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Global Status Report: Alcohol and Young People

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Abstract

The global burden of disease from alcohol exceeds that of tobacco in large part because acute consequences of alcohol use lead to death and disability in the younger years of life. There is evidence of a convergence in drinking patterns among the young, towards products marketed to youth cultures and tastes, and associated in developed countries with drinking to intoxication and with acute consequences such as motor vehicle crashes, drowning, and interpersonal violence. It also appears that young people in many countries are beginning to drink at earlier ages, while research in developed countries has found early initiation of alcohol use to be associated with greater likelihood of both alcohol dependence and alcohol-related injury later in life. After a review of available research and statistics on behavioural and physical consequences of alcohol use, the document describes the globalisation of alcohol brands and marketing designed to embed alcohol products and consumption into the lifestyles of young people. Brief profiles of prevalence among young people in Member States in each of the WHO Regions point to the need for standardised monitoring of alcohol use and consequences, and attention is called to WHO's guidelines for doing this. Educational approaches to prevention of alcohol problems among young people have in and of themselves shown little effect, while brief treatment interventions have shown promise. Research has demonstrated the effectiveness of intervention at the community level as well as of policies such as minimum drinking age laws and alcohol taxation. Promotion of alcoholic beverages to young people is inappropriate and dangerous to health. Public health policy makers in Member States as well as international governmental and non-governmental organisations need to work for the adoption and implementation of a culturally appropriate mix of alcohol control policies to prevent alcohol's heavy toll on morbidity and mortality among young people and the population at large.

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GLOBAL STATUS REPORT:
YOUNG PEOPLE AND ALCOHOL

Introduction

World-wide, five per cent of all deaths of people between the ages of 5 and 29 in 1990 were attributable to alcohol use (Murray & Lopez 1997). The Global Burden of Disease Study found that alcohol was responsible in 1990 for 3.5 per cent of all disability-adjusted life years (more than tobacco or illegal drugs). The burden from alcohol exceeds that from tobacco largely because alcohol problems tend to take their toll earlier in life. While adverse health outcomes from long-term chronic alcohol use may not cause death or disability until late in life, acute health consequences of alcohol use, including intentional and unintentional injuries, are far more common among younger people.

Survey and anecdotal data from countries around the globe suggest that a culture of sporadic heavy or "binge" drinking among young people may be spreading from the developed to the developing countries. Globally, efforts to promote alcohol use have increased in both prevalence and sophistication in the past 30 years. Prevention technologies have not kept pace either with the spread of new and potentially harmful patterns of drinking, or with the expansion of promotional activities, despite the fact that there are numerous strategies that have been found to be effective, at least in the developed nations (Edwards et al. 1994).

Drawing on WHO's global alcohol database, this report will provide an overview of the prevalence of drinking among young people, alcohol-related mortality and other health effects, trends in the alcohol environment surrounding youthful drinking, and prevention policies designed to reduce alcohol-related problems among the young.

WHO data sources and methods

WHO has established a database providing a standardised reference source of information for global epidemiological surveillance of alcohol use and related problems. The database brings together a large amount of information on the alcohol and health situation in individual countries and, wherever possible, includes trends in alcohol use and related mortality since 1970. WHO has also collected information on alcohol production, trade, consumption, and health effects, as well as on national alcohol control measures, policies and programmes. In addition to large international databases maintained by other international governmental organisations, more than 850 published sources have been identified and consulted.

The scope and sources for the database are described in WHO Global Status Report on Alcohol published in 1999 (WHO 1999). Methods for data collection have included reviews of on-line databases and fugitive literature collections, consultation with regional key informants, and use of large statistical databases such as those maintained by WHO's Division of Evidence and Information for Health Policy and Analysis. A network of expert informants in the various WHO regions provided additional assistance.

Despite efforts made by WHO to obtain and validate data and information, many gaps in, and uncertainties about, the actual alcohol and health situation in WHO Member States remain. WHO therefore encourages comments or additional information from readers of this report, in order to improve the reliability of its global epidemiological surveillance and thereby increase the usefulness of this information in supporting efforts to reduce alcohol-related problems world-wide. **Any information, comments or suggestions may be sent directly to: Dr. Maristela Monteiro, WHO, 20 Avenue Appia, 1211 Geneva 27, Switzerland.**

Types of alcohol products and patterns of use

Alcohol in most societies is a luxury product rather than a necessity, and so the wealthier countries consume more alcohol than the rest of the world. At the same time that there is some evidence that young people are initiating heavier drinking at earlier ages (see below), the popularity, range and availability of inexpensive alcoholic beverages have increased. Survey evidence from the United Kingdom indicates that young people between the ages of 13 and 16 have been the most frequent consumers of at least some of these products, the alcoholic lemonades and other fruity beverages collectively known as “alcopops” (Hughes et al. 1997; Health Education Authority 1999).

There is evidence as well, particularly from Europe and North America, that national differences in beverage preferences are converging among younger drinkers. In southern Europe, young people are increasingly turning to beer instead of wine as their beverage of choice. For example, in 1993 the Spanish National Household Health Survey found that beer and spirits consumption were more frequent among young people, while older people continued the country’s historical preference for wine (Del Rio et al. 1995). A 1993 study of more than 11 000 French young people between the ages of 11 and 18 found that beer was the preferred drink, followed by hard liquor, and that these preferences were far more consistent throughout the country than the authors had expected. France is located at the centre of Western Europe, and its traditional differences in regional drinking patterns have historically reflected the variation in beverage preferences of the continent as a whole. Because of this, the uniformity of beverage preferences found by the authors led them to surmise that a convergence in European drinking patterns was emerging (Arvers & Choquet 1999). Meanwhile, in the United Kingdom, where the national preference already tilted strongly in the direction of beer, young people increasingly prefer to drink their lager cold, as is the drinking style in the US, as opposed to the British tradition of consuming it at room temperature (Hagerty 2000).

