

# Guidance to reduce alcohol-related harm for young people

Background Paper







# RARHA

REDUCING ALCOHOL RELATED HARM

## Main Partner



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**Authors:** Rebekka Steffens & Doris Sarrazin (on behalf of the Joint Action RARHA Work Package 5 consortium)  
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# 1. Scope and Purpose of the background paper

As a core work package of RARHA work package 5 “Guidelines” brings together scientific knowledge on risks and experiences in the use of drinking guidelines in order to clarify reasons behind divergences and work towards consensus on good practice principles for the use of drinking guidelines as a public health measure to reduce short-term and chronic harm from alcohol. As part of this work package, the LWL-Coordination Office for Drug-Related Issues has the task of giving an overview about guidelines related to young people’s alcohol consumption.

There are numerous reasons to specifically focus on young people: According to the EU Alcohol Strategy, the proportion of youth and young adults with harmful and hazardous consumption patterns has increased in many member states although the legal framework does not allow any alcohol drinking for youth under the legal age. Increasing trends in underage binge drinking and high frequency underage drinking have been reported which may cause long-term adverse health effects and increase the risk of social harm. The Health Behaviour in School-Aged Children (HBSC) study supports those reports with its statement that high-risk behaviours like binge drinking and drinking to intoxication is high among adolescents and young adults (Currie et al., 2012). In the European School Survey Project on Alcohol and Other Drugs (ESPAD) 3 % of the study population (15-16-year-old European students) has been admitted to the hospital during the last twelve months because of alcohol intoxication (Hibell et al., 2012).

Young people are especially at risk to experience alcohol-related harm; therefore, they are one priority theme of the current EU Alcohol Strategy (Commission of the European Communities, 2006). In 2014, the EU has additionally published the Action Plan on Youth Drinking and Heavy Episodic Drinking (Binge Drinking) for 2014-2016 and thus puts a special emphasis on young people's drinking. As the Joint Action project "RARHA - Reducing Alcohol-Related Harm" aims to support the implementation of the EU Alcohol Strategy and the Action Plan on Youth Drinking, young people are a specific target group in Task 3 of RARHA’s Work Package 5.

The target group in focus is young people until the age of 25, in accordance to the EU-Alcohol Action Plan and considering that the group of young adults between 18 and 25 are considered as a group with generally heavy alcohol consumption.

The objective of the present background paper is to give an overview about existing guidelines on reducing alcohol-related harm among young people in the EU member states, the relevant scientific background, e.g. on long- and short-term consequences of young people’s alcohol consumption and existing attitudes and opinions about this issue among European experts.



The central questions of this paper are: How can we reach young people with guidelines on alcohol consumption in order to reduce alcohol-related harm especially for this target group, which messages are effective and which measures are necessary to reduce alcohol-related harm?

In 2014, guidelines for young people's alcohol consumption in EU member states, Iceland, Norway and Switzerland have been collected by the LWL among the representatives of the Committee on National Alcohol Policy and Action (CNAPA) within a broader survey in RARHA's Work Package 5. Those guidelines or recommendations have been further addressed in a two round Delphi survey with a panel of European experts. The Delphi survey focused on qualitative advice for young people themselves, for parents and policy makers rather than on quantitative measures such as standard drinks or units.

Within the Delphi survey, which included a panel of European experts on alcohol consumption and young people, some recommendations or statements have been able to gain a fairly broad consensus among the experts while their views differed concerning others. Consensus as well as disagreements will be reported in this paper.

## 2. Stakeholder involvement

A main focus of the paper are the results of the Delphi study in which European researchers on alcohol consumption of young people and experts on preventing alcohol-related harm for young people participated. Their opinions have had a significant impact on the content of this paper. A list of the Delphi survey participants who agreed to be displayed is attached.

Most of the CNAPA representatives have participated in the joint RARHA survey in WP5 in 2014. They have also recommended the participants for the Delphi surveys and partly participated in the two Delphi rounds themselves. Further, some of them have participated in an international expert meeting to prepare the Delphi process and the structure of this paper in Muenster, Germany, in December 2014.

Furthermore, as funder of the RARHA project, the European Commission has an interest in the results of this paper as well the Federal Health Department of Germany who is a co-funder for the LWL's task within the project.





## 3. Background information

### *3.1. Effects of young people's alcohol consumption*

According to the HBSC study (Currie et al., 2012), which collected data on 11-, 13- and 15-year-old boys' and girls' health and well-being, social environments and health behaviours every four years, adolescent alcohol use is common in many European countries. There are several motives for young people to consume alcohol, e.g. to fulfill social and personal needs, initiate new relationships (with the opposite sex) and intensify contacts with peers. On the other hand, reasons for alcohol consumption are to deal with frustration and/or stress and to forget about individual problems (Stumpp et al., 2009).

However, alcohol consumption in adolescence can have numerous negative short- and long-term consequences, including social, physical, psychological and neurological consequences that reach into adult life.

In the ESPAD a number of students reported problems concerning their alcohol consumption during the last month. The reported problems mainly have been short-term consequences of their consumption which have been grouped as individual problems, relationship problems, sexual problems and delinquency problems (Hibell et al., 2012). Individual problems included poor performance in school or academic failure, accidents, injuries and hospital admittance. Sexual problems either meant the engagement in sexual intercourse that has been regretted the next day or the engagement in sexual intercourse without a condom. The latter can have numerous consequences such as unwanted pregnancies, sexually transmitted diseases or infertility. Delinquency problems included physical fights, victimization by robbery and theft, and trouble with the police. However, most common have been relationship problems which were mentioned by an average of 12 % in the study. The other types of problems were all mentioned by around 8 % of the students. Delinquency problems were mostly mentioned by boys. Specific problems mentioned the most have been poor performance in school (13 %) and serious problems with friends (12 %) and parents (12 %) (Hibell et al., 2012). Traffic accidents are another major risk of young people's alcohol consumption which are a main cause of death for this age group; a third of adolescents' traffic accidents are connected to alcohol consumption (Stolle et al., 2009).

Moreover, regular alcohol consumption of young people often occurs together with other risk behaviours, such as tobacco and illicit drug use and risky sexual behaviour. Early initiators, excessive drinkers and those engaging in multiple risk behaviours are especially likely to experience adverse health outcomes (Hibell et al., 2012).

Long-term consequences of young people's alcohol consumption include alcohol-related harm to organs and nerve cells; also, more than 200 illnesses are associated with alcohol consumption, including brain damage, liver cirrhosis and several types of cancer (Rehm et al., 2010). Young people are especially at risk for disruptions of the brain development (e.g. Fleming, 2015 & Crews et al., 2000) which lasts until young adulthood (Giedd & Rapoport,



2010), particularly in the cortical region which influences cognitive, emotional and social development. Young people with alcohol use disorders may display structural and functional deficits in brain development compared with their non-alcohol-using peers. In addition, heavy drinking during adolescence may affect normal brain functioning during adulthood (Donaldson, 2009: 42).

Binge drinking and heavy episodic drinking is a common phenomenon in youth culture. First of all, there are different definitions for the terms “heavy episodic drinking” and “binge drinking”. The World Health Organization (WHO) defines heavy episodic drinking as “at least 60 grams or more of pure alcohol on at least one occasion in the past 30 days”<sup>1</sup> whereas in the ESPAD (Hibell et al., 2012: 11) it is defined as “five drinks or more on the same occasion during the past 30 days”. Binge drinking is regularly defined similarly, as five or more standard drinks at one drinking occasion. In some cases, binge drinking is defined differently for males and females, e.g. five standard drinks at one occasion for males and four for females (Hingson, 2006). In order to simplify, both terms can be defined as “drinking a high amount of alcohol on one occasion” (Gmel et al., 2003). In this paper, both terms are used simultaneously.

Binge drinking or heavy episodic drinking poses severe health risks and can multiply negative short and long-term risks especially for children and adolescents, including academic failure, violence, traffic accidents, injuries, intoxication and risky sexual behaviour, addiction and adverse health effects such as the disruption of brain development (Currie et al., 2012). Furthermore, in connection with comorbid conditions like depression, anxiety disorders or phobias, and traumatic events of life, heavy episodic drinking increases the risk of suicide attempts and completed suicides (Stolle et al., 2009) and also seems to alter developmental trajectories and to interfere with normal neuroanatomical and neurocognitive development (Winward et al., 2014).

Besides negative consequences of young people’s alcohol consumption for the individual, their alcohol consumption also affects their surroundings and the whole society. Despite alcohol consumption being a part of most European cultures, having a long tradition and the majority of the population is consuming alcohol in a responsible and moderate way, the negative effects of young people’s alcohol consumption and particularly heavy episodic drinking are felt widely, whether through anti-social behaviour, reduced work efficiency, costs to the health care system and unemployment, absenteeism and low productivity in the workplace as well as disorder, property damages, violence in public places and domestic violence (CNAPA, 2014). Therefore, reducing alcohol-related harm is a task for the whole society.

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<sup>1</sup> [http://www.who.int/gho/alcohol/consumption\\_patterns/heavy\\_episodic\\_drinkers\\_text/en/](http://www.who.int/gho/alcohol/consumption_patterns/heavy_episodic_drinkers_text/en/)



### 3.2. *Legal regulations*

According to the Eyes on Ages project (Mulder & de Greff, 2013), the legal framework for age limits varies widely between and even within EU member states. Further, age limits differ for purchasing, consumption or possession and according to the location where it is purchased or consumed, i.e. on-premise, off-premise, public and private areas.

*Table 1: Legal age limits in EU member states, NO & CH (Mulder & de Greff, 2013; Kadiri, 2014). LA=Low alcoholic beverages, HA=High alcoholic beverages.*

Country	On-premise		Off-premise		Public				Private			
	Sales		Sales		Consumption		Possession		Consumption		Possession	
	LA	HA	LA	HA	LA	HA	LA	HA	LA	HA	LA	HA
AT <sup>1</sup>	16	16	16	16	16	16	16	16				
BE	16	18	16	18								
BG	18	18	18	18								
HR	18	18	18	18								
CY	17	17	17	17	17	17	17	17				
CZ	18	18	18	18								
DK	18	18	16	18								
EE	18	18	18	18	18	18	18	18	18	18	18	18
FI	18	18	18	20	18	20	18	20	18	20	18	20
FR	18	18	18	18								
DE	16	18	16	18	16 <sup>2</sup>	18						
GR	18	18	18	18	18	18	18	18				
HU	18	18	18	18	18	18	18	18				
IE	18	18	18	18								
IT	18	18	18	18								
LV	18	18	18	18								
LT	18	18	18	18	18	18	18	18	18	18	18	18
LU	16	16	16	16								
MT	17	17	17	17	17	17	17	17				
NL	18	18	18	18								
NO	18	20	18	20								
PL	18	18	18	18								
PT	18	18	18	18	16	16						
RO	18	18	18	18	18	18						
SK	18	18	18	18	18	18	18	18	18	18	18	18
SI	18	18	18	18								
ES	18	18	18	18								
SE	18	18	18	20	18	20	18	20	18	20	18	20
CH	16	18	16	18								
UK	18 <sup>3</sup>	18	18	18	18	18	18	18				

<sup>1</sup>Represents the legal age limit of the capital region. Age limits may vary in other regions.

<sup>2</sup>Consumption of Low Alcoholic Beverages (LA) by fourteen and fifteen year olds is permitted in attendance of the parents.

<sup>3</sup>A 16- or 17-year-old is permitted to drink wine, beer or cider with a meal in a restaurant, hotel or part of a pub set apart for eating meals. A condition is that it has to be purchased by an adult and that minor is accompanied by an adult.

