A response to the National Alcohol Harm Reduction Strategy Consultation Document

From

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Background

Our group carries out research into the consumption of alcohol and other drugs, as well as into potentially addictive behaviours such as gambling. The research we undertake may focus on consumption or activity which is unexceptional or on behaviour which is excessive, but to be undertaken by the group research must have clear relevance for either prevention or treatment. The group pursues those aims by carrying out research situated both in the clinic and in the community. Current and recent research projects include: a cohort study of untreated heavy drinkers (supported by DoH); a multi-centre trial comparing two leading treatments for alcohol problems (supported by MRC), a programme of studies on the impact of alcohol and other drug problems on the family, and the ways family members cope (supported by the Mental Health Foundation, WHO, etc); a series of studies evaluating primary care interventions with family members of people with alcohol or other drug problems (supported by NHS West Midlands and the Alcohol Education and Research Council); an evaluation of the Birmingham combined psychosis and substance misuse programme (supported by DoH); and a study of drinking amongst second and subsequent generation Black and ethnic minorities in the Midlands (supported by Alcohol Concern). Further details of these studies are provided in the appendix to this response. Our work involves close collaborations with colleagues in universities and NHS trusts in England and Wales and with colleagues in a number of countries overseas. The group represents a collaboration between the university and a local NHS trust that provides services for people with alcohol or other drug problems. We have strong links with Aquarius Action Projects, the non-statutory agency that provides a range of services for people with drinking problems in the Midlands. Several of us have whole or part-time contracts with Northern Birmingham NHS Trust. We believe we are in a position to respond to a number of the questions posed in the consultation document from our perspective as an active research group that spans the fields of alcohol research and service provision.

The principles that should underpin the strategy

Questions 1 and 2: Why should Government get involved and when does it have a responsibility to intervene?

We can make a comment on questions 1 and 2 because of our work in developing a model of addiction (Orford, 1985, 2001a, b). The implication to be drawn from that

model is that the Government has a responsibility for the prevention and treatment of alcohol-related harm because of the addiction or dependence-producing potential of alcohol which is promoted with the Government's encouragement, and from which the exchequer benefits. Because of the very wide availability of alcohol in British society, and because of the capacity of alcohol to produce powerful and rapid mood change, the consumption of alcohol, as well as producing many benefits for many people, has the capacity to create in some people a degree of dependence upon it. The 2000 ONS psychiatric household survey suggested that as many as 7.4% of the adult British population might have been at least mildly dependent on alcohol at some time in the previous six months (Singleton et al, 2001).

There are several additional important points to be made about addiction or dependence. One is that it lies on a continuum: hence there are more people mildly dependent than moderately dependent, and more people moderately dependent than severely dependent, and it is very difficult to say when mild dependence has begun. It is therefore very difficult for professionals to detect the early signs or stages, and equally difficult for individual drinkers themselves to recognise when they might be becoming dependent. A second point of importance concerns the nature of losing control. Some simple, popular conceptions of addiction suppose that addicts are quite unlike the rest of us and have totally lost control over their consumption. Modern conceptions of dependence, on the contrary, view control over drinking as something that is never totally lost however severe the level of dependence, but at the same time something that is eroded to some degree even when dependence is mild. Hence no dependent drinker ceases to be responsible for his or her consumption and its effects, yet control is partly lost to the extent that dependence has developed. A final important point concerns our understanding of the origins of dependence which are now widely held to be multi-factorial, including factors relating to the individual (genes, early environment, personality etc) and the social context (social norms, peer group influence, the price and availability of alcohol etc). The complexity of the etiology of addiction is such that no-one can be expected to be able to anticipate becoming dependent, nor are there obvious ways of identifying high risk groups. All of the above suggests that the availability and promotion of alcohol (supported by the Government) puts all of us at risk, and indeed a significant minority of people develop some dependence on alcohol, which erodes their ability to control their consumption, a state of affairs for which they cannot reasonably be held totally accountable.

The cultural and behavioural issues around alcohol use and misuse

Question 9: Family members

One very large group of stakeholders in these issues, missing from the Consultation Document, as they nearly always are from policy documents (Copello and Orford, 2002), consists of family members who are affected by and concerned about the excessive drinking of close relatives ('concerned and affected family members' for short). We have estimated, conservatively, that there are probably in the region of between one and two million such family members in Britain at any one time, who are significantly stressed by living with someone with a serious alcohol problem (Orford et al, 2003a). Many are children under the age of 16, and many others are wives or partners of men with drinking problems. Another large group consists of parents of

young adults with drinking problems. Other groups of family members including siblings and grandparents should also be included in this group.

There are two related reasons for focusing on family members and for integrating them into our treatment responses to a far greater extent than has been the case up to now. The first is on account of the high risk status of family members. We know from our own research (Velleman and Orford, 1999) and from that of others that children of problem drinking parents, at least while they remain at home, are at considerably raised risk of emotional, conduct and learning difficulties. We also know, again from our own research (Orford et al, 1998, 2003a) and from that of others that partners living with people with drinking problems are at raised risk of depression and anxiety and physical ailments. The second reason for recommending a focus on family members is the positive role that they can play in motivating and supporting reductions in their relatives' excessive drinking. At one time stereotyped and unsympathetic professional views of family members prevailed, and the conventional wisdom was that family members could and should do nothing to encourage change in their relatives. Fortunately that view has in recent years been replaced by a much more constructive view of family members as a large constituency of people who are negatively affected by their relatives' excessive drinking and are concerned and worried for their relatives, and who can be assisted to play a positive role in the change process. Recent years have seen the publication of a number of positive evaluations of such family member interventions, from the USA and Australia. The programmes evaluated have various titles including the 'pressures to change' approach, 'behavioural marital therapy' the 'community reinforcement family method', 'unilateral family therapy' and 'network therapy' (Barber and Crisp, 1995; O'Farrell and Rotunda, 1997; Myers et al,1999; Miller et al, 1999).

