



## RESEARCH SUMMARY

Date Compiled: September 2017

### **PREVALENCE OF 12-MONTH ALCOHOL USE, HIGH-RISK DRINKING, AND DSM-IV ALCOHOL USE DISORDER IN THE UNITED STATES, 2001-2002 TO 2012-2013: RESULTS FROM THE NATIONAL EPIDEMIOLOGIC SURVEY ON ALCOHOL AND RELATED CONDITIONS**

September 2017

#### **Key Points**

**Question:** Have the 12-month prevalences of alcohol use, high-risk drinking, and DSM-IV alcohol use disorder increased between 2001-2002 and 2012-2013?

**Findings:** In this study of data from face-to-face interviews conducted in 2 nationally representative surveys of US adults, including the National Epidemiologic Survey on Alcohol and Related Conditions (n = 43 093) and the National Epidemiologic Survey on Alcohol and Related Conditions III (n = 36 309), 12-month alcohol use (11.2%), high-risk drinking (29.9%), and DSM-IV alcohol use disorder (49.4%) increased for the total US population and, with few exceptions, across sociodemographic subgroups.

**Meaning:** Substantial increases in alcohol use, high-risk drinking, and DSM-IV alcohol use disorder constitute a public health crisis and portend increases in chronic disease comorbidities in the United States, especially among women, older adults, racial/ethnic minorities, and the socioeconomically disadvantaged.

#### **Abstract**

**Importance:** Lack of current and comprehensive trend data derived from a uniform, reliable, and valid source on alcohol use, high-risk drinking, and DSM-IV alcohol use disorder (AUD) represents a major gap in public health information.

**Objective:** To present nationally representative data on changes in the prevalences of 12-month alcohol use, 12-month high-risk drinking, 12-month DSM-IV AUD, 12-month DSM-IV AUD among 12-month alcohol users, and 12-month DSM-IV AUD among 12-month high-risk drinkers between 2001-2002 and 2012-2013.

**Design, Setting, and Participants:** The study data were derived from face-to-face interviews conducted in 2 nationally representative surveys of US adults: the National Epidemiologic Survey on Alcohol and Related Conditions, with data collected from April 2001 to June 2002, and the National Epidemiologic Survey on Alcohol and Related Conditions III, with data collected from April 2012 to June 2013. Data were analyzed in November and December 2016.

**Main Outcomes and Measures:** Twelve-month alcohol use, high-risk drinking, and DSM-IV AUD.

**Results:** The study sample included 43 093 participants in the National Epidemiologic Survey on Alcohol and Related Conditions and 36 309 participants in the National Epidemiologic Survey on Alcohol and Related Conditions III. Between 2001-2002 and 2012-2013, 12-month alcohol use, high-risk drinking, and DSM-IV AUD increased by 11.2%, 29.9%, and 49.4%, respectively, with alcohol use increasing from 65.4% (95% CI, 64.3%-66.6%) to 72.7% (95% CI, 71.4%-73.9%), high-risk drinking increasing from 9.7% (95% CI, 9.3%-10.2%) to 12.6% (95% CI, 12.0%-13.2%), and DSM-IV AUD increasing from 8.5% (95% CI, 8.0%-8.9%) to 12.7% (95% CI, 12.1%-13.3%). With few exceptions, increases in alcohol use, high-risk drinking, and DSM-IV AUD between 2001-2002 and 2012-2013 were also statistically significant across sociodemographic subgroups. Increases in all of these outcomes were greatest among women, older adults, racial/ethnic minorities, and individuals with lower educational level and family income. Increases were also seen for the total sample and most sociodemographic subgroups for the prevalences of 12-month DSM-IV AUD among 12-month alcohol users from 12.9% (95% CI, 12.3%-17.5%) to 17.5% (95% CI, 16.7%-18.3%) and 12-month DSM-IV AUD among 12-month high-risk drinkers from 46.5% (95% CI, 44.3%-48.7%) to 54.5% (95% CI, 52.7%-56.4%).

**Conclusions and Relevance:** Increases in alcohol use, high-risk drinking, and DSM-IV AUD in the US population and among subgroups, especially women, older adults, racial/ethnic minorities, and the socioeconomically disadvantaged, constitute a public health crisis. Taken together, these findings portend increases in many chronic comorbidities in which alcohol use has a substantial role.

