Survey of State Underage Drinking Prevention Policies and Practices

Supporting Statement:

A. Justification

1. Circumstances of Information Collection

The Substance Abuse and Mental Health Services Administration (SAMHSA) is requesting a revision from the Office of Management and Budget (OMB) for the Survey of State Underage Drinking Prevention Policies and Practices (the "State Survey"). This data collection is under OMB No. 0930-0316, which expires on February 29, 2016.

Congress has recognized that a "coordinated approach to prevention, intervention, treatment, enforcement, and research is key to making progress" in addressing the problem of underage drinking in the United States. The *Sober Truth on Preventing Underage Drinking Act* (the "STOP Act")[1] (42 USCA 290bb-25b) was passed in 2006 and requires the "Secretary [of Health and Human Services…to] annually issue a report on each State's performance in enacting, enforcing, and creating laws, regulations, and programs to prevent or reduce underage drinking" (the "State Report"). SAMHSA has been designated as the lead agency to fulfill this Congressional mandate in concert with the Intergovernmental Coordinating Committee on the Prevention of Underage Drinking (ICCPUD)[2] (Attachment 1). The STOP Act mandates consultation with ICCPUD, which includes representatives from federal agencies with underage drinking prevention programs or activities. Data gathered with the State Survey are used to develop the state-by-state report on prevention and enforcement activities related to underage drinking in the *Annual Report to Congress on the Prevention and Reduction of Underage Drinking* ("*Report to Congress*").

Underage drinking and associated problems have profound negative consequences for underage drinkers, their families, their communities, and society as a whole. Underage drinking contributes to a wide range of costly health and social problems, including motor vehicle crashes (the greatest single mortality risk for underage drinkers); suicide; interpersonal violence (e.g., homicides, assaults, rapes); unintentional injuries such as burns, falls, and drowning; brain impairment; alcohol dependence; risky sexual activity; academic problems; and alcohol poisoning.

Alcohol continues to be the most widely used substance of abuse among America's youth, and a higher proportion use alcohol than use tobacco or other drugs. For example, according to the 2013 Monitoring the Future (MTF) study, 25.7 percent of 10th graders reported using alcohol in the past 30 days, 18.0 percent reported marijuana use, and 9.1 percent reported cigarette use in the same period.[3] Although youth generally consume alcohol less frequently than adults and

[1] Public Law 109-422.

[2] Members of ICCPUD can be found in Appendix D of the *Report to Congress*.

[3] Johnston, L.D., O'Malley, P.M., Bachman, J.G., Schulenberg, J.E., & Miech, R.A. (2014). Monitoring the Future national survey results on drug use, 1975–2013. Volume I: Secondary school students. Ann Arbor: Institute for Social Research, University of Michigan. Retrieved from http://www.monitoringthefuture.org/pubs/monographs/mtf-vol1_2013.pdf

consume less alcohol overall than adults, when they do drink they are much more likely to binge drink. For example, 92 percent of the alcohol consumed by 12- to 14-year-olds is via binge drinking.[4] In 2013, approximately 5.4 million youths 12 to 20 years old (14.2 percent) reported binge drinking in the past month[5] Data support a reduction of underage drinking, particularly among the 12- to 17-year-old age group, but new and concerning trends are emerging, such as the erosion of the traditional gender gap in binge drinking rates, and the increasing preference for distilled spirits among underage drinkers. Furthermore, the rates of binge drinking and alcohol abuse or dependence increase rapidly with age, raising concerns that 18 to 20 year olds are at greater risk.[6]

Efforts focused on underage drinking reduction should have long-term positive effects on problem drinking in adulthood. Early-onset alcohol use (≤ 14 years of age) is associated with alcohol problems later in life. More than 40 percent of persons who initiated drinking before age 13 were diagnosed with alcohol dependence at some time in their lives[7]. By contrast, rates of alcohol dependence among those who started drinking at age 17 or 18 were 24.5 percent and 16.6 percent, respectively[8].

In response to the health risks associated with underage drinking, states are increasingly adopting comprehensive policies and practices to alter the individual and environmental factors that contribute to underage drinking and its consequences; these can be expected to reduce alcohol-related death and disability and associated health care costs. These efforts can potentially reduce underage drinking and its consequences and change norms that support underage drinking in American communities. Currently, there are no state or federally sponsored databanks that have gathered information on state-level underage drinking policies and practices in a uniform and meaningful way.

