss = .001. '—' indicates data not available. Any apparent inconsistency between the change estimate and the prevalence of use estimate for the two most recent classes is due to rounding error.

SOURCE: The Monitoring the Future Study, the University of Michigan.

[a] Data based on one of five forms in 1975–88; N is approximately one-fifth of N indicated. Data based on one of six forms beginning in 1989. N is approximately one-sixth of N indicated.

# Table 33. Risk Perceptions of Having Four or Five Drinks of an Alcoholic Beverage Nearly Every Day, by Demographic Characteristics among Persons Ages 12 to 20: Percentages, National Survey on Drug Use and Health, 2002, 2003, and 2004

| | Have Four or Five Drinks of Alcoholic Beverage Nearly Every Day[1] | | |
|---|---|---|---|
| | Great Risk | | |
| **Demographic Characteristic** | **2002** | **2003** | **2004** |
| **Total** | 61.6 | 60.8 | 61.3 |
| **Age** | | | |
| 12–13 | 64.9 | 64.5 | 65.5 |
| 14–15 | 61.6 | 59.6 | 60.6 |
| 16–17 | 60.0 | 60.5 | 59.3 |
| 18–20 | 60.5 | 59.2 | 60.4 |
| **Gender** | | | |
| Male | 55.2 | 55.3 | 55.1 |
| Female | 68.3 | 66.4[a] | 67.9 |
| **Hispanic Origin and Race** | | | |
| Not Hispanic or Latino | 61.3 | 60.9 | 61.2 |
| White | 59.5 | 59.1 | 59.3 |
| Black or African American | 66.3 | 65.7 | 66.4 |
| American Indian or Alaska Native | 57.5 | 58.6 | 59.4 |
| Native Hawaiian or Other Pacific Islander | * | * | * |
| Asian | 71.2 | 70.8 | 70.0 |
| Two or More Races | 63.9 | 61.7 | 64.9 |
| Hispanic or Latino | 63.2 | 60.0 | 61.8 |
| **County Type** | | | |
| Large Metro | 64.0 | 63.4 | 63.9 |
| Small Metro | 61.0 | 59.4 | 60.0 |
| Nonmetro | 55.5 | 55.3 | 55.5 |

* Low precision; no estimate reported.

[a] Difference between estimate and 2004 estimate is statistically significant at the 0.05 level.
[b] Difference between estimate and 2004 estimate is statistically significant at the 0.01 level.

[1] Respondents with missing data were excluded.

Source: SAMHSA, Office of Applied Studies, National Survey on Drug Use and Health, 2002, 2003, and 2004.

# Table 34. Risk Perceptions of Having Five or More Drinks of an Alcoholic Beverage Once or Twice a Week, by Demographic Characteristics among Persons Ages 12 to 20: Percentages, National Survey on Drug Use and Health, 2002, 2003, and 2004

| | Have Five or More Drinks of Alcoholic Beverage Once or Twice a Week[1] | | |
|---|---|---|---|
| | Great Risk | | |
| **Demographic Characteristic** | **2002** | **2003** | **2004** |
| **Total** | 36.6 | 36.3 | 36.2 |
| **Age** | | | |
| 12–13 | 41.2 | 42.1 | 42.3 |
| 14–15 | 37.4 | 37.1 | 36.9 |
| 16–17 | 36.1 | 36.2 | 34.9 |
| 18–20 | 33.3 | 31.9 | 32.4 |
| **Gender** | | | |
| Male | 31.9 | 32.7 | 31.8 |
| Female | 41.4 | 40.0 | 40.8 |
| **Hispanic Origin and Race** | | | |
| Not Hispanic or Latino | 35.7 | 35.8 | 35.5 |
| White | 32.5 | 32.2 | 31.5 |
| Black or African American | 49.3 | 48.8 | 49.7 |
| American Indian or Alaska Native | 36.2 | 38.4 | 40.7 |
| Native Hawaiian or Other Pacific Islander | * | 47.2 | * |
| Asian | 38.1[a] | 41.9 | 45.0 |
| Two or More Races | 37.1 | 39.0 | 36.2 |
| Hispanic or Latino | 41.0 | 38.5 | 39.3 |
| **County Type** | | | |
| Large Metro | 37.6 | 37.2 | 37.9 |
| Small Metro | 35.6 | 35.6 | 34.2 |
| Nonmetro | 35.2 | 34.5 | 34.6 |

* Low precision; no estimate reported.

[a] Difference between estimate and 2004 estimate is statistically significant at the 0.05 level.
[b] Difference between estimate and 2004 estimate is statistically significant at the 0.01 level.