According to the Eyes on Ages project (Mulder & de Greff, 2013), the legal framework for age limits varies widely between and even within member states. Further, age limits differ for purchasing, consumption or possession and according to the location where it is purchased or consumed, i.e. on-premise, off-premise, public and private areas.



Table 1 shows that in most member states the age limit is 18 for every category. However, there are variations between 16 and 20 years of age, depending on the type of alcohol and outlet. In several countries 16 is the lowest age limit, in Malta and Cyprus 17 is the age limit for all categories, all other countries have an age limit of 18 or higher. Whereas all countries have regulations for sales of alcohol, only 14 countries have set age limits for possession and consumption in public and even fewer in the private domain. It is remarkable that in several member states, especially in the central European countries, 16 years is still a common age limit. The few countries that still have an age limit for high alcoholic beverages, i.e. spirits, below the age of 18 are Luxembourg and Austria with 16 years of age and Cyprus and Malta (both 17). On the other hand, Norway has set an age limit of 20 for the alcoholic beverages containing 22.0% or more alcohol by volume. When looking at the off-premise sales the picture is mostly the same, except for Sweden and Finland who have also adopted an age limit of 20 for purchasing high alcoholic beverages (Mulder & de Greff, 2013; Kadiri, 2014).

Despite the legal regulations established in the member states, alcohol is still perceived as easily available for young people in Europe. On average, 81% of the study population in the ESPAD, which not only covers the EU member states but most of the European continent, find it fairly easy to obtain alcohol (Hibell et al., 2012). Judging by this result, it can be assumed that the level of enforcement of the existing legal regulations is rather low in the member states. According to the Eyes on Ages study (Mulder & de Greff 2013), the differences in the member states regarding the lack of legal requirements supporting the enforcement, i.e. methods and tools to verify the customers' age, prohibitions of alcohol sales and a mandatory policy in alcohol selling places could be a reason for the lack in enforcement. As found out by the Dutch Institute for Alcohol Policy (STAP), an organized and regular enforcement is one of the most effective instruments to increase compliance with the laws on minimum purchase ages. Further, the study by Kadiri (2014) has shown that enhanced enforcements, trainings for bar personnel and efforts to create public support can lead to a much higher level of compliance among retailers. Besides differences in tools supporting the enforcement, there are also differences in sanctions for the underage customers, shop owners and sellers which can include fines, suspension of licenses or closure orders (Kadiri, 2014).

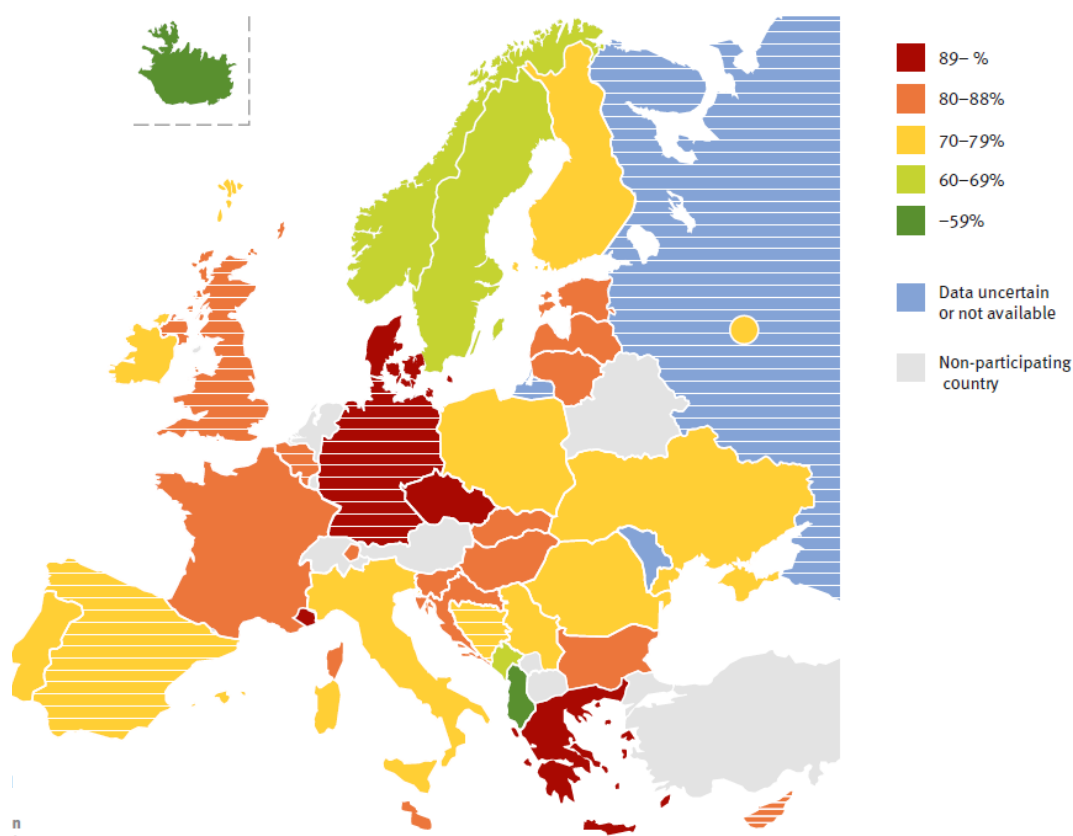
Compliance with the legal age limits is a problem in many member states. Further, different legislation within a member state such as Austria further limits the enforcement.



### 3.3. *Epidemiology*

The ESPAD study from 2011 which included 15-16-year-old students, found out that in all participating countries, except for Iceland, at least 70 % of the students in the sample had drunk alcohol at least once during their lifetime. On average, 87 % had drunk at least once in their life. The 12-month prevalence is 79 % and the 30-days prevalence 57 %. There are significant differences between countries as can be seen in Figure 1 and Figure 2. Generally, the Nordic and Balkan countries have a lower prevalence.

*Figure 1: Alcohol using during the past 12 months. All students. 2011. Percentages.*



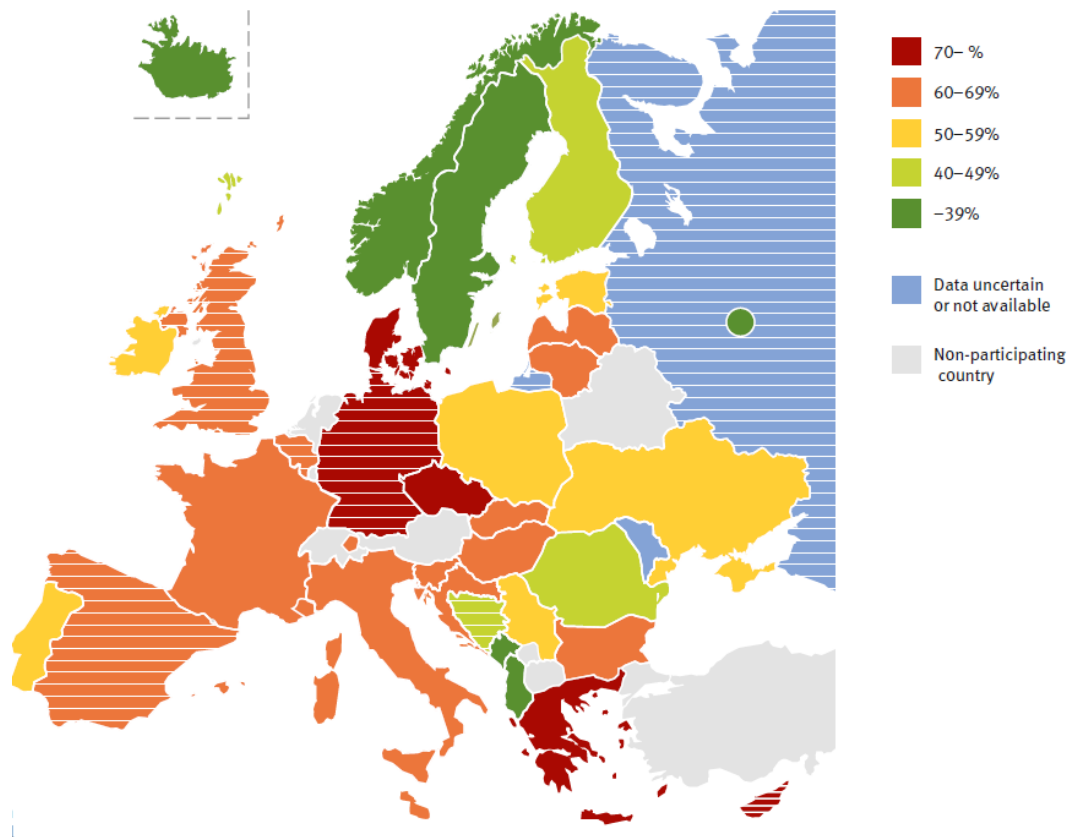
*ESPAD study (Hibell et al., 2012).*

Overall, there are no gender differences regarding the national numbers for all three time frames (lifetime, 12-month and 30-days prevalence), but if there are differences in individual countries, boys generally have a higher prevalence. Also, if the frequency during a certain time frame is addressed, boys usually have higher rates.

In terms of quantity consumed on the last drinking occasion, boys drink significantly more than girls (33 %). Further, there are gender differences regarding the type of alcohol consumed: Boys tend to drink beer, whereas spirits is the most important beverage among girls in more than 50 % of the countries.



Figure 2: Alcohol use during the past 30 days. All students. 2011. Percentages.



ESPAD study (Hibell et al., 2012).

It is important to state that there are huge differences between the ESPAD countries in regard to consumed quantities. Whereas students in the UK, Ireland and the Nordic countries consume larger quantities of alcohol, the south-eastern European countries often consume lower quantities. According to the study, there is no (statistical) correlation between the frequency and quantity of drinking alcohol in the panel.

About half of the study population had been intoxicated by alcohol at least once during their lifetime, 37 % have reported intoxication during the twelve months and 17 % during the last 30 days.

### Age of onset

In the ESPAD study, on average almost 60 % of the students reported to have at least consumed one glass of alcohol at the age of 13 or younger and 12 % stated that they had already been drunk at this age. More boys than girls have tried alcohol at the age of 13 or younger. Most often, beer is the first alcoholic beverage for adolescents (with an average of 44 %), followed by wine (38 %) and spirits with 20 %. Cider ranges at 34 % and alcopops at 27 % (Hibell et al., 2012).



According to Donaldson (2009: 36), an early age at the drinking onset is “associated with an increased likelihood of developing alcohol abuse”. The study by Hingson and colleagues (2006) supports this statement: 28 % of the study population has started drinking alcohol before the age of 13. Compared to adolescents who waited with drinking until they were 17 years or older, they were seven times more likely to engage in binge drinking on six or more occasions per month. They were also more likely to frequently drink to intoxication and show risky behaviours such as drink driving, getting into fights or having unplanned and unprotected sex (Hingson et al. 2006). Similar results have been shown by Pitkänen and colleagues in 2004. Dawson and colleagues (2007) found out that compared with those who started drinking at 18 years or later, youngsters with an onset age of 14 or younger consumed more than three times the volume of alcohol and experienced significantly more stressors. Increasing stress levels have been associated with a higher increase in consumption among those with an onset age of 14 and younger compared with the group with a higher onset age.

Donaldson also reports that an early onset age is “associated with [...] dependence in adolescence and adulthood, and also with dependence at a younger age. Vulnerability to alcohol abuse and dependence is greatest among adolescents who begin drinking before the age of 15” (Donaldson, 2009: 36). Hingson et al. (2006) also support this finding, suggesting that in the long term, the risk of developing alcohol dependence increases with a lower age of alcohol onset (Hingson et al., 2006). According to Stolle et al. (2009), the risk of developing an alcohol dependency for adolescents who start drinking alcohol at the age of 15 is four times higher than for those who start at the age of 20. An early onset age and frequent drinking occasions also increase the risk of developing other alcohol-related disorders.

