

CDC Town Hall Teleconference

Binge Drinking Among Women and High School Girls

January 15, 2013
2:00 pm–3:00 pm EST

Coordinator: Welcome and thank you for standing by. All participants will be on listen-only until the question and answer session. Today's conference is being recorded. If you have any objections you may disconnect at this time.

I'd now like to turn the meeting over to Dr. Rich Schieber, Coordinator for CDC *Vital Signs* Program, Centers for Disease Control and Prevention. Thank you, sir. You may begin.

Rich Schieber: Hi folks. This is Rich Schieber and I'm glad to help moderate this session. Those of you who have been on this before know that Judy Monroe likes to do this and she couldn't make it today and sends her hello.

Before we get started let me go over a few housekeeping details. Please remember to go online and download today's PowerPoint presentation so you can follow along with the presenters and I'll tell you how to do that now.

The web address is www.cdc.gov/stltpublichealth, all one word, stltpublichealth. And when you do that there's a link directly to the town hall website and you're going to find it under highlighted products and resources on the bottom right and on this page you can also see the bios for each of the presenters.

This is where we're going to add the audio recording and transcript available next week from this meeting. I'd also like to recognize a couple of audience members who are joining us today on the call.

And this is the second time they've joined us for these town halls. They are clinical educators and residency program staff who are part of CDC's new Primary Care and Public Health Initiative.

The Primary Care and Public Health Initiative, easily nicknamed PCPHI, aims to improve health by integrating clinical medicine and public health through residency training and more information about that can be found at www.cdc.gov/primarycare, all one word. So now to move on to today.

Today's joint call presents a real opportunity for public health and primary care together. We want you all to take this opportunity in a very, shall I say, aggressive way to interact, to exchange ideas, to learn from each other more about today's topic.

So today's topic focuses on binge drinking among women and high school girls in the United States, which is an under reported issue. This alcohol program was actually founded more than 10 years and it's been very productive.

Those folks bring a public health perspective to the widespread problem of excessive drinking and in fact just one simple statistic is that drinking too much, which includes binge drinking and underage drinking, contributes to 80,000 deaths in this country every year.

Now today we're going to narrow the scope of this topic to focus specifically on women and high school girls and we're going to talk about the health effect steps that CDC is taking and community based efforts that are having a positive impact.

So after I finish in a moment, we will hear from three colleagues who will share the latest statistics and insights concerning this. First we'll hear from Dr. Dafna Kanny. That's pronounced Kanny and spelled C-A, sorry K-A-N-N-Y. Dr. Kanny is the senior scientist for CDC's alcohol program in the National Center for Chronic Disease Prevention and Health Promotion.

And Dr. Kanny will start by providing a summary of today's Vital Science report. She'll then hand the call over to Dr. Karen Peterson who is an attending physician with the Denver Public Health STD and ID/AIDS Clinic.

Dr. Peterson will discuss lessons learned from their STD Choices Project. That's a project that was funded by CDC in 2009 and it's now in its final year. With participating in Maryland and Colorado, this update will provide an interesting comparison of data.

And then I'll hand the call over to Diane Riibe, R-I-I-B-E, who is the former exec direct of Project Extra Mile and we'll learn about that program today. She will summarize how Omaha is working to address alcohol outlet density issues through land use ordinances in her community.

This approach is a community guide evidence based strategy for preventing excessive alcohol consumption. So with those remarks let me please turn it over to Dr. Dafna Kanny. Please go ahead.

Dafna Kanny: Thank you Rich and thank you for inviting me to this town hall teleconference. We'll present to you a summary of the information published last week in the *Vital Signs* on binge drinking among women and girls. Please go to the next slide, slide number five.

Excessive drinking has a huge public health impact. We estimated excessive drinking is responsible for about 23,000 deaths in the U.S. each year among women and girls resulting in about 633,000 years of potential life loss (YPLL).

Binge drinking defined as four more drinks per patient for women accounted for over half of these deaths in YPLL. Excessive drinking is also very expensive. We estimated that it cost the U.S. about \$224 billion in 2006 or about \$1.19 per drink.

