Heavy Drinking on College Campuses: No Reason to Change Minimum Legal Drinking Age of 21

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Abstract. The recent Amethyst Initiative argues that a minimum legal drinking age (MLDA) of 21 has created a culture of heavy alcohol use on college campuses by making drinking clandestine and extreme. This group and others argue that lowering the MLDA will reduce the problem of “binge drinking” on college campuses. However, such a policy change would remove one of the most researched and supported policies in the nation’s alcohol control arsenal. There is little evidence that other interventions or policies are capable of working on the same broad level as MLDA 21, and there could also be a deleterious ripple effect in related legislation because MLDA 21 works in conjunction with other drinking laws. In addition, historic and international experiences with a lowered MLDA indicate there are serious social and public health consequences. Instead of removing efficacious interventions, we must remain committed to implementing and enforcing evidence-based practices and legislation.

Keyword: alcohol, Amethyst Initiative, binge drinking, college health, minimum legal drinking age

In the decades since the United States implemented the 1984 Uniform Drinking Age Act, there has been a reduction in youth alcohol use and a dramatic decrease in underage alcohol-related traffic injuries and fatalities in the United States.1 A number of factors may have contributed to these declines in addition to the institution of a minimum legal drinking age (MLDA) of 21, including additional alcohol control legislation, a shift in the age distribution of the US population, and community and youth prevention programs.1 Although empirical evidence for many of these contributing factors is variable, the influence of MLDA 21 is well documented. MLDA is the most researched and supported alcohol control policy, with 241 empirical analyses conducted to assess its effectiveness from 1960 to 1999 and a body of research that continues to grow today.2 This extensive literature overwhelmingly supports an association between MLDA 21, decreased alcohol consumption, and reduced alcohol-related morbidity and mortality.1–8 Despite this bulk of evidence, the debate about the MLDA continues today, with the most recent opposition coming from an initiative led by administrators from some of the nation’s most prestigious colleges and universities. These higher education leaders point to heavy alcohol use among college students as a reason to rethink MLDA 21.9,10 Given the recent media attention to this argument and to heavy alcohol use among college students in general, it is important to revisit MLDA 21 and its body of supporting evidence. Specifically, in light of the substantial empirical support for MLDA 21, does heavy use of alcohol on college campuses warrant a departure from current alcohol control practices and legislation?

Proponents of lowering the MLDA make a direct link between MLDA 21 and binge drinking, arguing that the higher age limit has created a culture of heavy alcohol use by making drinking clandestine and extreme.10 The 134 chancellors and presidents of universities and colleges across the United States who formed the Amethyst Initiative and launched a movement to reexamine US drinking laws more specifically link MLDA 21 and “binge drinking” on US college campuses. The term “binge drinking” has become familiar over the years as the media has increasingly covered alcohol-related deaths among college students, with a particular focus on the high risk groups of Greek-letter social organization members and college athletes.11 Although there is some controversy about terminology, binge drinking is commonly defined as 5 or more consecutive standard drinks in a row for men and 4 or more consecutive standard drinks for women.12,13 Binge drinkers consume a reported 91% of all alcohol used among the college population and frequent

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binge drinkers (those who binge on more than 3 occasions per week) consume 68% of this total amount, with half of these frequent binge drinkers reporting 5 or more different alcohol-related problems. Such heavy alcohol use among American college students has received considerable attention because of high alcohol-related morbidity and mortality, and is widely considered a public health concern with serious immediate and long-term consequences. It is not only associated with death and injury (particularly from motor vehicle accidents), but also risky sexual behavior, increased risk of physical or sexual assault, and violence. Additionally, such alcohol use has also been found to significantly affect academic performance, social relationships, risk-taking behaviors, and general health. Alcohol abuse in college can also lead to chronic problems with alcohol as an adult, and alcohol use at a younger age in general can have lasting repercussions such as an increased likelihood of alcohol-related disorders and substance abuse in adulthood.