Our group has developed and started to evaluate two forms of intervention involving families, both of which are looking very promising. One is designed to be used in the context of primary health care whenever a patient is identified as being a 'concerned and affected other' (CAO), living or very closely involved with a relative with a drinking problem. We have trained GPs, health visitors and practice nurses to identify CAOs and to provide an intervention (up to five sessions) involving five steps: listening; providing information; counselling about ways of coping; identifying additional support; further referral if necessary. In an initial before-and-after evaluation of a series of interventions, we were able to show changes in family members' ways of coping (particularly reduced tolerant coping) and reductions in family members' symptoms (Copello et al, 2000). In a second study, taking the form of a cluster randomised controlled trial, just completed, we have demonstrated that the provision of a self-help manual, based on the same five-step approach, which is more economical of primary health care worker time, is equally effective (Copello et al, 2003). We have also shown that the engagement of primary health care workers in the family programme results in significantly more positive attitudes towards this kind of work. We are aware of DoH's pilot training scheme for GPs and practice nurses aimed at enabling them to better identify problem drinking and to offer appropriate intervention and referral, but we are concerned that this may perpetuate what we see as the error of omitting family members from consideration. We strongly urge consideration of the possibility of combining primary care initiatives to recognise and respond to excessive drinking with at the same time recognising and responding to the needs of family members, and encouraging an integration of the two.

Our second family initiative has been in the context of the multi-centre UK Alcohol Treatment Trial (UKATT). All data from that trial are now collected and are being analysed. Of the two treatments compared in that trial, one was a treatment designed to involve close family members and friends: Social Behaviour and Network Therapy (SBNT), designed and cast in manual form specially for the trial, based upon social elements that had received favourable evaluations in previous work (Copello et al, 2002). Unlike our primary care work, SBNT starts out with the referral of a person with a drinking problem. Its main principle is the identification of a network member(s) who can support the focal problem drinker in the latter's efforts to change. We now have very positive experience of training therapists to use SBNT in seven different sites in three centres in England and Wales (Cardiff and vicinity, the West Midlands, and Leeds). SBNT has been popular with therapists who received close supervision during the trial. Each trial therapy session was video-taped and analysis of samples of the recordings is currently taking place. Results of the trial will be available in the second half of 2003.

Question 9: Minority ethnic groups

Our group collaborated with Aquarius Action Projects and the Mary Seacole Research Centre at De Montfort University, Leicester, in a study of the drinking of second and subsequent generation Black and ethnic minority groups in Birmingham and Leicester in 1999 (Purser et al, 2002; Orford et al, 2003b). The study involved men and women in each of five groups: African/Caribbean, Indian Hindu, Indian Sikh, Pakistani, and Bengali. Previous research had shown high rates of abstaining and lower rates of heavy drinking amongst British ethnic minority groups compared to White British (e.g. Meltzer et al, 1995; Cochrane and Bal, 1990; Cochrane and Howell, 1995; Modood et al, 1997) but had not distinguished between first and second or subsequent generation groups. Our study suggested that rates of drinking, of heavy drinking, and of alcohol-related problems, were as high amongst second or subsequent generation African/Caribbean men as amongst White British men of comparable age, and were also high amongst African/Caribbean women and Sikh men. Abstinence rates were very high amongst all other groups. Amongst all groups combined, strength of identity with religion was negatively associated with drinking and problem drinking for both men and women. For women there existed a number of other social and cultural variables that were associated with drinking and problem drinking: younger age, more qualified, employed, single, fewer members of the household, and fewer close friends from own ethnic group. Our conclusion from that research is that, whilst there continue to be social, cultural and religious factors that operate to protect members of British minority groups from engaging in heavy and problematic drinking, those factors are no longer operating to protect large numbers of members of ethnic minority groups who were born in this country or who came to Britain in their very early years. Amongst those groups who are now as much at risk as other young adult Britons are: large numbers of Black men and women and Sikh men, and minorities of other groups of South Asian men and women. They are going to require more attention in a national response than they have received hitherto.

Question 10: What are the positive cultural and behavioural aspects of alcohol use?

We have data that bear on this question from our cohort study of very heavy drinkers (The Birmingham Untreated Heavy Drinkers Study, BUHD) and from our study of second and subsequent generation ethnic minority groups in the Midlands. We have particularly detailed results from BUHD since the sample when first interviewed in 1997 consisted of 500 men and women drinking 50 or more units of alcohol most weeks (men) or 35 or more units (women), and 70% have now been interviewed three times at two-yearly intervals, and are due for their fourth interview in 2003. In BUHD and the ethnic minority project we used a technique that we devised which asked respondents to consider the benefits and drawbacks of their own recent drinking in each of 13 life areas. In BUHD we were able to supplement these data with in-depth interviewing to explore the same topic. The results from the first wave of BUHD interviewing on those issues have been published (Orford et al, 2002). In brief the picture that emerged can be summarised as follows: The social benefits of drinking dominate heavy drinkers' accounts of their drinking. It is not denied that drinking often serves the function of coping with negative events or circumstances, nor that drinking can lead to social drawbacks. But the ways in which these less positive facets of drinking are discussed allows their impact to be lessened under the domination of accounts of the positive, social facilitating or enhancing functions of drinking. This way of representing the benefits and drawbacks of heavy alcohol consumption could be seen as constituting a powerful mechanism supporting the maintenance of this behaviour in the face of health promotion messages.

