



Healthy Generations

From Maternal & Child Health, Division of Epidemiology, School of Public Health at the University of Minnesota

Volume 2 • Issue 2 • September 2001

Inside this Issue

An Epidemic with Staying Power: Underage Drinking

Carol L. Falkowski
Director of
Research Communications
Hazelden Foundation

Youth Substance Use Prevention—A Focus on Protective Factors

Laurie L. Meschke, Ph.D. and
Joan Patterson, Ph.D.
Maternal and Child Health Program
Epidemiology, School of
Public Health
University of Minnesota
PAGE 4

Reducing Youth Access to Alcohol

Traci L. Toomey, Ph.D.
Assistant Professor, Epidemiology
School of Public Health
University of Minnesota
PAGE 7

Selecting and Designing an Effective Prevention Program: Lessons from Project Northland

Carolyn L. Williams, Ph.D.
Professor, Epidemiology,
School of Public Health,
University of Minnesota
PAGE 10

Minnesota Join Together Coalition to Reduce Underage Drinking

Jeff Nachbar
Project Director
MN Join Together Coalition to
Reduce Underage Drinking
PAGE 12

An Epidemic with Staying Power: Underage Drinking

Carol L. Falkowski
Director of Research Communications
Hazelden Foundation

For decades the widespread prevalence and consequences of underage alcohol use have created health, safety, and criminal justice problems throughout the United States.

Prevalence of Alcohol Use

In all 50 states a person must be 21 years old to legally consume alcohol. Yet the 1999 National Household Survey on Drug Abuse reported that 10.4 million young people (12 to 20 years) are current drinkers. Alcohol is the most widely used drug in the United States, consumed by an estimated 105 million people—about 47% of the total population over age 12.¹

In a national survey of students, 80% of high school seniors, 71% of 10th graders, and 52% of 8th graders reported alcohol use at least once in their lifetime.² Current alcohol use was reported by half of high school seniors, 41% of 10th graders, and 22% of 8th graders. Forty-two percent of 9th grade students reported drinking alcohol at least once before age 13.3. Most 10th grade students (88%) and 8th grade students (72%) say it is "fairly easy" or "very easy" to get alcohol.²

An estimated 45 million Americans, or 43% of current drinkers reported binge alcohol use (5 or more drinks on the same occasion at least once in the past month). Young people age 18 -25 are the most likely to binge drink; 38% report it. Heavy drinking, having 5 or more drinks on the same occasion on 5 or more days in the past month, is also most prevalent among people age 18 - 25; 13.3% report heavy drinking.¹

continued on page 2

Adolescent alcohol use is a primary public health concern. Alcohol use increases the risk of accidental injuries, suicide, risk behavior, and violence. Yet 80% of high school seniors are consumers of alcohol. This issue of *Healthy Generations* examines various aspects of adolescent alcohol use. Carol L. Falkowski reminds us of how prevalent teen drinking is and also its consequences. Together with Joan Patterson I consider the protective factors that can promote resilience in the area of adolescent alcohol use. Traci Toomey examines policy and law enforcement efforts that help reduce the risk of adolescent alcohol consumption. Carolyn Williams discusses important issues to consider when developing or selecting an effective program in the area of adolescent alcohol use prevention. Project Northland of the University of Minnesota is used to exemplify the characteristics. Jeff Nachbar of the Minnesota Join Together Coalition to Reduce Underage Drinking (MJT) shares in the Partners in Health section. He outlines the mission and efforts of MJT in stopping adults from providing youth with alcohol.

As with every issue, there is a wide variety of resources available on the Maternal and Child Health Program's website. Resources in the area of adolescent alcohol use include PowerPoint presentations, relevant websites, and fact sheets (<http://www.epi.umn.edu/mch/HealthyGenerations/hga.html>).

The videoconference associated with this issue will be held on October 31 from 1-3 p.m. (see page 2 of this issue). Please check out our website (<http://www.epi.umn.edu/mch/HealthyGenerations/hga.html>) for any possible changes and updates. The videoconference provides you the chance to speak with the authors featured in this issue. If you are not able to attend the videoconference, free videotapes of the event can be requested from Jan Pearson (pearson@epi.umn.edu or call 612.626.8644). Tapes of the previous conference on adolescent tobacco use, childhood obesity, women's reproductive health, and child abuse can also be requested.

I welcome any feedback or comments about *Healthy Generations* and related activities. Previous letters to the editor have been posted at <http://www.epi.umn.edu/mch/HealthyGenerations/HealthyGenerationsRes.html#letterToEditor>. You can contact me at meschke@epi.umn.edu or call 612.625.4891.

Subscriptions to *Healthy Generations* are free, however, to insure you receive a copy of *Healthy Generations* regularly, you need to subscribe. To join our list of subscribers please contact Jan Pearson at pearson@epi.umn.edu or call 612.626.8644.

Laurie L. Meschke, Ph.D.
Editor

Healthy Generations Videoconference Adolescent Alcohol Use

October 31, 2001
1-3 p.m.

Minnesota Sites

Anoka RTC

3301 7th Avenue N.,
Anoka

Clay County

1st Floor
Family Services Center
715 11th Street N.,
Moorhead

Chisago County

Room 358
313 N. Main Street,
Center City

Ramsey County

MDH Distance Learning
Center
3rd Floor, Metro Annex,
130 E. 7th Street, St. Paul

Douglas County

809 Elm Street, Alexandria

Freeborn County

203 W. Clark Street,
Room 241, Albert Lea

Kandiyohi County

Room 2057, Health and
Human Service Building
2200 23rd Street NE,
Willmar

Koochiching County

715 4th Street,
International Falls

Rock County

204 E. Brown, Luverne

Steele County

630 Florence Avenue,
Owatonna

Registration is limited by site. To register please contact Jan Pearson by phone (612.626.8644) or email (pearson@epi.umn.edu). Please visit <http://www.epi.umn.edu/mch/HealthyGenerations.hga.html> for any changes to these sites.

Consequences of Adolescent Alcohol Use

Alcohol consumption by adolescents creates widespread consequences. Drinking alcohol impairs cognitive ability and judgment. Adolescent drinkers can find themselves in dangerous situations and because they are impaired, their ability to effectively reason or negotiate their way out of them is compromised. Most bad situations get much worse before they get better.

Particularly among adolescents, alcohol-impaired judgment can result in unwanted sexual activity. A National Center on Addiction and Substance Abuse study found that adolescents who drink were much more likely (than adolescents who did not drink) to engage in sex, initiate sex earlier, and have multiple sex partners.⁵ Another survey of high school students reported that 39% of boys and 18% of girls, thought it was acceptable for a boy to force sex on a girl if the girl was drunk or stoned.⁶ Sexual activity is most often accompanied by the risk of sexually transmitted disease and unintended pregnancy.

Because young people tend to have minimal experience in both drinking and driving, they represent a heightened threat when driving after drinking alcohol. Fourteen percent of the 7,973 drivers age 16 to 20 years old who were killed in traffic crashes in 1999 were intoxicated on alcohol.⁷ Alcohol use is also associated with an elevated risk of accidental injuries, suicide, risk of violence, and likelihood that aggressive behavior will escalate.⁸

Yet adolescent alcohol use is a risky business not just because of its short-term effects. One significant, long-term risk that few adults today fully appreciate is that the earlier the age of first alcohol use, the more likely future alcohol problems. Early onset of alcohol use predicts a greater likelihood of both future alcohol abuse and dependence. A recent, longitudinal research study by the National Institute on Alcohol Abuse and Alcoholism found that the earlier one starts drinking, the more likely one is to develop alcohol dependence.⁴ This study involved the analysis of data from the National Longitudinal Alcohol Epidemiologic Survey and interviews with 27,616 current and former drinkers in 1992.

