

CHAPTER 1

Preventing and Reducing Underage Drinking: An Overview

INTRODUCTION

Alcohol remains the most widely used substance of abuse among America's youth. According to the Substance Abuse and Mental Health Services Administration (SAMHSA) through a special analysis of data from tables in 2009, a higher percentage of youth ages 12 to 20 used alcohol in the past month (27.2 percent) than tobacco (21.4 percent) or illicit drugs (14.4 percent) (SAMHSA, 2010). The extent of alcohol consumption by those under the legal drinking age of 21 constitutes a serious threat to both public health and public safety. In response, governments at the Federal, State, and local levels have sought to develop effective approaches to reduce underage drinking and its associated costs and consequences. The actions of government alone, however, cannot solve this serious problem. Only a broad, committed collaboration among government, parents of underage youth, other caregivers and adults, and private sector organizations and institutions can reach an effective solution to this national challenge.

Underage drinking is a complex and challenging social problem that has defied an easy solution. Although it is illegal in all 50 States to sell alcohol to youth under the age of 21, some States make it legal to provide (but not sell) alcohol to youth under special circumstances, such as at religious ceremonies, in private residences, or in the presence of a parent or guardian. Despite such broad restrictions, underage youth find it relatively easy to acquire alcohol, often from adults. Alcohol use often begins at a young age; the average age of first use is now about 15.9 years old, and 10 percent of 9- to 10-year-olds have already started drinking (Donovan et al., 2004). Alcohol use increases with each year of high school, and by 12th grade, more than half (54.2 percent) of all students report having had one or more drinks in the past 30 days (Eaton et al., 2008). Underage drinkers are much more likely than adults to drink heavily and recklessly. Studies consistently indicate that about 80 percent of college students, of which 48 percent are underage, drink alcohol, and about 40 percent of all college students engage in binge drinking⁴—consuming 5 or more drinks in a row for men or 4 or more drinks in a row for women (National Institute on Alcohol Abuse and Alcoholism [NIAAA], 2002a).

Scientific research over the past decade has broadened our understanding of the ways and extent to which underage alcohol use threatens the immediate and long-term development, well-being, and future mental development of young people. Alcohol is a leading contributor to fatal injuries, a major cause of death for people under 21 years of age. The potential consequences of underage drinking include alcohol-related crashes and fatalities, other unintentional injuries such as burns and drowning, increased risk of suicide and homicide, physical and sexual assault, academic and social problems, inappropriate and/or risky sexual activity, and adverse effects on the developing brain (NIAAA, 2005a).

⁴ **Binge drinking: Consuming a large amount of alcohol over a relatively short period of time.** No common terminology has been established to describe different drinking patterns. Based on National Survey of Drug Use and Health (NSDUH) data, SAMHSA defines binge drinking as five or more drinks on the same occasion on at least one day in the past 30 days and heavy drinking as five or more drinks on the same occasion on each of five or more days in the past 30 days. Some studies, including Wechsler's (2002) survey of college students, define binge drinking as five or more drinks in a row for men and four or more for women. Other sources use the term frequent heavy drinking for five or more drinks on at least five occasions in the past 30 days. Appendix A further discusses these differences.

The consequences of underage alcohol use extend beyond underage drinkers; society also pays. For example, half of all deaths in traffic crashes involving alcohol-impaired drivers under the age of 21 are people other than the drinking driver (National Highway Traffic Safety Administration [NHTSA], 2003). The social costs of underage drinking are estimated at \$53 billion, including \$19 billion from traffic crashes and \$29 billion from violent crime (PIRE, 1999).

A NATIONAL EFFORT TO REDUCE UNDERAGE DRINKING

Underage drinking has been recognized as a public health problem for many years. Recently, however, the national effort to prevent alcohol use by America's young people has intensified as the multifaceted consequences associated with underage drinking have become more apparent.