[1] Respondents with missing data were excluded.

Source: SAMHSA, Office of Applied Studies, National Survey on Drug Use and Health, 2002, 2003, and 2004.

# Table 35. Youths' Perceptions of Parents' Feelings about Youths Having One or Two Drinks of an Alcoholic Beverage Nearly Every Day, by Demographic Characteristics among Persons Ages 12 to 20: Percentages, National Survey on Drug Use and Health, 2002, 2003, and 2004

| | Parents' Feelings about Youths Drinking Alcoholic Beverages[1] | | |
|---|---|---|---|
| | Strongly Disapprove | | |
| **Demographic Characteristic** | **2002** | **2003** | **2004** |
| **Total** | 89.0 | 88.5 | 89.0 |
| **Age** | | | |
| 12–13 | 92.3 | 92.0 | 92.8 |
| 14–15 | 89.5 | 88.9 | 89.2 |
| 16–17 | 85.2 | 84.6 | 85.0 |
| **Gender** | | | |
| Male | 87.7 | 87.6 | 87.9 |
| Female | 90.4 | 89.5 | 90.2 |
| **Hispanic Origin and Race** | | | |
| Not Hispanic or Latino | 89.2 | 88.8 | 89.6 |
| White | 89.2 | 88.6[a] | 89.8 |
| Black or African American | 88.9 | 89.5 | 89.7 |
| American Indian or Alaska Native | 80.8 | 89.1 | * |
| Native Hawaiian or Other Pacific Islander | * | * | * |
| Asian | 91.9 | 90.8 | 89.2 |
| Two or More Races | 92.7[a] | 87.1 | 86.9 |
| Hispanic or Latino | 87.9 | 86.8 | 86.2 |
| **County Type** | | | |
| Large Metro | 89.7 | 89.4 | 90.1 |
| Small Metro | 89.4 | 88.5 | 88.3 |
| Nonmetro | 86.2 | 85.9 | 86.8 |

* Low precision; no estimate reported.

[a] Difference between estimate and 2004 estimate is statistically significant at the 0.05 level.
[b] Difference between estimate and 2004 estimate is statistically significant at the 0.01 level.

[1] Respondents with missing data were excluded.

Source: SAMHSA, Office of Applied Studies, National Survey on Drug Use and Health, 2002, 2003, and 2004.

# OTHER RISKY BEHAVIORS

# Table 36. Percentage of High School Students who Had Sexual Intercourse With One or More Persons,* by Alcohol Use, Sex, Race/Ethnicity, and Grade—United States, Youth Risk Behavior Survey, 2003

| | Currently Sexually Active | | | | | |
|---|---|---|---|---|---|---|
| | Among Non-Drinkers | | Among Current Drinkers† | | Among Binge Drinkers‡ | |
| Category | % | CI§ | % | CI§ | % | CI§ |
| **Sex** | | | | | | |
| Female | 20.1 | ±2.6 | 50.9 | ±3.0 | 58.0 | ±4.5 |
| Male | 20.2 | ±2.5 | 48.2 | ±3.6 | 55.4 | ±4.6 |
| **Race/Ethnicity** | | | | | | |
| White, non-Hispanic | 16.1 | ±2.7 | 45.6 | ±3.1 | 53.2 | ±3.9 |
| Black, non-Hispanic | 36.6 | ±3.4 | 67.0 | ±4.9 | 75.4 | ±7.4 |
| Other,** non-Hispanic | 16.6 | ±4.9 | 55.0 | ±9.9 | 63.6 | ±10.5 |
| Hispanic | 22.8 | ±3.7 | 52.8 | ±3.4 | 61.4 | ±4.5 |
| **Grade** | | | | | | |
| 9 | 11.0 | ±2.5 | 36.5 | ±3.6 | 47.1 | ±7.1 |
| 10 | 16.4 | ±2.5 | 46.8 | ±3.7 | 55.8 | ±5.1 |
| 11 | 28.0 | ±4.5 | 53.9 | ±4.1 | 58.0 | ±5.4 |
| 12 | 33.6 | ±3.7 | 59.9 | ±4.0 | 63.4 | ±4.8 |
| **Total** | 20.1 | ±2.3 | 49.6 | ±2.6 | 56.8 | ±3.1 |

* Sexual intercourse during the 3 months preceding the survey.

† Drank one or more drinks of alcohol on one or more of the 30 days preceding the survey.

‡ Drank five or more drinks of alcohol in a row on one or more of the 30 days preceding the survey.

§ 95% Confidence Interval.