**Source:** *JAMA Psychiatry*

*Related Media Coverage:*

The Economist: "Minorities, the elderly and women are drinking much more alcohol"  
<https://www.economist.com/news/united-states/21726738-heavy-drinking-still-kills-many-more-people-opioid-overdoses-minorities-elderly>

Washington Post WonkBlog: "One in eight American adults is an alcoholic, study says"  
[https://www.washingtonpost.com/news/wonk/wp/2017/08/11/study-one-in-eight-american-adults-are-alcoholics/?utm\\_term=.ae1774522952](https://www.washingtonpost.com/news/wonk/wp/2017/08/11/study-one-in-eight-american-adults-are-alcoholics/?utm_term=.ae1774522952)

Newsday: "America's drinking problem is worsening"  
<http://www.newsday.com/opinion/commentary/america-s-drinking-problem-is-worsening-1.13995303>

HuffPost: "Americans Are Drinking More, But Why?"  
[http://www.huffingtonpost.com/entry/americans-are-drinking-more-but-why\\_us\\_598c9b1ce4b0caa1687a5e6c](http://www.huffingtonpost.com/entry/americans-are-drinking-more-but-why_us_598c9b1ce4b0caa1687a5e6c)

Science of Us: "A New Study Says Heavy Drinking Has Become a 'Public Health Crisis'"  
<http://nymag.com/scienceofus/2017/08/a-study-says-heavy-drinking-is-now-a-public-health-crisis.html>

## **TOWARD LIQUOR CONTROL: THE BEGINNING OF US ALCOHOL REGULATION**

August 2017

Critics often attempt to marginalize our alcohol regulations as just Prohibition Era “nanny state” measures attempting to legislate morality. In a recent article in the Washington Post, Dr. Mark Schrad of Villanova University, worked to correct the “common understanding of the Prohibition Era” which he says is based “more on folk lore than fact.” As Professor Schrad notes, “Prohibitionists were the enemies of predatory business, not individual choice.”

The book [*Toward Liquor Control*] is the foundation of our alcohol regulatory system and bolsters the notion that alcohol control is about curbing business practices that create social problems, not legislating morality. *Toward Liquor Control* describes how regulation does that.

Before Prohibition, alcohol was sold by large companies that owned retail establishments, called saloons, in most local communities. Competition was fierce and aggressive sales were the order of the day. Social problems were rampant and included sales to children, family ruination, public nuisances, intoxication and addiction. This situation led to a Constitutional Amendment to prohibit all alcohol manufacture, transportation and sales....

... *Toward Liquor Control* is well worth reading and has a lot of wisdom for today’s policy makers. The book can be obtained via Amazon or from the Center for Alcohol Policy, which secured the publishing rights and has republished this important book.

**Full article:** <http://healthyalcoholmarket.com/wordpress/>

**Source:** *Healthy Alcohol Marketplace*

## **ALCOHOL SCREENING AND BRIEF INTERVENTION: A POTENTIAL ROLE IN CANCER PREVENTION FOR YOUNG ADULTS**

July 2017

**Summary:** Excessive or risky alcohol use is a preventable cause of significant morbidity and mortality in the U.S. and worldwide. Alcohol use is a common preventable cancer risk factor among young adults; it is associated with increased risk of developing at least six types of cancer. Alcohol consumed during early adulthood may pose a higher risk of female breast cancer than alcohol consumed later in life. Reducing alcohol use may help prevent cancer. Alcohol misuse screening and brief counseling or intervention (also called alcohol screening and brief intervention among other designations) is known to reduce excessive alcohol use, and the U.S. Preventive Services Task Force recommends that it be implemented for all adults aged  $\geq 18$  years in primary healthcare settings. Because the prevalence of excessive alcohol use, particularly binge drinking, peaks among young adults, this time of life may present a unique window of opportunity to talk about the cancer risk associated with alcohol use and how to reduce that risk by reducing excessive drinking or misuse. This article briefly describes alcohol screening and brief intervention, including the Centers for Disease Control and Prevention’s recommended approach, and suggests a role for it in the context of cancer prevention. The article also briefly discusses how the Centers for Disease Control and Prevention is working to make alcohol screening and brief intervention a routine element of health care in all primary care settings to identify and help young adults who drink too much.

