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Short communication

Supply of alcohol to underage drinkers: Misperceptions of community norms

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ABSTRACT

Rationale: Adult approval and acceptance of alcohol use is highly correlated with underage drinking. Social norms influence young people's decisions to drink alcohol. While there is a dearth of studies to date, it is likely that social norms also influence adults' decisions to provide adolescents with alcohol.
Objective: The current study explored the (in)consistencies between own and perceptions of others' views of underage drinking and the provision of alcohol to underage drinkers.
Methods: Computer assisted telephone survey of 1160 adults in two communities in New South Wales, Australia.
Results: Parents and community members were generally opposed to underage drinking and supply of alcohol to adolescents. Females, older respondents, and those who were parents were significantly more likely to disapprove of both underage drinking and supply of alcohol. However, across all of the behaviours, parents and non-parents alike perceived general community attitudes to be more liberal than their own.
Conclusion: There is a need for community-based interventions that target parental misperceptions about the prevalence of youth drinking and the acceptability of drinking and supply of alcohol within their local community.

1. Introduction

In Australia, 29% of high school students (aged 12–17 years), including 59.3% of 17-year-olds, report having consumed alcohol in the past 30 days (White and Bariola, 2012). Adolescent drinking is associated with increased risk of short-term and long-term harms (Gilchrist et al., 2012; Healey et al., 2014). Regular alcohol consumption or binge drinking during adolescence also predicts heavier alcohol consumption, alcohol dependence, and poor health outcomes in early and middle adulthood (Bonomo et al., 2004; Pitkänen et al., 2008).

1.1. Parental (and secondary) supply

Adult approval and acceptance of alcohol use is highly correlated with underage drinking behaviour (Foley et al., 2004). In 2011, 32.9% of 12–17 year old drinkers reported that their last alcohol drink was provided to them by their parents (legal in all Australian jurisdictions), 22.8% by their friends, 21.3% by someone purchasing it for them, 8.0% by their sibling (White and Bariola, 2012).

There are a range of factors associated with parental provision of alcohol to minor children, such as parent gender, socio-demographic status, own drinking, ethnicity, religion, education level and employment status (Jackson et al., 2012; Smyth et al., 2010). There is also a substantial body of evidence that many parents believe that supplying their teenage child with alcohol is an effective method to teach socially responsible drinking, and that a controlled and supervised introduction to alcohol minimises the likelihood of children engaging in excessive consumption as an act of rebellion (Gilligan and Kypri, 2012; Jackson et al., 2012; Roberts et al., 2010).

There is extensive evidence that young people's drinking is heavily influenced by perceived social norms (Brooks-Russell et al., 2014; Voogt et al., 2013). While far less researched, it is likely that social norms also influence the decisions made by parents and other adults in relation to the supply of alcohol to minors; that these norms may also be inaccurate; and that they may be in part the result of (incorrect) information provided to parents by

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adolescents themselves (Gilligan et al., 2012).

Perceived norms surrounding the drinking behaviours 'other parents' condone influence parental attitudes; a qualitative study found that perceived pressure from other parents was an important factor in allowing teenagers to drink (Gilligan and Kypri, 2012). Similarly, a survey of 161 mothers found that 17% reported feeling pressured by others to allow their children to drink before the age of 18 [injunctive norm] and 37% said they would teach their children about alcohol the same way their parents taught them [descriptive norm] (Roberts et al., 2010).

In relation to the supply of alcohol to minors by adults other than parents without parental consent (illegal in the majority of Australian jurisdictions), an evaluation of a communication campaign in New South Wales found that many respondents perceived the provision of alcohol to minors to be culturally and socially acceptable and felt that this was a more important consideration than the law (Jones et al., 2012).

1.2. Study purpose and hypotheses

Despite the substantial evidence that parents and other adults provide alcohol to children and adolescents, there is a dearth of research into adults' views, and their perceptions of community views, on the acceptability of this behaviour. The purpose of the current study was to explore adults' views and the (in)consistencies between their own and perceptions of others' views. We did not seek to compare perceived norms to actual behaviour given the increasing evidence that self-reports of parental alcohol provision are inaccurate (Jones, 2015; Jones et al., 2015). As it has been suggested that alcohol-related norms are likely to exist in small networks, such as parents of children in a defined community, and that understanding these community-level norms is an important step in the development of interventions (Gilligan et al., 2012), data were collected from adults in two discrete regional communities.