Among respondents who began drinking before the age of 15, over 40% were classified as alcohol dependent at some point in their lifetime.

Yet among respondents who began drinking at the age of 21 and 22, only 10% became alcohol dependent at some point in their lifetime. The same patterns held true for the development of alcohol abuse.⁴ These findings suggest that great benefit can be derived from delaying the onset of drinking among young people, because it significantly reduces the risk of developing future alcohol-related problems.

Nationwide about half of all admissions to addiction treatment programs were for alcohol (48%) in 1997. Of those, slightly over half (56%) were for alcohol only, and 44% were for alcohol with a secondary drug. For the alcohol-only clients, 5% were under age 20, and 81% were age 30 and older. For the alcohol with secondary drug admissions, 12% were under age 20, and 74% were age 30 and older.⁹

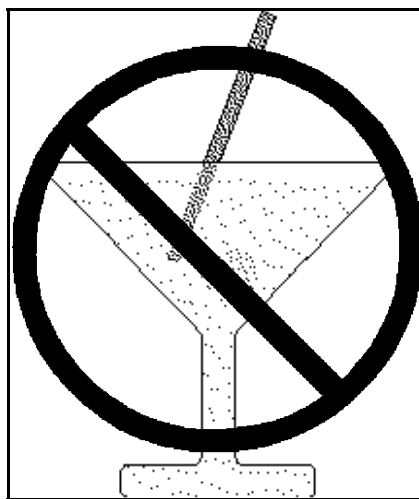
Current Challenges

Mothers Against Drunk Drivers, a group that began in the 1980s, has been credited with advancing a public agenda that significantly reduced the extent of drinking and driving among all age groups. In addition, age 21 minimum drinking age laws reduced traffic fatalities among 18 to 20 years olds by 13%, and thereby saved 18,000 lives since 1975.¹⁰ Since 1998, all 50 states have "zero tolerance laws," or "not a drop laws," where the legal BAC level for drivers under the age of twenty-one, is between .00% and .02% depending on the state.¹¹

Yet many of today's parents, who grew up when the legal drinking age was 18 years, voice few objections to alcohol use among their teenaged children, just as long as they don't drive after drinking. So while public safety improved when driving under the influence of alcohol declined, were the other dangers associated with youth alcohol use minimized?

Widespread underage alcohol use occurs in the context of these cultural norms that, to some extent, look the other way, or view teen drinking as an acceptable rite of passage into adulthood. Children are exposed to alcohol advertising at very young ages, observe alcohol use by their parents and family, and are not always educated about the concept of "appropriate" use

New and daring drinking games flourish: group activities with the goal of drinking alcohol to intoxication. Some, for example, require all players to drink a shot of distilled spirits at a specified moment of a TV show or group conversation. And there are also innovative ways of administering alcohol, such as a "beer bong," a long, flexible, plastic tube inserted down a person's throat directly into the stomach. With a funnel attached to the exterior end of the tube, alcoholic beverages are poured directly into the

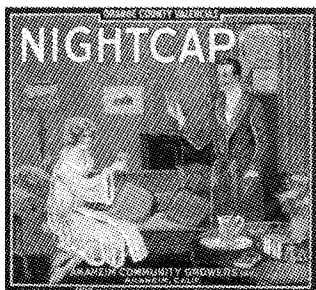


stomach, thus allowing ingestion of a large volume of alcoholic beverage in the briefest time possible, for more rapid onset of effects.

There are many possible explanations of why underage drinking continues unabated. Perhaps our heavy-handed efforts to discourage illegal drug abuse by young people inadvertently resulted in greater tolerance of alcohol use, as somehow the "lesser of two evils." Perhaps many adults are genuinely not concerned about youth drinking, because "kids will be kids," and it's something they did themselves in their youth. Whatever the case, underage alcohol use remains a primary, preventable public health and public safety issue among adolescents.

References:

1. U.S. Department of Health and Human Services (DHHS), Substance Abuse and Mental Health Services Administration. National Household Survey on Drug Abuse Series: H-12. Summary of findings from the 2000 National Household Survey on Drug Abuse. DHHS; 2000. Pub. No.(SMA) 00-3466.
2. University of Michigan, Institute for Social Research. Monitoring the future: A continuing study of America's youth. 2000. Available at: <http://www.monitoringthefuture.org>. Accessed June 25, 2001.
3. Centers for Disease Control and Prevention. Youth risk behavior surveillance - U.S. 1997. MMWR Surveillance Summ 1997;47 (no. SS-3):1-89.
4. Grant, BF, Dawson, DA. Age at onset of alcohol use and its association with DSM - IV alcohol abuse and dependence: Results of the National Longitudinal Alcohol Epidemiologic Survey. J Subst Abuse 1998;10:163-173.
5. National Center on Addiction and Substance Abuse. Dangerous liaisons: Substance abuse and sex. New York: Columbia University; 1999.
6. U.S. Department of Health and Human Services. Youth and alcohol: Dangerous and deadly consequences: Report to the Surgeon General, Inspector General; 1992. As summarized by National Clearinghouse for Alcohol and Drug Information (NCADI) in: Sex under the influence of alcohol and other drugs. Making the Link Fact Sheets. Washington, D.C.: NCADI; 1992. Inventory No. ML005.
7. U.S. Department of Transportation, National Highway Traffic Safety Administration. Traffic safety facts, 1998. DOT-HS-809-086. Available at: <http://www.nhtsa.dot.gov>. Accessed June 25, 2001.
8. U.S. Department of Health and Human Services, Public Health Service, National Institutes of Health (NIH), National Institute on Alcohol Abuse and Alcoholism. Tenth special report to the U.S. Congress on Alcohol and Health. NIH Publication; 2000. No. 00-1583.
9. U.S. Department of Health and Human Services (DHHS), Substance Abuse and Mental Health Services Administration, Office of Applied Studies. Treatment episode data set 1992 -1997. DHHS Publication; 1999. No. 99-3324.
10. U.S. Department of Transportation (DOT), National Highway Traffic Safety Administration. Traffic safety facts, 1998. DOT; 1999. DOT-HS-808-950.
11. U.S. Department of Transportation, National Highway Traffic Safety Administration. The effects of .08 BAC laws. 1999. Available at: <http://www.nhtsa.dot.gov/people/ncsa/Effectsof08.html>. Accessed on June 28, 2001.