Over 40% of that cost or about 80 cents per drink was paid by government. So we are all subsidizing the cost of excessive drinking. Next slide.

Binge drinking is a risk factor for many health and social problems. These include injuries, violence, chronic diseases, cancer, sexually transmitted diseases, unintended pregnancy, and fetal alcohol spectrum disorders. Next slide.

For this study we used data on self-reports of binge drinking within the past 30 days or about 278,000 adult women, aged 18 years and older, from the 2011 Behavioral Risk Factor Surveillance System. We also used about 7500 high school girls' responses from the 2011 National Youth Risk Behavior Survey. Next slide.

Despite many health and social problems due to binge drinking, more than 40 million or one in eight U.S. adult women binge drink about three times a month and consume on average six drinks per binge. Almost 40% percent of high school girls drink alcohol and one in five binge drink. Next slide.

Binge drinking affects everyone across the lifespan but is most common among young women ages 18 to 24 and women ages 25 to 34 and among high school girls. Next slide. Binge drinking is most common among women with household incomes about \$75,000 a year. Next slide.

Binge drinking is also most common among Hispanic and non-Hispanic white high school girls. Among women, binge drinking is most common among non-Hispanic white and Hispanic. Black girls and women have the lowest prevalence of binge drinking. Next slide.

What can be done? Communities can reduce the binge drinking frequency intensity and ultimately the prevalence of binge drinking as well the health and social cost related to it by implementing evidence-based strategies such as those recommended by the community guide.

In general these interventions deal with increasing the price and limiting the availability of alcoholic beverages. The same effective strategies for reducing binge drinking in the general population can work for women and girls too.

Detailed information of these strategies can be found at the community guide website. Next I will highlight the findings for the first two interventions. Next slide.

Overall a 10% increase in the price of alcoholic beverages would be expected to reduce alcohol consumption by about 7%. Tax increases result in the price increases and subsequent reductions in excessive drinking are proportional to the size of the tax increase. Next slide.

Alcohol outlet density refers to the concentration of alcohol retailers in a particular geographic area. A higher concentration of retail alcohol outlets is associated with increased alcohol consumption and related harms.

It is also worth noting that most of the studies reviewed assessed the impact of relaxing controls on alcohol outlet density reflecting the general trend toward the deregulation of alcohol sales. Next slide.

So what's CDC's doing? We are developing action guides to assist state and local public health agencies and coalitions in implementing community guide recommended strategies.

The first action guide on regulating alcohol outlet density has been released. We're also funding state capacity building in alcohol epidemiology and providing technical assistance to states and communities. Next slide.

So in summary, binge drinking is a common problem among women and girls. Implementation of effective prevention strategies can reduce binge drinking in communities and monitoring the frequency and intensity of binge drinking, in addition to the prevalence, are key to evaluate the impact of evidence-based strategies to prevent binge drinking. Next slide.

At this point I would like to turn it over to Dr. Karen Peterson. Thank you.

Karen Peterson: Hi, I'm Karen Peterson. I'm at Denver Public Health and if you'll go to slide 18 you can see the title STD Choices is already noted as a demonstration project which is aimed at preventing alcohol exposed pregnancy in women attending urban STD clinics.

We're one participating site through a grant to Colorado State Department of Public Health and Environment and then Baltimore with Dr. Heidi Hutton as the lead is the second site.

We are sites that both have busy urban STD clinics and we have about 16% of the reproductive age women coming through who are at risk of alcohol exposed pregnancy because they are doing high-risk drinking and lack of effective contraception despite having sex with men.

High-risk drinking means either bingeing four or more drinks on one occasion for women and/or heavy drinking. So that would be eight or more drinks in a week. What we've found in our own data is that almost all of our heavy drinkers are binge drinkers also, 98% of them. So fundamentally it is a binge drinking problem I would say. Next slide, slide 20.

The Denver Metro Health Clinic, which is our STD clinic, is the only dedicated urban STD clinic in the Denver-Aurora metropolitan statistical area which has over 2.5 million residents in it. It is housed at Denver Public Health which is a department of Denver Health which is Denver's big safety net public hospital and community health center system.