** Other includes Asian, Native Hawaiian, Pacific Islander, American Indian, Alaska Native, and multiple races.

Source: Youth Risk Behavior Survey, 2003.

# Table 37. Percentage of High School Students who Used a Condom During Their Last Sexual Intercourse,* by Alcohol Use, Sex, Race/Ethnicity, and Grade—United States, Youth Risk Behavior Survey, 2003

| | Condom Used During Last Sexual Intercourse | | | | | |
|---|---|---|---|---|---|---|
| | Among Non-Drinkers | | Among Current Drinkers† | | Among Binge Drinkers‡ | |
| **Category** | % | CI§ | % | CI§ | % | CI§ |
| **Sex** | | | | | | |
| Female | 59.0 | ±4.8 | 56.3 | ±3.9 | 55.4 | ±5.0 |
| Male | 71.1 | ±4.5 | 66.4 | ±4.0 | 64.7 | ±4.8 |
| **Race/Ethnicity** | | | | | | |
| White, non-Hispanic | 62.6 | ±5.5 | 61.5 | ±4.5 | 61.5 | ±5.2 |
| Black, non-Hispanic | 74.1 | ±5.0 | 70.0 | ±5.8 | 67.6 | ±9.2 |
| Other,** non-Hispanic | –†† | – | 51.3 | ±10.1 | 51.0 | ±12.6 |
| Hispanic | 58.8 | ±7.5 | 56.9 | ±6.5 | 55.5 | ±6.2 |
| **Grade** | | | | | | |
| 9 | 73.3 | ±7.8 | 65.2 | ±10.5 | 63.4 | ±13.1 |
| 10 | 68.2 | ±6.9 | 69.2 | ±5.1 | 68.7 | ±5.6 |
| 11 | 62.8 | ±7.1 | 58.5 | ±6.7 | 57.1 | ±8.0 |
| 12 | 60.2 | ±7.7 | 55.7 | ±4.8 | 54.8 | ±6.2 |
| **Total** | 65.2 | ±3.7 | 61.1 | ±3.6 | 60.1 | ±4.3 |

* Among currently sexually active students.

† Drank one or more drinks of alcohol on one or more of the 30 days preceding the survey.

‡ Drank five or more drinks of alcohol in a row on one or more of the 30 days preceding the survey.

§ 95% Confidence Interval.

** Other includes Asian, Native Hawaiian, Pacific Islander, American Indian, Alaska Native, and multiple races.

†† Fewer than 100 valid responses.

Source: Youth Risk Behavior Survey, 2003.

# Table 38. Percentage of High School Students who Drank Alcohol or Used Drugs Before Their Last Sexual Intercourse,* by Alcohol Use, Sex, Race/Ethnicity, and Grade—United States, Youth Risk Behavior Survey, 2003

| | Drank Alcohol or Used Drugs Before Last Intercourse | | | | | |
|---|---|---|---|---|---|---|
| | Among Non-Drinkers | | Among Current Drinkers[†] | | Among Binge Drinkers[‡] | |
| **Category** | % | CI[§] | % | CI[§] | % | CI[§] |
| **Sex** | | | | | | |
| Female | 5.1 | ±2.2 | 28.1 | ±3.4 | 35.2 | ±3.9 |
| Male | 8.2 | ±3.0 | 39.8 | ±4.5 | 46.7 | ±5.8 |
| **Race/Ethnicity** | | | | | | |
| White, non-Hispanic | 6.9 | ±3.3 | 33.9 | ±4.0 | 39.2 | ±4.8 |
| Black, non-Hispanic | 5.6 | ±2.4 | 29.6 | ±3.2 | 43.5 | ±4.3 |
| Other,** non-Hispanic | –[††] | – | 45.7 | ±11.9 | 59.7 | ±11.7 |
| Hispanic | 7.0 | ±3.2 | 31.4 | ±3.7 | 39.2 | ±4.4 |
| **Grade** | | | | | | |
| 9 | 7.4 | ±4.2 | 31.4 | ±5.9 | 39.6 | ±7.7 |
| 10 | 8.8 | ±5.8 | 35.0 | ±5.4 | 41.5 | ±7.4 |
| 11 | 6.5 | ±3.1 | 33.5 | ±4.7 | 40.8 | ±5.5 |
| 12 | 5.0 | ±3.2 | 33.7 | ±3.0 | 40.9 | ±3.9 |
| **Total** | 6.7 | ±2.0 | 33.7 | ±2.8 | 41.0 | ±3.7 |

* Among currently sexually active students.

[†] Drank one or more drinks of alcohol on one or more of the 30 days preceding the survey.