Youth Substance Use Prevention – A Focus on Protective Factors*

Laurie L. Meschke, Ph.D. and Joän Patterson, Ph.D.
Maternal and Child Health Program
Division of Epidemiology
University of Minnesota

The decision to use or avoid alcohol happens in a social context. Rarely is there a single factor or event that causes behavior as complex as alcohol use. Many adolescents grow up in high-risk environments - such as crime-ridden neighborhoods, high conflict families, or schools with frequent exposure to alcohol-using peers - and are at increased risk of alcohol use.¹

Despite popular belief, the majority of teens transition to adulthood without lasting problems.^{2,3} The process by which successful developmental or adaptive outcomes occur within a high-risk environment and/or stressful circumstances is referred to as *resilience*.⁴ Various protective mechanisms buffer the influence of risk factors on adolescent alcohol use. Over the past decade, interest in youth's capacity to be resilient and avoid substance use has increased.^{5,6}

Resilience is not a trait of any individual or system, but rather a set of processes that can be inferred when the individual or system of interest shows competence in response to significant risk exposure.⁷ At the individual level, examples of chronic risk exposure would be growing up with a mentally ill parent, one of the foci of Rutter's⁸ and Garmezy's⁹ work; or growing up in poverty, a focus of Werner and Smith's work.¹⁰

Risk and protective factors can be found within adolescents, in their families, and within their communities. Most of the current information in the area of adolescent alcohol use tends to focus on factors that put teens at *risk*. Here we focus primarily on factors at the individual, family and community level that *protect* teens from risky behaviors, including alcohol use.

Individual Resilience Processes

Although genetic markers have been related to an increased risk of alcohol abuse,⁶ no specific gene or bodily function has been shown to be a key protector against alcohol use. However, psychological factors have been associated with an increased likelihood of resilience for high-risk youth.

For youth ages 11-13, **self-perceived competence, academic competence and healthy interactions with adults** buffered the effect of negative life events on adolescent alcohol use.¹¹ The importance of **religion and prayer** in the lives of youth was a significant protector against adolescent alcohol use.¹² Higher levels of religiosity also were related to lower levels of drinking and drunkenness.¹³

In a recent study of over 130 middle-class, Caucasian youth (ages 10-12), parental norms had a direct effect on early adolescent alcohol consumption. However, further investigation revealed that the relation

between parental norms and adolescent consumption was actually moderated by norms of the target adolescent.¹⁴ This finding implies that the risk presented by parents with alcohol-tolerant norms might be buffered by **anti-alcohol norms** of the adolescents and their peer groups.

Alcohol use may or may not be accompanied by the use of other substances. In a compelling longitudinal study, four patterns of substance use by teens were examined: (1) alcohol use only; (2) alcohol and tobacco use (AT); and (3) alcohol, tobacco, and marijuana use (ATM); and (4) abstainers. Adolescents who used only alcohol were more likely to display **socially skilled behavior** in the elementary grades than the abstainers. Compared to AT users (girls and boys), the abstainers had better early academic performance and handled aggression more appropriately. Teachers viewed abstaining girls as more popular during childhood than the AT girls. Elementary teachers also reported that abstaining males displayed more likeable behavior and were less likely to be loners on the playground than the male AT users.¹⁵

According to teachers, the abstaining girls were less withdrawn and more mature in responding to conflict than the ATM girls. Boys in the ATM group had higher teacher disapproval, increased negative verbal interaction with teachers, less on-task behavior, poorer school adjustment and academic performance, more isolated play behavior, less social preference (peer rating), more aggressive and less likable peer-related behavior, and less mature responses to conflict than their abstaining peers.¹⁵

The strength of this longitudinal study emphasizes the influence of early developmental skill acquisition on subsequent adolescent substance use, particularly more extreme substance use. It is interesting to note that adolescents who used only alcohol were more likely to display socially skilled behavior in the elementary grades compared to the abstainers.¹⁵

Summary. Several individual factors have been associated with delayed and less frequent substance use, including religious beliefs and practices, norms against youth alcohol use, and academic competence. Social skills, both as a child and an adolescent, also appear to be a potential protector of youth from substance abuse.

Family Resilience Processes

Many parents feel helpless in supporting their teens to make healthy decisions about alcohol use because so many factors, such as peer pressure, low alcohol and tobacco prices, lack of law enforcement, and depression, have increased the risk of adolescent alcohol use. Yet the research clearly shows that parents can and do make a difference in the lives of American adolescents.

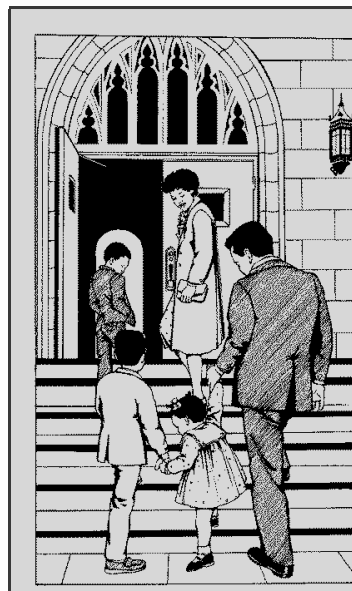
High levels of **marital harmony** have been related to lower levels of adolescent substance use.¹⁶ Harmonious marital relationships are likely to alleviate stress, a common antecedent of alcohol use.¹¹ Adolescents whose **parents abstain** from using cigarettes, alcohol, or drugs have been less likely to abuse substances than peers with substance using parents.^{12,17} If parents do drink alcohol, high levels of **family management** (monitoring, clear expectations, and positive reinforcement for desired behavior) have reduced the effect of parental alcohol use on adolescent alcohol use. **Psychologically healthy** parents also lower the risk of adolescent alcohol abuse.¹⁹

Family hardiness, an adolescent's perception that his or her family works together toward a common goal to manage stress, has been related to lower levels of adolescent alcohol use.²⁰ High levels of **parental support** have been related to less adolescent alcohol use.^{11,13,15,21,22} Parental support actually has reduced the effect of negative life events on adolescent alcohol use.¹¹ **Family bonding** has an indirect effect on adolescent alcohol use by influencing adolescent choice of friends and their educational commitment.²³ **Family connectedness** (i.e., feeling loved and wanted by family members) also has lowered the risk of adolescent substance use.¹²

Healthy parent-adolescent communication has been associated with less teen substance use. Affectionate

parent-adolescent communication and interaction has been a protective factor, reducing the influence of risk factors on adolescent drug use.²⁴ Parent-adolescent communication also has buffered the effects of media on adolescent alcohol use. Parents who countered media messages reduced the positive expectancies (identification and perceived realism) that adolescents attributed to alcohol. Yet parents who reinforced media messages increased adolescents' expectancies, identification and perceived realism about alcohol use as portrayed by the media.

Summary. Parent characteristics and parent-adolescent relationships have been well examined



regarding their association with adolescent alcohol use. Important protective factors offered by parents include effective parent-adolescent communication, authoritative parent-child relationships, and parents who abstain from substance use. Parents continue to have a great impact on the lives of their teens. Health educators should strive to empower parents to take advantage of their positive influence on adolescent substance use prevention.

Community Resilience Processes

Research examining the relation between community or neighborhood characteristics and adolescent alcohol use is rather new compared to the individual and parent research in this area. No studies have yet examined the potential buffering effect that communities might provide to high-risk teens. However, early studies that examined the direct relation between community mechanisms and adolescent substance use are encouraging.

Schools are a primary community for adolescents. Characteristics or norms espoused by schools have been related to adolescent alcohol use. Schools that allow for **greater student autonomy and influences** had students with lower levels of alcohol use.²⁶ **School norms** about illicit drug use (substances other than alcohol, cigarettes, and marijuana) were positively related to the adolescents' alcohol, tobacco, and marijuana use and also the use of harsher substances.²⁷ School norms were measured as the average substance use by the students, minus the substance use of the target student. Thus, schools with overall low substance use promoted lower substance use among individual students.