Results from the study with ethnic minority groups suggested that the latter experience much the same benefits (Orford et al, 2003b). We have also carried out a smaller study focusing on a university student drinking, which again emphasizes the importance of the social dimension: heavier drinking students had greater expectations of the positive effects of alcohol, and had much stronger encouragement and modelling of heavy drinking from their immediate friends (Orford et al, 2003c). We have also focused attention in some studies on high volume single occasion ('binge') drinking. In-depth interviews with a sub-sample of the BUHD cohort, and with a new sample of students, show clearly that such drinking is explained as being engaged in for reasons of positive socialising, fun, and celebration.

Health: prevention, treatment and the impact on the NHS

Question 14: Defining harmful or problematic drinking

A lot of work has gone into trying to answer this sort of question, and a number of standard sets of questions exist to operationally define problem drinking or alcohol dependence (e.g. the Severity of Alcohol Dependence Sale, SADQ, Stockwell et al, 1983; the Leeds Dependence Questionnaire, LDQ, Raistrick et al, 1994; or the 12 questions used in the first OPCS household psychiatric survey, Meltzer et al, 1995). All view harmful or problematic drinking as lying on a continuum, implying that there is no absolute threshold. They all also imply that problematic drinking is something that can be measured more or less irrespective of the social and cultural context within which drinking takes place. Others have challenged that assumption (e.g. Room et al, 1996; Orford, 2001a, b), arguing that what constitutes a drinking problem must to

some degree depend upon what is defined as normal or acceptable or non-problematic in a particular socio-cultural group.

Leaving aside the question of socio-cultural relativity, there is also the question of whether harmful or problematic drinking is best thought of as a single dimension, or as two dimensions as in the bi-axial concept of excessive drinking (which sees alcohol dependence and alcohol-related problems as separate dimensions), or as a larger number of dimensions (e.g. Skinner, 1990). The evidence appears to be against the bi-axial model, with support being found for a single dimension that combines symptoms of dependence and signs of problems, subsuming a larger number of more specific factors. Sets of items are probably best since any one item is inadequate in some way. For example, salience of or preoccupation with drinking is probably one of the best hallmarks, but has a relatively low frequency of endorsement by respondents. On the other hand social problems such as fights while drinking or harmful effects of drinking on relationships have higher frequencies of endorsement but are less reliable as indicators. In our ethnic minority project we used six indicators or signs that a respondent's might be of concern: drinking most days, high volume weekly drinking, regular single occasion heavy drinking, very large quantity occasional drinking, social harms from drinking, and contemplation of drinking change.

Question 16: Costs for the NHS both directly and indirectly

This is one of the main questions being addressed in our BUHD cohort study. Interviews have included questions that enable us to estimate primary care, accident and emergency, out-patient and in-patient NHS costs of the care provided in the previous 12 months to members of this cohort who entered the study in 1997 as very heavy drinkers (Dalton, et al, 2002, 2003). Our conclusions are as follows:

Comparative analysis indicated that in 1997 the health of the sample as measured by the SF-36 was poorer than their general population counterparts. Whilst this 'poorer' health was not reflected in greater usage of all health care services (for example GP consultations were little different from general population figures), this sample did appear to be using certain hospital based services (e.g. accident and emergency departments; hospital inpatient care) more than might be expected from general population figures. At the second wave in 1999, 24 per cent of the cohort had attended at an hospital accident and emergency department in the previous 12 months, which is greater than the 13 per cent of the general population 16-44 year olds reported by the General Household survey in 1996 as having used an accident and emergency service in the previous year. Similarly, the 91 inpatient admissions for 1999 which were reported by 58 of the participants, exceeds the expected 48 as calculated from general population figures for 25 to 64 year olds living in Birmingham wards. Between them 53 of the these 58 participants accrued a total of 333 nights in hospital (the remaining 5 were day patients). The total cost of hospital based care for 12 months was calculated at around £110,000 of which about half may be considered 'excess' costs incurred by this sample.

Question 18: Brief interventions offered to patients who have been identified as at risk. How effectively do you think those at risk are identified?

Results from the BUHD cohort study indicate that although this heavy drinking cohort are visiting their GP at rates very similar to those in the general population, discussion of drinking is uncommon during a consultation. This reported infrequency of discussion of drinking may be explained by poor identification of those at risk and/or a reluctance on the part of either or both the patient and the doctor to engage in such discussions. Doubts regarding the efficacy of such brief interventions and a lack of confidence regarding their own ability to intervene have been found to be associated with a reluctance to engage in alcohol interventions on the part of the GP (Kaner et al, 1999). Investigation of the drinker patients' perspective within the BUHD project revealed that the drinking patients are often equally as unwilling to discuss the topic of their drinking. The patients' often erroneous beliefs that their present problems are unconnected with their drinking plus concerns regarding the negative impact of being identified as a 'drinker' particularly as it might affect the quality of their future medical care were found to contribute to the patients' reluctance to enter into discussion of their drinking during a consultation with their doctors.

Question 19: Treatments for alcohol problems

Although we know that many people with alcohol problems alter their drinking without the assistance of formal treatment (e.g. Sobell et al, 1996), and it is very difficult to design studies that include non-treatment control groups, nevertheless a number of sound reviews have concluded that treatment does have a measurable effect on outcome (Miller et al, 1995; Babor, 1994). On the other hand it has been difficult to find any one treatment that is measurably better than others, and there is therefore a strong case to be made that the effective ingredients of treatment are not specific to a particular treatment theory or form of practice (Orford, 2001a, b). The largest published study to date, the US Project MATCH, found no significant difference in outcome between three theoretically very different treatments (Cognitive Behaviour Therapy, CBT; Motivational Enhancement Therapy, MET; 12- Step Facilitation Therapy, TSF) (Project MATCH Research Group, 1997a). Project MATCH was particularly designed, as its name suggests, to look at client-treatment matching or interaction effects which might suggest ways in which treatments could be chosen to meet differing individual needs. The results in that regard were disappointing, with very little evidence of matching effects that would be clinically significant or were replicated across different arms of the study (Project MATCH Research Group, 1997a, b). One of the few such effects found that clients with heavier drinking social networks benefited more from TSF treatment (Longabaugh et al, 1998).

