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Early initiation of drinking and its consequences

The case of the Czech Republic[1]

Abstract

Background: The WHO European Region has the highest alcohol consumption of all six WHO regions. The research presented here is conducted in the Czech Republic, which has the highest average per capita alcohol consumption in Europe. The problem of alcoholism among children and adults is still not sufficiently perceived by Czech society as a risk and threat to the population's future health. Objective: The research aimed to confirm a relationship between the onset of alcohol consumption at a young age and the amount/frequency of current alcohol consumption. Method: Data analysis was conducted on a representative sample of children aged 6–17 (n = 2948; man: 1492; 50,61 %; woman: 1456; 49,39%). Only 36.87% of children in our sample do not drink alcohol at all. 6.28% of children tasted alcohol for the first time before the age of 6. 19.30% tasted alcohol between the ages of 6 and 10, and 38.16% between the ages of 11 and 14. Results: The research confirms the association between early initiation of alcohol consumption and increased risk of binge drinking at older ages. Children who drink alcohol daily start very early. Children who consume alcohol only infrequently start drinking after age 15. Conclusion: The text intends to draw attention to the fact that despite existing prevention programs and interventions, alcohol consumption among children and adolescents is still a severe and contemporary problem related to the high tolerance of society towards alcohol consumption. The degree of denormalization of underage drinking in the Czech Republic is still low. However, even if we

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accept the thesis of gradual demoralization of drinking, which is based on the assumption of declining alcohol consumption, it appears that early initiation of drinking is thus becoming an increasingly important indicator of wider risk behavior and needs increased attention. As part of social prevention, it is necessary to focus not only on direct information about risks and effects, but above all on the issue of behavioural change.

Keywords: alcohol misuse; children; prevention; excessive consumption; transmission of patterns.

1. Introduction

Alcohol use is a significant risk factor for death and ill health worldwide. It is a major item on the public health agenda. In 2010, the World Health Organization (WHO) endorsed the Global Alcohol Strategy (GAS) to reduce the harmful use of alcohol. (Rinaldi *et al.*, 2021)the World Health Organization (WHO Although the European region was the only region where per capita alcohol consumption declined, according to data from the WHO Global Status Report on Alcohol and Health, the WHO European Region still has the highest alcohol consumption of all six WHO regions. (WHO, 2019) The research presented here is conducted in the Czech Republic, which has the highest average per capita alcohol consumption in Europe (along with Lithuania and Austria). (WHO, 2019) Nearly 10 litres of pure alcohol per person are consumed annually. While alcohol consumption among adolescents has decreased since 2011, it is still considered very high in Europe (Chomynová, Csémy and Mravčík, 2020; Chomynová, 2022; Csémy *et al.*, 2022).

An alcoholic beverage (hereinafter referred to as alcohol) is defined by Czech law (65/2017 Coll. § 2f) as a beverage that contains more than 0.5% ethanol by volume. According to the Czech Criminal Code (40/2009 Coll. § 130), alcohol is considered a substance that is capable of adversely affecting a person's psyche, his or her control or cognitive abilities or social behaviour. The ingestion of alcoholic beverages causes a condition called drunkenness. In smaller doses, it has a stimulating effect, a state of relaxation and euphoria, or feelings of tension. When ingested in larger doses, alcoholic beverages cause depression, nausea or alcohol poisoning. There is a wide range of alcoholic beverages with alcohol concentrations typically ranging from 1,5 % to 60 %. The total alcoholic strength shall be expressed in grams and shall be calculated according to the formula 0,8 (ethanol density) x content of the glass/bottle (ml) x alcoholic strength (% vol.): 100. Proof of alcohol impairment by blood alcohol content is defined by ICD-10 (MKN-10, 1992) as follows:

1. Y90.0 Blood alcohol level less than 20 mg/100 ml
2. Y90.1 Blood alcohol level 20–39 mg/100 ml
3. Y90.2 Blood alcohol level 40–59 mg/100 ml
4. Y90.3 Blood alcohol level 60–79 mg/100 ml
5. Y90.4 Blood alcohol level 80–99 mg/100 ml
6. Y90.5 Blood alcohol level 100–119 mg/100 ml
7. Y90.6 Blood alcohol level 120–199 mg/100 ml
8. Y90.7 Blood alcohol level 200–239 mg/100 ml
9. Y90.8 Blood alcohol level 240 mg/100 ml or more
10. Y90.9 Blood alcohol present' level undetermined

According to the level of alcohol in the blood and its effect on the human organism, alcohol intoxication is divided into four stages (Kalina, 2008):

1. Light drunkenness – excitation stage (alcoholemia up to 1.5‰; i.e. 1.5 g/kg) – smell of alcohol on the breath' slight behavioural disturbance in actions and reactions or slightly reduced coordination
2. Moderate drunkenness – hypnotic stage (1,6 –1,99 ‰ of alcohol) – odour of alcohol on the breath' moderate impairment of behaviour in activities and reactions or moderately impaired coordination
3. Severe drunkenness – narcotic stage (alcoholemia 2.00 –2.99‰) – Severe impairment in activities and reactions' severely impaired coordination or impaired ability to cooperate
4. Severe intoxication with loss of consciousness (alcoholemia above 3.00‰) – very severe impairment in activities and reactions' very severely impaired coordination or loss of ability to cooperate; a lethal dose of 5‰ of alcohol in the blood is considered to be lethal in 50% of patients. Even small doses of alcohol have been linked to increased risk of car accidents, violent deaths, falls in older age, dangerous drug interactions (e.g. with non-steroidal antirheumatic drugs), and breast cancer in women (Nešpor, 2008). The CINDI dietary guide recommends limiting alcohol consumption to a maximum of 2 drinks (each containing 10 g of alcohol) per day. However, as Nešpor points out, this is not a recommended dose, but a relatively safe dose for a proportion of the adult population. (Nešpor, 2008) The number of grams of alcohol consumed on average over a period of time, and especially on a single occasion, plays a role in alcohol consumption. The maximum daily intake cannot be stacked up and drunk in one sitting at the end of the week, for example, if safe drinking is observed.

Czech society has a highly tolerant attitude towards alcohol (its regular consumption is rated acceptable by 90 % of people). Only 25 % of Czechs would ban the advertising of spirits, and only 10 % of the advertising of beer or wine. (Chomynová *et al.*, 2023) Alcohol has always been essential in establishing relationships and social engagement. This tolerance applies not only to adult consumption but drinking alcohol is also standard practice among children and adolescents. The situation has persisted for many years and needs to improve, demonstrated, for example, by comparison with 2009 (Hladík, 2009).

According to the 2023 Report, over 40 % of children aged 13 have experienced alcohol, while 25 % of children aged 15 report at least twice the incidence of drunkenness. For the 16-year-old age group, 95 % have experienced alcohol. In the last 30 days, a total of 47 % of adolescents aged 15–19 have experienced binge drinking (5 or more glasses). Frequent drinking of excessive doses of alcohol is reported by 20 % of adolescents (23 % of boys, 17 % of girls). (Chomynová, 2022) Research agency Nielsen Admosphere found that although 84 % of parents perceive alcohol consumption by children in the Czech Republic as a major problem, 78 % of parents drink alcohol at least occasionally in front of their underage children (3–15 years), and in addition, 38% of parents have offered their child alcohol before the age of 15, of which 15 % are children aged 3–6 years (Bowden *et al.*, 2022; Freimann, 2022). It was also found that 23 % of children drink non-alcoholic flavoured beers.

Also problematic is that Radlers containing up to 0.5 % alcohol are not considered by parents as alcoholic beverages (56.5 %) and are perceived as risk-free (27.2 %). Even 25 % of parents consider these beverages healthier than conventional sodas (or up to 33 % of parents of children aged 11–15). (Freimann, 2022) Alcopops are popular among young and underage drinkers, especially teenage girls, and the industry also uses packaging materials and marketing strategies that target young people (Precieuse *et al.*, 2018).