Furthermore, an early onset of alcohol is also connected to a higher risk of using tobacco and other drugs; an onset age below 16 years has been associated with an early use of tobacco whereas alcohol use before the age of 14 has been associated with early cannabis and drug use (Agrawal, 2006).

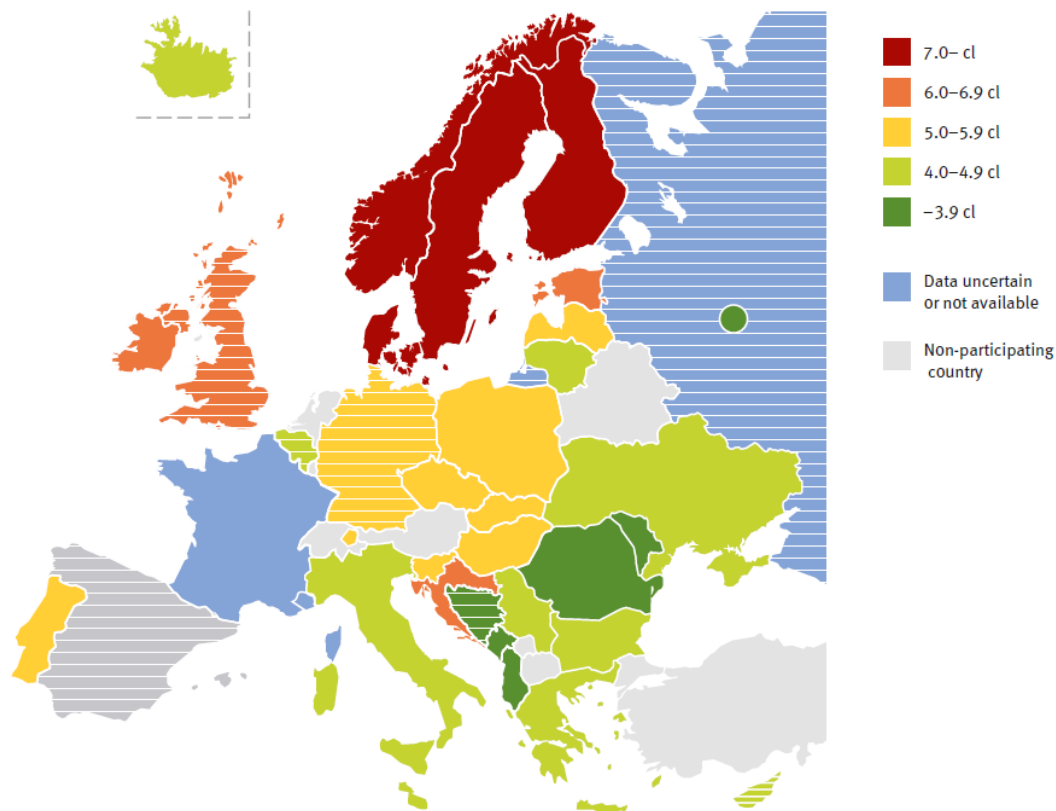
Other studies as for example by Kuntsche and colleagues (2012) suggest that not the age of first alcohol initiation but first early drunkenness is a relevant risk factor for connected alcohol-related harms in adulthood.

### **Binge drinking and heavy episodic drinking**

In the ESPAD study, 38 % of the students reported to have engaged in heavy episodic drinking during the last 30 days, significantly more boys than girls, although the gender gap is decreasing across all countries. On average, 39 % of the students reported heavy episodic drinking during the last month, 14 % reported heavy episodic drinking on at least three different occasions during this time period. In general, boys tend to engage in heavy episodic drinking more than girls. In eleven countries the numbers for heavy episodic drinking during the last month are similar; these countries include Nordic countries, Great Britain and Ireland, France and Monaco as well as Belgium, Estonia and Russia. According to Winward et al. (2014), in contrast to adults, adolescents drink alcohol less frequently but in higher amounts when they do (compare Figure 3).



Figure 3: Estimated average alcohol consumption during the last alcohol drinking day among students reporting any last day-alcohol consumption. 2011. Centilitres 100% alcohol.



ESPAD study (Hibell et al., 2012).

### 3.4. Family factors

Parents' alcohol consumption increases the likelihood that young people will consume alcohol as well. Additionally, they can be exposed to alcohol-related risky behaviour if their parents consume alcohol regularly. A family history of alcoholism is associated with an increased risk of alcoholism in male and female offspring (Donaldson, 2009).

Further, parental monitoring is an important factor in young people's alcohol use. Poor monitoring increases the likelihood of an early onset of alcohol use. Those youngsters tend to drink more, are more likely to develop problematic drinking patterns and to get in contact with peers who have a bad influence on them or show deviant behaviour. According to Donaldson (2009) family standards and rules, parental monitoring and adolescent family attachment are important in delaying alcohol initiation in early adolescence. Harsh parenting, conflict and a permissive approach to the use of alcohol by parents have been associated with heavy episodic drinking/binge drinking in adolescence.

Family structure-related factors may influence alcohol use in children and adolescence as well. There is evidence for a greater risk of alcohol use initiation for adolescents living with a step-parent, or with a sole parent, than for those living in intact families.





According to the HBSC study (Currie et al., 2012), family affluence only has a small or no effect in most countries and regions. Social position among peers may be more important than the family's socioeconomic status in predicting alcohol use. Family influence may decrease as the influence of peers and youth culture increases with age. This will particularly apply in relation to behaviours that do not start until adolescence (such as alcohol consumption).



## 4. Methodology

To receive a comprehensive overview about existing guidelines on young people's alcohol consumption in Europe and prevailing views of European experts with the best knowledge and experience in the field, systematic methods have been used to search for evidence. The first step has been a literature review of relevant research on alcohol-related harm for young people and existing guidelines for young people's drinking in German and English language. In a second step a survey has been developed in cooperation with the other task leaders in work package 5 to collect information about scientific knowledge and existing guidelines in the other member states and other languages. Finally, to explore whether some degree of consensus could be achieved among European experts on guidelines for young people, a Delphi study has been carried out in two rounds.

### 4.1. Survey

The survey about guidelines for young people has been included in a broader survey in work package 5 and has been jointly developed with the task leaders in this work package. It has been disseminated among members of the CNAPA as they are the advisory board for the RARHA consortium and they either have the best overview about the situation in their country or can forward the survey to a suitable expert.

In the young people survey the following information has been addressed: Information about existing guidelines with respect to their content of youth drinking as well as the nature of those guidelines has been gathered. The respondents have also been asked for the specific target group of the guideline (young people, parents, professionals or others) and the provider (governmental body, scientific societies, medical associations or others). Relevant research in fields like social learning, neurobiology, epidemiology and others as well as existing brief intervention and early identification approaches have been addressed. As this is especially relevant for young people, rules and law enforcement regarding young people and drink driving has been addressed. Finally, the respondents had the possibility to add important aspects to include in guidelines for young people's alcohol consumption.

Out of 31 CNAPA representatives from 28 member states plus Norway, Iceland and Switzerland who have been invited to participate in the survey, the LWL has received replies from 24 EU member states and from Switzerland, Norway and Iceland. For Denmark, the reply has been received through the prevention network euro net<sup>2</sup>. No information could be obtained from Bulgaria, Sweden, Slovakia and Romania. The results have been summarized

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<sup>2</sup> <http://www.euronetprev.org/>



and discussed with international experts during a work meeting in December 2014 where a two-round Delphi survey has been planned and prepared.

## **4.2. *Delphi survey***

The Delphi method is generally used “to structure a group communication process in order to reach consensus to a complex problem” (Jander et al., 2015: 341). It is designed to provide material for decision making when facing uncertainty and incomplete knowledge, in particular on complex issues that are difficult to analyze precisely. Further, the Delphi method:

- brings together expert knowledge from a variety of backgrounds;
- allows anonymous participation to minimize group dynamics;
- structures communication and interaction;
- provides opportunity to gain new information from others;
- provides potential for some degree of consensus;
- gives insight into the reasons behind disagreement;
- helps in choosing and formulating statements and
- provides an explicit link between the statement and the supporting evidence.

In order to display the whole range of expert views, opinions and attitudes in the member states and convergence as well as disagreements regarding guidelines for young people have been assessed in a two-round Delphi Study and will be reported in chapter 5.2.

Questions in the two Delphi rounds have been mainly close-ended questions or ratings according to importance. The majority of the questions asked for the panelists’ agreement or disagreement with certain statements or recommendations that have been reported in the survey with cooperation of the CNAPA members and arguments supporting their decisions. In contrast to the original Delphi method, not all questions from the first round have been asked again in the second round because little change in opinion or increase in consensus could be expected. Rather, new input from the panelists’ comments has been transformed into new questions for the second Delphi round. However, in cases where a change in opinion seemed possible, the collected arguments have been presented to the panel in the second Delphi round which gave them the opportunity to make a completely informed decision and possibly change their decision from the first round. Generally, the respondents have been encouraged to make use of the comment section.

The main topics in the first Delphi round included areas for action and main priorities of the EU Action Plan on Youth Drinking and Heavy Episodic Drinking (Binge Drinking), important measures for reducing alcohol-related harm for young people, short- and long-term consequences of young people’s alcohol consumption, specific recommendations for young people of different age groups, gender-specific aspects for guidelines, recommendations for parents, risk minimizing advice and important aspects and conditions to enable young people to learn how to deal with alcohol consumption as an existing phenomenon in their living environment.



Recurring themes in the second round have been measures for reducing alcohol-related harm, gender-specific aspects for guidelines and short- and long-term effects of young people's drinking aspects for supporting young people in developing a healthy handling and attitude towards alcohol consumption in society. Based on the first round new questions have addressed existing good practices in the EU member states to reduce the availability of alcohol for young people, the concept of an integral alcohol policy and guidelines specifically for young adults between 18 and 25 years of age.

### **Panel recruitment**

To include different views on the issue of alcohol-related harm, to give a comprehensive overview and to be able to see the whole range of opinions among European experts, the aim has been to involve researchers as well as practical prevention workers from all member states, Iceland, Norway and Switzerland in the study. To recruit suitable experts, the representatives of the CNAPA have been contacted and asked to recommend two researchers on young people and alcohol consumption and two experts on practical prevention for alcohol-related harm for young people. The experts who have participated in the preparation meeting in Muenster (DE) in December 2014 have also been invited to participate.

### **Panel description**

In total, 94 experts have been nominated by the CNAPA representatives from all countries except Sweden, Slovakia and Bulgaria and have been invited to participate in the study by the LWL. In the end, 55 European experts on young people's alcohol consumption participated in the first round of the Delphi study. To preserve the experts' anonymity as promised in the recruitment letter, the panel has not been asked for their nationality but only for their professional background which 37 % answered with practical prevention work, 35 % with field of research/science and 27 % with "other". The last category included quite a large share of people working in both sectors, but also clinicians, members of youth associations or governmental bodies. In this way, by recruiting a heterogeneous panel, expertise from different perspectives has been included.

For the second Delphi round, all experts recommended by the CNAPA representatives have been reinvited, followed by the participation of 59 experts in the second round. 53 of them (90 %) had already participated in the first round. Based on the results of the first round, the answer category "both" has been added for the question on professional background which has been answered as follows: 33 % of the respondents are working in research/science, 20 % in practical prevention work, 35 % in both areas and 12 % in other sectors as mentioned for round 1.