The results of UKATT, which is the largest trial of treatments for alcohol problems conducted in Britain to date, will be available later in 2003. It compares MET, which as a comparatively brief treatment (three or four sessions) is a strong contender for an economical treatment of choice, and SBNT which, as described above, incorporates the support of a network member(s) who is a close family member or friend. The study is testing for a main treatment effect (a direct comparison of MET and SBNT outcomes) and for matching effects which may indicate whether there are people who are likely to benefit more from one treatment or the other. Treatment manuals, as

used in UKATT, will shortly be available for general use, and as a result of the trial there are now three centres in the country with experience of training and supervising therapists in MET and SBNT which could be applied more generally. A further issue to emerge from this trial was the central importance of training and on-going supervision to achieve high quality in the delivery of evidence based treatments for alcohol problems.

A final observation in answer to this question relates to models of treatment. It is worth pointing out there is growing dissatisfaction on the part of a number of treatment researchers regarding the currently dominant model of treatment which looks for outcome effects several months after the application of time-limited, single treatment episode, individually-focused treatments. That model takes little account of the high relapse rate following an episode of treatment, the fact that successful change may occur after a number of treatment episodes, and that the social environment that a client experiences following treatment may be equally as important if not more important than the treatment episode. It is for that reason that suggestions have been made that treatments should be viewed, not as an isolated episode, but as a system of support for change which allows for continued follow-up, repeated episodes of treatment, and attention to the quality of the environment (McLellan et al, 1998; Orford, 2001a; Humphreys and Tucker, 2002).

Question 22: Links between alcohol misuse and mental health problems, and how services are best coordinated

Associated with our research group is the work of the Birmingham COMPASS programme (Combined Psychosis and Substance Misuse Programme) which has assessed the co-occurrence of substance problems (mainly alcohol) amongst individuals with severe mental health problems in Birmingham (Graham et al, 2001) and is coming towards the end of a study of treatment provision for clients with combined problems. The Birmingham COMPASS work has attracted attention nationally because of its model of treatment and its current work in evaluating the application of that model. Rather than set up a new direct service for people with combined problems, the COMPASS integrated model is one in which a small specialist team provides training, modelling of good practice, and consultancy to the staff of assertive outreach and other mental health teams who learn to address the substance misuse element of their clients' problems. Results to date are very encouraging.

Crime, disorder and anti-social behaviour

Question 23: Links between alcohol, crime and anti-social behaviour

The Birmingham Untreated Heavy Drinkers (BUHD) cohort study referred to earlier has included questions on this subject at each wave. For example findings from the second wave included the following: 33% reported a serious argument during or after drinking and 21% reported one or more violent incidents or fights in the previous year. Detailed data collected on the two most recent violent incidents provided more information. For example: on 81% of occasions the participant had drunk 10 or more units of alcohol in the previous 24 hours; on 74% of the occasions the opponent was known to have been drinking prior to the incident; the police attended on 30% of the

occasions; additionally the data showed that the majority of violent incidents took place either in the street (33%) or in a pub or other licenced setting (32%) on a Friday, Saturday or Sunday. Although many of these violent incidents are not reported to the police, when they are the public nature of the venue and weekend timing of such incidents suggest that police response will be costly in terms of number of officers and shift allowances. These drinking related incidents may also incur other costs to society in terms of injury to other persons and damage to property and problems needing recourse to social care services. Including costs for court appearances, total 12-month costs of alcohol-related crime for 403 heavy drinkers was calculated to be just over £450,000 or about £1,200 per heavy drinker. The large bulk of that cost was contributed by a minority of about 1 in 5 heavy drinkers. 24% of the sample admitted to driving after consuming quantities of alcohol that we calculate would have put them above the legal driving level. Between them those drinking drivers admitted to a staggering total of 2,700 drinking and driving occasions in the previous 12 months.

Question 25: Can alcohol convincingly be demonstrated to be factor in criminal and disorderly behaviour?

There is no doubt that the link between alcohol consumption and crime is a complicated one, and the present answer is limited to considering the relationship between alcohol and violence. The literature on this subject has been reviewed on a number of occasions, comprehensively so by Lipsey et al (1997). They reviewed four kinds of evidence: experimental studies with animals; experimental studies with humans; individual-level correlational studies; and macro-level or aggregate-level studies. Each of these bodies of research were found to be predominantly positive about the relationship between alcohol and violence and each provided substantial evidence in favour of an association. On the other hand there were problems with each type of evidence. Hence, although the possibility of a causal influence of alcohol consumption on violence could not be ruled out, the causal issue was thought still to be 'cloudy and uncertain'.

What does seem clear is that there is no simple effect of alcohol on the probability of violence, and simple disinhibition theories that suppose a direct effect of alcohol on the brain have fallen from favour. Other theories of the alcohol-violence link include: less direct disinhibition theories such as cognitive disruption which suggests that alcohol impairs cognition in such a way that attention becomes focused on only the most immediate contextual characteristics including those of a threatening or provocative nature, hence facilitating aggressive behaviour; expectancy i.e. alcohol increases aggression because people expect it to; a closely related view that periods of intoxication represent socially defined periods of 'time out' from the usual social rules, and that whether aggressive behaviour is expected during such periods varies from one socio-cultural group to another; 'deviance disavowal' which emphasizes the role of alcohol in providing a socially acceptable excuse for aggressive behaviour; a theory focusing on interpersonal power and patriarchy, suggesting that power is at the root of both men's heavy drinking and wife abuse; a marital mediation model which posits that excessive drinking results in increased marital conflict which in turn puts couples at risk for aggression. A variation on the hypothesis that alcohol consumption increases the probability of violence, is that violence following the consumption of alcohol is not necessarily any more likely but is more serious, persistent or indiscriminate.