**Free full text:** [http://www.ajpmonline.org/article/S0749-3797\(17\)30306-9/fulltext](http://www.ajpmonline.org/article/S0749-3797(17)30306-9/fulltext)

**Source:** *American Journal of Preventive Medicine*

# **GLOBAL PREVALENCE OF FETAL ALCOHOL SPECTRUM DISORDER AMONG CHILDREN AND YOUTH A SYSTEMATIC REVIEW AND META-ANALYSIS**

June 2017

## **Key Points**

**Question:** What is the prevalence of fetal alcohol spectrum disorder among children and youth in the general population?

**Findings:** In this meta-analysis of 24 unique studies and 1416 unique children and youth with fetal alcohol spectrum disorder, approximately 8 of 1000 in the general population had fetal alcohol spectrum disorder, and 1 of every 13 pregnant women who consumed alcohol during pregnancy delivered a child with fetal alcohol spectrum disorder. The prevalence of fetal alcohol spectrum disorder was found to be notably higher among special populations.

**Meaning:** The prevalence of fetal alcohol spectrum disorder among children and youth in the general population exceeds 1% in 76 countries, which underscores the need for universal prevention initiatives targeting maternal alcohol consumption, screening protocols, and improved access to diagnostic services, especially in special populations.

## **Abstract**

**Importance:** Prevalence estimates are essential to effectively prioritize, plan, and deliver health care to high-needs populations such as children and youth with fetal alcohol spectrum disorder (FASD). However, most countries do not have population-level prevalence data for FASD.

**Objective:** To obtain prevalence estimates of FASD among children and youth in the general population by country, by World Health Organization (WHO) region, and globally.

**Data Sources:** MEDLINE, MEDLINE in process, EMBASE, Education Resource Information Center, Cumulative Index to Nursing and Allied Health Literature, Web of Science, PsychINFO, and Scopus were systematically searched for studies published from November 1, 1973, through June 30, 2015, without geographic or language restrictions.

**Study Selection:** Original quantitative studies that reported the prevalence of FASD among children and youth in the general population, used active case ascertainment or clinic-based methods, and specified the diagnostic guideline or case definition used were included.

**Data Extraction and Synthesis:** Individual study characteristics and prevalence of FASD were extracted. Country-specific random-effects meta-analyses were conducted. For countries with 1 or no empirical study on the prevalence of FASD, this indicator was estimated based on the proportion of women who consumed alcohol during pregnancy per 1 case of FASD. Finally, WHO regional and global mean prevalence of FASD weighted by the number of live births in each country was estimated.

**Main Outcomes and Measures:** Prevalence of FASD.

**Results:** A total of 24 unique studies including 1416 unique children and youth diagnosed with FASD (age range, 0-16.4 years) were retained for data extraction. The global prevalence of FASD among children and youth in the general population was estimated to be 7.7 per 1000 population (95% CI, 4.9-11.7 per 1000 population). The WHO European Region had the highest prevalence (19.8 per 1000 population; 95% CI, 14.1-28.0 per 1000 population), and the WHO Eastern Mediterranean Region had the lowest (0.1 per 1000 population; 95% CI, 0.1-0.5 per 1000 population). Of 187 countries, South Africa was estimated to have the highest prevalence of FASD at 111.1 per 1000 population (95% CI, 71.1-158.4 per 1000 population), followed by Croatia at 53.3 per 1000 population (95% CI, 30.9-81.2 per 1000 population) and Ireland at 47.5 per 1000 population (95% CI, 28.0-73.6 per 1000 population).

**Conclusions and Relevance:** Globally, FASD is a prevalent alcohol-related developmental disability that is largely preventable. The findings highlight the need to establish a universal public health message about the potential harm of prenatal alcohol exposure and a routine screening protocol. Brief interventions should be provided, where appropriate.

**Source:** *JAMA Pediatrics*

## **THE SEVEN TACTICS UNHEALTHY INDUSTRIES USE TO UNDERMINE PUBLIC HEALTH POLICIES**

August 2017

... If you are working to improve public health and the environment ... you need to know what your opponents are up to... Below is a quick guide to their tactics, which I have assembled as a summary from three sources: Naomi Oreskes and Eric M Conway, *Merchants of Doubt*, William Wiist's *The Corporate Playbook, Health, and Democracy: The Snack Food and Beverage Industry's Tactics in Context*, and Nicholas Freudenberg's *Lethal but Legal*.