Younger people are more affected by alcohol consumption than older people. In addition, early drinking by children poses the risk of alcohol misuse and other serious complications in adulthood (alcohol dependence, liver cirrhosis, premature mortality, disability, etc.). (Livingston *et al.*, 2023) The early onset of alcohol and substance misuse is an important predictive factor for developing alcohol and substance misuse disorders and mental disorders later in life. If a child starts drinking before age 10, there is more significant damage and more rapid destruction of their brain cells. This damage is irreversible. (Skylstad *et al.*, 2021; Vilde Skylstad *et al.*, 2022) Alcohol, a toxic, psychoactive, and addiction-inducing substance, and group 1 carcinogen, is causally associated with seven can-

cers, including oesophageal, liver, colon, and breast cancers (Šejvl *et al.*, 2019; Anderson *et al.*, 2023).

Estimates of what can already be considered risky or harmful use vary, and individual alcohol tolerance is very broad. However, four categories can be defined (Mravčík, 2021):

1. abstainers
2. low-risk consumers (less than 20 g of pure alcohol per day for women and 40 g for men),
3. at-risk drinkers, i.e. health-threatening alcohol use (≥20–40 g for women and ≥ 40–60 g for men per day, or a weekly n*et al*cohol intake of 140 grams or more for women and 210 grams or more for men); and
4. harmful use, i.e. alcohol consumption that already causes harm to health and may also have symptoms of dependence (≥40 g for women and ≥60 g for men).

The transition from harmful use to alcohol dependence is usually relatively subtle, and the development of dependence is characterised by a gradual increase in tolerance to alcohol, gradual loss of control over alcohol use, gradual neglect of other pleasures and interests, and changes in thinking and behaviour (Popov, 2003). Zábranský in his publication Drug Epidemiology (Zábranský, 2003) lists four stages of use leading to addiction:

1. Experimentation (The experimenter takes the addictive substance with others only when offered, cognizing euphoric experiences. Health is not impaired, nor is work capacity and performance. This type of use does not affect the finances of the person concerned. In the emotional sphere, curiosity prevails),
2. Active seeking stage (In this stage, the substance user associates with other users, separates himself from the original circle of people. He creates his own resources and supplies, sharing with others who take with him. Health is mostly intact, but the first 'highs' and 'hangovers' occur. Work activity is sometimes affected by this, already spending money on addictive substances. On a feeling level, he seeks pleasure, but already experiences dysphoria),
3. Stage of drug preoccupation (Consumption increases and so does the money spent, distances himself from the original environment, changes his attitudes. Eating and sleeping disorders appear. Underperforms in the workplace, blackouts, looks unkempt, changes appearance, distances himself from others. Spends excessive amounts, goes into debt. On the

feeling level, mood swings, attempts to control the situation and unpleasant states are frequent),

4. Stage addiction (Health is impaired by multiple physical and mental problems, has an unkempt appearance. Loses job, has significant financial problems. Uses the substance to feel normal, overcomes guilt feelings, is completely preoccupied with the drug.)

The reasons for underage drinking can be divided into personal and social reasons. Personal reasons include curiosity, seeking feelings of happiness, a lack of self-control, imitation of adults, and a desire for immediate pleasure. Social reasons include ubiquitous alcohol use in Western culture, alcohol marketing, easy access, affordability, media advertising, intern*et al*cohol marketing, and "toothless" politics and laws. (Sharma and Avan, 2022) Alcohol use in childhood occurs in complex interactions with factors related to family situations, mental health, stressors, and living conditions and norms. (Vilde Skylstad *et al.*, 2022) Despite declining trends, alcohol use is still a 'social necessity' for many young people, as it continues to determine how young people build and maintain relationships with friends and construct their identity, as heavily normalised drinking means that not drinking can increase the risk of social exclusion. (Herold and Kolind, 2022) Alcohol consumption is also part of the rite of passage from childhood to adulthood (Herold and Frank, 2022).