The importance of **school connectedness** also has been emphasized as a protective force related to adolescent substance use. High levels of school connectedness, measured as the adolescents' sense of belonging and fairness related to their schools, were associated with less frequent alcohol, cigarette, and marijuana use for a nationwide group of students in grades 7-12.¹²

School sense of community also has been related to less adolescent substance use. School sense of community reflects caring and supportive interpersonal relationships and student autonomy and influence. After controlling for student differences

in sense of community and other student- and school-level characteristics (e.g., grade, poverty level), higher levels of sense of community at the school level were related to significantly less student alcohol use.

Based on studies examining direct linkages between community characteristics and adolescent substance use, a number of factors could potentially promote resilience in high-risk youth. Some neighborhoods have less access to alcohol than others, thus deterring youth substance use.²⁹ Community members also can unite in a **no tolerance approach** to adolescent alcohol use. No tolerance attitudes towards substance use include enforcing regulations to ensure low youth access to substances.

Community policies at the local and state level also can be effective in preventing adolescent substance use.

Local law enforcement has significantly deterred youth alcohol use. In a review focusing on the minimum legal drinking age (MLDA), Toomey and her colleagues concluded that high levels of MLDA enforcement and legal consequences for adults who provide alcohol to minors can help prevent injuries and death among youth.³⁰

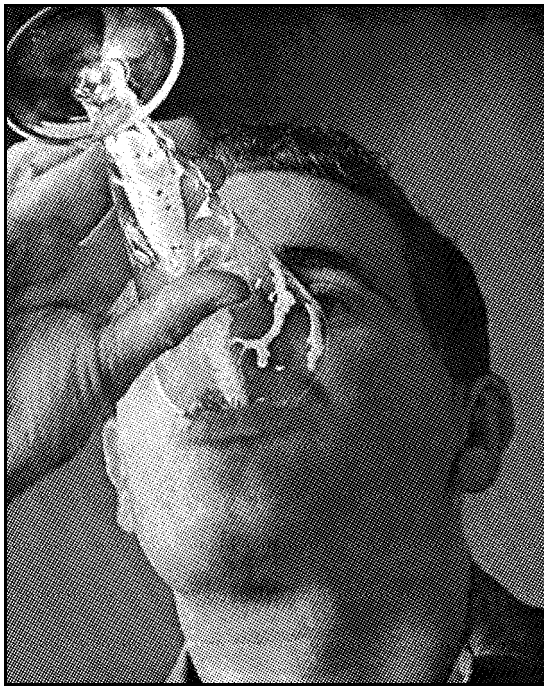
At the state level, Grossman and his colleagues examined the relation between alcohol prices and youth outcomes via several national secondary data sets. The price of beer for a particular state was attached to each of the survey participants based on area of residence. Higher beer prices were associated with lower alcohol use and lower motor vehicle accident mortalities. **Higher alcohol prices** were also related to higher college completion rates.³¹ Based

on the analyses, it is not known if this perceived protective effect was consistent for high and low risk youth.

Summary. Each of the reviewed studies examined the direct relation between community mechanisms and adolescent alcohol use. In general, communities that provide youth with a sense of belonging or connectedness are most influential in deterring alcohol use. Policy also has had a strong impact on youth substance use. Research findings suggest that prevention opportunities exist for communities of all sizes - from schools to neighborhoods to states.³¹

Conclusions

Prevention opportunities for adolescent alcohol use exist at the individual, family, and community levels.



Often times prevention efforts focus on reducing risk mechanisms. The literature reviewed here encourages practitioners to also consider enhancing and fostering protective factors.

***This article was adapted from Meschke, LL, Patterson, JM. Resilience as a theoretical basis for substance abuse prevention. J Prim Prev, in press.**

References:

1. Swadi, H. Individual risk factors for adolescent substance use. *Drug Alcohol Dependence* 1999;55:209-224.
2. Graber, JA, Brooks-Gunn, J, Petersen, AC, editors. *Transitions through adolescence: Interpersonal domains and context*. Mahwah, NJ: Lawrence Erlbaum Associates, Inc.; 1996.
3. Petersen, AC, Leffert N. What is special about adolescence? In: Rutter M, editor. *Psychosocial disturbances in young people*. New York, NY: Cambridge University Press; 1995.
4. Luthar, SS, Cicchetti, D, Becker, B. The construct of resilience: A critical evaluation and guidelines for future work. *Child Development* 2000;71:543-562.
5. Braverman, M. Research on resilience and its implications for tobacco prevention. *Nicotine Tobacco Res* 1999;1:S67-S72.
6. Hawkins, JD, Catalano, RF, Miller, JY. Risk and protective factors for alcohol and other drug problems in adolescence and early adulthood: Implications for substance abuse prevention. *Psychol Bull* 1992;112:64-105.
7. Masten, AS, Coatsworth, JD. The development of competence in favorable and unfavorable environments: Lessons from research on successful children. *American Psychologist* 1998;53:205-220.
8. Rutter, M. Resilience in the face of adversity: Protective factors and resistance to psychiatric disorder. *Brit J Psychiat* 1985;147:598-611.
9. Garmezy, N. Stress, competence, and development: Continuities in the study of schizophrenic adults, children vulnerable to psychopathology, and the search for stress-resistant children. *Am J Orthopsychiat* 1987;57(2):159-174.
10. Werner, EE, Smith, RS. *Vulnerable but invincible: A longitudinal study of resilient children and youth*. New York: McGraw-Hill; 1982.
11. Wills, TA, Vaccaro, D, McNamara, G. The role of life events, family support and competence in adolescent substance use: A test of vulnerability and protective factors. *Am J Commun Psychol* 1992;20:349-374.
12. Resnick, MD, Bearman, PS, Blum, RW, Bauman, KE, Harris, KM, Jones, J et al. Protecting adolescents from harm: Findings from the National Longitudinal Study on Adolescent Health. *JAMA* 1997;278:823-832.
13. Barnes, GM, Farrell, MP, Banerjee, S. Family influences on alcohol abuse and other problem behaviors among black and white adolescents in a general population sample. *J Res Adolescence* 1994;4:183-201.
14. Brody, GH, Ge, X, Katz, J, Arias, H. A longitudinal analysis of internalization of parental alcohol-use norms and adolescent alcohol use. *Appl Develop Sci* 2000;4:71-79.

15. Hops, H, Davis, B, Lewin, LM. The development of alcohol and other substance use: A gender study of family and peer context. *J Stud Alcohol* 1999;13:22-31.
16. Grossman, FK, Beinashowitz, J, Anderson, L, Sakura, M, Finnin, L, Flaherty, M. Risk and resilience in young adolescents. *J Youth Adolescence* 1992;21:529-550.
17. Denton, RE, Kampfe, C. The relationship between family variables and adolescent substance abuse: A literature review. *Adolescence* 1994;29:475-495.
18. Peterson, PL, Hawkins, JD, Abbot, RD, Catalano, RF. Disentangling the effects of parental drinking, family management, and parental alcohol norms on current drinking by black and white adolescents. *J Res Adolescence* 1994;4:203-227.
19. Merikangas, KR, Rounsaville, BJ, Prusoff, BA. Familial factors in vulnerability to substance abuse. In: Glantz, MD, Pickens, RW, editors. *Vulnerability to Drug Abuse*. Washington, DC: American Psychological Association; 1992. p.75-97.
20. Stephenson, AL, Henry, CS, Robinson, LC. Family characteristics and adolescent substance use. *Adolescence* 1996;31:59-77.
21. Barrera, M, Chassin, L, Rogosch, F. Effects of social support and conflict on adolescent children of alcoholic and nonalcoholic fathers. *J Pers Soc Psychol* 1993;64:602-612.
22. Brook, JS, Brook, DW, Gordon, AS, Whiteman, M, Cohen, M.