The higher education leaders who formed the Amethyst Initiative are calling for a different approach to alcohol control to address the significant public health problem of alcohol abuse among college students. The initiative is paired with the efforts of Choose Responsibility, a nonprofit organization formed by a former college president that supports lowering the drinking age and using alcohol education alongside a "license to drink" requirement as a means to address alcohol use among young adults and adolescents. The experience of these higher education leaders should be respected and they make valid points about important areas where our alcohol policies need improvement, such as easy underage access to alcohol and low enforcement of underage policies. However, public policy should be informed by a careful consideration of available evidence and empirical research, and the extensive literature that surrounds alcohol use reveals crucial issues that must be considered in any discussion of lowering the legal drinking age.

First, a comprehensive body of research supports MLDA 21, whereas there is little convergent evidence that other interventions or policies (such as educational and awareness programs, social norms marketing, and behavioral skills training) could work on the same broad level. There is an extensively documented association between MLDA 21 and decreased alcohol consumption, fewer alcohol-related problems, and reduced traffic accidents and fatalities. Indeed, raising the legal drinking age to 21 has been particularly effective as a traffic safety policy, and MLDA 21 laws have been found to be an essential factor in the significant reductions in alcohol-related traffic fatalities and injuries among the under 21 population that have occurred over the past several decades. It is important to note that alcohol-related crash rates have not decreased uniformly across all age groups, as one might expect if these decreases were simply a result of such factors as increased seat belt use or stricter penalties for driving under the influence. Instead, in the years following the initiation of MLDA 21, underage drivers reduced their rates of drinking and driving by about 37% more than drivers aged 25 to 54 and 13% more than drivers aged 21 to 24. It has been noted that this preponderance of positive findings is even more remarkable because they have occurred despite the fact that MLDA 21 is often not fully enforced.

There is also evidence that MLDA 21 has had a more subtle but equally important effect on alcohol-related traffic injuries and fatalities by increasing the separation between drinking and driving among the under 21 population. Specifically, although underage drinking decreased in a fairly uniform manner across all regions of the country between 1982 and 1998, the rate of underage drinking and driving rate decreased by more than twice as much. One explanation for this difference is that, although the underage population still uses alcohol, they are less likely to combine their use of alcohol with driving. There are several studies that support this idea, possibly evidencing a significant decrease in the social acceptability of driving under the influence among the underage population.

In comparison, there is a plethora of alternative interventions to reduce alcohol abuse that have mixed results, including social norms marketing, educational/awareness programs (such as values clarification and normative re-education), cognitive/behavioral skills-based programs (such as alcohol-specific skills and general life skills training), and motivational/feedback-based approaches (such as brief motivational interventions). These interventions are as diverse in approach as they are in outcome and the literature is clouded by ambiguity, indicating a dearth of empirical support for many of the methods currently being used on college campuses. Although there is some empirical support for a number of these approaches and particularly for the short-term efficacy of brief motivational interventions, none rival the documented effectiveness of MLDA 21. This makes it difficult to conclude that any of these approaches could effectively replace or surpass the current policy.

In particular, there is little support for the education- and information-based approaches advocated by opponents of MLDA 21, particularly in college populations. Proposals such as the “license to drink” emphasize choice and propose that young people make their own informed choices about alcohol use. Although the philosophical underpinnings of these arguments are laudable, their ability to achieve the overall goal of reducing heavy alcohol use and alcohol-related injuries and fatalities is questionable. Decades of research about college alcohol use indicate that alcohol education, although important, is an ineffective intervention strategy. Previous studies and reviews of interventions that aimed to decrease alcohol in college populations have found that alcohol education and awareness programs are not effective when used alone and often fail even when used in combination with other strategies. In addition, given the differences in student populations and campus environments and the need for interventions to be delivered in a way that is sensitive to the needs, developmental stage, and readiness of the target population, it might not be feasible to have a universal approach to college drinking in terms of an education or awareness intervention. This means that such interventions are not...
only largely ineffective, but also could not readily replace a broader and more universal policy such as MLDA 21.