As background information, the experts have been asked for the number of years they had worked in their field of profession and if they also could relate to the topic based on personal experiences. In both rounds, almost 60 % of the experts had more than 20 years of experience in their professional field and approximately 80 % could relate to the topic based on personal experiences, e.g. with their own children.



## 5. Results

This chapter presents the survey as well as the Delphi results. As described above, the items for the Delphi surveys have been developed based on the reported information by the CNAPA representatives in the survey.

### *5.1. Survey results*

In the survey, the respondents have been asked for guidelines on alcohol consumption for young people in their countries. In the case of 23 countries, some sort of guidelines for young people's alcohol consumption has been reported. These included guidance on young people's alcohol consumption, directed at young people themselves, parents and professionals. Besides guidelines for standard drinks and age limitations, qualitative recommendations and risk minimizing strategies have been reported.

#### *5.1.1. Existing guidelines*

##### **Target group and provider**

Out of the 23 country representatives who reported guidelines for youth drinking, 16 respondents indicated separately published guidelines; ten reported guidelines which have been part of a National Plan or Strategy and five reported guidelines with a different background, e.g. websites of prevention centres.

Further, the guidelines differ in their origin and target group; in 18 countries guidelines targeting young people directly exist, 17 respondents reported guidance for parents, e.g. regarding alcohol-related communication, how to react when their children come home drunk, which precautions to take if children go out etc. and 17 reported guidelines for professionals such as school staff or professionals in the health sector.

There have been 17 countries with guidelines issued by the governmental body, five experts mentioned guidelines by the scientific society, six by medical associations and seven reported guidelines by other institutions like prevention centres. The results are shown in Table 2. In two countries there are guidelines directed at parents and/or professionals but none directed directly at young people.



Table 2: Number of countries that reported guidelines according to provider and target group.

Target group	Provider			
	Govern- mental body	Scientific society	Medical association	Other <sup>2</sup>
Young people	14	3	6	6
Parents	13	2	4	6
Professionals <sup>1</sup>	13	4	7	4

Note: <sup>1</sup>) e.g. school staff, professionals in health sector, bar staff, <sup>2</sup>) e.g. Prevention centres

### 5.1.1.1. *Guidance directed at young people*

Reported guidelines have included general statements and recommendations and specific guidance for different age groups and, targeted on young people themselves, parents or professionals. General guidance included:

- Underage people should not drink at all;
- Not drinking alcohol is the safest option;
- Young people should keep drinking to a minimum;
- Young people above the minimum age should only drink moderately;
- Rules for young people should be communicated in the way “you should not drink but if you do, consider...”;
- Young people should be slowly introduced to the issue of alcohol consumption;
- As a period of transition from childhood to adulthood, adolescence should be used to learn to deal with alcohol consumption;
- Young people guidelines should include safety advice for alcohol consumption;
- Young people should avoid binge drinking;
- Abstaining from alcohol consumption for some days a week is always beneficial;
- The maximum of alcohol consumption advised for young people has to be significantly lower than those of adults to not harm their health.

In some countries, guidelines for young people included advice on risk minimizing, unrelated to specific age groups. According to guidelines in some countries, if young people decide to drink alcohol, they should:

- not drink alcohol to quench their thirst;
- drink non-alcoholic drinks before and in between alcoholic beverages;
- drink slowly and keep to beverages with a lower alcoholic content;
- if drinking in rounds, skip some rounds or order non-alcoholic drinks in between
- orientate themselves on those who are not consuming alcohol;
- learn to say no in a friendly way;
- avoid drinking games or flat rate parties;
- not drink when sad or upset and not try to use alcohol to solve problems;



- avoid mixed drinks as assessing their alcohol content is difficult;
- not drink in particular situations, e.g. at school or work, before/while driving, when sick or under medication, during pregnancy or lactating, if feeling depressed, miserable or suicidal.

In some cases different guidelines have been reported in the survey for boys and girls, regardless their specific age. The issue of gender specific guidelines will be discussed further below in chapter 5.2.7.

Besides general guidance for young people including risk minimizing advice, recommendations and statements addressing different age groups have been reported for children under the age of 16, 16- to 17-year-olds and young people of 18 years and above. This issue is specifically sensitive as legal regulations in the countries covered differ concerning the legal age for alcohol purchase and consumption as described in chapter 3.2. At this point, the collected guidance from the participating countries is reported for the separate age groups which partly contain contrary statements. The results suggest different opinions, attitudes and ideologies in the member states; this aspect has will receive further discussion in chapter 5.2.6.

### **Children under 16**

- Children under 16 should not drink alcohol at all. Already very small amounts can have harmful effects.
- Children under the age of 15 are at the greatest risk of experiencing alcohol-related harm. For this age group not drinking is especially important. Children should not drink at least until the age of 15.
- Children between 12 and 13 should not drink at all. Children between 14 and 15 ideally should still not drink but if they do, they should only take a sip.

### **16- to 17-year-olds**

- Not drinking is the healthiest option for young people at the age of 16- to 17. There is no risk-free consumption of alcohol for young people under 18.
- Not drinking alcohol is the safest option for young people under 18 years of age.
- Young people should not drink under the age of 18 (exceptions in some countries with minimum ages of 16 or 21).
- They should not drink strong liquor under the age of 18 (or 20 e.g. in Finland, Norway and Sweden).
- Alcohol is deeply embedded in our society and young people are bound to get in contact with it.
- Young people between 16 and 17 should not drink alcohol. But if they drink they need risk minimizing advice.
- If people between 15 and 17 years drink alcohol it should always be with guidance of a parent or caregiver and in a supervised and safe environment.

For young people above the age of 18 which is the legal age for alcohol consumption in most European countries the following has been reported:



- Young people between 18 and 21 need guidelines for single occasion drinking and everyday consumption.
- For young people over the age of 18, gender specific guidelines are required.
- At least two alcohol-free days a week should be kept to avoid tolerance development.

### ***5.1.1.2. Guidance directed at parents***

A large share of the reported information from the participating countries has been guidance for parents. In 17 participating countries guidelines for young people targeting parents have been reported and their importance has been underlined. It has been stated survey respondents that the relevance of the parents' influence needs to be communicated to them and to caregivers and professionals. Parents should receive advice on how to respond to their children's alcohol use and misuse; they are role models in terms of their own consumption behaviour and have an educational responsibility. Parents are key actors when it comes to establishing the children's trust with their environment.

A large collection of recommendations and statements has been reported via the survey and has been grouped by "Monitoring and enforcement", "Communication", "Parents' own consumption" and "Parties and transport".

#### **Monitoring and rule enforcement**

- Parents should lay down rules concerning alcohol consumption together with their children and specify consequences if the rules get broken;
- They should set clear rules and monitor their children;
- They should check how alcohol is treated in sport and other clubs;
- They should talk to other parents about monitoring;
- They should keep in contact with school;
- They should get active if they recognize any violation of legal regulations;
- They should visit a consultant centre if their children's alcohol consumption leads to problem, rules do not work and they cannot reach them or communicate with them.

#### **Communication**

- Parents should inform themselves about the effects of alcohol consumption and about general legal provisions. They should have the knowledge lead and can therefore give orientation and support to their children;
- They should try to keep in close contact with their children and keep up the communication;
- They should talk about the short-term effects and risks of alcohol consumption, reasons for consumption and explain why it is sensible to limit alcohol intake;
- They should communicate with their children in an age-appropriate way and objective, not dramatizing manner;
- They should talk to their children when they recognize that they drink alcohol regularly or in high quantities or if their friends are consuming alcohol in high quantities;
- They should not panic or overreact if their children drink or drink too much They should try to get to know the motives behind the alcohol consumption;





- They should talk to their children in a relaxed manner if they have been drinking;
- If their children come home drunk, they should wait with talking to them until they are sober.

#### **Parents' own consumption**

- Because they are their children's role models, parents should check their own alcohol consumption;
- Parents need to know that they have a big influence on their children, even when the influence of peers increases.

#### **Parties and transport**

- Parents should make arrangements with their children about parties or get-togethers at home remaining alcohol-free zones;
- Parents should explain to their children that they should never get into a car with someone who has been drinking;
- They should help their children with organizing a safe way home from parties;
- They should not provide alcohol for their children.

### ***5.1.1.3. Guidance directed at professionals***

Further, although to a lesser extent, the country representatives have reported guidance for professionals working with young people or with parents. It has been stated that support services must be available for children and young people who have alcohol-related problems as well as for their parents. Guidelines for young people that target professionals implied that individual and collective skills of professionals need to be strengthened. The prevention of risky consumption, harmful consumption and dependence has to be the aim for professionals. Experimentation needs to be delayed and the transition from occasional drinking to regular consumption prevented.

School settings seem to have a high relevance in the national guidelines; there have been several aspects concerning the reducing of alcohol-related harm for young people in school settings that have been mentioned by the respondents.

- Schools should be involved in alcohol prevention;
- Schools should be an alcohol and drug-free zone (e.g. school parties);
- Addiction prevention should be part of the health curriculum in schools;
- Providing drug education through curriculum based and extra curriculum activities
- Schools can be a good place for brief interventions and early identification;
- Guidelines should be adaptable in different school forms (e.g. elementary schools, secondary schools, universities and others);
- Schools should cooperate with parents, youth organizations, youth centres and youth police;
- Students, parents, school staff and community should be involved and cooperate with each other;
- It is important to create a positive, secure and supportive atmosphere when actively working in alcohol prevention;



- Children’s and youth’s development needs to be supported;
- Opportunities for free time and extracurricular activities should be created.

According to the survey respondents, information that should be given to parents, e.g. by professionals in the school or health sector, included first aid knowledge, background information about alcohol, information about brain development and impact of addictive substances, common myths, ways to prevent their child from getting addicted, ways to make agreements with their children on alcohol, the right time to have conversation and how to talk to children of different ages.

### ***5.1.2. Brief intervention and early identification for young people***

Early identification and brief intervention approaches have been addressed in the survey as they are necessary for assessing if a person consumes alcohol on a risky level, to intervene if that is the case and to determine if there has been an improvement. Before brief intervention approaches can be applied, tools for early identification are needed to identify young people with harmful alcohol consumption.

Concerning the application of early identification and brief intervention tools, the setting in which they are used is important (Harris et al., 2012). Most studies evaluating brief interventions and early identification tools have been taken place in schools, emergency facilities and on college campuses. According to Harris et al. (2012), those tools are potentially powerful in primary care settings because professionals in this setting see a high number of patients and mostly know them for a long time. Screening for risky alcohol consumption in primary care settings can provide an opportunity to educate and raise awareness about alcohol-related harm and how to reduce it. This procedure also offers the opportunity for practitioners to take preventative measures which have proven to be effective<sup>3</sup>.

In the survey, early identification approaches have been reported by 16 country representatives; eleven of them use the Alcohol Disorder Identification Test (AUDIT) (Babor et al., 2001) or some variation of AUDIT. The AUDIT has been developed as a method of screening for excessive drinking. It provides a starting point for interventions to help risky drinkers reduce or quit alcohol consumption and thereby avoid harmful alcohol-related consequences.

The corresponding manual for AUDIT is particularly designed for health care practitioners and a range of health settings, but with suitable instructions it can be self-administered or used by non-health professionals<sup>4</sup>. However, this might be somewhat outdated. In 2015, the US

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<sup>3</sup> [http://www.who.int/substance\\_abuse/activities/sbi/en/](http://www.who.int/substance_abuse/activities/sbi/en/)

<sup>4</sup> [http://www.who.int/substance\\_abuse/activities/sbi/en/](http://www.who.int/substance_abuse/activities/sbi/en/)



National Institute on Alcohol Abuse and Alcoholism has published a manual for health care practitioners particularly tailored for young people<sup>5</sup>.