Healthy Generations Event

The Minnesota videoconference on adolescent alcohol use is on October 31, 2001 from 1-3 p.m. This event is free of charge. To register, contact Jan Pearson (612.626.8644 or pearson@epi.umn.edu). See the sites listed on page 2.

The psychosocial etiology of adolescent drug use: A family interactional approach. *Genet Soc Gen Psych* 1990;116:111-267.23. Bahr, SJ, Marcos, AC, Maughan, SL. Family, educational and peer influences on the alcohol use of female and male adolescents. *J Stud Alcohol* 1995;56:457-469.

24. Brook, JS, Brook, DW. Risk and protective factors for drug use: Etiological considerations. In: McCoy, CB, Metsch, LR, Inciardi, JA, editors. *Intervening with Drug-Involved Youth*. Thousand Oaks, CA: Sage Publications; 1996.
25. Austin, EW, Picketon, BE, Fiyoka, Y. The role of interpretation processes and parental discussion in the media's effects on adolescents' use of alcohol. *Pediatrics* 2000;105:343-349.
26. Battistich, V, Schaps, E, Watson, M, Solomon, D. Prevention effects of the child development project: Early findings from an ongoing multisite demonstration trial. *J Adolescent Res* 1996;11:12-35.
27. Allison, KW, Crawford, I, Leone, PE, Trickett, E, Perez-Febles, A, Burton, LM, Le Blanc, R. Adolescent substance use: Preliminary examinations of school and neighborhood context. *Am J Commun Psychol* 1999;27:111-141.
28. Battistich, V, Hom, A. The relationship between students' sense of their school as a community and their involvement in problem behaviors. *Am J Public Health* 1997;87:1997-2001.
29. Carroll, CR. *Drugs in modern society*. 3rd ed. Dubuque, IA: Brown and Benchmark; 1993.
30. Toomey, TL, Rosenfeld, C, Wagenaar, AC. The minimum legal drinking age: History, effectiveness, and ongoing debate. *Alcohol Health Res W* 1996;20:213-218.
31. Grossman, M, Chaloupka, FJ, Saffer, H, Laixuthai, A. Effects of alcohol price policy on youth: A summary of economic research. *J Res Adolescence* 1994;4:347-364.

Reducing Youth Access to Alcohol

Traci L. Toomey, PhD
Assistant Professor, Epidemiology
School of Public Health
University of Minnesota

Following Prohibition, most states had an age 21 minimum legal drinking age (MLDA). During the early 1970s, however, many states lowered their MLDA to ages 18, 19, or 20. Because of concern over high rates of alcohol-related traffic crashes among youth, a grassroots movement developed during the mid-1970s to put pressure on policymakers to raise the MLDA back to age 21. By the mid-1980s most states had re-enacted the age-21 MLDA, but a few states resisted the grassroots pressure. This resulted in concern over potential increases in traffic crashes resulting from youth crossing into border states to purchase alcohol in neighboring states that had lower MLDA. In 1984, the federal government increased pressure on these remaining states, threatening to take federal highway funds from states that failed to increase their MLDA. By 1988, all states had established an age-21 MLDA.¹

Over 130 studies have evaluated the effects of lowering and raising the MLDA. The preponderance of research findings indicate that lowering the MLDA resulted in higher consumption and traffic crashes among young people. Increases in the MLDA had the opposite effect -- less alcohol use and fewer traffic crashes.^{1,2} The National Highway Traffic Safety Administration estimates that the age 21 MLDA has saved over 19,000 lives since 1975 through prevention of traffic crashes.³ More recent studies suggest that the age-21 MLDA may also be preventing other alcohol-related problems among youth such as suicides and vandalism.^{1,2}

Despite the effectiveness of the MLDA in preventing alcohol-related problems, a large percent of youth continue to drink alcohol.⁴ One explanation for this is that the MLDA has not been well enforced across most states until recently.^{5,6} When enforcement of the MLDA did occur, it usually targeted underage individuals who were caught drinking. Adults who illegally provided alcohol to underage youth and licensed establishments that illegally sold alcohol to youth were unlikely to face any legal consequences. As a result, youth have had easy access to alcohol.

Youth participating in focus groups and school surveys indicate that they can easily obtain alcohol from both social (e.g., friends, siblings, parents, coworkers) and

commercial (e.g., bars, restaurants, liquor stores) sources.^{7,8}

Observations of alcohol service practices at licensed establishments confirm that prior to enforcement, many establishments will sell alcohol to underage youth.⁹⁻¹¹ Several studies conducted in the early 1990s showed that youth who appeared to be 18 or 19 years old could buy alcohol without showing any age identification at least once out of every two tries.^{9,10,11}

Where youth obtain alcohol changes with age.¹² Adolescents just starting to drink report getting alcohol from their own home or from the homes of friends. As youth get a little older, they are more likely to begin attending parties where alcohol is sup-



Alcohol purchased by buyers without age identification who appeared younger than age 21.

plied by parents or peers. They may also begin approaching adults outside alcohol establishments to ask them to purchase alcohol. Older youth are more likely to attempt to purchase alcohol than younger youth. Once they have obtained alcohol, many underage youth become a source of alcohol for other underage youth.

To increase the effectiveness of the age-21 MLDA, many communities and states are developing and enforcing policies targeting specific sources of alcohol. One promising strategy for reducing rates of illegal alcohol sales is compliance checks, where underage youth attempt to purchase alcohol under the supervision of law enforcement agents. If illegal alcohol sales are made, servers who sold the alcohol may face a criminal penalty and the license holders may be fined or have their licenses suspended or

revoked. Compliance checks can also be used to prevent illegal sales made in private residences during home deliveries of alcohol. Home deliveries of alcohol may be made through internet sales or by local alcohol retailers in many areas. Research studies and community data suggest that regular compliance checks significantly reduce the number of licensed establishments that sell alcohol to underage youth.^{13,14} Many communities use graduated administrative penalties to complement compliance checks. These penalties are applied against the license holders and begin as small fines for a first offense and gradually increase with each subsequent offense.

Another popular approach used by states and communities to prevent illegal alcohol sales to underage youth is training servers of licensed establishments. Server training programs attempt to provide servers with the skills to check age identification and to refuse service to underage youth. Just training the alcohol servers, however, may not be sufficient.¹⁵ Training for alcohol establishment managers and owners is also needed to give them the skills to develop establishment policies that clearly define management's expectations about responsible service of alcohol. Despite the popularity of owner/manager training programs, very few high quality programs exist. In addition, training programs by themselves are not likely to significantly reduce rates of illegal alcohol sales to underage youth.¹⁶

Several policies have also been identified to reduce the number of social providers of alcohol; however, few of these policies have been evaluated. Keg registration policies require alcohol retailers to record identification information of keg purchasers along with unique identification numbers attached to beer kegs. Keg registration helps police identify adult purchasers of kegs who supply alcohol to underage youth.

