Alcohol and the young. What problem? Whose problem?

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This conference, which took place on 27 October 1998 at the Royal College of Physicians, was organised by Professor Philip Graham, Chairman of the RCP/BPA Working Party on Alcohol and the Young (1993–1995), as a joint meeting between the Royal College of Physicians and the Royal College of Paediatrics and Child Health.

Alcohol is the most commonly used psychoactive substance in the western world, with its role as a 'lubricant for the enjoyment of the company of friends' widely accepted. Its impact upon the individual and society are myriad, with every aspect of the psycho-socio-biological landscape being dampened by its effects. The states of acute intoxication, chronic misuse, dependency and withdrawal have had changing prominence over the past few centuries and are reflected in the historical recordings of alcohol use since antiquity. The state of acute intoxication has been frowned upon since a drunken Noah was chastised in biblical times, while the call for moderation can be traced back to sources as unlikely as Genghis Khan. Thomas Trotter's view of alcoholism as a 'disease of the will' and the damnation of its use by the temperance movement complement the Dickensian portraits of delirium tremens and rum fits in sailors.

While problems associated with alcohol have been widely recognised as impacting on adult health and functioning, recent reports suggest that, contrary to popular belief, problem alcohol use is greatest among the 16–24 years age group. While accepting that the majority of consumers use alcohol without a significant problem to themselves or their community, alcohol inhabits a narrow margin of safety as an agent in our society today. The focus of the meeting at the RCP was to highlight that the problem of alcohol use extends from 'the cradle to the grave' in all its guises, and to alert professionals from all disciplines to the benefits of sharing their skills, knowledge and experience in the development of comprehensive and effective prevention. As Professor Philip Graham quoted in his introduction: 'if you see a cliff, it is better to put a fence around it at the top than to put an ambulance at the bottom'.

Before reviewing the issues raised at the conference, it is wise to consider the thought behind the title; that is, whether or not a behaviour is considered a problem depends on one's perspective. Even among the healthcare professions there are widely differing perceptions of what problem drinking means. Such a murky and inconsistent view is matched only by the diffusion of responsibility that such views permit.

Medium and long-term effects of fetal alcohol exposure

Fetal alcohol exposure through maternal consumption has been advised against since antiquity, with women prohibited from consuming alcohol on their wedding night in Sparta. First described in the English scientific literature in 1973 by Jones and Smith, the fetal alcohol syndrome is characterised by pre- and post-natal growth retardation, central nervous system (CNS) involvement with developmental delay, and a characteristic pattern of craniofacial dysmorphism, the degree of dysmorphism correlates with the decrement in IQ. The full syndrome with an incidence of 1/1000 live births is, however, less common than the spectrum of milder and less frequently diagnosed disorders covered by the term 'fetal alcohol effect'. The financial impact of caring for those affected by fetal alcohol exposure has been estimated at $250 million per year in the USA; the high incidence of both intellectual impairment and psychological morbidity being largely responsible for this cost.

Highlighting that binge drinking during pregnancy is more harmful to the developing fetus than continuous drinking, Professor Hans-Christoph Steinhausen (University of Zurich) discussed the issue of safe levels of consumption during pregnancy. The threshold probably lies in the region of about one standard unit of alcohol per day, though even light consumers may demonstrate some developmental delay compared with abstainers. When asked what level he would suggest for a member of his family, the speaker strongly recommended zero consumption, reiterating that the CNS develops over an extended period, and so there is no safe prenatal period for alcohol consumption. Consumption effects also impact differentially upon organs depending on the stage of gestation.

The teratogenicity of alcohol is compounded by the lack of fetal alcohol dehydrogenase, the chronicity of abuse, and, probably, malnutrition, nicotine and other drug abuse. Thus, many of the affected children will come from multiply deprived environments; and subsequent problems arise from an interactive web of causation. Follow-up studies suggest that associated psycho-behavioural disorders, such as hyperkinetic and emotional disorders, persist with increasing age; the impact on social development and education is, therefore, profound.

Professor Steinhausen concluded his presentation by asserting that there is a need for greater awareness of fetal alcohol effect among obstetricians and paediatricians, screening programmes in antenatal clinics, and education of professionals in detecting the less obvious clinical cases. Early identification would allow pragmatic intervention,
which may reduce functional impairment secondary to the high levels of psychological and behavioural morbidity in this group. Interventions may include:

1. Supporting the development of a structured home environment
2. Provision of special education
3. Help with sleep and eating problems
4. Behavioural therapies
5. Pharmacotherapies, such as methylphenidate
6. Support groups for both biological and foster parents.

Theoretically, fetal alcohol syndrome is completely preventable. Increased awareness of the effects of maternal alcohol consumption among both clinicians and the public is paramount. Health care professionals in all relevant specialties need to be educated in how to assess alcohol consumption sensitively. Above all, the assessment of drink and drug taking must be given a higher priority in the general medical curriculum. Educating the doctors of tomorrow may render fetal alcohol syndrome yesterday's diagnosis.

