chusetts that documented an increase in illegal tobacco sales to minors after funding cuts to that state’s antitobacco program. These findings are of particular concern in states where antitobacco efforts have been cut substantially. For example, programs in Massachusetts and Florida included paid media campaigns and substantial youth components before funding declined 92% and 99%, respectively, from peak levels.

The prevalence of smoking among youths has declined most rapidly in states that have used the most extensive paid media campaigns in combination with other antitobacco activities. For example, after a comprehensive program with an extensive paid media campaign was initiated in Florida, smoking prevalence among middle school students declined 40% in 2 years.

In 1998, the Master Settlement Agreement (MSA) was accepted by states and the tobacco industry. MSA provided more than $200 billion to states over 25 years. Proponents of MSA, including governors and other state leaders, supported using these funds for antitobacco programs. However, at least 20 states and the District of Columbia have issued or plan to issue bonds backed by MSA payments, allowing them to receive their MSA funds in advance, often to help reduce state revenue shortfalls. As a result, MSA funds in multiple states might not be available to sustain effective antitobacco efforts.

The findings in this report are subject to at least four limitations. First, all data are self-reported and might be subject to recall bias. Second, participants’ campaign awareness was assessed on the basis of their TM brand awareness; certain respondents might not have recognized the logo yet still might have been aware of the campaign and vice versa. Third, susceptibility to smoking might be caused by factors other than cuts in antitobacco programs, such as increased marketing of tobacco products. Finally, not all adolescents categorized as having increased susceptibility become regular cigarette smokers. However, in prospective studies, this categorization has been found to be strongly and independently associated with increased likelihood of regular cigarette smoking.

The components of successful state youth antitobacco programs are based on substantial research; such programs include countermarketing, increased tobacco excise taxes, comprehensive school-based education programs, enforcement of tobacco-control laws, and ongoing surveillance and evaluation. Paid media campaigns are critical to countermarketing. When combined with other interventions, such campaigns are strongly recommended by the Task Force on Community Preventive Services to prevent initiation of tobacco use by youth. In Minnesota, paid advertisements consistently have accounted for >90% of total campaign awareness.

Because tobacco use remains the leading preventable cause of death in the United States, efforts to prevent smoking initiation among youths can have a profound impact on public health. While cutbacks in state programs were occurring, the tobacco industry spent $11.2 billion in 2001 (the most recent year for which data are available), or $39 per person in the United States, on advertising and promotion expenditures. These tobacco industry expenditures were 17% higher than the previous year and nearly double the amount spent on marketing in 1997, the year before MSA. The decline in campaign awareness and increase in adolescent susceptibility in Minnesota suggest that antitobacco funding cuts could reverse the recent declines in youth tobacco use.

REFERENCES


Alcohol Use Among Adolescents and Adults

MMWR. 2004;53:174-175
3 tables omitted

Alcohol abuse is the third leading preventable cause of death in the United States. Because binge and heavy drinking increase the risk for cirrhosis, cancer, heart disease, stroke, injury, and depression, public health efforts have focused on reducing these patterns of alcohol use. The Council of State and Territorial Epidemiologists, the Association of State and Territorial Chronic Disease Program Directors, and CDC developed Indicators for Chronic Disease Surveillance, which provides a standard set of measures for alcohol surveillance. The New Hampshire Department of Health and Human Services used these measures to facilitate statewide trend analysis of alcohol use among adolescents and adults. This report summarizes the results of that analysis, which indicated that, in 2003, a total of 30.6% of adolescents reported binge drinking. In 2001, a total of 15.8% of adults reported binge drinking, and 6.3% reported heavy drink-
ing. Interventions are needed to prevent adolescent drinking and to reduce excessive alcohol use among adults.