Based on the limited literature on parents' and other adults' attitudes and perceived social norms regarding adolescent drinking and supply of alcohol, and extrapolating from the literature on adolescents' perceptions of social norms, we hypothesised that:

H1. respondents will largely disapprove of underage drinking and parental supply of alcohol to underage drinkers, and more so of the supply of alcohol to underage drinkers by other adults.

H2. respondents will perceive that other adults are more approving of underage drinking, and of parents and non-parents providing alcohol to underage drinkers, than they are themselves.

2. Study methods

The protocol for the study was approved by the Human Research Ethics Committees of the University of Wollongong and the Australian Catholic University.

2.1. Participants and recruitment

Data were collected in two communities in New South Wales, Australia. Both are coastal locations on the Australian eastern seaboard that are scenic tourist attractions. In both communities the main source of employment is retail, accommodation and food services, followed by health care. Community A has a population of approx. 20,000 and is 120 km from a large major city; Community B has a population of approx. 40,000, and is 200 km from a large major city. The population of 12–17 yr olds is approx. 8% for both communities; and both have the same Accessibility/Remoteness Index of Australia (ARIA) classification and comparable socio-economic index (SEIFA) scores.

Two commercial providers were contracted to conduct computer-aided telephone interviews (CATI) in two communities in October 2013; with a target of 550 completed responses per community. The selection criteria were residents who had lived there for 6 months or longer and were aged 18 years or older. Quotas were established to ensure an approximately even number of male and female respondents, and approximately 50% with dependent children. The two providers utilised slightly different processes for selecting telephone numbers and interviewees. In Community A the sample base was the electronic White Pages, using a technique that starts with the population of numbers listed and adds new and unlisted numbers; with a computer program used to randomise the database and extract a sequential sample. In Community B, numbers to be called were drawn from a large database of validated Random Digit Dial (RDD) fixed line telephone numbers; with the downloaded numbers loaded in the CATI sample management system and randomised.

In Community A, 3360 valid numbers were called; 2204 were not eligible or outside quotas, 546 refused, and 610 interviews were completed (53% completion rate from eligible contacts, 18.2% of numbers called). In Community B, 4511 valid numbers were called; 1998 were not eligible or outside quotas, 1963 refused, and 550 interviews were completed (22% completion rate from eligible contacts, 12.2% of numbers called).

Overall there were 1160 respondents, with no differences between Community A and B with regard to parental status or child(ren) age. A total of 22.4% (260) respondents had no children of any age; 25.7% (298) had one or more children aged zero to 11 years; 29.4% (341) one or more children aged 12 to 17; and 45.7% (530) one or more children aged 18 and over. In total, 33.2% (385) had children over the age of 18 only, 31.9% (370) children under 18 only, and 12.5% (145) children aged over and under 18 years at the time of the survey. There were 674 (58.1%) female respondents; and respondent age was distributed across less than 40 years (22.4%); 40–54 years (44.4%), and 55 years or more (33.1%).

2.2. Survey instrument

Respondents were asked to respond to a series of seven opinion statements (on a five-point scale from 'strongly agree' to 'strongly disagree') on their personal opinion as to the acceptability of various behaviours. There was one statement in relation to adolescent drinking; three in relation to parental supply of alcohol; and three in relation to supply of alcohol by other adults. They were then asked to respond to the same series of statements in the context of their community of residence ("As far as you know, among adults in the [name] community is it acceptable or unacceptable for … ."). The rate of missing data was very low (0–1.3%); therefore imputation was not used, and those cases with missing values were excluded.

3. Findings

Univariate analysis found that members from community A tended to be more likely to approve two of the seven behaviours compared to community B, but these differences were not significant after controlling for the demographic differences between the two communities. However, members from community A were more likely to believe that others in the community disapproved of four out of seven behaviours compared to community B, and these differences remained after controlling for these demographic differences (see limitations section).