In this emerging drinking pattern, young people are less likely to consume wine and distilled spirits, and more likely to consume beer (Gabhainn & François 2000; Business Research Centre 1997) or a wide range of other relatively low-alcohol products often apparently designed to appeal to young or inexperienced drinkers. These include alcopops, wine coolers, wines fortified with distilled spirits to bring their alcohol content up as high as 20 per cent, ciders, alcoholic “energy” drinks, and so on. The alcohol in these beverages results from the inclusion of malt, wine or spirits-based products. What they tend to share is a price within a range competitive with popularly priced beer or cider, a sweet taste, and an image designed to appeal to the young.

In developing countries, convergence towards this drinking pattern is more likely to be found in those living in urban areas, and rising in affluence (Room et al. in press). For instance, in Mexico urban drinkers are much more likely to drink beer, while rural drinkers and those at the lower end of the socio-economic scale are more likely to drink the local products *pulque* and *aguardiente* (Medina-Mora 1999). In Benin, alcohol consumption has shifted from adults and old people to younger people of both genders (Agossou et al. 1999), while studies in Zimbabwe have found that young people who identify with a Western as opposed to a traditional cultural identity are more likely to drink alcohol and to drink it heavily (Eide & Acuda 1996; Eide et al. 1998).

Age of initiation

Age of initiation of alcohol use is important for at least two reasons. First, research in the US has found that the earlier the age at which people begin drinking, the more likely they are to become alcohol dependent later in life (Grant & Dawson 1997). Those who begin drinking in their teenage years are also more likely to experience alcohol-related unintentional injuries (such as motor vehicle injuries, falls, burns, drowning) than those who begin drinking at a later age (Hingson et al. 2000). Adverse effects of early onset of drinking may be shorter term as well: prospective research has found a younger age of initiation to be strongly related to a higher level of alcohol misuse at ages 17 and 18 (Hawkins et al. 1997).

Costa Rican survey data confirm the proposition that an earlier age of initiation may predict a greater likelihood of alcohol problems later in life. According to that country's 1995 national survey of drug use, 55 per cent of those identified as alcoholic and 40 per cent of those determined to be drinking excessively (defined as consumption of more than 100 millilitres of absolute alcohol for men and 60 millilitres of absolute alcohol for women on two or more occasions in the past month) had begun drinking before the age of 15, compared with only 31 per cent of those drinking at lower levels (Bejarano et al. 1996).

Second, trends in the age of initiation are one indicator that may be used to monitor larger changes in overall drinking patterns among youth. When prevalence of experimentation not only with alcohol use but with heavy use at earlier ages increases, there may be substantial cause for concern.

Since surveys generally rely on self-reporting and recall, it is difficult to measure age of initiation of alcohol use precisely, and most of the information on this subject is available from the developed countries. Trend data are also rare. However, using data from the 1998 National Drug Strategy Household Survey, Australian researchers looked at the age of initiation by five-year age cohorts for persons born between 1940 and 1984. They found that more than half (56 per cent) of the 1980-84 birth cohort reported alcohol use by age 15, compared to only 16 per cent of those born between 1940 and 1944 (Degenhardt et al. 2000).

In the US, the average age of first use of alcohol is 13.1 years (US Department of Health and Human Services 1998). Among young people surveyed in 1997 and 1998 in 23 European countries, more than half of 11 year-olds in most countries reported

having tasted alcohol. There was little difference between the genders at this level of consumption. However, boys are somewhat more likely to have initiated weekly drinking by age 13 than girls, and substantially more likely to have done so by age 15 (Gabhainn & François 2000). These figures run the risk of obscuring national differences. For instance, a 1993 survey in the Czech Republic found that most young people had used alcohol prior to age 12, a substantial increase over a similar study conducted in 1978 (Ferrer et al. 1995). In contrast, a national survey in Spain of persons aged 18 and over conducted in 1989 found the average age of first use to be 16.7 years (Royo-Bordonada et al. 1997). Age of initiation is subject to many cultural factors. However, in at least some developing countries, the age of experimentation is much younger – 10.1 years, for instance, in Porto Alegre, Brazil (Pechansky & Barros 1995).

A standardised survey in 1999 asked young people born in 1983 in 25 European countries if they had been drunk before the age of 13. Table 1 below shows the results for this question. In comparison with an identical survey conducted in 1995, in 11 countries the numbers initiating at this age had increased, while in 8 countries the numbers had fallen (Hibell et al. 1997).

Table 1. Percentage of 15-16 year olds in European countries who had been drunk at age 13 or earlier, 1999.

	Drunk by age 13 or earlier		
Country	**Males**	**Females**	**Total**
Bulgaria	19	11	15
Cyprus	10	5	7
Czech Republic	20	12	16
Denmark	48	37	42
Estonia	26	14	19
Faroe Islands	18	11	15
Finland	34	33	33
Former Yugoslav Republic of Macedonia	12	3	8
France	15	10	12
Greece	11	6	9
Hungary	13	7	10
Iceland	19	16	17
Ireland	28	21	25
Italy	8	7	7
Latvia	22	11	16

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