In short, MLDA 21 has been the most successful underage alcohol control effort to date, even when compared to the diverse range of other programs and interventions that target the alcohol consumption of adolescents and young adults. The current push for lowering the MLDA centers on college campuses and the argument that an age 21 limit is ineffective or even worsens the problem of college binge drinking. However, a review of the numerous alcohol-related interventions that are aimed specifically at college populations begs the question: If MLDA 21 is not working, what evidence exists for a superior alternative?

Second, MLDA 21 is part of a set of drinking laws that work in conjunction, meaning that changes in the legal drinking age could have a ripple effect in related legislation that has unknown and potentially serious consequences. There are 2 “core” MLDA laws that prohibit the public possession and purchase of alcohol by individuals who are less than 21 years of age. These core laws have been found to be effective, and states have implemented a number of expanded MLDA 21 laws to support them and further prevent underage drinking. The expanded laws address such issues as keg registration, use of fake identification, minimum server/seller ages, open containers in public, beer sold in pitchers, and providing underage drinkers with alcohol in a party setting. There are also a number of related driving laws such as zero tolerance (making it illegal for underage drivers to have anything other than a blood alcohol concentration of 0.00), graduated driver licensing with night restrictions, and use-and-lose laws (that suspend driving privileges for underage alcohol offenses). These expanded MLDA laws vary significantly by state and appear to work in concert as a “lump” package. A revision to MLDA 21 would require a reevaluation of this entire collection of alcohol-related legislation and a departure from the decades of research that have shown this “lump” of alcohol control policies to be associated with positive outcomes.

Finally, previous experiences with lowering the MLDA, both here and abroad, indicate that there are serious repercussions in terms of increased alcohol use and its related social and public health consequences. MLDA 21 was created in response to a bulk of research that occurred after many states lowered their MLDAs in the late 1970s and early 1980s. Controlled studies emerged by the mid-1970s that evidenced a significant association between a lowered legal drinking age and alcohol-related accidents among young drivers, with some studies finding a 10% to 30% increase in crashes among this population. Comparisons to states with a higher MLDA and evidence of a direct relationship between an increased MLDA and improved rates of alcohol-related crashes among states that raised their MLDAs provided further impetus for change. Such findings are more recently supported by a meta-analytic review that showed raising the MLDA is associated with a 16% median decrease in alcohol-related crash outcomes, while lowering the MLDA results in a 10% median increase in such crash outcomes.

In addition, a recent international example can shed light on the consequences of lowering the MLDA. New Zealand lowered its legal drinking age from 20 to 18 in 1999, and research conducted in the following years on the effect of this policy change has found increases in youth alcohol-related crashes and injuries that mirror the US findings from previous decades. Among newly enfranchised drinkers (18- to 19-year-olds), the ratio of the alcohol-related crash rate after the MLDA was lowered to before the change was 12% larger for 18- to 19-year-old males, and 51% larger for 15- to 17-year-old females (using 20- to 24-year-olds as a referent group). There was also evidence of a “trickle-down” effect on alcohol-related crashes among drivers, with the ratio of the alcohol-related crash rate before and after the policy change 14% larger for 15- to 17-year-old males and 24% larger for females in the same age range. The incidence rate of hospitalizations for crash-related injuries among young men also rose after the MLDA was lowered.

Heavy alcohol use among college students is a serious public health concern and has led to tragic consequences for many young people, families, and communities. However, a solution to this problem is not as simple as lowering the drinking age and asking young people to choose responsibility. Indeed, as MLDA 21 has been shown to influence alcohol use among both those under and over age 21, lowering the drinking age to address problematic college alcohol use could have broad repercussions that affect a far larger population. Although underage drinkers can access and abuse alcohol despite MLDA 21, the documented low levels of enforcement indicate that this promising policy approach has not reached its full potential. Instead of removing one of the most researched and supported policies in the alcohol control arsenal, we should seek to add to and improve this effort with increased enforcement, additional legislation, and efficacious interventions. Addressing the deleterious effects of youth alcohol use presents an extremely complex and challenging public health and policy issue, but we must remain committed to implementing and enforcing evidence-based practices and legislation.

NOTE

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