[‡] Drank five or more drinks of alcohol in a row on one or more of the 30 days preceding the survey.

[§] 95% Confidence Interval.

** Other includes Asian, Native Hawaiian, Pacific Islander, American Indian, Alaska Native, and multiple races.

[††] Fewer than 100 valid responses.

Source: Youth Risk Behavior Survey, 2003.

# Table 39. Percentage of High School Students who Used Marijuana* During the Past 30 Days, by Alcohol Use, Sex, Race/Ethnicity, and Grade—United States, Youth Risk Behavior Survey, 2003

| | Current Marijuana Use | | | | | |
|---|---|---|---|---|---|---|
| | Among Non-Drinkers | | Among Current Drinkers† | | Among Binge Drinkers‡ | |
| **Category** | % | CI§ | % | CI§ | % | CI§ |
| **Sex** | | | | | | |
| Female | 4.0 | ±1.1 | 37.7 | ±3.2 | 48.4 | ±4.2 |
| Male | 7.1 | ±1.0 | 48.2 | ±4.5 | 58.0 | ±5.5 |
| **Race/Ethnicity** | | | | | | |
| White, non-Hispanic | 4.3 | ±0.8 | 42.0 | ±4.6 | 51.3 | ±5.9 |
| Black, non-Hispanic | 8.9 | ±2.0 | 46.7 | ±4.6 | 62.8 | ±7.2 |
| Hispanic | 6.8 | ±3.5 | 43.6 | ±10.2 | 59.7 | ±10.7 |
| Other,** non-Hispanic | 6.8 | ±1.5 | 43.1 | ±4.0 | 55.2 | ±3.1 |
| **Grade** | | | | | | |
| 9 | 5.3 | ±1.2 | 40.8 | ±6.2 | 55.2 | ±6.8 |
| 10 | 5.4 | ±1.3 | 44.0 | ±5.2 | 55.4 | ±7.3 |
| 11 | 6.4 | ±2.0 | 43.9 | ±3.9 | 53.4 | ±4.7 |
| 12 | 5.5 | ±1.5 | 42.4 | ±4.3 | 49.9 | ±5.1 |
| **Total** | 5.6 | ±0.7 | 43.0 | ±3.6 | 53.5 | ±4.7 |

*Used marijuana one or more times during the 30 days preceding the survey.

† Drank one or more drinks of alcohol on one or more of the 30 days preceding the survey.

‡ Drank five or more drinks of alcohol in a row on one or more of the 30 days preceding the survey.

§ 95% Confidence Interval.

** Other includes Asian, Native Hawaiian, Pacific Islander, American Indian, Alaska Native, and multiple races.

Source: Youth Risk Behavior Survey, 2003.

# Table 40. Percentage of High School Students who Smoked Cigarettes* in the Past 30 Days, by Alcohol Use, Sex, Race/Ethnicity, and Grade—United States, Youth Risk Behavior Survey, 2003

| | Current Cigarette Use | | | | | |
|---|---|---|---|---|---|---|
| | Among Non-Drinkers | | Among Current Drinkers† | | Among Binge Drinkers‡ | |
| **Category** | % | CI§ | % | CI§ | % | CI§ |
| **Sex** | | | | | | |
| Female | 5.9 | ±1.4 | 42.1 | ±4.3 | 55.7 | ±4.9 |
| Male | 5.6 | ±1.2 | 43.2 | ±3.1 | 53.8 | ±3.2 |
| **Race/Ethnicity** | | | | | | |
| White, non-Hispanic | 6.5 | ±1.5 | 46.9 | ±3.3 | 57.2 | ±4.0 |
| Black, non-Hispanic | 5.6 | ±1.8 | 30.7 | ±4.9 | 47.0 | ±5.3 |
| Other,** non-Hispanic | 4.4 | ±1.4 | 34.5 | ±4.8 | 45.6 | ±6.5 |
| Hispanic | 3.3 | ±1.4 | 40.5 | ±10.8 | 59.1 | ±11.1 |
| **Grade** | | | | | | |
| 9 | 5.4 | ±1.9 | 38.4 | ±5.1 | 52.5 | ±7.4 |
| 10 | 5.3 | ±1.3 | 44.3 | ±4.8 | 57.8 | ±6.3 |
| 11 | 5.5 | ±1.6 | 44.8 | ±4.6 | 55.5 | ±4.9 |
| 12 | 7.3 | ±2.5 | 42.5 | ±3.6 | 52.6 | ±4.1 |
| **Total** | 5.7 | ±1.0 | 42.7 | ±3.2 | 54.8 | ±3.3 |

*Smoked cigarettes on one or more of the 30 days preceding the survey.