We do see about 3000 unique women yearly for new problem visits. About 75% are 18 to 44 years old and are sexually active with a male. One of the things to note about this project is that we were limited to adults, i.e. 18 and older.

So we don't know for sure how efficacious this would be in high school girls who are a little bit younger than that and I think clearly that's an area that needs a little more attention.

About half the women in that reproductive age are not using effective contraception, meaning either no contraception at all or ineffective use of a method. We actually have very good data on that for our clinic because family planning is integrated into our routine STD clinic visits as it is a Title X clinic site.

We've always viewed that pregnancy, if it is unwanted and unintended, is actually a sexually transmitted disease. So it fits very well in this setting. And what we have found in our own setting is about 35% of women binge drink or heavy drink. So again, this gives us this fairly population at risk for alcohol exposed pregnancy. Next slide 21.

We have had some previous experience with expert screening brief intervention referral to treatment. There was a Denver Health Expert Demonstration grant which was cited in the emergency departments, the adult urgent care, and then in our STD clinic.

And we were able to see that immediate brief intervention actually had a lot of value at first. We had many people who screened positive but secondly, as they collected their data, it turned out that many people actually made positive changes in their lives from this brief intervention.

Our expert is screening for alcohol, as well as other substance use, and offers a very brief intervention within about a 10 minute range for those using at risk levels and then referral to treatment for those needing more. So we were predisposed to think that we were a site that could benefit and that a short type of an intervention could actually be very useful.

Choices is a little bit longer than this truly brief intervention and it comes out of an evidence-based, it was originally a randomized trial as Project Choices,

which you can find if you simply search on the web if you're interested in the original paper.

But what we are doing with this is two, twenty to thirty minute sessions using motivational interviewing tools such as a decisional balance, importance readiness, confidence rulers to help women set goals to reduce drinking and/or use effective contraception to prevent an alcohol exposed pregnancy.

So they get some information about the fact that they would be at risk with their current behaviors and then really are offered a choice about how they might want to address that. Next slide, number 22.

So with outcomes, I wanted to show you both Baltimore and Denver's data. Both because we have some similarities and to show you a little bit of some of the differences. We're certainly substantially different sites in terms of our demographics.

Baltimore is very heavily African-American, very inner-city, very high poverty level. Denver, even at our poorest, is nothing like Baltimore and our biggest population would actually be white non-Hispanic, but then secondly Hispanic women. Our population is slightly younger than the Baltimore population although there is considerable overlap.

We both have seen if you look at the graph on the left, the session delivery and follow-up. Both seem and been able to screen a large number of women coming through the clinics. Baltimore's had to do this by hand as it were because they don't have an integrated record they could work with.

We were able to get questions into our electronic medical records for the clinic which allowed us to have the clinicians asking every woman who came

through. And you can see that we were fairly similar, although there's a huge drop off from first screening, finding somebody who might be positive, finding people even who are interested and then actually getting them in, in sessions.

And you can see that we drop off between session 1 and session 2. We feel this speaks to the importance of really grabbing women while they're in the clinic and doing as much as possible at that time because we know they may not return for a follow-up session, certainly even for a birth control visit.

When you look at the graph on the right side of slide number 22, the types of birth control method used, you can see that it actually was distributed mainly hormonal or an IUD method. We were able to do the long-acting methods of the Mirena, the copper IUD, and the Implanon IUD.

Sexual abstinence I think is one of the interesting things. Baltimore had more women that were likely to choose sexual abstinence. Now it's a somewhat iffy birth method in the sense that you're just a next drink away from not being abstinent anymore, but as long as women really are sticking with it, of course, it's extremely effective contraception.

And in Baltimore I think there was much more conscious choice on the slightly older women's part to say I can make this as a positive choice in my life but even some of the younger women in Denver, really I believe, were making a conscious choice about this.

And then finally 100% condom use, once again, not the best contraceptive form because there is a relatively high failure rate with that. Nonetheless, better than they had been doing, and once again Baltimore with the much

higher HIV risk for heterosexual women than Denver has, we see that there is more condom use.