Impact of parental alcohol consumption on children and adolescents

Between 1–2 million people in the UK have been brought up by parents with a drinking problem and 46% of those children on the at risk register have a parent with a substance misuse problem. The impact of alcohol on the growing child is not confined to the biological effects of prenatal exposure; when one or both parents have an alcohol problem, there is also often a disordered family environment. Accepting that problem alcohol consumption rarely stands in isolation from other deprivations, the potential impact upon a child's personal development is immense.

Presenting results from his forthcoming book, Risk or resilience: adults who were the children of problem drinking parents, based on a study of 164 young adults who had one or more parents with a drink problem, Professor Jim Orford (University of Birmingham) gave a moving account of the impact of parental drinking upon children. Violence, parental discord, a hostile, unsupportive and critical home with little cohesion frequently characterise such families. Faced with such adversity, the child develops adaptive responses to minimise the impact of the trauma: boys develop antisocial traits including aggressiveness, stealing and destructive behaviours, whilst among girls, social withdrawal, demoralisation and impaired concentration at school are compounded by depression and anxiety. These gross disturbances occur against a background of more subtle disruptions. Professor Orford found that, fearful of embarrassment by a drunken parent, children could not bring friends home; special occasions were always in fear of being spoiled; and unpredictable parental responses gave rise to fear and low self-esteem.

Not only at risk of severe emotional and family disruption, children of problem drinkers are themselves at risk of developing problematic substance misuse in later years – 30% of the familial transmission of alcoholism in men is thought to be attributable to genetic factors. However, not all children of problem drinking parents are thus affected. Some children interviewed for the study recalled that they viewed their experiences as normal at the time, explaining that they felt it was 'just how life was'; adversity experienced when young may lead to the development of resilience in later life.

The findings of Professor Orford's study must be interpreted with caution, given the limitations imposed by both the sampling frame and retrospective data collection (which is subject to recall bias). Methodological issues aside, my lasting impression of the presentation was one of sadness at the lives that so many of these children have to endure, often without support or recognition, as the 'uncares for carers' of our society.

Family support

It was appropriate and therapeutic for the audience that Professor Orford's rather grim depiction of the disruption of childhood by parental drinking was followed by Dr Ian McGregor's (Haringey Advisory Group on Alcohol, London) presentation on his lottery funded integrated multi-disciplinary service in Hackney. Combining counseling for children and their parents within a family-focused framework, the service also provides home detoxification, community care assessment and a day centre for all members affected by alcohol consumption within the family. The frequent role-reversal between children and the drinking parent was highlighted; the majority of problem drinkers have comorbid psychological problems. Dr McGregor emphasised the need for a service that supports the child's efforts to adapt to what are often chronic and immutable problems within the home. He reported that children often do not wish to be relieved of their responsibility or to be told that their situation is inappropriate, rather what they want is better support.

Since no one discipline can provide the range of skills and resources that are required for this multi-disadvantaged group, Dr McGregor advocates liaison between services, that is: integration, communication and dissemination of experience and expertise. The question of whether a specialist service is required remained a moot point; some members of the audience felt that the necessary skill base already exists, albeit on a diffuse basis. If a specialist service is to be developed, the consensus was that it should be located within primary healthcare centres, with general practitioners and healthcare visitors considered as having the potential to bridge the void in current service provision.

Adolescents

The second half of the conference was more contentious than the earlier review of the negative impact of alcohol upon the fetus and the young child, about which there
could be no argument. The issue of when voluntary exposure (consumption) of alcohol should be viewed as a problem – and, if so, whose problem it is – was to be in no way as clear. Young people’s drinking can sometimes lead them into problems such as accidents, violence and emotional distress. Whilst such incidents may concurrently affect their community, acts that the individual may regard as ‘just being drunk’, such as trampling on the flower bed of a stranger’s garden or kicking over bins in the early hours, may also cause problems for others. Interestingly, on a number of occasions throughout this session, when concern was expressed as to the harmful effect of alcohol consumption on young people, doctors in the audience defended such drunken behavior with reference to medical school drinking practice.