† Drank one or more drinks of alcohol on one or more of the 30 days preceding the survey.

‡ Drank five or more drinks of alcohol in a row on one or more of the 30 days preceding the survey.

§ 95% Confidence Interval.

** Other includes Asian, Native Hawaiian, Pacific Islander, American Indian, Alaska Native, and multiple races.

Source: Youth Risk Behavior Survey, 2003.

# Table 41. Percentage of High School Students who Used Inhalants* During the Past 30 Days, by Alcohol Use, Sex, Race/Ethnicity, and Grade—United States, Youth Risk Behavior Survey, 2003

| | Current Inhalant Use | | | | | |
|---|---|---|---|---|---|---|
| | Among Non-Drinkers | | Among Current Drinkers† | | Among Binge Drinkers‡ | |
| **Category** | % | CI§ | % | CI§ | % | CI§ |
| **Sex** | | | | | | |
| Female | 0.9 | ±0.4 | 5.7 | ±1.5 | 7.8 | ±2.3 |
| Male | 1.1 | ±0.4 | 7.5 | ±1.3 | 10.0 | ±2.0 |
| **Race/Ethnicity** | | | | | | |
| White, non-Hispanic | 1.2 | ±0.4 | 6.0 | ±1.3 | 7.4 | ±1.8 |
| Black, non-Hispanic | 0.5 | ±0.3 | 5.0 | ±1.8 | 10.5 | ±4.4 |
| Other,** non-Hispanic | 1.5 | ±1.2 | 12.0 | ±7.7 | 19.6 | ±11.0 |
| Hispanic | 0.5 | ±0.4 | 8.1 | ±2.4 | 10.9 | ±4.3 |
| **Grade** | | | | | | |
| 9 | 1.3 | ±0.6 | 11.3 | ±2.6 | 16.6 | ±4.7 |
| 10 | 0.9 | ±0.8 | 6.8 | ±1.8 | 9.3 | ±2.7 |
| 11 | 0.6 | ±0.4 | 5.2 | ±1.8 | 7.2 | ±2.4 |
| 12 | 1.0 | ±0.6 | 3.3 | ±1.1 | 4.3 | ±1.7 |
| **Total** | 1.0 | ±0.3 | 6.7 | ±1.0 | 9.1 | ±1.5 |

*Sniffed glue, breathed the contents of aerosol spray cans, or inhaled any paints or sprays to get high one or more times during the 30 days preceding the survey.

† Drank one or more drinks of alcohol on one or more of the 30 days preceding the survey.

‡ Drank five or more drinks of alcohol in a row on one or more of the 30 days preceding the survey.

§ 95% Confidence Interval.

** Other includes Asian, Native Hawaiian, Pacific Islander, American Indian, Alaska Native, and multiple races.

Source: Youth Risk Behavior Survey, 2003.

# Table 42. Percentage of High School Students who Carried a Weapon* During the Past 30 Days, by Alcohol Use, Sex, Race/Ethnicity, and Grade—United States, Youth Risk Behavior Survey, 2003

| | Carried a Weapon | | | | | |
|---|---|---|---|---|---|---|
| | Among Non-Drinkers | | Among Current Drinkers† | | Among Binge Drinkers‡ | |
| **Category** | % | CI§ | % | CI§ | % | CI§ |
| **Sex** | | | | | | |
| Female | 3.0 | ±0.8 | 10.7 | ±2.3 | 13.9 | ±3.3 |
| Male | 15.7 | ±2.4 | 39.5 | ±3.6 | 43.8 | ±4.8 |
| **Race/Ethnicity** | | | | | | |
| White, non-Hispanic | 10.5 | ±2.3 | 22.8 | ±2.3 | 25.8 | ±3.6 |
| Black, non-Hispanic | 7.7 | ±2.6 | 31.4 | ±5.0 | 43.4 | ±7.0 |
| Other,** non-Hispanic | 7.1 | ±3.7 | 36.6 | ±10.8 | 51.2 | ±12.7 |
| Hispanic | 9.1 | ±2.0 | 22.9 | ±3.9 | 28.7 | ±4.7 |
| **Grade** | | | | | | |
| 9 | 9.1 | ±1.7 | 30.5 | ±8.5 | 39.2 | ±11.8 |
| 10 | 9.6 | ±2.0 | 23.4 | ±3.4 | 28.2 | ±4.9 |
| 11 | 11.1 | ±3.0 | 24.6 | ±3.6 | 28.3 | ±4.7 |
| 12 | 7.9 | ±2.2 | 20.9 | ±2.6 | 23.1 | ±2.7 |
| **Total** | 9.5 | ±1.4 | 25.0 | ±2.6 | 29.4 | ±3.7 |

*For example, a gun, knife, or club on one or more of the 30 days preceding the survey.