Now obviously you'd like even more for the HIV risk but I think it speaks to some of the demographic differences, again, between our populations. Interestingly, we didn't necessarily do better with getting women choosing contraception than Baltimore did even though Denver has the Integrated Family Planning Clinic and Baltimore does not.

So I think that speaks also to the fact that you can have quite different populations and quite different clinic settings and yet have a good deal of success in what you see. Next slide, slide 23.

This actually shows our outcomes and you can see that for Baltimore, at three and six month follow-up, the first two clusters and Denver, then three and six month the last two clusters. Women were more likely to choose some birth control change rather than simply lowering alcohol but a number actually did lower their drinking and use birth control as well.

And so you can see the total reduced risk for AEP which is the last column in each of those clusters ran around the 80% mark for Baltimore and was sustained at the six-month mark. Denver's numbers aren't quite as good. We do feel that one of the things that happened here is we had what's called intervention drift.

Our interventionist was probably not delivering the intervention really quite to script as much as the Baltimore interventionist was. Now we're still very happy. I mean this is a huge reduced risk for women who were coming in at risk and that's important to keep in context but again it's a real-world effect that circumstances will vary clinic to clinic.

But I particularly want to highlight that even at a very difficult population such as Baltimore's, it's possible to have tremendous success with this particular approach. Next slide.

So in conclusion, as far as our lessons learned. Certainly we're attracting populations of women at risk for alcohol exposed pregnancy. You can implement this particular intervention in diverse settings, e.g. Baltimore versus Denver.

As I just alluded to though, intervention drift can reduce effectiveness, so it's going to be important to really keep some tabs on the program, make sure it keeps being delivered well. I already said capture women on that first visit; provide the key elements at the first session as follow-up does diminish rapidly.

And then finally as we were thinking about sustainability now in our last year, we're thinking about ways that we can add this intervention skill to the repertoire of our current staff because any clinic of course has limited resources. We aren't going to be able to sustain an independent interventionist in the long-term.

Baltimore and Denver are both approaching this in slightly different ways. Baltimore actually has a lot of social workers in the health department and they're all getting trained in the intervention. So women will be captured not only in the STD clinic but in various other settings. They come in and interact with social workers.

For us at our building, it'll still be in our STD clinic, but we're actually capturing staff from different programs in the building in order to have an on-

call staff that can supplement the clinic itself and we've had tremendous cooperation from the administration for this. So that concludes my portion, and I'd like to hand it back to our moderator.

Rich Schieber: Thank you, very good. We'll now go to Diane Riibe, the former executive director of Project Extra Mile. Diane are you there?

Diane Riibe: Great. I am, thank you. If we can go ahead and start on slide 26 that would be helpful. I did 17 years as the executive director for Project Extra Mile in December, so I have been intimately involved in this work I'm about to describe to you.

We're a statewide community-based effort, both coalition building and community organizing, as you've heard, to prevent underage drinking and youth access to alcohol. We don't really talk about the partnering of the community and the community-based organization really brings the science to the practice. Next slide please.

I wanted to make sure that there was an understanding just in terms of who we are, that we're very comprehensive in our efforts and we really do look to the science, the evidence-based efforts that we know that's out there. It brings us and draws us to a comprehensive approach using those environmental strategies. Next slide please.

We knew from our earliest days back in mid-nineties that not only was underage drinking and youth access to alcohol a public health issue, but we've fully connected the community's adult drinking behavior to the problems that we were seeing with alcohol and the youth population which is somewhat, as we connect earlier, the women and young girls drinking and binge drinking.

We see the similar responses required and needed in a community as have been outlined in the community guide. And we understood that the problem really required a larger, multiple response from the community, in the community and the state. Slide 29 please.

So just to go quickly and briefly over one of our first areas of response was in the policy area. We looked at policies that were in place in our community and in the state and again use the science, looked at the CDC's community guide that nicely brought together that science into one easy-to-use document.

We've worked on such policies and policy initiatives as dram shop, compliance checks, alcohol densities you'll hear and (reporting) the H21 laws and we've monitored that legislation in local communities in an effort to kind of avoid the erosion of those policies as much as possible. Slide 30 please.