Shoulder tap campaigns are similar to compliance checks. Under the supervision of law enforcement agents, underage youth approach adults to ask them to purchase alcohol. Adults who illegally provide alcohol to the youth are given a warning or citation. Other types of policies have been used to decrease access to alcohol at parties, for example, by preventing parties from occurring on public property (e.g., at beaches or parks) or by giving law enforcement agents the ability to break up parties (e.g., noisy assembly laws).

Some states, including Minnesota, also enable people to sue adults who provide alcohol to underage youth if that provision of alcohol results in an injury to a third party (in these situations, the provider can also be charged with a felony in Minnesota). Summaries of these and other policies to reduce youth access to alcohol are available at www.epi.umn.edu/alcohol.

This website also provides model ordinances for communities attempting to reduce youth access to alcohol and a manual on how to conduct alcohol compliance checks.

In conclusion, evaluation of the MLDA laws indicate that reducing youth access to alcohol is a promising approach for decreasing drinking and alcohol-related problems among youth. To make the age 21 MLDA even more effective, communities and states need to actively enforce the MLDA laws. Several policies have been identified to target specific sources of alcohol used by underage youth. Support is high throughout the United States for policies that target both commercial and social sources of alcohol.¹⁷

References:

1. Toomey, TL, Rosenfeld, C, Wagenaar, AC. The minimum legal drinking age: History, effectiveness, and ongoing debate. *Alcohol Health Res W* 1996;20(4):213-218.
2. Wagenaar, AC, Toomey, TL. Effects of minimum drinking age laws: Review and analyses of the literature. *J Stud Alcohol*, in press.
3. National Center for Statistics and Analysis. Traffic safety facts 1999 - Alcohol. Washington, DC: US Department of Transportation; 2000.
4. Johnston, LD, O'Malley, PM, Bachman, JG. National survey results on drug use from the Monitoring the Future study, 1975-1997. Volume I: Secondary school students. (NIH Publication NO. 98-4345) and Volume II: College students and young adults. (NIH Publication No: 98-4346). Rockville, MD: National Institute on Drug Abuse; 1998.
5. Wagenaar, AC, Wolfson, M. Deterring sales and provision of alcohol to minors: A study of enforcement in 295 counties in four states. *Public Health Rep* 1995;110:419-427.6. Wagenaar, AC, Wolfson, M. Enforcement of the legal minimum drinking age in the United States. *J Public Health Pol* 1994;15:37-53.
7. Jones-Webb, R, Toomey, TL, Short, B, Murray, DM, Wagenaar, A, Wolfson, M. Relationships among alcohol availability, drinking location, alcohol consumption, and drinking problems in adolescents. *Subst Use Misuse* 1997;32:1261-1285.
8. Wagenaar, AC, Toomey, TL, Murray, DM, Short, BJ, Wolfson, M, Jones-Webb, R. Sources of alcohol for underage drinkers. *J Stud Alcohol* 1996;57:325-333.
9. Forster, JL, McGovern, PG, Wagenaar, AC, Wolfson, M, Perry, CL, Anstine, PS. The ability of young people to purchase alcohol without age identification in northeastern Minnesota, USA. *Addiction* 1994;89:699-705.
10. Forster, JL, Murray, DM, Wolfson, M, Wagenaar, AC. Commercial availability of alcohol to young people: Results of alcohol purchase attempts. *Prev Med* 1995;24(4):342-347.
11. Preusser, DF, Williams, AF. Sales of alcohol to underage purchasers in three New York counties and Washington, D.C. *J Public Health Pol* 1992;13:306-317.
12. Wagenaar, AC, Finnegan, JR, Wolfson, M, Anstine, PS, Williams, CL, Perry, CL. Where and how adolescents obtain alcoholic beverages. *Public Health Rep* 1993;108:459-464.
13. Preusser, DF, Williams, AF, Weinstein, HB. Policing underage alcohol sales. *J Safety Res* 1994;25:127-133.
14. Grube JW. Preventing sales of alcohol to minors: results from a community trial. *Addiction* 1997; 92(Suppl 2 Jun):S251-60.
15. Toomey, TL, Kilian, GR, Gehan, JP, Wagenaar, AC, Perry, CL, Jones-Webb, R. Qualitative assessment of responsible alcohol service training programs. *Public Health Rep* 1998;113(2):162-169.
16. Toomey, TL, Wagenaar, AC, Gehan, JP, Kilian, G, Murray, D, Perry, CL. Project ARM: Alcohol risk management to prevent sales to underage and intoxicated patrons. *Health Educ Behav* 2001;28(2):186-199.
17. Wagenaar, AC, Harwood, EH, Toomey, TL, Denk, CE, Zander, KM. Public opinion on alcohol policies in the United States: Results from a national survey. *J Public Health Pol* 2000;21:303-327.

Teens across America could use your help.



- o Adolescents (ages 15-19) represent less than 16 percent of the population of reproductive age (ages 14-44), yet account for almost 27 percent of new STI cases (4 million of 15 million new STIs)
- o Of rural 10th graders, 30.4% report cigarette use in the past 30 days
- o Among the world's developed countries, the United States has one of the highest teen pregnancy rates-double the rate of France, and nine times the rate of the Netherlands and Japan.
- o The risk for sexually transmitted diseases in African-American and American Indian adolescents is almost twice as high as that of European-Americans

Adolescents face a variety of challenges and opportunities in the United States. Public health workers, including maternal and child health professionals, are working to develop programs, policies, and surveillance methods to promote optimal health for all adolescents and their families.

If you have an interest in public health—especially adolescence—consider applying your talents and your passion to a career in Maternal and Children Health. One- and two-year Master's in Public Health (MPH) training is provided through the Maternal and Child Health (MCH) Program in the Division of Epidemiology, School of Public Health at the University of Minnesota. The program of study integrates practical experience with scientific and methodological content.

What does an MCH professional do? MCH professionals, at the master's and Ph.D. level, focus on developing individual- and community-level programs, policies, and surveillance systems that promote and preserve the health of families, including mothers, children, and adolescents.

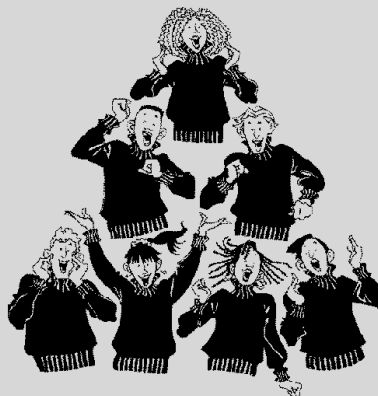
Who should apply for an MPH in Maternal and Child Health? People who want to positively influence health outcomes of mothers, youth, and families in the United States should apply. Students may be interested in program development and evaluation, policymaking, assessment, surveillance, teaching, or research. Individuals with degrees in MCH work in multidisciplinary collaborations in health-care organizations, community-based programs, public health departments, and private or public research organizations.

The Master's in Public Health in MCH is an appropriate degree for individuals interested in applying to PhD programs in behavioral or biological epidemiology, such as those offered in the Division of Epidemiology, where the MCH Program is housed.