Question 30: Targeting on young people

Results from our BUHD study are relevant here. When first recruited to the study in 1997, participants were aged between 25 and 55. By the time of the second wave in 1999, the minimum age was 27. The rate of alcohol-related crime reported by the BUHD cohort at the second wave (see above), and our calculation of the costs involved, suggest that targeting anti-crime and anti-social behaviour initiatives solely at young people would miss a great deal of relevant behaviour.

Question 34: Drink driving policies are generally acknowledged to have been successful. What can we learn from them?

Findings from our work with the cohort of untreated heavy drinkers suggest that the acknowledged success of drink driving policies may need some qualification. Results from both the second and third waves of the BUHD project indicate that some 30% of male and 14% of female heavy drinkers reported at least one occasion of drink driving in the previous year. Mean averages of 35 occasions during the year for men and 9 for women suggest that drink driving is not uncommon for many of these individuals. Furthermore, our findings suggest that a core of drinkers are impervious to the deterrent effect of losing their licence. Almost one half of the 723 cohort members who had previously received a ban for drink driving had driven a car after drinking at least once in the year before their 2001 interview.

On a more positive note our exploration of the social norms associated with drinking revealed that not drinking and driving was a very readily socially accepted way to avoid social or peer pressure to drink alcohol. In view of the role of social context in the multi-factorial origins of alcohol dependence it would seem prudent to note this serendipitous side effect of drink driving policies and explore ways in which it might be exploited to introduce other equally as socially accepted ways to resist social pressure to drink or consume large quantities of alcohol.

Question 35: Domestic violence

Our answer to question 25 is relevant here. The link between alcohol consumption and domestic violence has been the subject of a number of reviews and studies. A particularly good example is O'Farrell and Murphy's (1995) report of the responses of 88 male 'alcoholics' and their wives to the Conflict Tactics Scale (CTS) both before and one year after receiving behavioural marital therapy in the USA. Compared to a matched sample of men and women selected from a US national family violence survey, the reported occurrence amongst men with drinking problems and their wives was very significantly greater: 43% of drinking problem husbands reported that they had shown any violence towards their wives and 52% of their wives reported any violence from their husbands (equivalent percentages in the control group were 7% and 13%); 14% of husbands reported any severe violence to their wives and 28% of wives reported such violence from their husbands (0% and 3% of controls). One year after therapy violence was substantially reduced and in those couples where the husbands' drinking problems had remitted the level of violence at follow-up was indistinguishable from that in the control group.

Domestic violence has been a regularly recurring theme in our own programme of research interviewing family members of close relatives with drinking problems in England, Mexico and Australia. Although violence is not always described by family members, it is very commonly reported and varies in severity sometimes taking a very brutal form. Also very often described are forms of verbal aggressiveness that vary in severity and are frequently as intimidating as physical violence itself. Aggressiveness was described in a number of different ways including: irritability, anger, verbal abuse, arguments, rudeness, shouting, insults, complaints, criticism, domineering behaviour, pushing, punching and hitting, breaking furniture or other household objects, threatening with weapons such as a knife or a screwdriver, hitting with dangerous objects, and make death threats (Orford et al, 1998, 2003a).

Our understanding of the link between excessive drinking and domestic violence, based on our extensive experience of interviews with family members and our reading of the literature on the subject, is that there is a real link between the two (i.e. violence cannot solely be attributed to patriarchal attitudes and behaviours on the part of male partners, although that is surely a contributory factor) and that there are a number of mechanisms responsible for the link. One is to be understood in terms of the nature of alcohol dependence itself, which creates an uncomfortable state of conflict or 'dissonance' for those who experience it, and which leads to moodiness and irritability, suspiciousness and blaming of others, and an over-sensitivity to apparent slights and insults, all of which makes aggressiveness and violence more likely. Dependence also leads to interactions in the family which are by their nature conflictual and contain the seeds of aggressiveness: for example regular interactions around requests or demands for money for drinking (which we refer to as family members being 'humbugged' – an Australian expression), and interactions around the dependent person being a bad timekeeper, failing to turn up for meals, being absent for important family occasions etc. A further mechanism brings in the factor of how family members attempt to cope with having a dependent relative. Most family members, feeling upset, hurt and angry about excessive drinking, at some stage respond with open upset or anger, or with attempts to control the relative's drinking in some way. Many such coping attempts are badly received by excessively drinking relatives, and the likelihood of aggression and violence is raised as a result.

Domestic violence towards children has been the subject of much special study, including our own study of young adults who had parents with drinking problems (Velleman and Orford, 1999). Forty-two per cent reported receiving violence from a parent during childhood (compared to 18% of a matched comparison group without parents with drinking problems), 31% over a prolonged period (versus 15%), 21% regular violence (versus 5%), and 20% any violence involving an instrument or weapon or leaving a mark (versus 9%). Rates of recalling violence between their parents were just as high if not more so: 66% reporting any parent-to-parent violence during childhood (versus 21% in the comparison group), 48% over a prolonged period (versus 8%), 27% regular violence (versus 5%) and 29% serious violence (versus 9%).