**When is adolescent drinking problematic?**

‘Young people’s drinking worries adults’ ‘Adolescent drinking is normal behaviour, reflecting adult behaviour, and is only problematic in a minority when alcohol represents only one of myriad problems in this group’. Ms Rachel Herring (The Centre for Research on Drugs and Health Behaviour, London) presented an ethnographic, qualitative study of drinking patterns among a group of ‘teenage lads’ aged between 17-19 years old. A jaunt through their Friday and Saturday nights revealed not only an aim of ‘getting very, very pissed’ and the predictable consequences of hangovers and financial problems, but also, among some, a demonstration of elementary harm reduction. Limiting alcohol consumption in the face of responsibilities the next day or due to financial considerations and avoiding potential trouble areas, were common among those studied. Assessing consumption in this group was more difficult, with intoxication doing little to aid accurate recall, but it appeared that young people define alcohol consumption not only in terms of absolute consumption, but also in terms of the acute physiological and social consequences of consumption. The frequently adopted ‘big bang’ approach of binge drinking (defined as half the adult weekly maximum recommended amount in a single session), although not seen as an abnormal pattern of consumption by this group, is however one that is more likely to lead the young drinker to problems, particularly to the accident and emergency (A&E) department.

Whether alcohol is ultimately considered to be a problem or not, depends upon the parameters one chooses to consider. Although most young people use alcohol irresponsibly at some time in their lives, most appear to get away with it. Ms. Herring suggested that periods of heavy alcohol consumption throughout adolescence may be viewed as no more than rites of passage, with concern often being greater among the parents than the child. Thus, one viewpoint could be ‘Hang on, most of us do this at some point in our lives, so why make such a fuss?’ or ‘Don’t label the majority of young drinkers with the same stigma as the minority who cause problems for themselves and others’.

Lively discussion ensued, and, whilst accepting this view, Dr Ian MacFarlane stressed that problematic alcohol use could be symptomatic of other disruptions in young people’s lives, and it is important, therefore, to identify factors that underlie the transition from experimental, non-chronically problematic alcohol use to alcohol consumption that impairs the functioning of the individual and his/her community. Focusing on those at risk would certainly be a more prudent use of limited resources, but such an approach in a morally and politically shaped society such as ours, runs the risk of being seen as condoning episodes of youthful intoxication. The impact of cheap drinks in socially sanctioned environments (such as student bars) on excessive consumption by this group cannot be ignored.

**Perspective from an accident and emergency department**

If for a moment the audience were to be allowed to consider periods of excessive alcohol use as acceptable, even normal, and thus little cause for concern, then the moment was disrupted by Dr Christopher Luke’s (Royal Liverpool University Hospitals) visually daunting and emotive presentation from the front line of a busy A&E department. He presented a view almost diametrically opposed to that of Ms. Herring, though of course his perspective is, by definition, chosen by parameters that define problem use. Dr Luke argued forcefully that explanations and understanding did not alter the unacceptability of the mayhem and distress of alcohol-related presentations at his department. This was a pragmatist’s view, informed by clinical experience and concern for the functioning of his chosen specialty. With 80% of nurses feeling safer on the streets than at work and 70% of ambulance crews reporting assault, Dr Luke proposed alcohol use and drug use as the prime candidates responsible for these statistics. Recognising the sharp increase in drug use and alcohol consumption by club goers, he pointed to the enormous drain on resources of attending to the health consequences of alcohol use. From nightclub finger (a shard of glass in the finger tip, brought on by flicking off a bit of glass stuck to a trainer in the belief it was a cigarette butt) to victims of assaults with glass containers and drunk driving, Dr Luke recollected a cascade of horror good enough for any episode of *Casualty*. Managing the intoxicated and uncooperative patient for the simplest of conditions, is a skill in itself and distracts staff from other patients in need of care. Third party violence and other trauma only compound the problems of severe acute intoxication in the young person.

Dr Luke reviewed a frightening set of statistics from his own experience: 80% of weekend admissions to his A&E ward were related to alcohol or drug use and 20% of inappropriate 999 calls nationally are from drunken persons. However, he also placed alcohol in a wider perspective, informing us that 18 of the 38 World Health Organization’s global health targets are related to alcohol. He pleaded that stories such as his should not give rise to pessimism, but
advocated a proactive stance with co-operation between the police, club promoters and healthcare services including the emergency services. Citing the impact that education has had upon the public perception of drunk driving as socially unacceptable, Dr Luke suggested policy changes that would lead to a reduction in alcohol associated problems. Getting rid of glass would reduce injuries within drinking environments, increasing pressure on licensees to comply with legal statutes and instituting primary healthcare pathways to allow early intervention were some of his pragmatic suggestions.

Dr Luke considered specialist liaison nurses within A&E departments as the future for alcohol intervention among high-risk groups. Skilled professionals delivering brief intervention with education, advice and follow-up, at and around the time of their presentation, could reduce recidivism among this group. Dr Luke concluded his talk with a warning of the chaos that may ensue in A&E departments all over the UK on New Year's Eve 1999, which he dramatically described as Millennium Armageddon. I hope I am not on call!

