

individuals, are needed to determine the particular practices and processes that result in health disparities in these groups.

APPLYING THE SEQUENTIAL INTERCEPT MODEL

Our final set of recommendations are inspired by the sequential intercept approach to reducing justice involvement. Although originally developed to describe how individuals with mental illness become justice involved and how to prevent them from entering or becoming more deeply enmeshed in the criminal justice system, the model is applicable to other stigmatized and marginalized groups. The model identifies five points of interception or opportunities for intervention along the criminal justice system trajectory.⁶ Two of these points of interception—prearrest

interactions with law enforcement and emergency services and the postarrest initial detention period—were beyond the stated scope of Baćak et al. but warrant our consideration and discussion.

First, numerous studies and legal cases document discrimination, abuse, and harassment of LGBT individuals by law enforcement officers, and qualitative research on the health care experiences of LGBT individuals and people living with HIV evidences stigmatizing and discriminatory treatment by emergency personnel.² Understanding the health disparities affecting justice-involved LGBT individuals will require further attention to this important point of first contact with the criminal justice system.

Second, with an estimated half-million Americans confined to jails each year while awaiting trial and an average of 68 days between arrest and adjudication, the pretrial detention period is

another important point of interception. Even short jail stays have been linked to negative criminal justice and health outcomes. In fact, suicide, the leading cause of death in jails, is far more common among pretrial detainees, with the majority of jailhouse suicides occurring shortly after admission.⁷

Although Baćak et al. referenced jails and prisons in their essay, they did not have time to make fine line distinctions between the two and to explore the unique health threats posed during the pretrial detention period. Expanding the scope of future discussions to include both the point of first contact with the criminal justice system and the pretrial detention period will help paint a more complete picture of the health disparities created or exacerbated by mass incarceration. **AJPH**

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The Story Behind the Sharp Decline in US Tanning Bed Rates

Since the first use of tanning beds in stand-alone salons in the early 1980s, hundreds of thousands of Americans, primarily female adolescents and young women (estimated ages 14–30 years), have used them¹ resulting in far too many cases of skin cancer.¹ Melanoma and basal cell cancers, once rare events among the young, have become increasingly common. For these past 30 years, we have witnessed an insidious epidemic of tanning bed use among adolescent girls and young women (which peaked in 2009 at a rate of 37% among 17-year-old

White female adolescents).² More than half of users reported frequently visiting a tanning salon in the year before completing a health survey² countering the myth that high-school girls tanned indoors only in advance of a prom or trip to a warm climate.

REAL DECLINE

Remarkably, we may now finally be seeing a real decline in the use of indoor tanning. A report published by Qin et al. in the July issue of *AJPH*

indicates that the reach of tanning bed legislation has cut a wide swath across the United States with the percentage of high-school girls affected by age restrictions precipitously rising from only 2% living in states with age restrictions in 2009 to 57% living in states with age restrictions just six years later (and likely higher today).³ The

broad reach translated into widespread impact—the association between states with the strongest age restrictions and the reduction of tanning bed use is now abundantly clear for adolescent girls of all ages (14, 15, 16, and 17 years); among adolescents who are White, Black, and Hispanic; and across all calendar years—most markedly 2015, the year that the data were last collected. It was only among young men, who are infrequent users, that the association between new legislation and

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curtailment of tanning bed use was not evident. In all, adolescent girls affected by age restrictions experienced a 47% decline in tanning bed use compared with their counterparts in states with only parental permission laws or no laws at all. The fact that only 7% of adolescent girls living in states with age restrictions reported past-year use of indoor tanning beds would have been unimaginable until recently.

AGE RESTRICTIONS

In both the cases of tobacco use and tanning bed use in adolescents, there appears to be a 10- to 20-year time period between the peak use and its decline. We have some indications for the drop in combustible tobacco use that once reached a high of 36% of all adolescents in 1997 to a rate now below 10%—the rising cost of a pack of cigarettes, the difficulty in smoking at schools and restaurants, a large-scale counter-advertising campaign, the denormalization of smoking, and banning of tobacco sales to those younger than 18 years. Until now, we have had scant evidence for the decline in use of indoor tanning as tobacco-related factors other than age bans were irrelevant. Although new age restrictions are not the only explanation, the decline seems to have heightened with the passage of the first tanning bed ban for those younger than 18 years in California in 2012. Strikingly, within five years, 15 other states and the District of Columbia imposed bans for those younger than 18 years; adolescent bans are now present in every geographic region of the United States and cover so-called “blue” and “red” states, such as Delaware, Hawaii, Illinois, Kansas, Louisiana,

Massachusetts, Minnesota, Nevada, New Hampshire, North Carolina, Oklahoma, Oregon, Texas, Vermont, and Washington. Such legislation left industry with far fewer customers (not coming from only the young)—from the tanning bed industry, we know that there may only be 9000 stand-alone units at last count compared with more than 19 000 just 10 years ago.

MAJOR SUCCESS STORY

This is an important and major success story that can be inextricably tied to public health advocacy and the production and dissemination of research-based scientific information, which, when linked together, resulted in convincing arguments before legislators in these diverse states. Documentation of the results from well-designed and rigorous studies became part of the public record and testimony that profoundly influenced legislators. Among the most influential studies were the work of Mayer et al.,⁴ Lazovich et al.,⁵ and Cust et al.⁶ In addition, advocates, including the American Cancer Society’s Cancer Action Network, AIM at Melanoma, American Academy of Dermatology, American Academy of Pediatrics, and the National Council on Skin Cancer Prevention, and informal networks of family members of young women who lost their lives to melanoma were armed with information on the disproportionate toll of tanning bed-related melanoma in young women. Finally, advocates reminded legislators that these are “your daughters” and “our daughters,”

and this became the advocates’ rallying cry.