The implications for vulnerable groups

Question 36: Most vulnerable children and young people

Our study, referred to above, of young adults who had parents with drinking problems, plus a review of the literature (both summarised in Velleman and Orford, 1999), lead to some fairly clear-cut conclusions about the risks for that group of young people who have had the experience of being brought up in a home where one or more parents had a drinking problem. The first and most straightforward conclusion is that such children have a raised risk, *whilst they remain living at home*, of a range of childhood and adolescent conduct, emotional, school and learning, and peer friendship difficulties. They are undoubtedly an at risk group, and one that continues to be neglected. Those who are most at risk are those living in families where the parental drinking problem is associated with greater family discord or disharmony (more family arguments, family violence, more negative childhood experiences such as lack of social life for the family and family arrangements going wrong, and fewer joint family activities and less emotional closeness from and between parents).

There is a tendency for offspring of parents with drinking problems to leave home early, to have an unsettled transition to adulthood, and to have a raised risk of excessive drinking or drug use, but the majority do not experience the latter, and in terms of general mental health *as adults* they are as a group no more at risk than other people. Those who experience the most disharmonious homes as children and/or suffered childhood problems, are however at greater risk of mental health problems as adults. Others, however, appear to be particularly resilient.

When the parent with a drinking problem is the mother, problem drinking is more likely to occur at home and certain negative experiences for the child are greater (e.g. involvement in parental rows). On the other hand relationships with problem drinking mothers are less negative than are relationships with problem drinking fathers, and the onset of mothers' drinking problems occurs on average later in childhood, and positive family experiences are on average better preserved. Overall there is no greater risk if the mother is the parent with a drinking problem. Nor is there any greater risk if the parent with a drinking problem is of the same sex as the child. Having had two parents with drinking problems does appear to confer greater risk however.

Question 39: How can services to vulnerable groups be joined-up most effectively?

We have referred earlier (question 22) to services for people with combined alcohol and mental illness problems, and we believe the COMPASS model is an effective way of providing joined-up services for that group.

We continue to be concerned, however, about services for vulnerable family members (see questions 9, 35 and 36 above). We have expressed our concern at the neglect of services for concerned and affected family members in general (wives of men with drinking problems would constitute the largest group, but the group would also include children, parents, husbands and others) (Copello and Orford, 2002). We estimate this to be a very large group, likely to number at least one million adults in

Britain (Orford et al, 2003a). Neglect of this group can be attributed to the failure of both alcohol problems treatment services and general family services to prioritise this group or to plan joined-up services. Specialist alcohol problems treatment services tend to prioritise clients who themselves are misusing alcohol to the exclusion of family members, and in addition often adhere to practices (e.g. concerning confidentiality) and theories (e.g. those that blame or pathologise partners or parents) which make it difficult for them to attend to the needs of family members (Howells, 1996; Copello and Orford, 2002). For their part, general family services very often downplay the importance of excessive drinking for family members' health and well-being, sometimes adhering to views that make it difficult for them to recognise the contribution that drinking might play (e.g. taking the view that pinpointing excessive drinking provides men with an excuse for domestic violence). With their separate sets of priorities, and often conflicting professional theories, it is perhaps not surprising that good joined-up services for family members are very rare.

We have expressed a particular concern about the absence of, and need for, joined-up services specifically for children of problem drinking parents (Velleman and Orford, 1999). We have suggested that, since the problems of such children are both highly prevalent and liable to be disguised or invisible to service providers, a broad strategy is called for involving specialist agencies, non-specialist agencies, and good collaboration between the two. We have suggested that alcohol problems treatment agencies should make their services available to family members, should consider designating one or more members of their teams to specialise in work with children, and to set up cross-referral systems and joint working with school counselling and child psychology and psychiatry services for example. Similarly generic services for children need to be aware that parental alcohol problems are highly prevalent and that many difficulties with which children present may have such parental problems as an underlying causative factor. Staff need to be trained in methods of raising the topic of parental drinking in a manner that is unthreatening to children.

Education and communication

Question 43: How well is the sensible drinking message reaching its audience?

We have material on this question from in-depth interviews carried out with sub-samples of the untreated heavy drinkers cohort (BUHD). Although that group consists of very heavy drinkers who arguably are a special group of people for whom sensible drinking messages have failed, they are representative of a very sizeable minority who must be an important target for health education and who we hope would respond to such messages in time. The results included a model of how the many health education messages to which heavy drinkers were exposed (from the media, mainly television news and documentaries and newspaper articles, plus their own and others' experience, and specific messages to reduce their drinking received from partners and other family members) had not worked their way through to a reduction in consumption (Kerr et al, 2002). We refer to this as the Health Education Messages Barrier Model. Although heavy drinkers might engage in harm reduction behaviours such as avoiding spirits, having drink free days, or compensating for heavy drinking with a good diet or exercise , there was for most an effective barrier between awareness of sensible drinking messages and of the harm that their own drinking might be causing them on the one hand, and on the other hand a reduction in

drinking. The main elements of that barrier consisted of: minimisation of the severity of effects of drinking, belief that ageing will naturally bring reduction, trust in individual differences ('I am an exception'), and the valued benefits to well-being (especially social and recreational) of current drinking.

The economic costs and benefits of alcohol

Question 59: Can the economic benefits of having an alcohol industry be easily quantified?

