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Gentrification and binge drinking in California neighborhoods: It matters how long you've lived there

Jacob M. Izenberg^{a,*}, Mahasin S. Mujahid^b, Irene H. Yen^c^a Department of Psychiatry, UCSF School of Medicine, 401 Parnassus Avenue, Box 0984, San Francisco, CA, 94143-0984, United States^b Division of Epidemiology, UC Berkeley School of Public Health, 50 University Hall #7360, Berkeley, CA, 94720-7360, United States^c Public Health, School of Social Sciences, Humanities and Arts, University of California, Merced, 5200 North Lake Road, Merced, CA, 95343, United States

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ABSTRACT

Background: Neighborhood context plays a role in binge drinking, a behavior with major health and economic costs. Gentrification, the influx of capital and residents of higher socioeconomic status into historically-disinvested neighborhoods, is a growing trend with the potential to place urban communities under social and financial pressure. Hypothesizing that these pressures and other community changes resulting from gentrification could be tied to excessive alcohol consumption, we examined the relationship between gentrification and binge drinking in California neighborhoods.

Methods: California census tracts were categorized as non-gentrifiable, stable (gentrifiable), or gentrifying from 2006 to 2015. Outcomes and covariates were obtained from the California Health Interview Survey using combined 2013–2015 data (n = 60,196). Survey-weighted logistic regression tested for associations between gentrification and any binge drinking in the prior 12 months. Additional models tested interactions between gentrification and other variables of interest, including housing tenure, federal poverty level, race/ethnicity, sex, and duration of neighborhood residence.

Results: A third of respondents reported past-year binge drinking. Controlling for demographic covariates, gentrification was not associated with binge drinking in the population overall (AOR = 1.13, 95% CI = 0.95–1.34), but was associated with binge drinking among those living in the neighborhood < 5 years (AOR = 1.49, 95% CI 1.15–1.93). No association was seen among those living in their neighborhood ≥ 5 years.

Conclusions: For those newer to their neighborhood, gentrification is associated with binge drinking. Further understanding the relationship between gentrification and high-risk alcohol use is important for policy and public health interventions mitigating the impact of this process.

1. Introduction

Excessive alcohol use accounts for 1 in 10 deaths among working age adults (Stahre et al., 2014) and costs more than \$249 billion in 2010 in the United States alone (Sacks et al., 2015). Roughly one in five US adults engages in binge drinking, defined by the Centers for Disease Control and Prevention as consumption, on a single occasion, of ≥ 5 drinks for men or ≥ 4 drinks for women (Centers for Disease Control and Prevention (CDC), 2013). Binge drinking accounts for half of the deaths, 7 of 10 years of potential life lost, and three quarters of the financial burden associated with excessive alcohol use (Sacks et al., 2015; Stahre et al., 2014). The societal costs of binge drinking include lost productivity, property damage, criminal justice expenditures, and medical care (Sacks et al., 2015), while the specific health risks are wide ranging, including liver damage (Åberg et al., 2017),

cardiovascular disease (Murray et al., 2002), breast cancer (White et al., 2017), sexually-transmitted infections (Kuntsche et al., 2017; Rowe et al., 2016), and depression (Paljärvi et al., 2009), to name a few. Binge drinking is a complex behavior toward which genetics, individual sociodemographic characteristics, personality and temperament, past experiences, parental role-modeling, social norms, and policy all contribute risk (Galea et al., 2004; Kuntsche et al., 2017). Given the heavy social and economic burdens involved, there is considerable interest in better understanding the modifiable risk factors for binge drinking.

1.1. Binge drinking in the context of neighborhood

Neighborhoods shape the health and behavior of those who live in them (Diez-Roux, 2016; Sampson, 2003), and an unequal distribution of neighborhood resources contributes to health disparities (Do et al.,

* Corresponding author.

E-mail addresses: jacob.izenberg@ucsf.edu, jacobizenberg@gmail.com (J.M. Izenberg), mmujahid@berkeley.edu (M.S. Mujahid).

2008; Sampson, 2012). This logic of these so-called “neighborhood effects” has been applied widely, from heart disease (Diez-Roux et al., 2016) to depression (Mair et al., 2008), framed in part by ecosocial theory, an explanatory framework for the multiple biobehavioral pathways leading from community social and environmental conditions to health outcomes (Krieger, 2012).

A number of mechanisms linking neighborhood context to drinking behavior in particular have been proposed. One hypothesis views excessive alcohol consumption as a stress-coping response, and thus is more likely to occur in stressful environments such as those characterized by socioeconomic deprivation and physical disorder (Galea et al., 2005; Hill and Angel, 2005). Indeed, binge drinking has been linked empirically to both (Bernstein et al., 2007; McKinney et al., 2012; Rhew et al., 2017).

Another hypothesized pathway linking neighborhood to alcohol use relates to collective efficacy, the informal social control and collective regulation of behavior (Sampson, 1997). Collective efficacy is believed to be, at least in-part, an emergent social property of place, undermined by deprivation, residential instability and displacement, and other forms of disadvantage (Fullilove, 2005; Sampson, 2012; Wallace and Fullilove, 2008) and potentially influenced by physical features of the built environment (Cohen et al., 2008; Izenberg and Fullilove, 2016). Data are mixed with regard to collective efficacy and alcohol use. Some studies have suggested collective efficacy may be protective, reducing isolation and mitigating stress (Fagan et al., 2014; Vaeth et al., 2015). Others, by contrast, have linked increased collective efficacy to increased binge drinking frequency in adolescents (Jackson et al., 2016). A recent study factoring in alcohol-related neighborhood social norms found that these norms appeared to predict drinking behavior, whereas measures of collective efficacy did not (Chauhan et al., 2016).