Other examples for early identification approaches being used in the participating countries have been:

- CRAFFT (Knight et al., 2002) in the Czech Republic
- CAGE questionnaire (O'Brian, 2008) which has been reported by the UK and Croatia
- "Kenn dein Limit", an online self-evaluation tool from Germany<sup>6</sup>
- SEM-J in Belgium (de Paepe, 2011)

Brief interventions aim to change risky alcohol consumption patterns. They can range from five minutes of brief advice to 15-30 minutes of brief counseling or even include several sessions. The aim of brief interventions is to help young people understand alcohol-related risks and to motivate them to reduce or give up alcohol consumption. Brief interventions should be personalized and offered in a supportive, non-judgmental manner. There is strong evidence for the effectiveness of brief interventions in primary care settings for alcohol and tobacco, and growing evidence of effectiveness for other substances. Further, numerous studies have shown that brief interventions have been effective across the spectrum of alcohol problems, low in cost and easy to administer and therefore are ideally suited as a method of health promotion and disease prevention with primary care patients (WHO, 2003).

Brief interventions have become increasingly valuable in the management of individuals with alcohol-related problems<sup>7</sup>, and health workers as well as policy-makers have increasingly focused on them as tools to fill the gap between primary prevention efforts and more intensive treatment for persons with serious alcohol misuse or alcohol use disorders. However, it has to be noted that brief interventions are not designed to treat alcohol dependence although they might serve well as initial treatment for severely dependent patients seeking extended treatment.

In the survey, specific brief intervention approaches have been named by CZ, BE, DE, DK, EE, FI, IT, NL, PT, SI and UK. In Germany the project HaLT, a brief intervention for young people who are delivered to the hospital due to alcohol intoxication, has been established and successfully evaluated (Kuttler & Lang, 2010). HaLT further targets parents as key persons and other responsible persons like sales staff, teachers, members of associations and event promoters on a regional level. The project combines an indicated preventive approach ("reactive module") and a universal preventive approach ("proactive module"). The modules complement each other and are implemented in a local network. The reactive module includes individual counseling for adolescents in in-patient treatment for alcohol intoxication

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<sup>5</sup> <http://pubs.niaaa.nih.gov/publications/Practitioner/YouthGuide/YouthGuide.pdf>

<sup>6</sup> <http://www.kenn-dein-limit.info/home.html>

<sup>7</sup> [http://www.who.int/substance\\_abuse/activities/sbi/en/](http://www.who.int/substance_abuse/activities/sbi/en/)



and their parents and an 8- to 12-hour group-offer to examine their risky alcohol consumption. As a proactive module, a local prevention strategy is implemented in order to prevent risky alcohol consumption. The aim of the proactive module is to promote responsible behavior among adults, considering their function as role models. HaLT further promotes the compliance with youth protection regulations at events, in bars and restaurants and in retail sales and aims at raising awareness in the population<sup>8</sup>.

"Fred goes to school" is a program aiming at early intervention and prevention of smoking and alcohol abuse by students between twelve and 15 years and is being used in Cyprus. The program follows the successful model of "FreD — Early intervention for first-time drug offenders"<sup>9</sup> which is the continued development of the German federal pilot project "FreD – Early Intervention for Young Drug Users" and has been adapted to the Cyprus school setting. According to the program's protocol, students who are being reported for smoking in the school premises or during a school event are referred to the school counselor who is trained for the program. The program gives those students the support they need and thus avoid being punished by the school for defying the school regulations. Should the intake interview show that the course is unsuitable for the student, the counsellor may refer him/her to other services. The course comprises eight hours in total which is subdivided in four sessions of two hours each. The intervention covers the effects and risks of alcohol and smoking and legal aspects, reflecting on personal patterns and motives of consumption, practical tips for limiting or quitting alcohol consumption.

SYPREDOS ("Systematic prevention of drug use in adolescents through brief intervention of paediatricians") from the Czech Republic is an educational program with a consecutive intervention for paediatricians. The project results are supposed to serve as a background for the development of a website for support and further education of paediatricians in the field of prevention of addictive drug use in adolescence. Within the framework of the project which is supposed to run for 30 months, an effective method of screening, consulting and brief intervention in the field of prevention of addictive drugs use in the age range 12 to 17. Efficiency of this method will be verified in cooperation with paediatricians from regions, that are most affected by this<sup>10</sup>.

Overall, there are not many brief intervention tools at hand in the member states for young people although several studies have suggested their effectiveness. Many respondents have therefore reported tools for the adult population or such targeting illicit drugs instead. It seems that especially school or primary care settings carry the best potential for successful interventions.

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<sup>8</sup> <http://www.aaaprevent.eu/strategies/countries/germany/halt-hart-am-limit-alcohol-prevention-for-children-and-adolescents->

<sup>9</sup> <http://www.euronetprev.org/projects/fred-goes-net/>

<sup>10</sup> [http://www.grant-garant.cz/project.php?region=eu&ptid=1340639436\\_sfJA6QJEE&pid=1340639512\\_v1gqhTAjQ](http://www.grant-garant.cz/project.php?region=eu&ptid=1340639436_sfJA6QJEE&pid=1340639512_v1gqhTAjQ)



## ***5.2. Delphi Results***

### ***5.2.1. EU Action Plan on Youth Drinking and Heavy Episodic Drinking 2014-2016***

In September 2014 the EU has published The "Action Plan on Youth Drinking and on Heavy Episodic Drinking (Binge drinking)" for 2014-2016. In the Action Plan six areas for action have been defined. To take advantage of the assembled expertise of the panel, in the first Delphi round the experts have been asked for their opinion on the relevance of those areas for action and rate them a scale from zero (=not relevant) to five (=highly relevant). The answers show that all of those areas are assessed as highly important; still, reducing heavy episodic drinking and reducing the exposure of youth to alcohol marketing and advertising have been assessed as the areas with the highest priority.

1. Reduce heavy episodic drinking (binge drinking) (4.58)
2. Reduce exposure of youth to alcohol marketing and advertising (4.55)
3. Reduce harm from alcohol during pregnancy (4.47)
4. Reduce accessibility and availability of alcoholic beverages for youth (4.44)
5. Ensure a healthy and safe environment for youth (4.25)
6. Support monitoring and increase research (4.20)

Furthermore, the Action Plan addresses different age groups among the youth which have been rated by the experts on a scale from zero (=not relevant) to five (=highly relevant):

1. Protecting children from alcohol-related harm caused by others (4.65)
2. Prevention of and minimizing the consumption of alcohol by adolescents until they reach the drinking age limit (4.57)
3. Protecting the unborn child and the baby (4.46)
4. Prevention of harmful and hazardous drinking among youth over the legal drinking age limit (4.44)

Despite assessing all of those priorities as important, the most important ones in the panel's opinion are "Protecting children from alcohol-related harm caused by others" and "Prevention of and minimizing the consumption of alcohol by adolescents until they reach the drinking age limit".

### ***5.2.2. Measures to reduce alcohol-related harm***

In line with defining the most important areas for action, target group and priorities, in the first Delphi round the respondents have been asked for good practice measures to reduce alcohol-related harm. Those measures have been fed back to them in the second Delphi round and then have been ranked by the panel in the following order of importance:

1. Reducing the accessibility of alcohol for young people



2. Developing an integrated policy with the aim to reduce alcohol-related harm for young people
3. Reducing the affordability of alcohol for young people, e.g. by introducing a minimum pricing policy and/or increase of taxes
4. Regulation of marketing
5. Adjustment, enforcement and control of legal regulations
6. Promotion of prevention measures in relevant settings of young people's lives, e.g. online or in nightlife scenes
7. Raising awareness about alcohol-related harm for young people, e.g. by improving relevant information and education in the general public

As the measure with the highest priority, the respondents have assessed “reducing the accessibility of alcohol for young people”. This aspect has also been stressed in the comment sections several times. However, reducing the accessibility is not a concrete measure which can be implemented practically; the expert panel has been asked in the second Delphi round to give examples of good practices to decrease accessibility. The following approaches have been mentioned by one or several respondents to reduce the accessibility and grouped by different types of action (compare Casswell & Maxwell, 2005):

1. Pricing & taxation
  - Increase of taxes and prices
2. Regulating physical availability
  - Higher legal drinking age, in combination with extra enforcement
  - Strengthening law enforcement
  - Legal regulations for young people below the legal age limit for purchasing alcohol
3. Restricting the hours of sale and density of liquor outlets
  - Alcohol monopoly like in Northern Europe
  - Limited opening hours for sales points of alcohol
  - Prohibition of selling alcohol after a certain hour
4. Managing the drinking environment
  - Increase controls, ID checks at events and locations where alcohol is sold
  - Penalties for shops selling alcohol to young people under the legal age
  - Automatic warnings at checkout in supermarkets
  - Promote awareness raising and trainings for sales staff concerning the alcohol purchases
  - Mystery shopping
  - Prohibition of selling alcohol to intoxicated people
  - Community-based prevention

The enforcement of legal age regulations apparently is a key factor to lowering the accessibility of alcoholic beverages for young people. Currently, the legal age limits are not the same for all EU member states. 84 % of the Delphi panel is in favour of aligning the age limits and change it to 18 in all member states (Delphi round 2).

As supporting measures for the enforcement of the legal age limit, mainly structural prevention measures including mandatory trainings for sales staff, test purchases, mystery



shopping, increased penalties and mandatory ID checks have been named in round 2. Another point mentioned several times has been to raise the awareness among the population and specifically sales and bar staff who sell alcohol and have to verify the customers' age. It has also been commented that not isolated actions but an integrated alcohol policy with structural and individual prevention measures would be necessary to promote enforcement.

### *5.2.3. Integrated alcohol policy*

As developing an integrated policy aiming at reducing alcohol-related harm for young people has been suggested as a measure for reducing alcohol-related harm for young people and the role of the community and/or municipality in preventing alcohol-related harm has been mentioned several times in the comment sections of the first Delphi round, further questions in the second round have addressed this issue.