NO COMPLACENCY

However, this is no time for complacency. Much work remains to reduce indoor tanning use among current users and to ensure that young adolescents intending to indoor tan are discouraged from doing so. This large public health effort will be in vain if former indoor tanners compensate by spending far more time in the sun, if enforcement is lax, or if adolescents seek to indoor tan in the 34 states without tight age restrictions. First, Hay et al.⁷ have argued for the need to study the long-term trajectory of former young indoor tanners—will they totally desist from seeking UV exposure, maintain their current sunbathing habits, or compensate for their lost indoor UV time to now seek greater exposure to natural UV exposure? Advocates can seek to expand two policies. Crucially, the US Food and Drug Administration (FDA) can build on the critical mass of the 16 states with bans for those younger than 18 years to call for a single, universal, national ban on use by youths younger than 18 years. With this in place, advocates can then promote the elimination of tanning bed use among all high-school students by seeking to increase the legal age of use by one year, to younger than 19 years. It is not unfathomable to imagine either of these new policies as the current FDA Commissioner, Scott Gottlieb, is strongly advocating major reductions in the nicotine level of cigarettes while a number of towns, communities, and states are advocating restrictions on

tobacco sales to anyone younger than 21 years.

OTHER POLICIES

As seen in the study by Qin et al.,³ state legislation was clearly impactful, but other policies also played a role in the marked decline in indoor tanning use. These include the Federal Trade Commission agreement with the Indoor Tanning Association and the voluntary agreement between the New York State Attorney General and industry to desist from deceitful advertising directed to children. Under its settlement with the Federal Trade Commission, the Indoor Tanning Association is prohibited from “making misrepresentations challenged in the complaint, from misrepresenting any tests or studies, and from providing deceptive advertisements to members” (<http://bit.ly/2LeCz1Q>).

MANY YOUNG LIVES

Public health successes of this magnitude are rare, and critical investigations must go beyond this single study to learn lessons and more deeply explore mechanisms leading to success. Nevertheless, the vast number of individuals and organizations who coalesced around this single goal of restrictions for those younger than 18 years can be assured that, without their efforts, many young lives would have otherwise been lost to melanoma. **AJPH**

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Preventing Risk for “Deaths of Despair” Among American Indian Youths: Unanswered Questions for Future Research



See also Moore et al., p. 1035.

Increases in “deaths of despair”—alcohol-related liver disease mortality, drug overdoses, and suicides—have led to an unprecedented rise in midlife mortality in the United States among non-Hispanic White men and women with educational attainment of a high school diploma or less.¹ Although these rising mortality rates are now rightly capturing considerable public and scientific attention, these deaths of despair have long been endemic among American Indian (AI) and Alaska Native populations, with minimal attention or alarm. All-cause and suicide mortality rates among AIs and Alaska Natives are nearly 50% greater than are those of non-Hispanic Whites.² Even more dreadful, death rates attributable to chronic liver disease and injuries are, respectively, 5.0 and 2.5 times greater among AIs and Alaska Natives than among non-Hispanic Whites.³ Clearly, the alcohol prevention partnership that Moore et al. (p. 1035) report on addresses an urgent and challenging public health and prevention

science priority, and I commend them for their successful partnership, resourcefulness, and important prevention efforts.

QUASIEXPERIMENTAL COMMUNITY TRIAL PARTNERSHIP

Moore et al. report on a long-term collaboration between clinicians, prevention scientists, and tribal leaders from nine rural California Indian reservations to prevent and reduce alcohol use among underage youths. The team designed a strong quasiexperiment with repeated measures and multiple comparison groups to evaluate a multilevel intervention designed to reduce the prevalence and frequency of alcohol use among youths. To assess alcohol use patterns, the team cleverly made use of the biannual California Healthy Kids Survey and analyzed patterns of anonymous self-reported alcohol use among 9th and 11th grade students before

(2002–2007) and after (2008–2015) the intervention was initiated. They compared three groups of students: (1) AI youths in the schools serving the nine reservations participating in the intervention, (2) non-AI youths in those same schools but reportedly not exposed to the individual- or community-level interventions, and (3) AI youths in schools serving nine comparison reservations.

To further evaluate the individual-level intervention, the team conducted an embedded randomized trial at the intervention reservations to test the effectiveness of a brief intervention. They compared motivational interviewing by a counselor with a psychoeducation video; both were delivered in either an individual or a group session. The community-level intervention

included community mobilization and awareness activities, as well as an intervention to reduce the sales of alcohol to underage youths at off-premise alcohol outlets near the reservations.

MULTILEVEL INTERVENTION ON NINE RESERVATIONS

Clear strengths of the project included the successful long-term collaboration between tribal leaders, practitioners, and prevention scientists not only to implement evidence-based prevention strategies but also to embark on a National Institutes of Health-funded study to evaluate the prevention efforts. The community intervention involved nearly 300 community awareness activities and three “reward and reminder” visits to 13 off-premise alcohol outlets within 10 miles of the nine reservations. The intervention rewarded those who do not sell alcohol without checking age identification and reminded those that do that it is against the law. Moore et al. did not provide details on how participation and implementation

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