After Prohibition ended in 1933, States assumed authority for alcohol control, including the enactment of laws restricting youth access to alcohol. The majority of States designated 21 as the minimum legal drinking age (MLDA) for the "purchase or public possession" of alcohol. Beyond setting a minimum drinking age, the Nation's alcohol problems were largely ignored through the 1960s (NIAAA, 2005b). However, on December 31, 1970, Congress established NIAAA "to provide leadership in the national effort to reduce alcohol problems through research."

Between 1970 and 1976, 29 States lowered their MLDA to 18, 19, or 20 years of age, in part because the voting age had been lowered (Wagenaar, 1981). However, studies conducted in the 1970s found that motor vehicle crashes increased significantly among teens, resulting in more traffic injuries and fatalities (Cucchiari et al., 1974; Douglass et al., 1974; Wagenaar, 1983, 1993; Whitehead, 1977; Whitehead et al., 1975; Williams et al., 1974). As a result, 24 of the 29 States raised their MLDA between 1976 and 1984, although to different minimum ages. Some placed restrictions on the types of alcohol that could be consumed by persons under 21 years of age. Only 22 States set an MLDA of 21 years of age. In response, the Federal Government enacted the National Minimum Drinking Age Act of 1984, which mandated reduced Federal highway funds to States that did not raise their MLDA to 21 years of age. Thereafter, all remaining States raised their MLDA to 21 years of age.

In 1992, Congress created SAMHSA "to focus attention, programs, and funding on improving the lives of people with or at risk for mental and substance abuse disorders." In 1998, Congress mandated that the Department of Justice, through the Office of Justice Programs' Office of Juvenile Justice and Delinquency Prevention (OJJDP), establish and implement the Enforcing the Underage Drinking Laws (EUDL) program, a State- and community-based initiative.

RECENT EFFORTS

As national concern over underage drinking grew, in part because of advances in science that increasingly revealed adverse consequences, Congress appropriated funds for a study by The National Academies to examine the relevant literature to “review existing Federal, State, and nongovernmental programs, including media-based programs, designed to change the attitudes and health behaviors of youth.” That report was issued in 2004 by the National Research Council (NRC) and the Institute of Medicine (IOM). Since then, a number of programs aimed at preventing and reducing underage drinking have been initiated at the Federal, State, and local levels. Chapter 3 describes major programs at the Federal level.

The conference report accompanying H.R. 2673, the “Consolidated Appropriations Act of 2004,” directed the Secretary of the U.S. Department of Health and Human Services (HHS) to establish an Interagency Coordinating Committee on the Prevention of Underage Drinking (ICCPUD) and to issue an annual Report summarizing all Federal agency activities related to the problem. The Secretary of HHS directed the Administrator of SAMHSA to convene ICCPUD in 2004. ICCPUD includes representatives from HHS’s Office of the Surgeon General (OSG), Centers for Disease Control and Prevention (CDC), Administration for Children and Families (ACF), Office of the Assistant Secretary for Planning and Evaluation (ASPE), National Institutes of Health (NIH); NIAAA; NIDA; OJJDP; the Department of Education/Office of Safe and Drug Free Schools (ED/OSDFS); the Department of Transportation’s NHTSA; the White House’s Office of National Drug Control Policy (ONDCP); the Department of the Treasury; the Department of Defense; and the Federal Trade Commission (FTC).

ICCPUD coordinates Federal efforts to reduce underage drinking and served as a resource for the development of *A Comprehensive Plan for Preventing and Reducing Underage Drinking*, which Congress called for in 2004. ICCPUD received input from experts and organizations representing a wide range of parties, including public health advocacy groups, the alcohol industry, ICCPUD member agencies, and the U.S. Congress. The latest research available at the time was analyzed and incorporated into the plan, which HHS reported to Congress in January 2006. It included three goals, a series of Federal action steps, and three measurable performance targets for evaluating national progress in preventing and reducing underage drinking.