First of all, the respondents have rated the importance of an integrated alcohol policy under the leadership of the municipality for reducing alcohol-related harm for young people on average as 4.0 on a scale from 1=low to 5=high. When asked for good practice approaches in this area, a few concrete examples have been mentioned:

- "Bebeu menys" in Catalonia and "Argos" in Murcia (Spain)
- "GigA gemeinsam initiativ gegen Alkoholmissbrauch bei Jugendlichen"<sup>11</sup>:
- „Stadt, Land Alkohol- Lokale Alkoholpolitik"<sup>12</sup>
- Youth protection concept of the cities of Winterthur<sup>13</sup>, Zurich<sup>14</sup> & St.Gallen<sup>15</sup> in Switzerland
- RADIX, Switzerland<sup>16</sup>
- Risk reduction actions in the city of Coimbra, Portugal, in which the university, city council, health facilities, medical and nursing schools work together.
- The concept of the municipality of Katwijk in the Netherlands
- In France, some cities are developing devices for prevention and harm reduction in nightlife scenes, including information for young people, harm reduction tools, training in awareness of nightlife professionals (e.g. Paris "Fêtez Clairs", Bordeaux

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<sup>11</sup> GigA basically has the objective to strengthen the prevention of alcohol abuse at the local level. In the course of existing initiatives and programs in the prevention of alcohol abuse in the North Rhine-Westphalian municipalities have become better connected and thus intensified the cooperation between the various local actors. <http://www.gemeinsaminitiativ.de/>

<sup>12</sup> The project "Local alcohol policy" aims to connect various local policies and activities and address the issue of abusive alcohol consumption and its consequences for a municipality. [http://www.lwl.org/LWL/Jugend/lwl\\_ks/Praxis-Projekte/lokale\\_alkoholpolitik](http://www.lwl.org/LWL/Jugend/lwl_ks/Praxis-Projekte/lokale_alkoholpolitik)

<sup>13</sup>[http://soziales.winterthur.ch/fileadmin/user\\_upload/DepartementSoziales/Dateien/SoDi/Berichte/Jugend\\_schutzkonzept\\_20Alkohol.pdf](http://soziales.winterthur.ch/fileadmin/user_upload/DepartementSoziales/Dateien/SoDi/Berichte/Jugend_schutzkonzept_20Alkohol.pdf)

<sup>14</sup> [https://www.stadt-zuerich.ch/ssd/de/index/gesundheit\\_und\\_praevention/suchtpraevention/jugendschutz.html](https://www.stadt-zuerich.ch/ssd/de/index/gesundheit_und_praevention/suchtpraevention/jugendschutz.html)

<sup>15</sup> [http://www.stadt.sg/home/gesellschaft-sicherheit/jugendliche/drogen-alkoholsuchtmittel/\\_jcr\\_content/Par/downloadlist/DownloadListPar/download\\_0.ocFile/Alkoholkonzept%20Feb%202014.pdf](http://www.stadt.sg/home/gesellschaft-sicherheit/jugendliche/drogen-alkoholsuchtmittel/_jcr_content/Par/downloadlist/DownloadListPar/download_0.ocFile/Alkoholkonzept%20Feb%202014.pdf)

<sup>16</sup> <http://www.radix.ch/>



"Festiv' Attitude", Marseille "Plus Belle la nuit", Toulouse "Fêtons plus, Risquons moins")

- Zell am See: "Zell by Night" - Risreflecting: High & Responsible<sup>17</sup>

According to the Delphi expert panel, an integrated alcohol policy on the a local level should entail should entail the prohibition of drinking in public areas (e.g. parks, streets, squares), limited hours for selling alcohol in shops, bars and restaurants and measures addressing the festival culture and nightlife scenes, e.g. providing free transport. Such an integrated alcohol policy aims at changing the behaviour of adults as well as young people.

An integrated alcohol policy needs the cooperation of relevant actors in the field. According to the repondents, actors whose involvement in the integrated alcohol policy is essential are the city or municipality council (92.2 % of agreement), local health authorities (90.2 %), schools (90.2 %), youth centres, leisure time offers, sports and music clubs (76.5 %), alcohol retailers, e.g. liquor stores, supermarkets, kiosks, petrol stations (74.5 %), bar owners / hospitality association (74.5 %), social welfare and youth welfare offices (72.6 %), press (70.6 %) and festival organizers (68.6 %).

#### ***5.2.4. Provider of guidelines***

When talking about official guidelines for reducing alcohol-related harm for young people, a basic question is who should be responsible for publishing such guidelines. Currently, the most existing guidelines in the participating countries are published by governmental bodies, followed by medical associations and scientific societies (RARHA Survey 2014). In the first Delphi round the respondents have been asked which institutions in their opinion should be responsible for providing official guidelines for young people. The experts' replies have not been pointing in one clear direction; governmental bodies, scientific societies and medical associations have gained the experts' votes to an equal degree. In the comment section however, many experts declared themselves in favour of guidelines jointly developed and published by governmental bodies, scientific societies and medical associations. This approach has been supported by the following arguments:

- Alcohol use and misuse is a complex issue that crosses boundaries of political, scientific or medical disciplines. As the support and collaboration from various sectors is required to achieve the needed results, only a joint effort is suitable.
- It is most efficient if the institutions work together, develop the same messages and disseminate them by different sources and from different angles.
- Different target groups may accept and prefer different institutions as publisher for the guidelines. By including different institutions young people, parents and professionals can be reached.

Concerning the question of who should be responsible for identifying risks related to alcohol consumption of young people the opinion of the panel was clearer: 43 % voted for the

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<sup>17</sup> <http://www.risreflecting.at/projekte/high-and-responsible>





scientific society whereas only 20% voted for policy makers and 11% for medical associations. Again, some respondents commented that those three actors should work jointly in identifying those risks.

### ***5.2.5. Participation of young people***

In addition to voting for a joint development of governmental bodies, scientists and medical professionals, respondents suggested involving the target group itself in accordance with the EU Youth Strategy<sup>18</sup> that aims to support the health of young people, including preventing addictions and substance abuse. The Strategy seeks to encourage young people to participate in the society and promote the dialogue with young people to facilitate their participation in the shaping of national policies.

The Delphi panel provided several ideas in which way to involve young people in the development of guidelines, e.g. through youth advisory boards, youth organizations and associations in focus groups, round tables or through surveys. The target group can help find the right language and design for the guidelines, give information on popular communication tools for dissemination and be involved in disseminating the guidelines. Comments in favour of the target group's participation have been:

*"At all levels youth should be involved at the early stage of development, review, dissemination and implementation to get better informed policies and understanding of the target group."*

*"Once the consumption limits are defined by experts, young people can help design the best messages [...], as peers."*

However, there have been also voices arguing against involving young people in the development:

*"The danger is that adults put young people in a role where they have to act as adult decision makers, [...] without having the necessary knowledge. This is a form of child/youths abuse commonly leading to absurd rules. As a workshop to learn democracy and to argue – perfect – but not to base serious decisions on."*

### ***5.2.6. Recommendations for different age groups***

After addressing the nature of guidelines for young people, the respondents have been asked for their agreement or disagreement with statements which had been collected from different European guidelines in a previous RARHA survey in 2014. The statements differentiated between children under the age of 16, 16- to 17-year-olds and young adults between 18 and 25. The results are presented in Table 3 to Table 5. Further, the respondents have been asked

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<sup>18</sup> [http://ec.europa.eu/youth/policy/youth\\_strategy/civil\\_society\\_en.htm](http://ec.europa.eu/youth/policy/youth_strategy/civil_society_en.htm)



to support their decision by arguments based on scientific evidence and/or practical experience.

### 5.2.6.1. Children under the age of 16

From the results of the RARHA WP5 survey in 2014 two main statements have been derived for children under the age of 16 (Table 3). They summarize the guidance given in the participating European countries for this age group. In Delphi round 1 the experts have been asked if they agree with these statements or not. These statements are not mutually exclusive; therefore multiple answers have been possible.

Table 3: Statements for children under the age of 16 (N=49) and agreement of respondents in %.

Statement	Agreement in %
Children should not drink alcohol at all.	75.5
Children between 14 and 15 ideally should not drink at all, but if they do, e.g. in special situations like family celebrations, they should only take a sip.	36.7

Whereas three quarters of the panel agreed with the first statement only one third agreed with the second. Arguments supporting the first include the promotion of zero tolerance and the delay of the onset of young people's drinking as much as possible.

*"The later the better"*

*"There is no evidence that some quantity of alcohol is safe."*

However, several respondents admit that although children should not drink, in reality some of them do. In that case, they prefer that young people's first alcohol consumption should be in company of significant adults.

*"It's a pragmatic attitude! Normally, children under 16 must not drink, but in reality there are many occasions to taste alcohol. We must prevent that alcohol is being considered a "demonic" substance, prohibited and therefore fascinating!"*

### 5.2.6.2. 16- to 17-year-olds

For the age group of 16- to 17-year-olds the respondents' opinions differ more than for the younger age group (Table 4). Again, the statements summarize the information gained through the survey in 2014.



Table 4: Statements for 16- to 17-year-olds (N=53) and agreement of respondents in %. Multiple answers possible.

Statement	Agreement in %
Young people should not drink under the age of 18.	60.4
Young people between 16 and 17 should be careful when they drink and how much.	47.2
If consuming alcohol, they should do so infrequently and certainly not more than once a week.	30.2
If they drink alcohol, it should always be with guidance of a parent or career or in a supervised and safe environment.	28.3
They should never exceed adult limits.	24.5
To drink a beer or a glass of wine from time to time is presumably not harmful for 16- to 17-year-olds in general.	22.6
16- and 17-year-olds should not drink more than 1 beer or 1 glass of wine a day, no more than 2 times a week.	11.3

For this age group, the statements in Table 4 did not gain much agreement from the respondents. Some of them argued that there is no safe limit of alcohol, the brain is still developing until the age of 25 and that there should be no alcohol consumption before reaching the legal drinking age which is 18 in most EU countries. Others stated that 16- and 17-year-olds should be given knowledge about alcohol and its consequences and that a harm reduction approach would be closer to the reality in which a great share of young people of this age group is consuming anyway.

*"We need to provide guidance that takes into account the reality of young people between 16 and 17 years for whom alcohol consumption is common and unlikely to disappear soon. As a result guidance on consumption needs to be provided for this group along with clear warnings about the alcohol-related harms."*

*"Due to the negative consequences of alcohol consumption, e.g. injuries while intoxicated, one could argue the later young people start the better. However, from surveys like ESPAD we know that many start drinking anyway."*

Relating to that, further recommendations have been suggested by the respondents include risk minimizing advice like not to get drunk, not drink when or before driving, to keep track on how much they drink, especially when alcohol is being mixed with soft drinks.

*"Alcohol is ubiquitous in our cultures, therefore learning how to deal with alcohol sensibly is a developmental task young people need to complete. Therefore, they need detailed knowledge rather than limiting guidelines."*

The question if the first alcohol consumption should happen together with parents or other responsible adults has gained contrary feedback. Some support the idea that first experiences



are ideally made in a safe environment and together with significant adults. Others argue that parents as role models should not engage in alcohol consumption with their children.

### 5.2.6.3. Young people between 18 and 25

*Table 5: Statements for 18- to 25-year-olds (N=43) and agreement of respondents in % (N=43). Multiple answers possible.*

Statement	Agreement in %
If people are over 18, healthy and want to drink alcohol in a low-risk way, women should not exceed 1-2 SD a day; men should not drink more than 2-3 SD a day.	62.8
At least 2 alcohol-free days a week should be kept to avoid tolerance development.	60.5
Young people between 18 and 21 should not drink more than 2 units on a single occasion and not more than once a week.	34.9

The information collected in the RARHA survey in 2014 did not include qualitative advice for the age group of 18- to 25-year-olds but only recommendations of limits of standard drinks/units (Table 5). Usually, this age group receives the same advice as the general population, despite several circumstances could lead to risky alcohol consumption like frequent social gatherings, trying to find a sex and/or relationship partner, reaching the legal age, moving out from of their parents' house and exploring their freedom. Also, this age group is included in the EU Action Plan on Youth Drinking and Heavy Episodic Drinking (Binge Drinking). 83.3 % of the panel agrees that there should be special advice for young adults between 18 and 25 years which should focus on the issues of binge drinking and heavy episodic drinking.

### 5.2.6.4. Age vs. experience groups

An alternative way to address different age groups with drinking guidance is to address young people with different levels of drinking experience, e.g. pre-drinking, experimental drinking patterns and experience with drunkenness or hospitalization. The respondents have been asked to indicate which approach they would prefer and to provide comments or other ideas. Whereas 62.5 % preferred the traditional approach of age groups, 37.5 % have voted for the experience approach. Arguments supporting the use of age groups are e.g. that non-experienced people would read the guidelines for the more experienced and that it is easier to direct guidelines to age groups. An argument for the experience group approach is that individuals would be characterized by their specific problems and it therefore would make sense to target them with specific recommendations. Also, it cannot be assumed that all young people of a certain age have the same level of drinking experience; therefore, less experienced individuals should not get the impression that a certain level of experience is something they need to have.