Although Act No. 65/2017 Coll governs the regulation of the availability of alcoholic beverages in the Czech Republic., it is still insufficient. Alcohol is available in households, grocery stores, snack stands, catering services, accommodation facilities, etc. (Mravčík, 2021) Unfortunately, children and young people are increasingly exposed to alcohol marketing on social networks thanks to smartphones and tablets. (WHO, 2021) People younger than the legal age for buying alcohol obtain it through its accessibility directly at home or through social networks, friends, siblings, or other people. According to the WHO, restricting the marketing of alcohol is an effective policy to reduce alcohol consumption, including calls for its monitoring, control, and regulation of sales. (WHO, 2021) Traditional regulation of the availability of alcohol should be complemented by price measures and strategies related to social nature. (Lam *et al.*, 2020; V Skylstad *et al.*, 2022)

The article intends to draw attention to the fact that despite existing preventive programs and interventions, alcohol consumption in children and adolescents in Czech society is still a severe problem related to society's high tolerance for alcohol consumption. Our data show a demonstrable association between early alcohol consumption and increased risk of alcohol misuse at older

ages, thus questioning the thesis of an emerging denormalization of adolescent drinking.

2. Methods

The data was collected by a combined method as an online research tool developed as part of the Social Survey Project platform (Pospíšil, 2018). To collect data, the Ethics Committee of the Department of Christian Social Work was asked for permission to conduct the research and handle the data. The processing of research data was conducted in accordance with the Manual of Quantitative Research of the Department of Christian Social Work, Faculty of Theology, Cyril and Methodius University Palacky in Olomouc. In the first phase, a total of 240 schools selected by random systematic selection from a list of primary schools, special schools, gymnasiums, secondary vocational schools, and schools were approached. Schools were offered participation in the research with the possibility of obtaining results for their school. In the second phase, trained interviewers were used to collect data on a representative population from a gender perspective. In the representative population (n = 2948), the gender breakdown was as follows: males (1492; 50.61 %) and females (1456; 49.39 %). The age of the respondents was determined using a closed answer. Only respondents aged 6–17 were allowed to answer the questionnaire. For the purpose of the research, age categories were created according to two age stages: primary school children aged 6–14 (1240; 42.06 %) and secondary school and apprenticeship children aged 15–17 (1708; 57.94 %).

In terms of other sociodemographic characteristics, the composition of the cohort was as follows:

Education: primary school student (1338; 45.39%); secondary school student (1541; 52.27%); employed (35; 1.16%); on maternity/parental leave (6; 0.2%); unemployed (13; 0.44%); other alternative (16; 0.54%).

Family situation: Living with both own parents (2004; 67.98%); Living with one parent (448; 15.20%); Living with one own parent and his/her partner (324; 10.99%); living without parents with grandparents (grandfather and/or grandmother) (36; 1.22%); living in foster care (13; 0.44%); living in a children's home (33; 1.12%); living alone (18; 0.61%); otherwise (72; 2.44%).

Economic situation, which was measured by a closed categorical scale: 'What is the economic (financial) situation of your household? (Does your family have enough money?)": very bad (we suffer from a lack of money, we live with difficulties "from paycheck to paycheck", we often have debts) (35; 1.19%), not very good

(we do not suffer from a lack of money, but we can hardly afford to save anything and buy anything just "for fun") (150; 5.09%), rather medium (we have enough money, our parents can even save some money) (940; 31.89%), good (we have enough money, we have no money problem and we can afford to save enough) (1336; 45.32%), very good (we have so much money that we do not have to think whether we can afford to buy what we want and we can also afford to save a lot) (249; 8.45%), can not judge (238; 8.07%).

The variable first alcohol experience was measured by the question: How old were you when you first tasted alcohol?