Three data sources were used to examine trends in alcohol use: New Hampshire (NH) Youth Risk Behavior Survey (NHYRBS), NH Behavioral Risk Factor Surveillance System (NHBFSS), and NH Vital Records (NHVR). NHYRBS is a biennial, self-administered, school-based survey of students in grades 9-12; NHYRBS was conducted in odd-numbered years during 1995-2003. Because the statewide response rate was <60% during 1997-2001, analysis of NHYRBS data was restricted to 1995 and 2003 (response rate: 65% and 62%, respectively). NHBFSS is an annual population-based, random-digit-dialed telephone survey of the noninstitutionalized, civilian population aged ≧18 years. Alcohol-related questions were asked annually during 1991-1993 and in odd-numbered years during 1995-2001 (response rate: 42.5%-70.9%). NHVR maintains and analyzes death-related data that are reported according to state law. The cause of death reported is the underlying cause of death or the specific disease, condition, or injury that leads to death.

For this analysis, seven public health indicators of alcohol-related impact were assessed: binge drinking among adults, women of child-bearing age (i.e., aged 18-44 years), and adolescents (indicators 1-3); heavy drinking among adult men and women (indicators 4-5); alcohol use among adolescents (indicator 6); and mortality from chronic liver disease (indicator 7). Binge drinking was defined as having five or more drinks on one or more occasions during the 30 days preceding the survey. Heavy drinking was defined as an average daily consumption of greater than two drinks for men and one drink for women. Alcohol use among adolescents was defined as having one or more drinks during the 30 days preceding the survey. Mortality from chronic liver disease was determined by using the underlying primary cause of death from International Classification of Diseases, Tenth Revision codes K70 or K73–K74 or, for years before 1999, Ninth Revision code 571. Age-standardized prevalence estimates were calculated by using the 2000 U.S. standard population for all indicators except those that were age specific.

In the 2003 NHYRBS, 47.1% of high school students reported alcohol use, and 30.6% reported binge drinking; in comparison with 1995 results, changes were not statistically significant. Both alcohol use and binge drinking among students increased significantly in grades 9 and 12 in 1995 and 2003.

In the 2001 NHBFSS, 15.8% of adults reported binge drinking. During 1991-2001, men were two to three times more likely than women to report binge drinking. In 2001, women of child-bearing age were six times more likely to report binge drinking than women aged ≧45 years (14.2% [95% confidence interval (CI) = 11.8%-16.6%] versus 2.3% [95% CI = 1.4%-3.2%]). In 2001, a total of 6.3% of adults reported heavy drinking. No statistically significant differences were observed in heavy drinking between men and women during 1991-2001.

According to the 2001 NHVR, 9.7 deaths per 100,000 New Hampshire residents were attributable to chronic liver disease. In 2001, males were significantly more likely than females to die from chronic liver disease (14.6 [95% CI = 11.5-17.8] versus 5.3 [95% CI = 3.6-7.1]). During 1991-2001, trends in mortality from chronic liver disease remained stable.

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**CDC Editorial Note:** The findings in this report indicate that adolescents and adults in New Hampshire use alcohol in ways that place them at increased risk for alcohol-related health problems. New Hampshire is the only state in the northeast with no alcoholic beverage sales tax, which contributes to low alcohol prices and the highest per-capita alcohol sales in the United States. Compliance checks of New Hampshire alcohol vendors indicate that approximately 30% of attempts to purchase alcohol by adolescents are successful.

The findings in this report are subject to at least four limitations. First, because approximately half of all adults and high school students reported no alcohol use, the prevalence of binge drinking among current drinkers was underestimated. Second, a trend analysis of alcohol use among high school students could not be performed because weighted data from NHYRBS during 1997-2001 were unavailable. Third, analysis of annual data at the substate level was not possible because of sample size limitations. Finally, the full burden of alcohol-related disease and death, including injuries, violence, and other health impacts, could not be determined because analysis of alcohol-related health effects was limited to deaths caused by chronic liver disease.

New Hampshire was one of 12 states that included a module on binge drinking in its 2003 BRFSS survey, which will provide more recent and comprehensive information on adult binge drinking, including the type and quantity of alcohol consumed, the location of consumption, and alcohol-impaired driving that might have resulted from binge drinking. Alcohol surveillance information in New Hampshire was published for the first time in 2003; the report will be updated annually to help policymakers and public health authorities implement programs to prevent adolescent drinking and excessive alcohol use among adults.

**REFERENCES**

6 available

**Acknowledgment**

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