We are not health economists and are not ourselves qualified to answer that question. It may be of some interest, however, that a recent attempt has been made to carry out a very similar exercise in the case of the gambling industry in Australia. We came across this report in the course of a comprehensive review of gambling and problem gambling in Britain (Orford et al, 2003d), and the following is an extract from our book on that subject that is currently is press:

"The Productivity Commission (APC, 1999) report on *Australia's Gambling Industries* considered the costs and benefits of gambling to a society in minute detail… in the case of gambling, advocates have typically pointed to benefits in terms of income and job generation, both directly and indirectly related to gambling, and to the contribution made to taxation (the British KPMG, 2000, report is a good example: it estimated that the British gambling industry as a whole paid £1,840 million in 1998 in the form of tax, duty and licences). The Australian report took the opposite approach, arguing that the latter kinds of benefit from gambling were likely to be small and were often exaggerated. The 'production side' economic benefits were largely illusory, they concluded, principally because resources associated with the gambling industry were mostly diverted from other industries [unlikely to be true in the case of the much larger drinking industry]… Two [other] ways in which gambling might be of economic benefit were considered by the report: spending by tourists, and the reduction of unemployment. Casino gambling particularly attracts tourists. The Australian Casino Association estimated that overseas visitors accounted for 25% of casino revenue in 1997-98. In Britain KPMG (2000) stated that over a third of the amount wagered in British casinos was by foreign nationals… In the round, however, calculations carried out for the Productivity Commission and submissions made to it indicated that the net income benefits were small. Regarding the possibility of reduced unemployment, the report referred to there being little evidence that unemployment rates are significantly affected by economic development policies such as the establishment of new gambling industries, although there might be a beneficial local effect in depressed areas where labour is comparatively immobile.

Paradoxically it was those benefits of gambling which might be thought to be most intangible and not amenable to costing on which the Productivity Commission report attempted to put a figure. They argued that spending on gambling by those who do not have a gambling problem is spending on a consumer benefit… and they went on to use the economic concept of 'consumer surplus' to calculate the overall amount of benefit that this represents for the community. Consumer surplus refers to the difference between what a consumer pays for a product and the amount that he or she would be prepared to pay rather than do without it. Put another way, it is a measure

of the degree to which consumers are paying less for a product than its real value to them. This can only be calculated if there is some basis for knowing how sensitive (or 'elastic' to use another economic term) demand for the product is to changes in price. If the price elasticity of demand for gambling is comparatively low, as submissions to the Commission by the gambling industry tended to suggest, indicating that consumers would be prepared to pay more for the product, consumer surplus would be relatively high, and the industry could be said to be responding to a 'need'. If on the other hand, as much of the literature reviewed by the Commission suggested, elasticity was higher, indicating that reductions in gambling would be comparatively great if price were to rise, then the estimate of consumer surplus would be that much lower.

All the evidence on which it could draw suggested to the Commission that the price elasticity of gambling for non-problem gamblers lay between a higher estimate of 1.3 and a lower estimate of 0.8 (elasticity of 1.0 means that a doubling in price would produce a halving of consumption; an elasticity of 2.0 would mean that if price were to double consumption would decrease to a quarter). The final figure needed to calculate consumer surplus is the amount of total expenditure on gambling that is attributable to non-problem gamblers as opposed to those with problems, a figure calculated for Australia at 65%... On the basis of all these calculations, the Commission came out with a final estimate of between 2.7 and 4.3 billion Australian dollars as their estimate of the overall national consumer surplus benefit of gambling as a desired form of entertainment.

Although that represents a brave attempt to quantify the benefits of gambling, the reasoning behind it seems to the present authors, who are not economists, to be tortuous and somewhat suspect. Apart from the fact that the calculation rests upon a crucial parameter that can only be estimated very approximately (the elasticity of demand), the whole idea of consumer surplus as an estimate seems to be clever but hardly convincing. A major flaw when dealing with a 'product' like gambling, which… has a propensity to cause addiction, is the admittedly arbitrary separation of people into those whose gambling is purely 'recreational' (and whose 'need' for gambling can be claimed not to have been artificially stimulated) and those with problems whose continuing need has been at least partly created by the marketing of the product itself".

We would be equally sceptical about the likelihood of quantifying the benefits of having an alcohol industry.

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APPENDIX TO:

A response to the National Alcohol Harm Reduction Strategy Consultation Document

From

The Birmingham Alcohol, Drugs and Addiction Research Group, The School of Psychology, The University of Birmingham and Northern Birmingham Mental Health NHS Trust

Birmingham

ALCOHOL, DRUGS AND ADDICTION RESEARCH

Collaborative Group for the study of Alcohol, Drugs and Addiction in Clinical and Community Settings

School of Psychology, The University of Birmingham & Northern Birmingham Mental Health NHS Trust

January 2003

Overall Aim

The aim of the Alcohol, Drugs and Addiction Research Group is to carry out, and disseminate the results of, research into the consumption of alcohol and other drugs, and involvement in other potentially addictive behaviours such as gambling. Research undertaken by the Group may focus on consumption or activity which is unexceptional, or on behaviour which is excessive. To be undertaken by the Group, research must have clear relevance for either the prevention or treatment of alcohol or drug-related harm, or other similar forms of difficulty. The group pursues this aim by carrying out research situated both in the clinic and in the community, drawing upon both clinical psychology and applied social/community psychology traditions. The Group has particular experience of research into the family aspects of alcohol and drug use and intends to preserve this as one emphasis.

Methods

Work carried out by the Group has a number of distinctive features, as follows:

1. Wherever possible the Group's work combines quantitative and qualitative research approaches. An aim of the Group is to keep abreast of latest developments in both types of methodology.

2. The Group has a tradition of carrying out research collaboratively with colleagues outside the School of Psychology – locally, nationally and internationally – and aims to continue such a tradition.
3. The Group will continue to seek, and hopefully obtain, research contracts with Research Councils, Government Departments, charitable organisations, and others.