- less than 6 years (6,28 %)
- 6 – 10 (19,30 %)
- 11 – 14 (38,16 %)
- 15 – 17 (18,18 %)

The question was preceded by a binomial question filtering Have you ever tasted alcohol? A total of 2415 (81.92 %) children responded positively and were included in further analyses.

The variable amount of alcohol was measured by the question How much alcohol do you drink?

- do not drink alcohol at all (36,87 %)
- only one sip (12,48 %)
- in small amounts only to quench my thirst – maximum 1 beer or 1 Frisco, or other similar drink (18,69 %)
- in larger amounts than to quench my thirst, but not enough to make me drunk (15,60 %)
- in amounts that induce my state of drunkenness (13,87 %)
- do not guard this and get drunk until I have no control over myself (2,48 %)

For statistical analysis, this variable was categorized as (a) in small amounts (919; 31.17 %), (b) in large amounts (942; 31.95 %), (c) never (1087; 36.87 %).

The frequency of alcohol consumption variable was measured by the question How often do you drink alcohol?

- I have not tasted it yet (18,08 %)
- every day (0,64 %)
- almost every day (at least 5 times a week) (0,44 %)
- several times a week (3–4 times a week) (1,39 %)
- once or twice a week (6,38 %)
- several times a month (2–3 times a month) (12,31 %)
- once a month (8,58 %)

- exceptionally (several times a year) (33,48 %)
- it was only once (18,69 %)

For statistical analysis, this variable was categorized as a) daily (32; 1,33 %); b) several times a week (229; 9.48 %); c) several times a month (616; 25.51 %); d) exceptionally (1538; 63,69 %).

The statistical significance of the hypothesis was tested using $\chi 2$ statistics for the two-dimensional (C×R) pivot table (Azen and Walker, 2011; Sheskin, 2011). Adjusted residues (z) in each cell were calculated to better interpret the results. The degree of statistical dependence in the tables is expressed in asterisks (* $p < 0.05$, ** $p < 0.01$, *** $p < 0.001$).

The research aimed to confirm a relationship between the onset of alcohol consumption at a young age and the amount/frequency of current alcohol consumption. Two basic hypotheses were therefore formulated:

H1 There is a link between the age at which the child first tasted alcohol and the amount of alcohol consumed at present;

H2 There is a link between the age at which the child first tasted alcohol and the frequency of alcohol consumed at present.

3. Results

Of 2948 children aged 6–17, only 18.08 % have never tasted alcohol. The figure for children aged 6–14 is 31.61 %, and in the 15–17 age group, it is 8.26 %.

In Table 1 we can see a frequency distribution of the amount of alcohol consumed per age group. Although the table shows that older children are expected to consume alcohol in larger quantities, relative numbers show that the number of children consuming alcohol in large quantities at the age of 6–14 (8.31 %) is not negligible.

The H1 and H2 hypothesis tests were only possible on children who already had at least one-time alcohol experience due to the methodology set.

The link between the age at which a child first tasted alcohol and the amount of alcohol consumed at present (H1, Table 2) has been demonstrated ($\chi 2$ (df = 6) = 73,5825, $p < 0{,}001$). No differences have been found regarding first consumption at a very early age. However, the data show that if children start experimenting with alcohol for the first time after age 15, the risk of high consumption increases (z: 4,21***). Conversely, the onset of consumption between 6–10 leads to moderate (z: 3,11**) or no (z: 5,41***) consumption. The results could thus support the parents' theory that it is better to taste alcohol in childhood and under

Table 1 Amount of alcohol according to the age

amount of alcohol	age	
	6–14	15–17
in small amounts	378	541
	30.48 %	31.67 %
	z: −0,69	*z: 0,69*
in large amounts	103	839
	8.31 %	49.12 %
	z: -23,46***	*z: 23,46****
never	759	328
	61.21 %	19.20 %
	z: 23,34***	*z: −23,34****
Total	1240	1708

supervision than to try without such supervision. However, it should be noted that the data, in this case, are skewed by the different age ranges (children who were not yet 15 years old answered the question). Reducing the data only to the 15–17 years cohort, we find that large quantities are consumed by children who first tasted alcohol before they were 6 years old (z: 2,33*). Between 6–14 years old, large quantities are consumed by those children who first tasted alcohol between 11–14 years old.