### **1. Attack legitimate science**

Accuse science of deception, calling it “junk science” or “bad science,” claiming science is manipulated to fulfil a political agenda.

Attack the scientific institutions and government agencies perceived to be acting against corporate interests ...

### **2. Attack and intimidate scientists**

Create doubt by attacking the authenticity and integrity of the author.

Have “attack dogs” intimidate opponents...

### **3. Create arm's length front organisations**

Create front groups.

Run projects through front groups (“information laundering”) – especially law firms, because they can avoid scrutiny due to attorney – client privilege...

### **4. Manufacture false debate and insist on balance**

Create the impression of a controversy.

Maintain the controversy, keep the debate alive...

### **5. Frame issues in highly creative ways**

Insist that the problem is very complex, thus implying it can't have a simple solution, if any.

Insist on personal or parental responsibility and insist that government should have no role in influencing individual health behaviour...

### **6. Fund industry disinformation campaigns**

Run industry disinformation campaigns using new and creative forms.

Pay and co-opt celebrities and sympathetic expert witnesses...

### **7. Influence the political agenda**

Donate to political parties across the political spectrum.

Get representatives from unhealthy industries around the policy table, for guideline development or standard setting ...

**Full article:** [https://theconversation.com/the-seven-tactics-unhealthy-industries-use-to-undermine-public-health-policies-81137?utm\\_source=twitter&utm\\_medium=twitterbutton](https://theconversation.com/the-seven-tactics-unhealthy-industries-use-to-undermine-public-health-policies-81137?utm_source=twitter&utm_medium=twitterbutton)

**Source:** *The Conversation*

## THE ROLE OF GOVERNMENT AND REGULATION IN CANCER PREVENTION

August 2017

### **Summary**

The world population is ageing and increasing in size. As a result, the numbers of people diagnosed with and dying of cancer are increasing. Cancer is also a growing problem in developing countries. Government, be it local, state, provincial, national, or even a union of nations, has clear roles in the control of cancer. It is widely appreciated that much of the research that has defined the causes and treatment of cancer was, and is, government funded. Less appreciated, the body of work about how to control cancer shows the importance of an environment that encourages individuals to adopt healthy behaviours, and government has a vitally important role. Through regulation, education, and support programmes, governments can create an environment in which tobacco use is reduced and citizens maintain good levels of physical activity, healthy bodyweight, and good nutrition. Cancer prevention and the creation of a culture of health is an essential mission of government, beyond that of the traditional health-focused departments such as health ministries; it is in the domain of governmental agencies involved in environmental protection, occupational safety, and transportation. Cancer prevention and health promotion are also in the realm of the zoning board, the board of education, and the board of health.

### **[Alcohol Consumption]**

Alcohol consumption, especially in excess, is linked to numerous cancers. One study of a European cohort estimated that alcohol is associated with 10% of all cancers in men and 3% of all cancers in women, including cancers of the head and neck, oesophagus, liver, breast, and colon.

The combination of alcohol and tobacco use is an especially potent cause of cancers of the aerodigestive tract (cancers of the mouth, throat, and oesophagus). Results from a European cohort study suggest that alcohol and tobacco use were associated with nearly 45% of head and neck cancers in men, and 25% of these cancers in women. As is the case with tobacco use, alcohol consumption is an unnecessary habit. Although there is no safe level of alcohol use, several developed governments have published guidelines with recommended upper levels of alcohol consumption in an educational effort that aims to encourage moderation ...

... The CDC Community Preventive Services Task Force has suggested strategies that state and local governments can use to create social and physical environments that reduce excess alcohol use. These strategies are garnered from systematic reviews of the scientific literature, and are similar to those of tobacco control ...

**Source:** *The Lancet Oncology*

*Please note: We are including the following study not to focus on individual-level behaviors, but to stress the role of alcohol consumption (and especially binge drinking) in youth obesity. Since obesity is a prime risk factor for chronic disease, this shows yet another way harmful alcohol use contributes to high rates of chronic disease.*

## **ESTIMATING HOW EXTRA CALORIES FROM ALCOHOL CONSUMPTION ARE LIKELY AN OVERLOOKED CONTRIBUTOR TO YOUTH OBESITY**

June 2017

### **Abstract**

**Introduction:** Youth obesity rates in Canada continue to rise. In this study, we produced conservative estimates of the potential excess calories from alcohol use across different alcohol consumption patterns common among Canadian youth to assess whether alcohol use should be considered in future obesity prevention strategies.