Why Minnesota? There are two major reasons that individuals who are interested in adolescent health should come to the University of Minnesota: (1) Minnesota has taken a progressive approach to adolescent health, including several adolescent health clinics and extensive funding from the Minnesota Department of Health to promote adolescent health; and (2) the MCH Program has a large and talented faculty with a great interest in adolescence. The MCH faculty have strong community ties and national reputations for excellence in research.

The MCH Program at the University of Minnesota is nationally recognized as one of 13 federally funded training programs. Of the 21-member multidisciplinary MCH faculty, 18 are currently conducting research in the area of adolescence. The adolescent research areas include obesity, tanning beds use, alcohol use prevention, tobacco use prevention, nutrition, pregnancy prevention and sexual health. They work collaboratively with faculty throughout the School of Public Health and the University, with particular strong linkages with the Adolescent Health Program in the Medical School, the School of Nursing, the School of Social Work, the Department of Family Social Science, and the Institute of Child Development.

For further information about the MCH Program-- call 612.626.8802 or 1.800.774.8636; email gradstudies@epi.umn.edu; or check out www.epi.umn.edu/mch and <http://www1.umn.edu/twincities/>



Selecting and Designing an Effective Prevention Program: Lessons from Project Northland

Carolyn L. Williams, Ph.D.
Professor, Epidemiology
School of Public Health
University of Minnesota

Popular culture has an enormous influence on young people, including their preferences for clothing, hairstyles, and music. Popular culture is often suggested as among the primary culprits for adolescents' use of alcohol, tobacco, and other drugs. Recent studies support this popular wisdom, given the persuasive and pervasive health-compromising messages promoted by mass media and advertising.^{1,2,3,4,5} For example, research indicates that sporting events and music videos, which are especially appealing to adolescents, expose youth to extensive alcohol and tobacco use by people they view as positive role models.^{1,4} In sporting events, beer commercials predominate and include images or themes that portray activities that are dangerous when combined with drinking (e.g., boating).

The pervasiveness and promotion of alcohol use in our society, contrasted with the needs and skills of youth, create a social environment that puts many adolescents at risk for alcohol-related problems. Public health strategies to prevent alcohol-related problems are most successful when they adopt both demand- and supply-reduction approaches to change the adolescent's social environment. Specific criteria have been linked with effective alcohol prevention programs.⁶ Unfortunately few programs meet these criteria. For example, multilevel interventions that include both individual behavior change (demand) and environmental change (supply) strategies are far less common in alcohol use prevention programs, despite their proven utility in reducing adolescent tobacco use. The development or selection of prevention programs should consider the established criteria.⁶ Project Northland [PN] is one of the programs that exemplify these criteria.⁷

Project Northland, planned by a team of researchers from the University of Minnesota, was a major community-wide research program developed to test the efficacy of a multilevel, multi-year intervention program for youth. It was the largest research trial that specifically targeted adolescent alcohol use, randomly assigned school districts and adjoining communities to intervention or delayed program conditions, and used a multilevel intervention program with both demand- and supply-reduction strategies. This multilevel program was designed to change parent-child communication about alcohol use, the functional meanings of alcohol use for young people, the students' self-efficacy to resist alcohol, peer influences to drink, alcohol use norms, and the students' ease of access to alcohol in their communities.⁸

The following describes how PN met the criteria of successful alcohol prevention programs.

Research based/theory driven. Basing a program on research and/or theory provides a framework by which to understand how attempts to change specific factors (e.g., resistance skills) should in turn prevent alcohol use. Social learning theory was used to develop PN interventions to decrease adolescent alcohol use and related problems through strategies to encourage adolescents not to drink, reduce alcohol availability, and modify community attitudes about youth drinking.

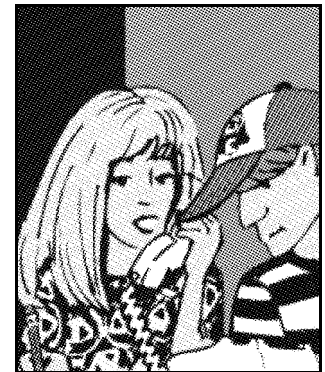
Developmentally appropriate information. In the area of substance use prevention, particular types of strategies work better for different age groups.^{9,10} PN began in sixth grade with education for parents to develop and communicate family guidelines discouraging underage drinking.

Peer leadership training was introduced in 7th grade. Community-level influences on underage drinking were gradually introduced by 8th grade, culminating in peer action teams during high school and a more complex curriculum in 11th grade. The name and content of PN programs changed annually to mark developmental changes in the cohort.

Social resistance skills training. Susceptibility to peer pressure peaks during early adolescence (6th-8th grade).¹¹ The 7th grade PN curriculum focused on developing skills to resist peer pressure as well as opportunities for peer leaders to plan alcohol-free student activities.

Normative education. Community norms around adolescent alcohol use must support youth efforts to engage in prosocial, alternate activities. Changes in norms about underage drinking were a major goal of the Project Northland interventions from 6th through 12th grades.

More broadly based skills training and comprehensive health education. In adolescent-focused programs, a number of broader social skills (e.g., communication¹²) and health components (e.g., stress management¹³) has been linked consistently to effective prevention efforts. Project Northland maintained a strong focus on alcohol but within that context taught youth leadership skills



Slick Tracy and Breathtest Mahoney of the 6th grade curriculum.

skills and ways to achieve developmental milestones in adolescence (e.g., autonomy and identity formation) without alcohol. Skills to identify and interpret unhealthy messages in the mass media also were taught.

Interactive teaching techniques. In order to attract and hold the attention of young program participants, the delivery of the materials should be interactive or incorporate active learning. Peer leaders, role plays (e.g., improvisational theater piece in 8th grade), comics, fun games, alternative activities, and small-group projects were used each year in PN.

Teacher training and support. Programs must be facilitated in the manner and apply the methods prescribed by the program designers, in order to ensure success.¹⁴ Teacher training helps accomplish this. Part-time field staff was available at each PN intervention school. Teachers attended half- or full-day training sessions before each classroom implementation.

Adequate coverage and sufficient followup. Successful prevention efforts last about two years and have a minimum of two years of booster sessions.¹⁵ PN covered 6th through 12th grades and had high participation rates each year.

Cultural sensitivity. Program materials must reflect the values and beliefs of the target audience to promote adherence. People of color were represented in PN program materials, which included content specific to northern Minnesota Indian tribes and were sensitive to rural and small-town life in a northern climate.

Additional components (e.g., family, community, mass media initiatives). Interventions that do not simultaneously incorporate multiple levels of intervention are likely to produce merely short-term changes in substance use.¹⁶ Parent training and communitywide initiatives were part of Project Northland from 6th grade onward. Print media also were used extensively throughout the program.

Evaluation. Evaluation determines whether a program is successful and how a program might be improved. Both design and measurement are critical in sound evaluation. PN was a randomized community trial using a cohort design beginning with sixth graders from 24 northern Minnesota school districts (N-2351; 91% of the eligible population). Outcome measures included an annual student survey; parent telephone interviews; observational studies of alcohol-purchase attempts by youthful buyers without age identification; and surveys of merchants, police, school principals, and community leaders.

Project Northland Works!

The results of Project Northland support the importance of incorporating the above criteria in program development and selection. The sixth to

to eighth grade Project Northland programs successfully (1) reduced adolescent alcohol use; (2) changed the functional meanings of alcohol use; (3) reduced peer norms and peer influence to use; (4) introduced skills to resist peer influences; and (5) increased parent-child communication about the consequences of drinking.