† Drank one or more drinks of alcohol on one or more of the 30 days preceding the survey.

‡ Drank five or more drinks of alcohol in a row on one or more of the 30 days preceding the survey.

§ 95% Confidence Interval.

** Other includes Asian, Native Hawaiian, Pacific Islander, American Indian, Alaska Native, and multiple races.

Source: Youth Risk Behavior Survey, 2003.

# Table 43. Percentage of High School Students who Experienced Dating Violence,* by Alcohol Use, Sex, Race/Ethnicity, and Grade—United States, Youth Risk Behavior Survey, 2003

| | Experienced Dating Violence | | | | | |
|---|---|---|---|---|---|---|
| | Among Non-Drinkers | | Among Current Drinkers† | | Among Binge Drinkers‡ | |
| **Category** | % | CI§ | % | CI§ | % | CI§ |
| **Sex** | | | | | | |
| Female | 4.7 | ±1.1 | 13.1 | ±1.6 | 15.5 | ±2.3 |
| Male | 5.4 | ±1.1 | 12.2 | ±1.8 | 13.8 | ±2.8 |
| **Race/Ethnicity** | | | | | | |
| White, non-Hispanic | 4.0 | ±0.9 | 9.9 | ±1.3 | 11.7 | ±1.8 |
| Black, non-Hispanic | 8.8 | ±1.4 | 19.6 | ±3.9 | 24.8 | ±6.0 |
| Hispanic | 5.4 | ±2.1 | 13.4 | ±2.5 | 15.6 | ±3.4 |
| Other,** non-Hispanic | 4.3 | ±3.0 | 25.9 | ±8.6 | 32.1 | ±8.9 |
| **Grade** | | | | | | |
| 9 | 3.8 | ±1.0 | 14.7 | ±2.8 | 18.3 | ±5.1 |
| 10 | 4.7 | ±1.5 | 13.3 | ±3.0 | 15.9 | ±4.2 |
| 11 | 5.8 | ±1.6 | 10.2 | ±2.0 | 10.9 | ±2.8 |
| 12 | 7.0 | ±1.9 | 11.9 | ±2.2 | 13.4 | ±3.0 |
| **Total** | 5.1 | ±0.8 | 12.6 | ±1.4 | 14.7 | ±2.0 |

* Hit, slapped, or physically hurt on purpose by a boyfriend or girlfriend during the 12 months preceding the survey.

† Drank one or more drinks of alcohol on one or more of the 30 days preceding the survey.

‡ Drank five or more drinks of alcohol in a row one or more of the 30 days preceding the survey.

§ 95% Confidence Interval.

** Other includes Asian, Native Hawaiian, Pacific Islander, American Indian, Alaska Native, and multiple races.

Source: Youth Risk Behavior Survey, 2003.

## Table 44. Trends in Health Risk Behaviors Among Students who Had One or More Drinks of Alcohol on One or More of the Past 30 Days—United States, Youth Risk Behavior Survey, 1991–2003

| Risk Behaviors | 1991 | 1993 | 1995 | 1997 | 1999 | 2001 | 2003 |
|---|---|---|---|---|---|---|---|
| Currently sexually active* | 50.1 | 51.8 | 49.9 | 48.0 | 49.3 | 48.2 | 49.6 |
| Alcohol or drug use before last sexual intercourse† | 29.3 | 30.0 | 34.4 | 33.4 | 33.5 | 34.0 | 33.7 |
| Condom use during last sexual intercourse† | 44.4 | 51.9 | 53.3 | 54.4 | 56.7 | 57.1 | 61.1 |
| Current cigarette use‡ | 45.2 | 51.2 | 55.7 | 60.1 | 56.5 | 50.5 | 42.7 |
| Current marijuana use§ | 26.7 | 31.7 | 43.1 | 45.2 | 46.8 | 43.6 | 43.0 |
| Current inhalant use** | – | – | – | – | 7.0 | 7.6 | 6.7 |
| Carried a weapon†† | 34.2 | 30.1 | 27.5 | 25.3 | 23.5 | 24.6 | 25.0 |
| Dating violence‡‡ | – | – | – | – | 12.0 | 13.4 | 12.6 |

* Sexual intercourse during the 3 months preceding the survey.
† Among currently sexually active students.
‡ Smoked cigarettes on one or more of the 30 day preceding the survey.
§ Used marijuana one or more times during the 30 days preceding the survey.
** Sniffed glue, breathed the contents of aerosol spray cans, or inhaled any paints or sprays to get high one or more times during the 30 days preceding the survey.
†† For example, a gun, knife, or club on one or more of the 30 days preceding the survey.
‡‡ Hit, slapped, or physically hurt on purpose by a boyfriend or girlfriend during the 12 months preceding the survey.
The dash (-) indicates that data is not available.
Source: Youth Risk Behavior Survey.