In December 2006, Congress passed the Sober Truth on Preventing (STOP) Underage Drinking Act, Public Law 109-422, popularly known as the STOP Act. The Act states that “a multi-faceted effort is needed to more successfully address the problem of underage drinking in the United States. A coordinated approach to prevention, intervention, treatment, enforcement, and research is key to making progress. This Act recognizes the need for a focused national effort, and addresses particulars of the Federal portion of that effort as well as Federal support for State activities.” The STOP Act requires the Secretary of HHS, in collaboration with other Federal officials enumerated in the Act, to “formally establish and enhance the efforts of the interagency coordinating committee (ICCPUD) that began operating in 2004.”

The STOP Act also calls for an Annual Report from the Secretary of HHS that “summarizes (I) all programs and policies of Federal agencies designed to prevent and reduce underage drinking; (II) the extent of progress in preventing and reducing underage drinking nationally; (III) data that

the Secretary shall collect with respect to the information specified in clause (ii); and (IV) such other information regarding underage drinking as the Secretary determines to be appropriate.” In addition, the Act requires information related to patterns and consequences of underage drinking, measures of the exposure of underage populations to messages regarding alcohol in advertising and the entertainment media as reported by FTC; surveillance data, including information on the onset and prevalence of underage drinking, consumption patterns, and the means of underage access; and certain other data included in this report.

In the fall of 2005, ICCPUD sponsored a National Meeting of the States to prevent and reduce underage alcohol use where the Surgeon General announced an intent to issue a Call to Action on the prevention and reduction of underage drinking. Subsequently, OSG worked closely with SAMHSA and NIAAA to develop the report. In 2007, the Surgeon General *issued A Call to Action to Prevent and Reduce Underage Drinking* (henceforth *Call to Action*), the first on that subject. Based on the latest and most authoritative research, particularly on underage drinking as a developmental issue, the *Call to Action* outlines a comprehensive national effort to prevent and reduce underage alcohol consumption, and includes six goals. The *Call to Action* describes the rationale, challenges, and strategies of each goal, including specific actions for parents and other caregivers, communities, schools, colleges and universities, the criminal and juvenile justice systems, law enforcement, the alcohol industry, and the entertainment and media industries.

ICCPUD agencies collaborated to provide information and data for the *Call to Action*. The comprehensive Federal plan contained in the 2006 Comprehensive Plan set forth three goals: strengthening a national commitment to address the problem of underage drinking; reducing demand for, availability of, and access to alcohol by persons under the age of 21; and using research, evaluation, and scientific surveillance to improve the effectiveness of policies and programs designed to prevent and reduce underage drinking. The six goals and associated strategies in the *Call to Action* for the Nation build upon these three goals.

As the Nation’s leading medical spokesperson, the Surgeon General is in a unique position to call attention to national health problems. By issuing a *Call to Action*, the Surgeon General has sought to raise public awareness and foster changes in American society—goals similar to those described to Congress in the Comprehensive Plan. The *Call to Action*, with its goals and recommended strategies, has incorporated and therefore superseded the Comprehensive Plan.

As with the Comprehensive Plan, ICCPUD agencies are implementing a variety of Federal programs to support the *Call to Action’s* goals. For example, SAMHSA and NIAAA worked with OSG to support rollouts of the *Call to Action* in 13 States; SAMHSA collaborated with ICCPUD to support over 1,600 Town Hall meetings, using the *Call to Action’s Guide to Action for Communities* (HHS, 2007) as a primary resource; and SAMHSA has asked community coalitions funded under the STOP Act to implement strategies contained in the *Call to Action*. These and other programs are described in more detail in Chapter 3.

PRINCIPLES AND GOALS OF THE CALL TO ACTION

The national effort to prevent and reduce underage drinking outlined in the *Call to Action* is based on the following principles from which its goals were derived:

1. *Underage alcohol use is a phenomenon that is directly related to human development.* Because of the nature of adolescence itself, alcohol poses a powerful attraction to adolescents, with unpredictable outcomes that put every child at risk.
2. *Factors that protect adolescents from alcohol use, as well as put them at greater risk, change during the course of adolescence.* Internal characteristics, developmental issues, and shifting factors in the adolescent's environment all play a role.
3. *Protecting adolescents from alcohol use requires a comprehensive, developmentally based approach* that is initiated prior to puberty and continues throughout adolescence with support from families, schools, colleges, communities, the healthcare system, and government.
4. *The prevention and reduction of underage drinking is the collective responsibility of the Nation.* Scaffolding the Nation's youth⁵ is the responsibility of all people in all of the social systems in which adolescents operate: family, schools, communities, healthcare systems, religious institutions, criminal and juvenile justice systems, all levels of government, and society as a whole. Each social system has a potential impact on the adolescent, and the active involvement of all systems is necessary to fully maximize existing resources to prevent underage drinking and its related problems. When all the social systems work together toward the common goal of preventing and reducing underage drinking, they create a powerful synergy that is critical to realize the vision.
5. *Underage alcohol use is not inevitable,* and parents and society are not helpless to prevent it.

The *Call to Action* proposes a vision for the future in which each child is free to develop his or her potential without the impairment of alcohol's negative consequences. The fulfillment of that vision rests on the achievement of six goals the *Call to Action* sets for the Nation:

- Goal 1: Foster changes in American society that facilitate healthy adolescent development and that help prevent and reduce underage drinking.
- Goal 2: Engage parents and other caregivers, schools, communities, all levels of government, all social systems that interface with youth, and youth themselves in a coordinated national effort to prevent and reduce underage drinking and its consequences.
- Goal 3: Promote an understanding of underage alcohol consumption in the context of human development and maturation that takes into account individual adolescent characteristics as well as ethnic, cultural, and gender differences.
- Goal 4: Conduct additional research on adolescent alcohol use and its relationship to development.
- Goal 5: Work to improve public health surveillance on underage drinking and on population-based risk factors for this behavior.
- Goal 6: Work to ensure that laws and policies at all levels are consistent with the national goal of preventing and reducing underage alcohol consumption.

⁵ Scaffolding the Nation's youth is the Surgeon General's term for a structured process through which parents and society facilitate positive adolescent development and minimize risk by protecting against the natural risk-taking, sensation-seeking tendencies of adolescents. It is a fitting metaphor for the support and protection that parents and society provide children and youth to help them function in a more mature way until they are ready to function without that extra support. This external support system, or scaffold, around the adolescent promotes healthy development and protects against alcohol use and other risky behaviors by facilitating good decision making, mitigating risk factors, and buffering potentially destructive outside influences that draw adolescents to use alcohol.

The strategies for implementing these goals for parents and other caregivers, communities, schools, colleges and universities, businesses, the health care system, juvenile justice and law enforcement, and the alcohol and entertainment industries are described in Appendix E.

TARGETS

The 2006 Comprehensive Plan proposed 5-year performance measures in the form of numerical targets for evaluating the Nation's progress in preventing and reducing underage drinking. The targets covered the years 2004 through 2009 and were National rather than Federal targets.

NSDUH data have been used to measure progress toward meeting those targets, which were:

- Target 1: By 2009, reduce the prevalence of past-month alcohol use⁶ by those aged 12 to 20 by 10 percent as measured against the 2004 baseline of 28.7 percent.⁷
- Target 2: By 2009, reduce the prevalence of those aged 12 to 20 reporting binge alcohol use⁸ in the past 30 days by 10 percent as measured against the 2004 baseline of 19.6 percent.
- Target 3: By 2009, achieve an increase of average age of first use⁹ among those who initiate before age 21 to 16.5 years of age, as compared with the 2004 baseline.

EXTENT OF PROGRESS

The STOP Act requires the Secretary of HHS to report to Congress on “the extent of progress in preventing and reducing underage drinking nationally.” The 2006 Comprehensive Plan contained 5-year numerical targets based on NSDUH data for measuring the Plan's effectiveness in producing its intended results.

It is generally inadvisable to draw conclusions based on changes from one year to the next because of natural fluctuations. Examining trends over a multiyear period is much more informative. Nonetheless, NSDUH data suggest modest progress, with most results across a wide range of underage drinking-related measurements moving in the desired direction or at least not in the wrong direction. Data from the Monitoring the Future (MTF) survey and Youth Risk Behavior Survey (YRBS) also suggest positive movement. This alignment within and across surveys, even without statistical significance, is a good sign. However, it is too early to claim a definite downward trend in underage alcohol consumption.