To monitor progress toward more effective responses to underage drinking, the STOP Act directs the U.S. Department of Health and Human Services (HHS) to develop the state-by-state report on prevention and enforcement activities related to underage drinking component of the *Report to Congress*, which will assess "best practices". The STOP Act lists nine separate categories under "best practices". These have been collapsed into four categories for data collection purposes. Several of the items listed are publicly available and will be collected independently so as to reduce the burden on the states. Other items have been bundled together based on their relevance and relationship to each other. For example, the STOP Act includes enforcement

[4] Pacific Institute for Research and Evaluation. (2002). Drinking in America: Myths, realities, and prevention policy. Washington, DC: U.S. Department of Justice, Office of Juvenile Justice and Delinquency Prevention.
[5] Substance Abuse and Mental Health Services Administration. (2014). Results from the 2013 National Survey on Drug Use and Health: Summary of National Findings, NSDUH Series H-48, HHS Publication No. (SMA) 14-4863. Rockville, MD: Substance Abuse and Mental Health Services Administration.
[6] Substance Abuse and Mental Health Services Administration. (2014). Results from the 2013 National Survey on Drug Use and Health: Detailed Tables. Substance Abuse and Mental Health Services Administration. Retrieved from http://www.samhsa.gov/data/sites/default/files/NSDUH-DetTabs2013/NSDUH-DetTabs2013.htm; Substance Abuse and Mental Health Services Administration. (2014). Results from the 2013 National Survey on Drug Use and Health: Special Data Analysis. Center for Behavioral Health and Statistics and Quality. Rockville, MD: Substance Abuse and Mental Health Services Administration.
[7] Grant, B. & Dawson, D. (1997). Age at onset of alcohol use and its association with DSM-IV drug abuse and dependence: Results from the National Longitudinal Alcohol Epidemiologic Survey. *Journal of Substance Abuse, 9,* 103-110
[8] Ibid.

activities in several of its categories. For data collection purposes, these have been bundled into a single category. This bundling streamlines data collection and avoids duplication. The collapsed categories are:

Category #1: Sixteen[9] specific underage drinking laws/regulations enacted at the state level (e.g., laws prohibiting sales to minors; laws related to minors in possession of alcohol);
Category #2: Enforcement and educational programs to promote compliance with these laws/regulations;
Category #3: Programs targeted to youths, parents, and caregivers to deter underage drinking and the number of individuals served by these programs;
Category #4: The amount that each state invests, per youth capita, on the prevention of underage drinking broken into five categories: a) Compliance check programs in retail outlets; b) Checkpoints and saturation patrols that include the goal of reducing and deterring underage drinking; c) Community-based , school-based, and higher-education-based programs to prevent underage drinking; d) Underage drinking prevention programs that target youth within the juvenile justice and child welfare systems; and e) Any other state efforts or programs that target underage drinking.

SAMHSA will use existing sources of data to the extent that they are available to complete each of the above categories. Data will be obtained for category 1 on state underage drinking laws and regulations from the National Institute of Alcohol Abuse and Alcoholism's (NIAAA's) Alcohol Policy Information System (APIS), an authoritative compendium of state alcohol-related laws. APIS data will be augmented with original legal research.

Data from categories 2, 3, and 4 do not currently exist in a complete or accessible form from secondary sources. Some states may be collecting some of the data, but not in a uniform fashion that allows meaningful cross-state comparisons.

Data from categories 2, 3, and 4 will be collected by the State Survey, a survey tool administered electronically via an online platform, with approximately 90 questions that each State and the District of Columbia will complete. (Attachment 2). There are four sections of questions: enforcement activities; underage drinking programs targeting youth, parents, and caregivers; state interagency collaboration, best-practice standards, collaborations with tribal governments, and state financial expenditures on underage drinking. As the survey is specifically designed to only ask for data that has already been collected, many states complete fewer than 90 questions. The State Survey is further described in Section 2.