**Methods:** Using data from 10144 Grade 12 students participating in the COMPASS study (2013/14), we estimated the number of calories consumed per year from alcohol consumption. Our estimates were based on three different generic types of alcoholic beverages, which were grouped according to average calorie content (vodka coolers; beer [5%]; and beer [4%], wine and liquor) across different frequencies of alcohol use and binge drinking.

**Results:** Results indicated high potential caloric intake for students who binge drank, as well as high variability in the estimates for calories consumed based on common consumption patterns for the different beverage types. For instance, 27.2% of students binge drank once per month, meaning they consumed between 6000 and 13 200 calories in one year (equivalent to 0.78 – 1.71 kg of fat). For the 4.9% of students who binge drank twice per week, the total calories in one year would range from 52 000 to 114 400 (equivalent to 6.74 – 14.83 kg of fat).

**Conclusion:** Current recommendations for preventing youth obesity do not generally include any consideration of alcohol use. The high prevalence of frequent alcohol consumption and binge drinking by youth in this study and the substantial number of calories contained in alcoholic beverages suggest alcohol use among youth may warrant consideration in relation to youth obesity prevention

**Full free text:** <http://www.phac-aspc.gc.ca/publicat/hpcdp-pspmc/37-6/assets/pdf/ar-03-eng.pdf>

**Source:** *Health Promotion and Chronic Disease Prevention in Canada*

## **ACCEPTABILITY OF ALCOHOL SUPPLY TO CHILDREN - ASSOCIATIONS WITH ADULTS' OWN AGE OF INITIATION AND SOCIAL NORMS**

### **Abstract**

**Issue addressed:** The aim of this study was to investigate predictors of adults' perceived acceptability of introducing alcohol to children less than 18 years of age.

**Methods:** An online survey. Logistic regression analyses were used to examine the association between demographic characteristics, alcohol consumption, and social norms and adults' own age of initiation.

**Results:** Alcohol consumption, age of initiation and perception of the acceptability of drunkenness were all correlated with the acceptability of introducing children to alcohol. The strongest predictor was adults' own age of initiation.

**Conclusions:** Adults who began drinking before the age of 18, and those who drink more heavily, are more likely to perceive the provision of alcohol to children as acceptable.

Source: *Health Promotion Journal of Australia*

## **INCREASED MINIMUM LEGAL AGE FOR THE SALE OF ALCOHOL IN THE NETHERLANDS AS OF 2014: THE EFFECT ON ALCOHOL SELLERS' COMPLIANCE AFTER ONE AND TWO YEARS**

November 2017

### **Abstract**

**Background:** As of January 2014, the Dutch minimum legal age for the sale and purchase of all alcoholic beverages has increased from 16 to 18 years of age. The effectiveness of a minimum legal age policy in controlling the availability of alcohol for adolescents depends on the extent to which this minimum legal age is complied with in the field. The main aim of the current study is to investigate, for a country with a West-European drinking culture, whether raising the minimum legal age for the sale of alcohol has influenced compliance rates among Dutch alcohol vendors.

**Methods:** A total of 1770 alcohol purchase attempts by 15-year-old mystery shoppers were conducted in three independent Dutch representative samples of on- and off-premise alcohol outlets in 2013 (T0), 2014 (T1), and 2016 (T2). The effect of the policy change was estimated controlling for gender and age of the vendor.

**Results:** Mean alcohol sellers' compliance rates significantly increased for 15-year-olds from 46.5% before to 55.7% one year and to 73.9% two years after the policy change. Two years after the policy change, alcohol vendors were up to 3 times more likely to comply with the alcohol age limit policy.

**Conclusion:** After the policy change, mean alcohol compliance rates significantly increased when 15-year-olds attempted to purchase alcohol, an effect which seems to increase over time. Nevertheless, a rise in the compliance rate was already present in the years preceding the introduction of the new minimum legal age. This perhaps signifies a process in which a lowering in the general acceptability of juvenile drinking already started before the increased minimum legal age was introduced and alcohol vendors might have been anticipating this formal legal change.

Source: *International Journal of Drug Policy*