Table 2 The test of H1

	amount of alcohol			
first alcohol experience	in small amounts	in large amounts	never	total
less than 6 years	75	73	37	185
	z: 0,72	*z: 0,13*	z: −0,99	
6–10	248	143	178	569
	z: 3,11**	*z: −7,76****	*z: 5,41****	
11–14	401	475	249	1125
	z: −2,28*	*z: 3,03***	*z: −0,88*	
15–17	195	251	90	536
	z: −0,90	*z: 4,21****	*z: −3,84****	
Total	919	942	554	2415

Similarly, a correlation between the age at which a child first tasted alcohol and the frequency of alcohol consumed at present (H2, Table 3) ($\chi 2$ (df = 9) = 75.7615, p < 0.001) has been demonstrated. Children who drink alcohol daily start drinking very early (z: 5.72***). When checking the hypothesis by age category, this trend appears to be reinforced in the older age group 15–17 years. Children

who rarely consume alcohol did not start drinking until after the age of 15 (z: 5.87***).

Table 3 The test of H2

	frequency of alcohol consumption				
first alcohol experience	daily	several times a week	several times a month	exceptionally	total
less than 6 years	11	31	41	102	185
	*z: 5,72***	*z: 3,51****	*z: −1,09*	*z: −2,52**	
6–10	7	49	104	409	569
	z: −0,23	z: −0,81	z: −4,53***	z: 4,65***	
11–14	11	112	310	692	1125
	z: −1,39	*z: 0,74*	*z: 2,16**	*z: −2,07**	
15–17	3	37	161	335	536
	z: −1,76	*z: −2,31**	*z: 2,73***	*z: −0,65*	
Total	32	229	616	1538	2415

4. Discussion

The association between the age at which a child first tasted alcohol and the amount and frequency of alcohol consumption in the present day was demonstrated in our age-and gender-representative sample for the Czech Republic. Those children who first tasted alcohol before the age of 6 years consumed alcohol in large quantities and with high frequency. For the 6–14 cohort, children who first tasted alcohol between the ages of 11 and 14 consume in large quantities. Thus, our data refute the thesis that alcohol initiation is 'safe', despite studies warning that very early initiation of drinking is very dangerous in terms of later abstinence (Bucci *et al.*, 2021). The low age of onset of alcohol consumption indicates that Czech parents are acting in line with the 'safe' alcohol introduction hypothesis (Kypri, Dean and Stojanovski, 2007; Gilligan *et al.*, 2014; Mattick *et al.*, 2018).

Early alcohol use patterns vary worldwide and are part of complex interactions between socio-cultural, economic, and health factors. A Takakura survey of Japanese students showed that students who started drinking at age 12 or younger showed a higher dependence rate at age 15 or older. (Takakura and Wake, 2003) According to Donovan's research (Donovan and Molina, 2011) conducted in the US, 25 % of children under 14 drink alcohol. Donovan has shown a link between children's drinking with a higher tolerance to alcohol and a ten-

dency to perceive their friends as more supportive of alcohol and drug use and their parents as less judgmental of children their age's drinking. The fact that the family context in which children were exposed to drinking by their parents and perceived consent to their alcohol use increases the likelihood of children starting drinking at age 14 or younger can be demonstrated by another research (Donovan and Molina, 2007). According to the available literature and theoretical concepts, parents shape their children's alcohol use in two ways: through their general socialization behaviors and through their alcohol-specific parenting practices (Barnes, Farrell and Cairns, 1986; Darling and Steinberg, 1993). The availability of alcohol is generally high in the Czech Republic, and it is no secret that children often get their first taste of alcohol from their parents or under their supervision. The transmission of alcohol behaviour from parents to children in the Czech population has been demonstrated in our previous study (Olecká, Pospíšil and Trochtová, 2023).