2. Purpose and Use of Information

The purpose of the data collection through the State Survey is to create a compendium of the states' best practices and performances in enacting, enforcing, and creating laws, regulations, and programs to prevent or reduce underage drinking. Congress mandated the collection of these data to provide policymakers and the public with currently unavailable but much-needed information regarding state underage drinking prevention policies and programs. SAMHSA and

[9] The *Report to Congress* now contains nine additional policies, added pursuant to Congressional appropriations language or the Secretary's authority under the STOP Act.

other federal agencies that have underage drinking prevention as part of their mandate use the results of the State Survey to inform federal programmatic priorities and to track progress in the national effort to reduce underage drinking. The information gathered by the State Survey is a resource for state agencies and the general public that describes enforcement activities and funding priorities, assesses policies and programs in their own state, and familiarizes them with practices in other states. The survey results may also be used as a first step in research to develop states' best practices guidelines for future *Reports to Congress*.

States are asked to complete an annual Survey that comprises the following four sections:

1. Enforcement of underage drinking laws including, but not limited to:
    a. The number of compliance checks (random and non-random) measured against the total number of alcohol retail outlets in each State; and
    b. The result of these checks;
    c. Implementation of Shoulder Tap and Party Patrol operations;
    d. The number of sanctions (fines, suspensions, revocations) imposed on retailers for violations of underage drinking laws.
2. Underage drinking prevention programs targeted to youth, parents, and caregivers, including data on the approximate number of persons served by these programs.
3. State best practices standards and collaborations with tribal governments and state interagency collaborations used to implement the above programs.
4. Estimates of the state funds, per youth capita, invested in the following categories, along with descriptions of any dedicated fees, taxes, or fines used to raise funds:
    a. Compliance checks and provisions for technology to aid in detecting false IDs for retail outlets;
    b. Checkpoints and saturation patrols;
    c. Community-based, school-based, and higher education-based programs;
    d. Programs that target youth within the juvenile justice and child welfare systems; and
    e. Other state efforts as deemed appropriate.

This latest version of the survey has been revised slightly. There are no new questions, nor were any deleted. All revisions are for the purpose of clarifying the existing questions. The total number of questions remains the same, so no additional time burden should be placed on the respondents. All questions continue to ask only for readily available data.

<u>Changes</u>

The changes can be summarized as follows:

Some global changes have been made; for example, the current HHS and SAMHSA style guides are applied so that "state" and "federal" are not capitalized. In addition, some instruction sentences are put in bold font, in response to frequent questions from respondents for clarification of these questions. These include questions about the time period for which they are asked to report specific data, or the type of prevention programs that should be included in responses.

In addition, the following specific changes are recommended as clarifications or improvements of existing questions:

Part 1, Enforcement:

A question requesting the total number of licensees in the state has been moved up to become the second question. It was previously located in the set of questions about state compliance checks, but was skipped if the respondent answered that the state does do not do compliance checks. The number of licensees is a general piece of information that could be very useful in analyzing survey response data, and therefore should be collected from all states, regardless of whether they conduct compliance checks.

The wording of the question asking for the number of random compliance checks conducted by the state has been changed, and a definition of random checks is included. The current wording is confusing, and has often elicited an answer that reflects all licenses in the state, rather than the actual number of random checks. Respondents have also requested clarification of the definition of random checks.

Part 2A, Programs:

Two changes have been made to shorten the length of program descriptions, in which states describe their underage drinking prevention programs. The program descriptions are the lengthiest portion of the survey response and are significant contributors to the length of the *Report to Congress*. In addition, the length of the responses may pose a burden on state respondents. The two changes are:

a) The instructions in the section have been modified to state: "Please briefly describe the program, including primary purpose, population served, and methods used."
b) The number of programs reported on has been reduced from 15 to 10. In the 2014 survey, 43 states (84%) reported 10 or fewer programs. The burden on respondents from those eight states that report more than 10 programs could be reduced by limiting the responses to 10 programs.

Part 2D, Expenditures:

In response to the question about expenditures on school-based prevention programs, some respondents have reported all expenditures for K-12, which resulted in artificially inflated data. The following statement has been added to the instructions: "If it is not possible to distinguish funds expended specifically for the prevention of underage drinking from a general fund targeted to an activity or program listed below, please check 'These data are not available in my state.'"