A third potential pathway from neighborhood context to alcohol use patterns involves the availability of alcohol retailers and drinking establishments. A large number of studies have demonstrated an association between alcohol outlet density and an increased prevalence of at least some patterns of alcohol use (Azar et al., 2016; Brenner et al., 2015; Popova et al., 2009; Slutske et al., 2016), while recent modeling efforts have suggested that reducing alcohol outlet density would likely have a considerable impact on population binge drinking, at least in a large urban area (Ahern et al., 2016).

1.2. Gentrification

Studies of neighborhood effects have frequently treated neighborhoods as static, when they in fact change over time with respect to a range of factors, from physical form to racial/ethnic and socioeconomic composition. After decades of decline and deterioration during the 20th century, many urban areas are experiencing an influx of wealthier residents—as well as capital investment, a process commonly termed gentrification (Lees et al., 2008; Smith, 1979). While some view gentrification as a sort of naturalistic process driven primarily by changing lifestyle preferences among the middle- and upper-classes, many scholars have argued convincingly that gentrification is, in effect, a set of policies that include, for example, development incentives, tax breaks, targeted infrastructure, and neighborhood branding (Lees, 2008; Lees et al., 2008).

Displacement of the poor and working classes, owing to increases in housing costs, is probably the most widely-debated impact of gentrification (Atkinson, 2000). However, even if, as some have suggested, the true extent of gentrification-related residential displacement is relatively limited (Freeman, 2005), the scope of gentrification’s potential impact remains broad (Smith et al., 2017b). For example, gentrification may place financial pressure on low-income residents, leading to stress, uncertainty, sub-optimal housing arrangements, and reduced mobility (Phillips et al., 2014). Profound alterations to the physical landscape or social norms of a community may undermine the security of attachment to place (Fullilove, 1996). Even low levels of displacement, particularly

in such coercive forms as eviction, may ripple across place-based social networks and disrupt the so-called “weak-ties” upon which community social cohesion and collective efficacy rely (Desmond, 2012; Granovetter, 1973; Greenbaum, 1982; Wallace et al., 2007; Werth and Marienthal, 2016). Finally, given the extensive history of residential racial segregation and targeted displacement of minority communities (Rothstein, 2017), gentrification may be experienced by people of color in particular as a form of racialized structural violence (Freeman, 2006).

Given that it may place significant stress on vulnerable neighborhood residents, disrupt the social networks foundational to collective efficacy, and alter the commercial landscape of a neighborhood, gentrification has the potential to influence all three of the aforementioned pathways linking neighborhood context to binge drinking. Yet, at the time of writing, there are, to our knowledge, no published studies examining the relationship between gentrification and the use of alcohol (or, for that matter, other substances). Indeed, empirical data on gentrification and health are few, with some findings mixed. Studies have suggested a link between gentrification and negative health outcomes, including preterm birth (Huynh and Maroko, 2014) and worsened self-rated health (Gibbons and Barton, 2016); in both cases negative effects were limited to black respondents, suggesting that gentrification’s effects may be moderated by race. A more recent study found increased depression and anxiety in older residents of gentrifying neighborhoods, though lower-income residents in the same study reported higher self-rated health (Smith et al., 2017a).

Our aim in this study was to evaluate the hypothesis that gentrification is associated with hazardous alcohol use, in the form of binge drinking, independent of individual level sociodemographic confounders, and to understand whether this association is modified by risk factors related to vulnerability to gentrification, including sex, race/ethnicity, household income, housing tenure, and neighborhood residential duration. For further exploratory analysis, we also examined three-way interactions between gentrification, neighborhood residential duration, and each of the following: sex, race, and income. With respect to these three-way interactions, we examined income and race because they are demographic characteristics often used to characterize so-called “gentrifiers”; we examined sex on account of evidence suggesting it may affect the relationship between the social environment and drinking patterns (Chauhan et al., 2016).

2. Materials and methods

2.1. Data and sampling

Outcomes and demographic data were from the California Health Interview Survey (CHIS), a statewide, cross-sectional, epidemiologic survey conducted annually by the UCLA Center for Health Policy Research. CHIS uses a stratified, random-digit dialing approach with mobile and land-line frames, recruiting a sample representing non-institutionalized, housed adults in California. CHIS conducted surveys in six languages in 2015, with response rates of 9.5% for cell phones and 12.3% for landlines; response rates in the combined 2013–2014 cycle were 16.6% and 14.8%, respectively. Our primary analytic sample comprised adults ≥ 18 from a combined CHIS 2013–2015 data file. Dropping 334 observations due to missing census-tract data (explanation of excluded tracts below) yielded a $N = 61,274$, and further excluding observations with responses of “don’t know,” “not-applicable,” or “refused” for covariates yielded a final analytic sample of $N = 60,196$.

2.2. Outcome and additional variables

Our primary outcome was any episode of self-reported binge drinking in the past year, defined as ≥ 5 drinks for men or ≥ 4 drinks for women on any single occasion. In addition to our primary outcome,

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