Motivational interviewing

Attempting to introduce a new method of communication to practicing professionals is difficult. For a clinical psychologist talking to an audience primarily composed of physicians, the task is compounded. However, using examples familiar to doctors such as gamma glutamyle transferase (GGT) and alanine transferase (ALT), Ms Gillian Tober (Leeds Addiction Unit) managed to communicate effectively the concept that what you say and how you say it can have a significant impact upon the choices a patient makes with regard to changing behaviour. Motivational Interviewing (MI) or Motivational Enhancement Therapy (MET) describes a means of communication that facilitates a client's readiness to change, by addressing ambivalence and moving clients through a cycle of change from precontemplation to action. First described by the American psychologist, Bill Miller®, MI is based on five key principles, which are useful in the fields of addiction and eating disorders, and may also be adopted in any aspect of the doctor-patient relationship in which the patient is ambivalent about implementing a change that in the doctor's opinion would be beneficial. The five principles are:

1. Express empathy
2. Help the clients to see discrepancies in their behaviours
3. Avoid argument
4. Roll with resistance
5. Support the patient's sense of self efficacy.

Results from Project MATCH®, a recent large multicentre alcohol treatment trial in the USA, demonstrated that four sessions of MET were as efficient as 12 sessions of Cognitive Behavioural Therapy (CBT) or Twelve Step Facilitation. What must be appreciated is that people are only motivated to change a behaviour when they 'mind about it', not when the doctor does. This is very different from the usual paternalistic and authoritarian approach on which most doctors are reared. It is not enough to expect a patient to do something we ask just because we say so. People only successfully change their behaviours when they perceive that they are able to and that they will be better for it. MET may be particularly useful as an intervention for young people since it:

- is brief
- is effective for a group often characterised by low self esteem/self efficacy
- is non-authoritarian
- could address changes at other levels that may compound problem drinking behaviour.

MI is a technique that all healthcare professionals could adopt to great therapeutic effect, and I strongly recommend reading Miller's book® to all those interested in improving their ability to assist their clients in implementing change successfully.

Services for young problem drinkers

Whilst alcohol dependence is rare in adolescence, prevalence studies among young adults in the UK in the last 12 months give dependence rates of 7.5% for men and 2% for women (4.7% overall). Among certain groups of adolescents such as juvenile offenders, however, the rates of substance misuse have been estimated at over 80%®. The greatest impact of alcohol consumption by the young is on accidents, violence and suicide, with depression a frequent comorbid disorder®. Against this background, Dr Eilish Gilvarry (Newcastle and North Tyneside Alcohol and Drug Service) outlined the difficulties of providing a service for young drinkers within the current health service provision. There is already a paucity of service provision for adults with dual diagnosis, perhaps the most needy yet underresourced group with mental health problems, and young people with alcohol problems not only fall between psychiatric and addiction services, but also between child and adult services.

Even if there were a dedicated service for young people with alcohol and substance misuse problems, there is an added difficulty in engaging this group with the services. Dr Gilvarry asserted that there is a two-fold need to break down the 'us and them' barrier at the patient/doctor and child/adult levels. Moreover, there would be a need to develop new skills: the service would need to address developmental issues, cognitive and emotional immaturity, education (as opposed to employment) problems, as well as family and child protection issues, all of which are uncommon in adult addiction services. Such a service should be comprehensive, competent, child-centred and lawful. Its separation from adult services would also prevent experienced drug users coming into contact with more naïve users.

Ultimately, a tiered approach would be most appropriate,
allowing full use of current services and focused development of new services. Primary healthcare centres could provide accurate screening with initial referral to youth services within existing departments. Beyond this, referral to specialist and super specialist regional services could be employed to provide secure environments, residential rehabilitation or therapeutic communities. Full and accurate assessment with early identification will be the key to ensuring that this vulnerable group is accessible to service providers. Once engaged, they may receive the full range of therapies, from family work and CBT to pharmacotherapy and self-help groups.

Conclusion

This was a fascinating meeting, not only educative in its own right, but thought-provoking and, at times, inspiring. Alcohol misuse places a huge burden on a struggling National Health Service. The impact of alcohol consumption upon individuals and their communities is multidimensional, with young people suffering the consequences of both their parents' and their own consumption. Whether alcohol consumption is viewed as problematic depends upon one's perspective, though alcohol use among the young must always be viewed in conjunction with the social matrix within which it takes place. Although most young people come away from teenage drinking bouts unscathed, a significant minority suffer the acute or longer-term consequences of their own or someone else's alcohol use. Co-ordinated national care pathways are required, with raised awareness and skills for screening and assessment among all healthcare professionals. Ignorance of the problem will not reduce its impact upon services nor the individuals who carry the burden of its associated problems. Diffusion of responsibility among a multidisciplinary healthcare team, police and government, must not result in dissolution of service provision. Instead, communication and integration should ensure a comprehensive, competent and user-friendly service. Any national strategy must, however, be dynamic, able to adapt proactively to changing trends in consumption and associated patterns of mortality and morbidity.

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