3. Use of Information Technology

As required by the STOP act, the unit of analysis for the State Survey is the state. Accordingly, there will be 51 total respondents (50 states and the District of Columbia). However, data to complete the survey will likely reside in a variety of state agencies, and multiple staff may thus be called on to provide specific data elements.

To ensure that the State Survey obtains the necessary data while minimizing the burden on the states, SAMHSA has conducted a lengthy and comprehensive planning process. It has sought advice from key stakeholders (as mandated by the STOP Act) by hosting an all-day stakeholders meeting, conducting two field tests with state officials likely to be responsible for completing the State Survey, and investigating and testing various State Survey formats, online delivery systems, and data collection methodologies.

Based on these investigations, SAMHSA collects the required data electronically, using an online survey data collection platform (SurveyMonkey). Links to the four sections of the survey are distributed to states via email. The use of the electronic format offers a key advantage since in most states, agencies providing data are unlikely to be co-located. In some states, agency offices may be geographically dispersed. The electronic format allows agencies to distribute copies of relevant sections to the appropriate offices for completion. During the last four years of administering the survey, SAMHSA has received feedback from states that this format will facilitate efficiency and coordination and reduce burden.

4. Efforts to Identify Duplication

The STOP Act requires a 51-state assessment of the four categories of information discussed in Sections A.1 and A.2. SAMHSA is relying on existing data sources where they exist. SAMHSA will use data on state underage drinking policies (Category #1 of the four categories included in the STOP Act) from APIS, an authoritative compendium of State alcohol-related laws. APIS data will be augmented by SAMHSA with original legal research on state laws and policies addressing underage drinking to include all of the STOP Act's requested laws and regulations.

Data on programs (Category 3) and financial investments (Category 4) are available piecemeal, covering some topics for some states. Few of these data have been systematically collected, and they do not provide the longitudinal data required by the STOP Act. Many states compile some of the data elements to be requested. In these cases, states can transcribe the data directly into the survey instrument.

NIAAA comprehensively analyzed alcohol policy enforcement databases (Category 2).[10] They conclude:

1. Data tend to be aggregated, making it difficult to differentiate between measures of enforcement that pertain to different alcohol policies and/or to different target populations, including those defined by factors such as age, which may be relevant to understanding the impact of enforcement on underage drinking.
2. Data collection may be limited to one or two years.
3. Sources used are not always consistent across years, raising issues of year-to-year comparability in longitudinal studies.
4. There are large gaps in the availability of data on significant measures. The available data are focused primarily on the actions of individual consumers (or violators of the law), whereas data on enforcement and compliance by alcohol merchants or retailers, institutions, or other corporate entities are much less available.

[10] http://alcoholpolicy.niaaa.nih.gov/uploads/Enforcement_and_Compliance_Data_Sources_12_18_07.pdf

5. Data on enforcement resources (e.g., budgets, staffing levels, numbers of compliance checks conducted, etc.) are not readily available.
6. Databases often do not contain data from all 50 States and the District of Columbia, or data coverage varies from year to year.

In short, no databases were identified that approach meeting the requirements of the STOP Act.

5. Involvement of Small Entities

This data collection will have no impact on small entities.

6. Consequences if Information Collected Less Frequently

Each respondent must respond once annually. This is in accordance with the STOP Act, which mandates the production of an annual Report.

7. Consistency With the Guidelines in 5 CFR 1320.5(d)(2)

This information collection fully complies with 5 CFR 1320.5(d)(2).

8. Consultation Outside the Agency

a. Federal Register Notice

The notice required in 5 CFR 1320.8(d) was published in the *Federal Register* on June 16, 2015 (Vol. 80, page 34449). SAMHSA did not receive any comments.

b. Consultations Outside of the Agency

SAMHSA consulted with several stakeholders in the revision of the State Survey. Stakeholders included ICCPUD committee members and the state representatives who would be likely to complete the actual Survey. Based on these consultations, SAMHSA ensured that the data to be collected did not exist in another form, the survey instrument was clearly written, and the survey was easy to complete.

Consultants

Michael Klitzner, Ph.D.
Senior Social Scientist
The CDM Group, Inc.

Rebecca Ramirez
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National Liquor Law Enforcement Association

9. Payment to Respondents

No cash payments will be made to states for completing the surveys.