Despite voting for one approach, several respondents suggested that the age and experience approaches would not be mutually exclusive but could be combined, depending on the setting. It has also been suggested that the experience approach would be far more useful when addressing specific individuals whereas the age approach would probably make more sense in group settings and consequently in official guidelines.

### *5.2.7. Gender differences*

The Canadian guidelines for young people (Canadian Centre for Substance Abuse, 2014) differentiate between boys and girls whereas e.g. the Australian guidelines (Commonwealth of Australia, 2009) for young people do not. In the first Delphi round the respondents have been asked which approach they would prefer and to provide arguments for both sides in the second round. The following arguments for differentiating between the sexes have been mentioned:

- Boys and girls need to be addressed with different arguments. The consequences of drinking are gender specific and the information provided for young people and parents should take this into account. Relevant consequences for girls include caloric content, impact on appearance, risk of sexual assault, risk of pregnancy etc. whereas boys are more likely to respond to arguments concerning performance in sports or reputation among girls;
- Boys and girls have different drinking behaviour and drinking motives;
- There are physical differences, i.e. a higher vulnerability for girls, e.g. water balance, organic aspects, average height and weight, slower rate of ingesting alcohol of females. The female body is more sensitive to the harmful effects of alcohol. The level of intoxication depends on body weight and therefore women can generally drink less;
- Differences in emotional maturation process;
- Higher probability for developing an alcohol addiction for men than for women in the general population.

Arguments for giving the same advice to both sexes and not differentiating have been:

- Up to the legal age, there should be zero tolerance. Different guidelines for boys and girls could appear to give tacit permission for underage drinking which should be avoided;
- The differences in culture across Europe will make it difficult to develop one male and one female strategy;
- Alcohol consumption takes place in the peer group. As boys and girls are drinking together and interacting in general, both genders should be aware of the risks for both genders. Differences are rather identified between peer groups than between boys and girls;
- Evidence increasingly suggests similar harms for young boys and girls under the age of 18. Problems related to binge drinking, social relations, parties etc. do not differ;
- Although boys/men are binge drinking more often than girls/women, females are more often the victim of violence, traffic accidents or sexual assault.



Whereas in the first round 55 % have voted for differentiating between boys and girls when communicating guidelines, after reviewing the arguments above only 45 % were still in favour of this approach. Some respondents stressed the fact that young people should indeed receive the same advice but that gender-specific information still can be given in guidelines directed at both sexes.

### ***5.2.8. Consequences of young people’s alcohol consumption – short and long-term***

There are numerous short- and long-term risks and consequences of young people’s alcohol consumption. Table 6 shows possible short-term consequences to be included in guidelines, rated by the respondents according to their importance.

*Table 6: Which short-term consequences should be addressed in official guidelines addressing young people? (N=55)*

<b>Short-term consequence</b>	<b>Reponses in %</b>
Traffic accidents	94.3
Injuries	84.9
Reckless sexual behaviour	83.0
Fights and violence	81.1
Intoxication	79.3
Academic failure	64.1

All in all the respondents agreed that the communication of short-term consequences has the most impact on the drinking behaviour of young people. However, 65.5 % also think that long-term effects should be included in guidelines for young people (27.3 % do not agree to include long-term effects and 7.3 % do not have an opinion on that issue). The following arguments against providing long-term consequences in guidelines for young people have been named:

- Long-term consequences generally have little impact compared to more immediate consequences as empirical studies show
- Young people will argue that they will quit or change their behaviour before it becomes a problem in the future.
- It is important to focus on young people’s reality which entails focusing on short-term consequences.

On the other hand the following arguments have been given in favour of also providing information about long-term consequences:

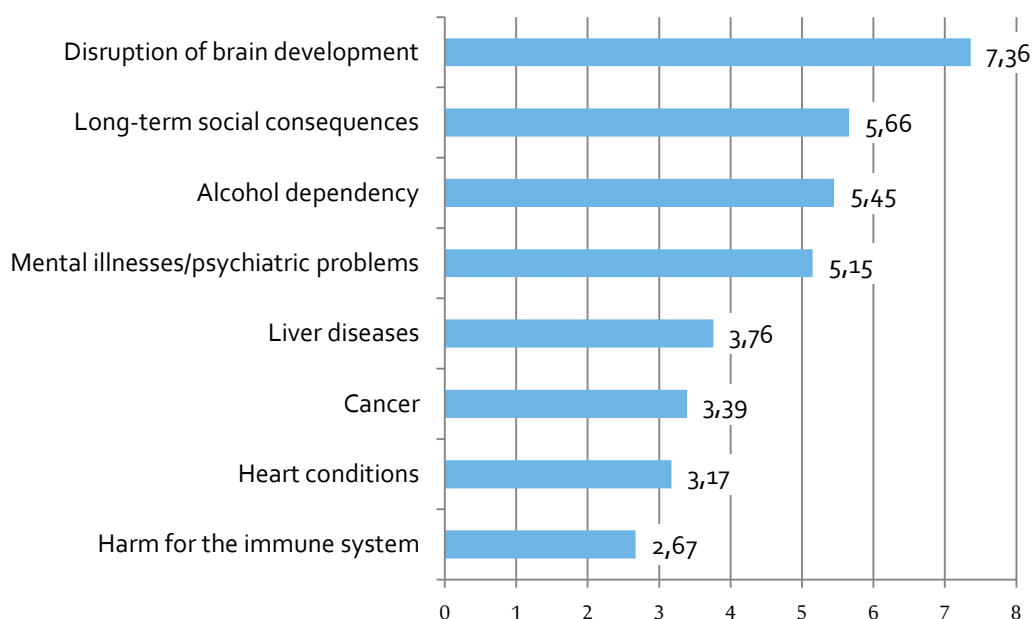
- Although short-term consequences need to be prioritized, long-term effects need to be addressed as well because young people and adults need to know ways to avoid them.
- An early onset of alcohol consumption can increase the risk of addiction in the long run; young people should be aware of this risk.



- The aim should be to empower, educate and guide young people in taking control over their health and life which includes giving them all relevant information.
- It is important to raise awareness on long-term effects among parents and professionals who will also read the guidelines and provide them with tools and support to give advice to their children.
- Adults who are aware of the harm caused by alcohol are more likely to support policies which reduce the affordability, availability and desirability of alcohol. If the culture and behaviour of young people shall be changed a change of the adult world in which children grow up is needed as well.

Long-term effects that could be included in guidelines are disruption of the brain development, alcohol dependency, cancer, liver diseases or heart conditions. Other long-term consequences that have been mentioned by the respondents in Delphi round 1 are long-term social consequences, mental illnesses and psychiatric problems, and harm for the immune system. In the second Delphi round the respondents have sorted those long-term risks according to their relevance for young people, starting with the most relevant. An average ranking score has been calculated, showing the overall ranking of the answer choices (Figure 4).

Figure 4: Relevance of long-term consequences of alcohol consumption for young people (N=47).



### **5.2.9. Safety advice and risk reduction**

Despite that 60.4 % agree that young people under the age of 18 should not drink (compare Table 4), the majority of the respondents (78.4 %) also agreed that the focus of guidelines for young people should be risk reduction which is supported by numerous arguments, some of them being:



- Young people are more receptive to risk reduction advice than advice on abstinence.
- The focus of guidelines should be on risk reduction because in western societies, young people are inevitably confronted with alcohol. Therefore, it is important not to prohibit alcohol but to learn responsible and low-risk alcohol consumption.
- Many of the risks for young people arise from the context in which they may drink rather than from alcohol itself.

Against focusing risk reduction the following argument have been named:

- Guidelines for young people should focus on not drinking alcohol at all.
- It should be clear that not consuming alcohol is a valid option.

*"If we focus on risk reduction we assume that everyone is going to drink. We should encourage those who choose not to drink."*

The majority of the respondents (60.4 %) think that safety tips and risk minimizing advice should already be given to young people between 16 and 17 whereas 15.1 % would only give risk minimizing advice to young people over 18. Others (24.5 %) even suggest that risk minimizing advice cannot be given early enough and should be given to everyone. Table 7 shows specific safety advice that can be included in guidelines for young people.

*Table 7: Which of the following pieces of advice should be included in guidelines for young people? (N=52)*

<b>Safety advice</b>	<b>Agreement in %</b>
Advice for safe transport	86.5
Not to drink in particular situations, e.g. if sad, alone, sick, etc.	78.6
Advice on how to say no	78.6
Advice for parties	76.9
Not to drink at particular times of day/week, e.g. in/before school, at/before work	67.3

Overall, the majority of the respondents have agreed with the statements above (67 % - 87 %). The following advice has been suggested by some respondents:

- To take care of friends and make sure everyone gets home.
- Advice that it is okay to chose not to drink
- Advice on the maximum number of SD a day.

### **5.2.10. Role of parents**

The parents' role in reducing alcohol-related harm for their children cannot be underestimated. Relevant aspects include the communication between parents and children (agreed by 100 % of the respondents), parents' own drinking behaviour (90.4 %), monitoring and rule enforcement (63.5 %) and parties and transport (57.7 %). Furthermore, importance of parents' networks has been emphasized (between parents and in schools). Furthermore, the panel has been asked which information parents should have to reduce alcohol-related harm for their children. Most important for the respondents is information on how and when to communicate with their children about alcohol and in general, followed by background





information about alcohol including risks and effects, information about brain development and the impact of alcohol. Assessed as less important is information about first aid and ways to prevent their children from getting addicted.

Following, statements concerning the parents' role that have been collected in the RARHA WP5 survey in 2014 and the according percentages of the panel's agreement are presented (Table 8).

*Table 8: Statements concerning the role of parents and corresponding percentage of agreement (N=52).*

<b>Statement</b>	<b>Agreement in %</b>
Parents need to talk to their children about:	
- risks of alcohol consumption/reasons for not drinking;	100.0
- short-term effects of alcohol;	98.1
- not getting into a car with someone who has been drinking.	98.1
If parents are hosting a party, they should provide enough non-alcoholic drinks for their guests.	98.1
Parents should be good role models.	96.2
Parents need to talk to their children about alcohol if children have questions about alcohol.	94.3
Parents should check their own alcohol consumption.	92.3
Parents should ensure a safe way home for their children if they go to a party.	90.4
Parents need to talk to their children about alcohol...	
- if parents notice that their children's friends consume alcohol;	88.7
- when recognizing regular alcohol consumption of their own children.	84.9
They should check how alcohol is treated in the children's environment, e.g. in their group of friends, sport and other clubs.	84.6
Parents should lay down clear rules together which children and determine consequences if rules get broken.	82.7
Parents should explain their concerns and why they worry so much.	79.3
Parents should not overreact if children come home drunk and wait with talking until they are sober.	79.3
Parents need to talk to their children about reasons why people drink alcohol in general.	67.9
Parents should communicate with their children in an objective manner.	62.3
Parents need to talk to their children about long-term effects of alcohol.	60.4
Parties should remain an alcohol-free zone if children are under 18.	57.7

### **Communication between parents and children and parenting styles**

According to some respondents, a high-quality parent-child relationship reduces the risk of adolescents' heavy drinking, while monitoring and control may not work as intended. If parents are strongly authoritarian conflicts may occur. The respondents mostly agreed that parents should talk to their children about alcohol as early as possible and continue talking to them about it. They should do so in an age-appropriate manner and in a relaxed conversation. In the panel's opinion parents should talk with their children about:



- Risks of alcohol consumption
- Differences between the effects on adults and children
- Alcohol policy and the importance of restrictions and regulations, e.g. legal age limits
- About reasons why people in general and parents in particular drink alcohol
- How to deal with peer pressure and how to say no
- About children's expectations on alcohol consumption, drinking motives and alternatives

### **Parents' own drinking behaviour**

In general the respondents agreed that parents function as role models for their children and need to be aware of that. Children and adolescents should not be exposed to parental heavy drinking and drunkenness. Despite that the understanding of what a good role model entails slightly differs among the experts, most would suggest that being a good role model does not require drinking no alcohol at all but communicating a "low-risk" handling of alcohol consumption. The following quotations give an overview of the range of opinions in the panel:

*"If parents are hosting a party and children are present, then adults should not drink alcoholic drinks."*

*"It is hard to formulate general rules for parents though, since the context is important. If parents do not drink at all different rules are adequate than in families where drinking alcoholic beverages is common when guests come, for celebrations or together with meals. If young people show no interest in alcohol the situation is different to situations where they strongly demand not to be excluded totally from drinking. Raising children sensibly means finding compromises that are acceptable for parents and children. It needs diplomacy and intuition not to induce problems but reduce problems; to guide and support a positive development."*

### **Monitoring and rule enforcement**

Respondents gave several comments towards the issue of monitoring and rule enforcement, including that parents should be clear in their norm setting but not punishing, that rules may be discussed and coordinated with other parents and that they should depend on the children's age. It has also been commented that parents should demonstrate trust in their children to act responsible because that is the way to learn and raise their self-confidence.