Community-wide, multi-component, multi-year approaches to alcohol use prevention can be very effective. Project Northland has demonstrated that a large number of school districts and communities can become involved in primary prevention efforts targeting adolescent alcohol use over a sustained period of time and will fully participate in multiple levels of social-behavioral interventions.

References:

1. DuRant, R. H., Rome, E. S., Rich, M., Allred, E., Emans, S. J., & Woods, E. R. Tobacco and alcohol use behaviors portrayed in music videos: A content analysis. *American Journal of Public Health*, 87 (7): 1131-1135, 1997.
2. Grube, J. W., & Wallack, L. Television beer advertising and drinking knowledge, beliefs, and intentions among school children. *American Journal of Public Health*, 84 (2), 254-259, 1994.
3. Klein, J. D., Brown, J. D., Childers, K. W., Oliveri, J., Porter, C., & Dykers, C. Adolescents' risky behavior and mass media use. *Pediatrics*, 92 (1), 24-31, 1993.
4. Madden, P. A., & Grube, J. W. The frequency and nature of alcohol and tobacco advertising in televised sports, 1990 through 1992. *American Journal of Public Health*, 84, 279-299, 1994.
5. Perry, C. L. The relationship between "Share of Voice" and "Share of Market" and implications for youth health promotion. *Health Education* 29 (4): 206-212, 1998.
6. Dusenbury, L., & Falco, M. Eleven components of effective drug abuse prevention curricula. *Journal of School Health*, 65 (10): 420-425, 1995.
7. Williams, C. L., & Perry, C. L. (1998). Lessons from Project Northland: Preventing alcohol problems during adolescence. *Alcohol Health and Research World*, 22, 107-116.
8. Perry, C. L., Williams, C. L., Veblen-Mortenson, S., Toomey, T., Komro, K., Anstine, P. O., McGovern, P., Finnegan, J. R., Forster, J. L., Wagenaar, A. C., & Wolfson, M. Outcomes of a community-wide alcohol use prevention program during early adolescence: Project Northland. *American Journal of Public Health* 86(7): 956-965, 1996.
9. Howard, M. & McCabe, J. B. (1990). Helping teenagers postpone sexual involvement. *Family Planning Perspectives*, 22, 21-26.
10. Tobler, N.S. (1992). Drug prevention programs at work: Research findings. *Journal of Addictive Diseases*, 11, 3, 1-28.
11. Brown, B., Clasen, D., & Eicher, S. (1986). Perceptions of peer pressure, peer conformity dispositions, and self-reported behavior among adolescents. *Developmental Psychology*, 22, 521-530.
12. Gorman, D. M. (1995). Are school-based resistance skills training programs effective in preventing alcohol misuse? *Journal of Alcohol and Drug Education*, 41, 74-98.
13. Botvin, G. J., Schinke, S. P., Epstein, J. A., Diaz, T., & Botvin, E. M. (1995b). Effectiveness of culturally focused and generic skills training approaches to alcohol and drug abuse prevention among minority adolescents: Two-year follow-up results. *Psychology of Addictive Behaviors*, 9, 1893-194.
14. Tobler, N. S.; & Stratton, H. H. (1997). Effectiveness of school-based drug prevention programs: A meta-analysis of the research. *Journal of Primary Prevention*, 18, 71-128.
15. Botvin, G. J., Baker, E., Dusenbury, L., Botvin, E. M., & Diaz, T. (1995a). Long-term follow-up results of a randomized drug abuse prevention trial in a white middle-class population. *Journal of the American Medical Association*, 273, 1106-1112.
16. Wagenaar, A. C., & Perry, C. L. (1994). Community strategies for reduction of youth drinking: theory and application. *Journal of Research on Adolescence*, 4, 319-345.



“Partners in Health” – Minnesota Join Together Coalition to Reduce Underage Drinking

Jeff Nachbar
Project Director
MN Join Together Coalition to Reduce
Underage Drinking

The Minnesota Join Together Coalition to Reduce Underage Drinking (MJT) is comprised of more than 800 youth, adults and organizations committed to state level policy change to restrict youth access to alcohol. Funded primarily by the Robert Wood Johnson Foundation and hosted by the Minnesota Institute of Public Health, MJT brings the voice of public health advocates to the Minnesota Legislature on issues impacting underage drinking. Founded in the mid-nineties by people alarmed at the power of the alcohol industry, MJT has become a credible voice influencing policy makers all across the state.

Instead of asking, "How can we stop young people from drinking?" MJT asks, "How can we stop adults from providing alcohol to youth?" and "How can we change the community environment that tolerates and even encourages underage drinking?" Research indicates that educational programs alone do not significantly reduce underage drinking. We should not stop educating young people. But to create long lasting, significant change, we must also change community environment to reinforce education and prevention programming.

During the past four years, MJT and its partners have made significant progress on state alcohol policy issues. Criminal and civil penalties for adult providers of alcohol to youth were increased. A state funded compliance check grant program was begun in 1998. More communities conduct alcohol compliance checks and passing local ordinances than before. Yet alcohol access is still too easy for young people. There are still too many adult providers, too many communities that tolerate it, and too many people who think underage drinking is no big deal - it's just a rite of passage.

Obviously, much work remains to be done. During the 2002 Legislative session MJT and its partners will be focusing on three primary issues:

Keg registration, an increase in the state alcohol excise tax and stopping supermarket wine sales.

Keg Registration

Statewide mandatory keg registration almost passed last year. Hopes are high that with organized public support it can be passed into law next year. This legislation will require all keg retailers to attach a label with purchaser information to every keg sold. This action will greatly aid legal investigative effort and provide a valuable deterrent to adults considering a keg purchase for minors. One of the most studied issues impacting underage drinking is pricing.

State Alcohol Excise Tax

Researchers conclude that alcohol price increases reduce underage drinking. Price increases also increase state revenues that can be directed toward increasing treatment, prevention and enforcement. The Minnesota alcohol excise tax is long over due for an increase. Currently Minnesota alcohol sales are taxed at the wholesale level (a fixed dollar amount based on volume). After adjusting for inflation this tax has actually decreased over time. Increasing Minnesota's alcohol excise tax is a long-term campaign.

Supermarket Wine Sales

Finally we are gearing up for the fight over the Minnesota Grocer's Association proposal to allow the sale of wine in supermarkets. This expansion of alcohol availability would be a giant step backward for Minnesota. The last thing we need is even more places for young people to get their hands on alcohol. This access might be more convenient for consumers, but "isn't the health of our youth worth an extra stop for that bottle of wine?"

For more information or to get involved contact Jeff Nachbar, MJT Project Director 763-427-5310 or jnachbar@miph.org. Or visit our website www.miph.org/mjt.

Interested in more information on adolescent alcohol use? PowerPoint presentations, website links, and factsheets are available. Check out the resources on the webpage of the Maternal and Child Health Program at <http://www.epi.umn.edu/mch/HealthyGenerations/Hgres5.html>

SPH

SCHOOL OF PUBLIC HEALTH

EPIDEMIOLOGY

Supported in part by the
Maternal and Child Health Bureau
Health Resources and Services Administration
US Department of Health and Human Services

U.S. Department of Health and Human Services

Health Resources and Services Administration
Maternal and Child Health Bureau 