The following tables provide NSDUH data on past-year alcohol use from 2004 through 2009. All age groups except 18 to 20-year-olds showed a statistically significant decline in past-month alcohol use in 2009 compared with 2004. The same is true for past-month binge alcohol use with the exception of the 12-13 age group for which levels of binge alcohol use remained basically unchanged since 2004. And while there have been significant downward trends in both past-month alcohol use and binge alcohol use between 2004 and 2008, no changes from 2008 to 2009

⁶ For the purposes of this target, “alcohol use” is defined as “other than a few sips.”

⁷ The 2004 baseline came from the NSDUH, which was published in 2005.

⁸ For the purposes of this target, “binge alcohol use” is defined as “drinking five or more drinks on the same occasion (i.e., at the same time or within a couple of hours of each other) on at least 1 day in the past 30 days.”

⁹ The ultimate goal is to increase the age of initiation to the minimum legal drinking age of 21; however, underage drinking is so strongly embedded in the Nation's culture that the more realistic goal of increasing the average age of initiation of those under the age of 21 to 16.5 by 2009 is being proposed.

were statistically significant. In addition, in 2006 compared with 2004 and 2005, there was a statistically significant increase in average age at first use among those under age 21 who initiated alcohol use in the past 12 months. The average age of first use remained statistically the same in 2007, 2008, and 2009 (SAMHSA, 2008, 2009; SAMHSA, CBHSQ, NSDUH 2010).

Table 1.1 – Past-Month Alcohol Use for 12- to 20-Year-Olds (2009 Target: 25.8 Percent)

Age	2004	2005	2006	2007	2008	2009
12-13	4.3%	4.2%	3.9%	3.5% †	3.4% †	3.5% †
14-15	16.4%	15.1%	15.6%	14.7% †	13.1% †	13.0% †
16-17	32.5%	30.1% †	29.7% †	29.0% †	26.2% †	26.3% †
18-20	51.1%	51.1%	51.6%	50.7%	48.7% †	49.7%
12-17	17.6%	16.5% †	16.6% †	15.9% †	14.6% †	14.7% †
12-20	28.7%	28.2%	28.3%	27.9%	26.4% †	27.2% †

†Difference between 2004 estimate and this estimate is statistically significant at the 0.05 level.

Table 1.2 – Past-Month Binge Alcohol Use for 12- to 20-Year-Olds (2009 Target: 17.6 Percent)

Age	2004	2005	2006	2007	2008	2009
12-13	2.0%	2.0%	1.5%	1.5%	1.5%	1.6%
14-15	9.1%	8.0%	8.9%	7.8% †	6.9% †	7.0% †
16-17	22.4%	19.7% †	20.0% †	19.4% †	17.2% †	17.0% †
18-20	36.8%	36.1%	36.2%	35.7%	33.7% †	34.7%
12-17	11.1%	9.9% †	10.3% †	9.7% †	8.8% †	8.8% †
12-20	19.6%	18.8%	19.0%	18.6%	17.4% †	18.1% †

†Difference between 2004 estimate and this estimate is statistically significant at the 0.05 level.

Table 1.3 – Average Age at First Use Among Past-Year Initiates of Alcohol Use, Age 20 or Younger (2009 Target: 16.5 Years)

Year	2004	2005	2006	2007	2008	2009
Average Age at First Use	15.6	15.6	15.8 †	15.8 †	15.9 †	15.9 †

†Difference between 2004 estimate and this estimate is statistically significant at the 0.05 level.

Despite various efforts to date and the promising results described thus far, underage alcohol use has proven resistant to change, and it is not surprising that progress has been slow. While progress was made toward achieving the goals, the 2009 targets were not met, underscoring the need for further efforts on the part of government at all levels, as well as individuals, organizations, and institutions in the private sector.