10. Assurance of Confidentiality

As required by the STOP Act, all data will be reported by state. The questionnaire requests the names of contact persons in five places with the following instructions:

> Please provide the name and phone number or email of someone SAMHSA can contact for additional clarification of the [type of data; e.g. enforcement, state expenditure, etc.] data reported in this section, if needed.
> This person will NOT BE IDENTIFIED in any reports that result from this survey.

The sole purpose of requesting these names is to facilitate the process of seeking clarification when submitted data are ambiguous; no names will appear in the Report to Congress.

Survey data will be stored in password-protected, encrypted files. Access to these files will be limited to the data analyst and supervisor. Upon completion of data collection and clarification with contact persons of any ambiguities, the contact persons' names will be purged from the data files.

11. Questions of a Sensitive Nature

No questions of a sensitive nature will be included in the survey.

12. Estimates of Annualized Hour Burden

Table 1 indicates that the estimated total annual burden on each state for data collection will be 17.7 hours. This estimate includes time for reviewing instructions, searching existing data sources, gathering the necessary data, completing and reviewing the collection of information, and entering the data into the form. The wage rate was obtained by taking an average of the wages of the types of employees who were responsible for filling out the survey in the pilot states.

The burden estimate in Table 1 is based on a lengthy and comprehensive planning process and pretesting conducted by SAMHSA. To design the State Survey, advice from key stakeholders (as mandated by the STOP Act) was sought by hosting an all-day stakeholders meeting, conducting two pilot tests with state officials likely to be responsible for completing the State Survey, and investigating and testing various survey formats, online delivery systems, and data collection methodologies[11]. The second pilot test was conducted with five states of various size and demographics using the drafted State Survey. This draft had gone through an iterative process of review and revision with input by stakeholders and key informants, and was expected to look as close to the final draft as possible. The state agencies responsible for filling out each

[11] For a complete outline of the procedures used to develop the State Survey, see section B.4.

section of the Survey were asked to report the amount of time it took to complete the Survey. These times were averaged and a burden of 17.7 hours per response was calculated.

Table 1: Estimated Burden for Respondents

Instrument	No. of respondents	Responses/ respondent	Total responses	Hrs. per response	Total hour burden	Wage rate	Total hour cost
State Survey	51	1	51	17.7	902.7	$23.55	$21,258.59

13. Estimates of Annualized Cost Burden to Respondents

There will be no capital, startup, operation, or maintenance of services costs to respondents.

14. Estimates of Annualized Cost to the Government

The estimated cost to the government for the data collection is $1,343,472. This includes approximately $1,327,922 for a 5-year contract for sampling, data collection, processing, reports, etc. and approximately $3,110 per year represents SAMHSA costs to manage/administrate the survey for 2% of one employee (GS-15). The total annualized cost is approximately $268,694.

15. Changes in Burden

There is no burden change.

16. Time Schedule, Publication, and Analysis Plans

Time Schedule

The State Survey will be administered to the states in the spring of each year. Each state will have 45 days from the receipt of the instructions to complete and submit the survey.

Analysis Plan

The analysis plan for the State Survey is designed to meet two goals:

1. Present each state's data in a clear, concise, and easily assessable fashion.
2. Allow each state to speak for itself by including unedited text responses.

All data from the State Survey are descriptive, and each response will constitute a separate entry in the proposed data tables (see publication plan). No data reduction is required, and no comparisons across states are appropriate to the purposes of the *Report to Congress*.

As discussed earlier, the State Survey instrument requests contact persons for each section. These individuals will be contacted if data are missing or if potential problems with text entries are identified (e.g., ambiguities, grammatical problems). States will be invited to rewrite these

entries. Consistent with the goal of allowing states to speak for themselves, however, the state respondents will have the final say concerning text entries.

Publication Plan

The data obtained through the State Survey will be part of the state-by-state report on underage drinking prevention and enforcement activities in the annual STOP *Report to Congress*. The State Survey data will be presented in a set of tables for each State (Attachment 3) corresponding to the four major sections of the report. The attached tables present actual data collected during the fourth survey year.

17. Display of Expiration Date

The expiration date will be displayed.

18. Exceptions to Certification Statement

This collection of information involves no exceptions to the Certification for Paperwork Reduction Act Submissions.