### **Parties and transport**

More than 90 % of the respondents agreed that parents should be good role models for their children, check their own alcohol consumption and serve enough non-alcoholic drinks when hosting a party. Furthermore, several comments imply that parents should not buy alcohol for their children or arrange parties for them where alcohol is served. Some experts pointed out that parents should not serve alcohol to children under the age of 18 and should encourage



other parents to act the same way. As a host they should insist that parties specifically for under 18-year-olds remain alcohol-free.

Studies from the United States (Komro et al., 2007, Hearst et al., 2007) and Germany (Baumgärtner, 2012) have shown that a frequently used access way for young people to get alcohol is actually through their own parents. The experts have been asked for comments on how this issue could be addressed and they mostly agreed that first of all parents need to be educated about risks of alcohol consumption and to raise awareness on alcohol-related harm.

### ***5.2.11. Alcohol as a phenomenon in young people's living environment***

In the first Delphi round, the respondents have named aspects that can support young people in developing a healthy handling and attitude towards alcohol consumption in their living environment. Those aspects have been presented to the panel in the second round and have voted on by the experts (Table 9). As most important the experts assessed the delay of the onset of drinking, role models and well-informed parents, communication of preventive messages which are close to young people's reality and the avoidance of binge drinking.

*Table 9: Aspects that can support young people in developing a healthy handling and attitude towards alcohol consumption as a phenomenon in their living environment (N=50).*

<b>Statement</b>	<b>Agreement in %</b>
Delay the onset of drinking	80.0
Role models and well-informed parents	72.0
Staying close to the actual reality of young people when communicating preventive messages	70.0
Avoiding of binge drinking	68.0
Inclusion of peers, schools and youth workers/street workers	62.0
Combination of individual and structural prevention	62.0
Settings and common rules for a responsible alcohol consumption provided by parents and society	58.0
Education, communication and information about alcohol and its consequences	54.0
Promotion of not drinking as a sensible option	54.0
A change of culture because the widespread adoption of alcohol consumption is the biggest problem in combating the harmful consequences of drinking	52.0



## 6. Concluding remarks

The results of the Delphi survey clearly show the diverse attitudes and opinions of Europe's experts in the field of alcohol consumption of young people but also points of convergence. Points of disagreement mostly originate from differences in the basic attitudes of the respondents. Whereas some strictly promote zero tolerance for all under the age of 18, others support a risk minimizing approach, emphasizing the reality of young people's alcohol consumption.

However, there are some points of convergence: For once the majority of experts support the idea of jointly developed guidelines by the governmental body, scientific society and medical associations and the participation of the target group in the development. Also, nearly all experts agree that children under the age of 16 should not drink at all. Further, young people of 16 and 17 still ideally should not drink but the majority agrees that risk minimizing advice and comprehensive information is required for this age group to consider their actual reality.

Key factors in reducing alcohol-related harm for young people include the parents' role, especially the quality of communication between parents and their children, the cooperation of key actors in reducing the accessibility of alcohol for young people and the development of an integrated alcohol policy that addresses the issue of alcohol-related harm on several levels and includes individual and structural prevention measures. The majority of the respondents also agree that the focus of guidelines for young people should be on short-term consequences but should include information on long-term consequences as well.



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## 8.ANNEX

Annex 1: Work Package 5 "Guidelines" partners 2014–2016

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The following Joint Action RARHA partners contributed in 2014–2016 to Work Package 5:  
 "Good practice principles in the use of drinking guidelines to reduce alcohol related harm"

Partner Organization	Participants
<b>AT</b> Gesundheit Österreich GmbH (GÖG)	Alfred Uhl
<b>BE</b> Service public fédéral Santé publique (SPF)	Mathieu Capouet
<b>HR</b> Croatian Institute of Public Health (CIPH)	Iva Pejnović Franelić
<b>HR</b> Institute of Public Health A Stampar (IPHAS)	Marina Kuzman
<b>CY</b> Ministry of Health	Lampros Samartzis
<b>CY</b> Cyprus Anti-Drugs Council (CAC)	Leda Christodoulou
<b>DK</b> Health and Medicines Authority (SST)	Kit Broholm
<b>EE</b> National Institute for Health Development (TAI)	Maris Jesse Mariliis Tael-Öeren
<b>FI</b> National Institute for Health and Welfare (THL)	Pia Mäkelä Marjatta Montonen
<b>FR</b> National Association on Addictology (ANPAA)	Claude Rivière
<b>DE</b> Coordination Office for Drug-Related Issues, Landschaftsverband Westfalen-Lippe (LWL)	Doris Sarrazin Rebekka Steffens
<b>DE</b> Federal Centre for Health Education (BzGA)	Axel Budde
<b>IS</b> Directorate of Health (EL)	Rafn M Jónsson
<b>IE</b> Health Research Board (HRB)	Deirdre Mongan Jean Long
<b>IE</b> Health Service Executive (HSE)	Sandra Coughlan Joseph Doyle Andy Walker
<b>IT</b> Istituto Superiore di Sanità	Emanuele Scafato Claudia Gandin Silvia Ghirini Sonia Martire Lucia Galluzzo
<b>MT</b> Foundation for Social Welfare Services (FSWS)	Manuel Mangani
<b>NO</b> Institute of Public Health (FHI)	Vigdis Vindenes Gudrun Høiseth



		Stig Tore Bogstrand
<b>PL</b>	State Agency for the Prevention of Alcohol-Related Problems (PARPA)	Katarzyna Okulicz-Kozaryn Krzysztof Brzozka
<b>PT</b>	Serviço de Intervenção nos Comportamentos Aditivos e nas Dependências (SICAD)	Graça Vilar Natacha Torres da Silva
<b>SI</b>	National Institute of Public Health (NIJZ)	Sandra Radoš Krnel
<b>ES</b>	Ministry of Health, Social Services and Equality	María V. Librada Tomás Hernández Pilar Campos
<b>ES</b>	Public Health Agency of Catalonia, Generalitat de Catalunya (GENCAT)	Joan Colom
<b>CH</b>	Federal Commission for Alcohol Issues (FCAL)	Michel Graf Jann Schumacher
<b>UK</b>	Liverpool John Moores University (LJMU)	Lisa Jones Geoff Bates
<b>(BE)</b>	European Alcohol Policy Alliance (Eurocare)	Mariann Skar Sandra Tricas-Sauras Aleksandra Kaczmarek Nils Garnes



Annex 2: Participants of the Delphi survey on guidance for young people and alcohol consumption  
2015

Name		Organizational background
<b>AT</b>	Alfred Uhl	Gesundheit Österreich GmbH - GÖG
<b>BE</b>	Tom Deffilet	VAD (Flemish centre of expertise on alcohol and other drugs)
<b>CH</b>	Françoise Vogel	Head of Prävention und Suchthilfe Stadt Winterthur
<b>CY</b>	Maria Karekla	Licensed Clinical Psychologist, Assistant Professor, Peer reviewed ACT trainer, Department of Psychology, University of Cyprus
<b>DE</b>	Georg Piepel	Head of Drogenhilfe, Stadt Münster
<b>DK</b>	Kit Broholm	Health and Medicines Security SST
<b>EE</b>	Mariliis Tael-Öeren	Estonia National Institute for Health Development
<b>ES</b>	Iñaki Galán Labaca	National Centre for Epidemiology, Instituto de Salud Carlos III, Madrid
<b>FI</b>	Tuuli Pitkänen	A-Clinic Foundation
<b>FI</b>	Marja Holmila	National Institute for Health and Welfare (THL)
<b>FR</b>	David Mourgues	Anthropologist, Fédération Addiction
<b>FR</b>	Guylaine Benech	trainer-consultant
<b>FR</b>	Philippe Michaud	Centre Victor-Segalen
<b>FR</b>	François Beck	Observatoire français des drogues et des toxicomanies
<b>GR</b>	Anna Kokkevi	Department of Psychiatry, Athens University Medical School
<b>HR</b>	Iva Pejnović Franelić	School medicine specialist, National Institute of Public Health (HZJZ)
<b>HR</b>	Marina Kuzman	Teaching Institute of Public Health "dr. Andrija Stampar", Head, School and Adolescent Medicine Service
<b>HR</b>	Diana Uvodić-Djurić	Institute of Public Health of Medjmurje County
<b>IT</b>	Gianni Testino	Alcoholological Regional Centre - Ligurian Region, IRCCS AOU San Martino-IST
<b>IT</b>	Emanuele Scafato	Istituto Superiore di Sanità
<b>IT</b>	Claudia Gandin	Istituto Superiore di Sanità
<b>LT</b>	Emilis Subata	Vilnius Center for Addictive Disorders
<b>LU</b>	Jean-Paul Nilles	CePT – Centre de Prévention des Toxicomanies
<b>LU</b>	Roland Carius	CePT – Centre de Prévention des Toxicomanies
<b>LV</b>	Aelita Vagale	Riga Stradins University, Faculty of Public Health and Social Welfare Programm of Health Psychology and Pedagogy
<b>LV</b>	Solvita Lazdina	Educational Center for Families and Schools
<b>MT</b>	Jesmond Schembri	Sedqa-The Maltese National Agency Against Drug and Alcohol Abuse and Compulsive Gambling



<b>NL</b>	Sandra B. van Ginneken	Dutch Institute for Alcohol Policy (STAP)
<b>NO</b>	Stig Tore Bostrand	Institute of Public Health FHI
<b>NO</b>	Hilde Pape	Norwegian Institute for Alcohol and Drug Research
<b>NO</b>	Odd Martin Vallersnes	Consultant & general practitioner, Oslo Accident and Emergency Outpatient Clinic City of Oslo Health Agency
<b>PT</b>	Teresa Bandeira	Portuguese Society of Pediatrics
<b>PT</b>	Diogo Frاسquilho Guerreiro	Psychiatry department, Faculty of Medicine, University of Lisbon
<b>PT</b>	Manuela Grazina	CNC – Center for Neuroscience and Cell Biology, Laboratory of Biochemical Genetics, University of Coimbra and Faculty of Medicine
<b>PT</b>	Ana Maria F. N. S. Gomes	Directora Clínica da Unidade de Alcoologia de Coimbra da Administração Regional de Saúde do Centro
<b>UK</b>	Joanne Vincenten	Expert Advisor – Child Health and Safety