Under the enforcement area we have long partnered and seen law enforcement as one of our strongest partners in this work and we've provided administrative assistance to those enforcement operations such as those that you see here.

We also provide an annual training for our law enforcement partners across the state focusing specifically on underage drinking and especially youth access to alcohol. Slide 31 please.

When we look at the media we see the media really as a critical partner in our communication plan to strategically advance our public health goals. They really need to tell the story in a broader sense to kind of continue that larger community discourse. Slide 32 please.

Education awareness is a component that always anyone doing public health on critical public health issues really have to deal with and so we provide and disseminated materials all over the place and at our highest probably 30,000 pieces in a year, which is pretty substantial for as small as we are. Slide 33.

We engage young people, and we see them having that unique voice on these issues. We've felt for a long time that it was our job to train them not only in the content and the process but also the rules of engagement for the issues, especially as it relates to their role and the responsibilities as informed citizens. Very much the same expectation that we have for adults and including the residents as you'll see coming up. Slide 34 please.

When we look at the issue of alcohol outlets in the neighborhoods, our community, Omaha, which in the city of Omaha is somewhere around 600,000, to 700,000 people, we were experiencing increasing issues that really generated a heightened level of discussion both with the residents or the neighbors as we call them and the policy makers.

The neighbors were concerned about liquor license outlets that were challenging their neighborhood. Oftentimes with fairly basic nuisance issues that one would think of pretty readily, loitering, panhandling, noise and at times those issues intensified as you can see. We were also looking at some of the state alcohol control policies that were eroding.

They were significant including the extension of hours of sale of alcohol. We saw a reduction in taxes paid on alcopops and also a reduction in the number of alcohol compliance checks that were happening across the state, not just in our own community.

At the same time we saw Nebraska being ranked by the CDC back in 2010 as Number 2 in the country for binge drinking rate per adult population, and four of our communities in the state were ranked in the top fifteen in the cities in the nation for binge drinking.

And in the meantime, we had the number of liquor licenses that were being granted in the state were growing at a rate that was twice the increase in the state's population over the last couple of decades.

So our neighbors were in Omaha were increasingly frustrated and knew that they had to organize to address alcohol by density and some of the issues that surround the sale of alcohol.

Thirty-five please, next slide. And that was at that point that they created the LOCAL campaign which stands for Let Omaha Control its Alcohol Landscape. Next slide please. And again a reminder that we use science as that solid foundation to the work to begin kind of undertaking that work within our community. Slide 37 please.

I wanted to make sure that at Project Extra Mile, we understood our role, which is really kind of the theme of all of the work that we're doing here is a lot of people within various segments of the community had a role to play, and we had to understand what ours was.

And ours was really linking and understanding the link between the limiting physical access, understanding that it reduces youth consumption, knowing that once we put reasonable controls in alcohol outlets we see positive public health outcomes.

There's some solid science on that, and we understood that our job was to provide that technical assistance to those neighbors and these were folks who are already working on the issues so it was very, if we can say, organic and came and bubbled up from the community.

And our job was really to connect those neighbors and the work that they were doing and sensed in their own neighborhood to not just our expertise but the national experts and the research, which also had brought a legal memo in terms of the research and the solid expertise.

We were able to bring and really answer the pre-emption question for Nebraska, to allow those local citizens to understand they could do this work at a local level. Slide 38 please. You can see there was an issue brief that was developed and designed, which was very helpful in communicating that information to others outside of kind of the immediate group.

Next slide please. There was a website that was developed, a Facebook page and a Twitter presence, so we used and the neighbors really used the social media perspective. That was really important for them.

Next slide. We provided some mapping and this was pretty basic because I won't say this is our expertise, but we did our best to bring not only what we knew but what we could garner from others within the community and the outside, some of the mapping skills that we had and had available.

Slide 41 please. The media was critical again as we talked about earlier, it was important to engage the media kind of alongside of the residents to heighten that community discussion. So the media became always the communication tool that was critical whether it be the social media piece of it or the traditional media.