Information on alcohol use by younger school-age children is not complete, but there are some examples, such as 5–8-year-olds in Uganda, 8 year-olds in Argentina, 10-year-olds in England, 9–11-year-olds in Vietnam, primary school pupils in US and rural 5–12-year-olds in Peru (Vilde Skylstad *et al.*, 2022).

The child's age is essential to monitor in the preventive action. When consuming alcohol, it is crucial to know when and under what circumstances the child is offered alcohol and at what age the child starts drinking repeatedly. The regularity of drinking is another factor to bear in mind, as there is a risk of the body becoming gradually addicted to alcohol, even in smaller quantities. Finally, family dependence is a cautionary tale and a dangerous factor in the consumption of alcohol in children and adolescents (Liang and Chikritzhs, 2013; Aiken *et al.*, 2022).

The implementation of short interventions by health professionals in the Czech Republic is governed by the Act. 65/2017 Coll., § 26. This is done with the parent's consent in the case of a minor patient. However, their frequency is half for high-risk and intensive users. It is assumed that only 25 % of people who meet the criteria of harmful alcohol consumption will receive the necessary recommendation from the doctor to limit it. (Chomynová *et al.*, 2023) Problems related to insufficient involvement in interventions aimed at reducing alcohol harm were previously overlooked and require further investigation (Healey *et al.*, 2014).

Primary care health professionals play a crucial role in identifying and detecting patients who put their health at risk by drinking alcohol. The ability of adolescents to share their experience with addictive substances with a doctor opens up the possibility of working with this issue. (Kabíček, Sulek and Mizerová, 2010; Kabíček *et al.*, 2020) Despite this, health professionals tend to

resist screening due to lack of time, lack of training, concern about inadequate patient response, unwillingness to cooperate, and the incorrect belief that alcohol is not on the agenda for detecting people in the early stages of addiction. (Babor *et al.*, 2010) When a doctor identifies the problem of alcoholism, an appeal should be made to provide accompanying information on the risks and recommendations on the use of additional professional care (D'Amico *et al.*, 2005). All experimental studies have found strong effects of an intervention (Healey *et al.*, 2014).

Early experience with alcohol influences its risky use throughout life. Interventions from childhood, when alcohol can be initiated, to older adulthood, when alcohol sensitivity is manifested, are needed. (Szabó *et al.*, 2021) In addition to screening, short intervention serves to prevent risky and harmful drinking. (Jonas *et al.*, 2012; Malinovská *et al.*, 2021) Short intervention, which integrates prevention, intervention, and treatment services (Anderson, Gual and Colom, 2005; Mattoo, Prasad and Ghosh, 2018), can also be effectively delivered via telephone or the internet (Saitz *et al.*, 2006; Tait and Christensen, 2010).

Children aged 11–15 drink flavoured beer drinks at 36 %, and children aged 3–6 even at 11 %. As a result, children become accustomed to the bitter taste of hops, which they can then seek out as they get older. (Nielsen Admosphere, a.s., 2022) The long-term incidence of repeated experience of being drunk increases significantly between the ages of 13 and 15. (Mravčík, 2021) Many studies suggest that drinking alcohol in early adolescence may have an impact on drinking patterns in late life. (Enstad *et al.*, 2019) Excessive risk in men is observed when starting drinking at the age of 15 or later. Excessive alcohol consumption in men manifests itself within two years of the first full consumption of alcohol. (Cheng and Anthony, 2018) Early onset of alcohol consumption is associated with heavy episodic drinking in women as well. Regular drinking, drinking at home and exposure to alcohol advertising increase the likelihood of this phenomenon occurring (Sonthon, Janma and Saengow, 2021).