## Table 45. Trends in Health Risk Behaviors Among Students who Had Five or More Drinks of Alcohol in a Row on One or More of the Past 30 Days—United States, Youth Risk Behavior Survey, 1991–2003

| Risk Behaviors | 1991 | 1993 | 1995 | 1997 | 1999 | 2001 | 2003 |
|---|---|---|---|---|---|---|---|
| Currently sexually active* | 56.1 | 58.6 | 57.0 | 52.2 | 55.1 | 54.4 | 56.8 |
| Alcohol or drug use before last sexual intercourse† | 37.4 | 36.3 | 41.0 | 39.9 | 40.6 | 41.3 | 41.0 |
| Condom use during last sexual intercourse† | 44.6 | 49.9 | 51.3 | 53.5 | 54.7 | 57.2 | 60.1 |
| Current cigarette use‡ | 56.7 | 60.4 | 65.9 | 69.7 | 67.9 | 60.6 | 54.8 |
| Current marijuana use§ | 36.8 | 41.1 | 53.6 | 54.0 | 57.6 | 53.9 | 53.5 |
| Current inhalant use** | – | – | – | – | 8.1 | 9.6 | 9.1 |
| Carried a weapon†† | 40.2 | 32.9 | 31.7 | 28.5 | 27.7 | 27.3 | 29.4 |
| Dating violence‡‡ | – | – | – | – | 14.0 | 15.3 | 14.7 |

*Sexual intercourse during the 3 months preceding the survey.
† Among currently sexually active students.
‡ Smoked cigarettes on one or more of the 30 day preceding the survey.
§ Used marijuana one or more times during the 30 days preceding the survey.
** Sniffed glue, breathed the contents of aerosol spray cans, or inhaled any paints or sprays to get high one or more times during the 30 days preceding the survey.
†† For example, a gun, knife, or club on one or more of the 30 days preceding the survey.
‡‡ Hit, slapped, or physically hurt on purpose by a boyfriend or girlfriend during the 12 months preceding the survey.
The dash (-) indicates that data is not available.
Source: Youth Risk Behavior Survey.

# APPENDIX C

## MEMBERS OF THE INTERAGENCY COORDINATING COMMITTEE ON THE PREVENTION OF UNDERAGE DRINKING (ICCPUD)

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# APPENDIX D

## GLOSSARY OF ABBREVIATIONS AND ACRONYMS

### Acronym Glossary of Federal Departments and Agencies

| | |
|---|---|
| Department of Defense | DoD |
| Department of Education | Education or ED |
| Safe and Drug-Free Schools | SDFS |
| Office of Elementary and Secondary Education | OESE |
| Department of Health and Human Services | HHS |
| Administration for Children and Families | ACF |
| Family and Youth Service Bureau | FYSB |
| Agency for Healthcare Research and Quality | AHRQ |
| Centers for Disease Control and Prevention | CDC |
| Center for Medicaid Services | CMS |
| Health Resources and Services Administration | HRSA |
| National Institute on Alcohol Abuse and Alcoholism | NIAAA |
| National Institute on Drug Abuse | NIDA |
| Office of Public Health and Science | OS/OPHS |
| Office of the Surgeon General | OSG |
| Substance Abuse and Mental Health Services Administration | SAMHSA |
| Center for Mental Health Services | CMHS |
| Center for Substance Abuse Prevention | CSAP |
| Center for Substance Abuse Treatment | CSAT |
| Office of Applied Studies | OAS |
| Department of Justice | DOJ |
| Office of Juvenile Justice and Delinquency Prevention | OJJDP |
| Office of Justice Programs | OJP |
| Department of Labor | DOL |
| Employment Training Administration | ETA |
| Office of Youth Services | OYS |
| Occupational Safety and Health Administration | OSHA |
| Office of National Drug Control Policy | ONDCP |
| Department of Transportation | DOT |
| National Highway and Traffic Safety Administration | NHTSA |