Slide 42. Back in October just of this last year, 2012, we saw success, and that's actually a picture there of the neighbors meeting in a standard meeting location for them. It was a picnic table in a garden area, and they were just doing the work of their neighborhoods. A long, long time coming.

It took a solid three years and probably to be really honest about it, it was probably upwards of six years from the time the original conversation started with a core group that really expanded and grew.

We know that what we got in that ordinance, that Land Use Ordinance includes nuisance abatement standards for those alcohol outlets and it provides for a loss of their certificate of occupancy if they are non-compliant.

So as complaints may come in and issues develop, then they're documented that those might be addressed in a way that if a business was non-compliant they ultimately could lose their certificate of occupancy which allows for a modicum of local opportunity to be engaged. And again it was a very multi-year effort.

Next slide please. When we look at the role of the Public Health Department, and I warned our Health Director, Dr. Pour, that she was going to be on my slide, so I can't say enough positive. We have a really longstanding, solid relationship with our local county health department.

They're top notch professionals. They brought a really, it was highly relevant that they brought their unbiased, science-based voice to the community discussion. So whether it was out in the places that they were in terms of their meetings and their gatherings and their audience, but also to the two opportunities of public hearing that we had, they provided testimony.

And that was just critically important because they were exactly as they are, unbiased and science-based and so it helped to provide that additional level of credibility to the neighbors which had very valid, very measurable issues that they were dealing with.

In addition as we look forward, not just our health department here, but anyone in terms of health departments and how you partner with them, some of the critical pieces that are there and would be helpful would be that data collection and some of the mapping capabilities as well as a need for just increased surveillance.

I think partnering community efforts such as this here in Omaha with the local health department is, we have seen for a long time, really one of the only solid connections that has to just continue and increase because that's where we see some real positive change happening. Next slide please.

In terms of next steps, because I have to say if we were going to do lessons learned, we could be here a very, very long time. But for next steps we know that the missing element that really didn't make it into the ultimate end of the ordinance that was passed, we need to see a cost recovery or an impact seize so that we can be certain that the enforcement component happens in a way that's consistent.

As all of us know in our communities resources are very, very sparse and so it's extremely important that there be some mechanism in place so that in a very modest way begins to address that. And finally in order to really complete that success we have to look at implementation and enforcement.

It's one thing to have passed it, which was, you know, a yeoman's effort and it's really solid success on the part of some really incredibly decent people working very, very hard over a long period of time, but if we aren't able to kind of follow through and see the implementation and enforcement, that would be a great loss.

So I know that the neighbors are currently working on those issues and have not really lost that focus, which is an extremely positive thing. So again I'll just reiterate that we saw a real need to make sure that we partnered and understood our role and then also to bring others within the community into that.

And so they saw their role particularly from a public health perspective because as we said from the beginning we saw this and continue to see this as a critical public health need and are encouraged by the information the CDC is putting out currently, so thank you. I think that completes my remarks.

Rich Schieber: Well, thank you, all three of you for excellent presentations. We heard about the STD Choices Program in Denver and the Project Extra Mile Program in Omaha and some new information about the incidence prevalence and severity from CDC from Dr. Kanny.

I'd like to then go to the next part of this, which is to invite people to take advantage of this opportunity by asking questions and offering any programs that they've had success with. So what you do is you press star and you'll need to record your name. It'll be prompted. And then you'll be announced into the conference by a queue through the operator.

So, just so I get a moment to ask questions I was going to ask what that shoulder tap line was all about that we heard it in the middle presentation from Denver.

Karen Peterson: I think the shoulder tap was actually from Omaha.

Rich Schieber: Oh, I'm sorry.

Diane Riibe: It was, and actually that's the difficulty of going so quickly. It's an enforcement strategy which looks at a social availability where you have older adults say in a parking lot of a convenience store and a young person would tap on a stranger's shoulder to say, "Hey mister? Would you go in and buy me some alcohol?" So it's either called shoulder tapping or hey mister.

Rich Schieber: Well, thank you. Operator, I can now turn it over to you to start the other questions.