There is a belief among parents that giving alcohol to children will reduce their attractiveness, which is not confirmed in many cases. Parents are responsible for children's first contact with alcohol by giving them their first sips. This behaviour will be beneficial to include in screening as an additional category for children who have only sipped alcohol but have not consumed a full drink, as the findings show that it is different from teetotallers. (Murphy, Dufour and Gray, 2021) First use of alcohol at the age of 11–14 significantly increases the risk of progression to the development of alcohol-related disorders and is therefore a reasonable target for intervention strategies that seek to delay the first use of alcohol as a means to avert problems later in life (DeWit, 2000; Staton *et al.*, 2020).

Most parents are naturally able to discern the basic manifestations that may indicate that something is wrong with the child. The best prevention in families is good family relationships, clear rules of behaviour that are shared and followed, a positive parental abstinence model to alcohol, sufficient time that parents devote to the child's needs, and communication with the child. (Ptáček and Kuželová, 2013) As part of alcohol prevention, parents are advised to inform themselves and, at the same time, inform their children about all the risks of alcohol, to speak to them openly, and to set an example. It is necessary to consider the child's age and choose the appropriate language, ask the child for their opinions, and present facts from verified sources in conversation. Agree with the child on standard rules and check and demand their observance. It is necessary to respect the need to be independent while communicating with the child. Last but not least, the child must learn to refuse and withstand the pressure of the environment, not only in the case of alcohol. (Freimann, 2022) In general, total abstinence is best for children's health (Manthey, Shield and Rehm, 2022).

Alcohol use by children and adolescents poses a major threat with negative consequences for the future health of the population. (Griswold *et al.*, 2018) Many studies point to a decline in underage drinking and support the thesis of the denormalization of drinking. (Caluzzi *et al.*, 2022) However, this thesis does not apply to the Czech environment. We argue that the rate of denormalization of underage drinking in the Czech Republic is still low, and the tolerance of underage drinking is high (Chomynová, 2022). As evidence, our data clearly show an association between early initiation of alcohol consumption and increased risk of binge drinking at older ages. If the emergent denormalization thesis was valid, tasting alcohol at an early age would not so strongly predict later heavy drinking. Nevertheless, we acknowledge that a decline in alcohol consumption can be recorded. For this reason, we postulate early initiation of drinking as an increasingly important indicator of broader risk behaviours that should be given increased attention (Livingston *et al.*, 2023).

Social prevention in the Czech Republic is significantly lacking in the use of social workers and social educators who understand the mechanisms of influence of the social environment on individuals and have knowledge of the etiology of risks to children and youth. Their work includes, among other things, primary prevention of social pathologies, including toxicology and related delinquent behavior. The problem, however, is the low effectiveness of preventive programs, which focus mainly on direct information about risks and effects, but less on the issue of behavioral change (Olecká, Pospíšil and Trochtová, 2023).

In the denormalization of alcohol drinking, in addition to the existence of common social services, a number of social work programs are developing, which work with children and youth and which are aimed at behavioral change and development of the individual, e.g. the Lipnice Holiday School, which teaches to take responsibility for oneself and others, Football for Development, a project that tries to eliminate violence and intolerance in young people. (Matoušek and Kroftová, 2003) But there are also many inspirational foreign experiences, e.g. LifeLine Projects in the UK, which helps participating youth develop their self-confidence, identify risky behaviour and change it in themselves and in others (LifeLine Projects, 2023).

5. Conclusion

Among the factors enhancing alcohol consumption among young people are their attitudes towards drinking alcohol and those of their parents. A permissive culture that considers alcohol drinking by minors a regular and acceptable activity should be challenged. The culture of celebrating significant events with alcohol should be challenged and changed towards minimizing alcohol consumption or eliminating alcohol at social events. Despite all social prevention measures, there is still a high tolerance for alcohol abuse, even in childhood. In order to reduce alcohol-related harm, it is not enough to educate children, adolescents and their parents and guardians, but to motivate them to change their behaviour through thoughtful prevention programmes. This change must include, among other things, the perception of abstinence itself as a non-problematic behaviour. We do not believe that this situation of high tolerance of alcohol use can simply be reversed. We therefore believe that the first stage of changing society's thinking in this area should be to focus on normalising abstinence.

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