**Acronym Glossary of Federal Programs and Agencies (alphabetical)**

| | |
|---|---|
| Access to Recovery | ATR |
| Addiction Technology Transfer Center | ATTC |
| Administration for Children and Families | ACF |
| Agency for Health Care Research and Quality | AHRQ |
| Alcohol Policy Information System | APIS |
| Basic Center Program | BCP |
| Behavioral Risk Factor Surveillance System | BRFSS |
| Birth Control and Alcohol Awareness: Negotiating Choices Effectively | Project Balance |
| Centers for Disease Control and Prevention | CDC |
| Center for Medicaid Services | CMS |
| Center for Mental Health Services | CMHS |
| Center for Substance Abuse Prevention | CSAP |
| Center for Substance Abuse Treatment | CSAT |
| Community Anti-Drug Coalitions of America | CADCA |
| Department of Defense | DoD |
| Department of Education | ED |
| Department of Health and Human Services | HHS |
| Department of Justice | DOJ |
| Department of Labor | DOL |
| Department of Transportation | DOT |
| Drug and Alcohol Services Information System | DASIS |
| Drug Free Communities Program | DFC |
| Employment Training Administration | ETA |
| Enforcing the Underage Drinking Laws | EUDL |
| Family and Youth Services Bureau | FYSB |
| Fatality Analysis Reporting System | FARS |
| Federal Alcohol Spectrum Disorder | FASD |
| Health Resource Services Administration | HRSA |
| Institute of Medicine | IOM |
| Interagency Coordinating Committee on the Prevention of Underage Drinking | ICCPUD |
| International Association of Chiefs of Police | IACP |
| Inventory of Substance Abuse Treatment Services | I-SATS |
| Iowa Strengthening Families Program | ISFP |
| Local Educational Agencies | LEAs |
| Monitoring the Future Survey | MTF |
| Mothers Against Drunk Driving | MADD |
| National Academy of Sciences | NAS |
| National Alcohol Screening Day | NASD |
| National Association for Children of Alcoholics | NACoA |
| National Association of School Resource Officers | NASRO |
| National Epidemiological Survey on Alcohol Related Conditions | NESARC |
| National Health and Nutrition Examination Survey | NHANES |

| | |
|---|---|
| National Highway Traffic Safety Administration | NHTSA |
| National Institutes of Health | NIH |
| National Institute on Alcohol Abuse and Alcoholism | NIAAA |
| National Liquor Law Enforcement Association | NLLEA |
| National Organizations for Youth Safety | NOYS |
| National Registry of Effective Programs and Practices | NREPP |
| National Survey of Substance Abuse Treatment Services | N-SSATS |
| National Survey on Drug Use and Health | NSDUH |
| Network for Employees of Traffic Safety | NETS |
| Occupational Safety and Health Administration | OSHA |
| Office of Juvenile Justice and Delinquency Prevention | OJJDP |
| Office of National Drug Control Policy | ONDCP |
| Office of Surgeon General | OSG |
| Office of the Assistant Secretary for Planning and Evaluation | ASPE |
| Office of Youth Services | OYS |
| Outreach to Children of Parents in Treatment | OCPT |
| Partnership for Drug-Free America | PDFA |
| Pregnancy Nutrition Surveillance System | PNSS |
| Pregnancy Risk Assessment Monitoring System | PRAMS |
| Protecting You/Protecting Me | PYPM |
| Public Service Announcements | PSAs |
| Robert Wood Johnson Foundation | RWJ |
| Safe and Drug-Free Schools and Communities Act | SDFSCA |
| Screening, Brief Intervention, Referral, and Treatment | SBIRT |
| State Incentive Grant Program | SIG |
| Strategic Prevention Framework | SPF |
| Street Outreach Program | SOP |
| Students Against Destructive Decisions | SADD |
| Substance Abuse and Mental Health Services Administration | SAMHSA |
| Substance Abuse Prevention and Treatment Block Grant | SAPT BG |
| Targeted Capacity Expansion Program | TCE |
| Techniques for Effective Alcohol Management | TEAM |
| Too Smart to Start | TSTS |
| Transitional Living Program | TLP |
| Treatment Episode Data Set | TEDS |
| Treatment Improvement Protocols | TIPS |
| Uniform Accident and Sickness Policy Provision Law | UPPL |
| Uniform Facility Data | UFDS |
| Virginia Commonwealth University | VCU |
| Youth Offender Demonstration Project | YODP |
| Young Offender Reentry Program | YORP |
| Youth Opportunity Grants | YOGs |
| Youth Risk Behavior Survey | YRBS |

# APPENDIX E

## REFERENCES

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