Personnel (including recent leavers and joiners)

Head of Group

Dr Jim Orford, Professor of Clinical and Community Psychology

Lecturing Staff

Dr Alex Copello, Lecturer in Clinical Psychology/Consultant Clinical Psychologist, and Service Director Substance Misuse Services, Northern Birmingham Mental Health NHS Trust

Research Staff

Dr Sue Dalton, Manager, Heavy Drinkers Project/ New Deal for Communities Project
Kate Fryer, UK Alcohol Treatment Trial (to August 2002)
Nicola Jones-Morris, Heavy Drinkers Project
Mya Krishnan, Family Coping and other projects
Catherine Painter, Heavy Drinkers Project
Asmita Patel, Primary Care Project (to July 2002)
Dr Alison Rolfe, Qualitative Research
Melanie Smith, UK Alcohol Treatment Trial (to Sept 2002)
Dr Mark Stein, Community Responses to Drug Issues
Heather Webb, Heavy Drinkers Project
Emmie Williamson, SBNT and Drugs Project

Administrative and Secretarial Staff

Pat Evans, Group Secretary and Project Secretary, UK Alcohol Treatment Trial and Community Responses to Drug Issues Project

Julie O'Connell, Project Secretary, Heavy Drinkers Project, Primary Care Project and New Deal for Communities Project

Honorary and attached Staff

Hermine Graham, Northern Birmingham Mental Health NHS Trust (COMPASS Programme)

Jenny Maslin, formerly COMPASS Programme

Maria Ferrins-Brown, formerly Heavy Drinkers Project

Emma Godfrey, Northern Birmingham Mental Health NHS Trust (COMPASS Programme)

Julie Ison, Psychology Assistant, Northern Birmingham NHS Trust

Simon Wilkes, Psychology Assistant, Northern Birmingham NHS Trust

Current and Recent Research Projects

Family Coping with Alcohol and Drug Problems in England, Mexico City, and Northern Australia (The Family Coping Project)

Supported in the UK by the Mental Health Foundation (1991 to 1994) and internationally by the World Health Organisation, the British Council, CONACyT (Mexico) and Northern Territory Health (Australia).

This area of the Group's work constitutes a programme of investigation comprising a number of studies. The largest involved lengthy interviews with a concerned and affected close family member in 107 families in Mexico City and 100 families in South West England. In sub-samples of families, interviews were carried out with second relatives, and with the problem alcohol or drug users, and joint family meetings were conducted. The focus of interest has been the causes, nature, and consequences of differences in ways of coping. A number of papers have been published and others are planned. Results have already been used to inform family treatment interventions being used in the Primary Care Project and UKATT (see below). Data from a parallel project in the Northern Territory, Australia have also been analysed and a final report delivered. Approximately 50 interviews were carried

out with Aboriginal family members in Darwin, Alice Springs, and remote communities and have contributed to Northern Territory Health family programmes. A research monograph, produced jointly with our colleagues in Mexico and Australia, focusing on cultural variation and invariance in ways of coping, is in preparation. A further extension of this programme to include family members in Italy is currently at the planning stage.

United Kingdom Alcohol Treatment Trial (UKATT)

Supported by the Medical Research Council (Feasibility Study, 1995; Main Trial April 1998 to September 2002).

This is a large multi-centre trial carried out in collaboration with colleagues in Cardiff, Leeds, Newcastle and York. The aim was to involve 720 people with alcohol problems and approximately 40 therapists, in three clinical centres, over a period of two years, with follow-ups at three and twelve months. Two treatments are compared: brief Motivational Enhancement Therapy (MET); and more intensive Social Behaviour and Network Therapy (SBNT). MET is now established as probably the most cost-effective treatment for alcohol problems, and SBNT, which is a new treatment designed for the trial, combines a number of family-oriented treatment components which are supported by our own earlier family work and by the treatment outcome research literature. Over 750 participants were finally entered into the trial; over 90% completed the three-month follow-up; and over 80% the 12-month follow-up. Papers on the trial design, and on SBNT, have been published, and others are in preparation (on therapist training and on clients' experiences of seeking treatment). Outcome results are expected to become available during 2003.

The Application of Social Behaviour and Network Therapy (SBNT) to Work with People with Drug Problems and their Networks: A Feasibility Study

Supported by Northern Birmingham Mental Health NHS Trust Research & Development Funds (September 2002 to August 2005)

The SBNT method is being adapted for work with focal clients whose principal problem is with the consumption of drugs other than alcohol. The professional manual has been amended and local drug services workers have been recruited to train in the method and to test its feasibility. The aim is to gain experience with approximately 25 focal clients and their networks, to draw conclusions about the applicability of the method for drug work, to revise the manual where necessary, and if the results warrant it to make an application for funds to carry out a larger trial.

Community Cohort Study of Heavy Drinkers (The Birmingham Untreated Heavy Drinkers Project)

Supported by Department of Health (January 1996 to June 2004).

This longitudinal cohort study will enter its fourth wave in 2003. At wave one in 1997, a sizeable sample (N=500) of heavy drinkers (men usually drinking more than 50 units of alcohol a week, women more than 35), and untreated specifically for their drinking within the previous ten years, were recruited from a variety of non-treatment sources within the Birmingham conurbation. Each received a 2-hour, partly computerised and partly open-ended, interview covering the following domains: present circumstances; current drinking; drinking career; perceived benefits and drawbacks of drinking; perceived dependence; readiness to change drinking; health; support and opposition for drinking; family influences on drinking; responses to health education. The overall purposes of the study are to explore how and why members of this sample are drinking in a way thought to be risky for health, and to examine the development of their drinking over successive follow-ups. Eighty per cent of the initial sample were followed-up at wave two in 1999. Many of the same assessments were repeated; some new areas were explored (e.g. alcohol and aggression; drinking and social exclusion); and more detailed cost data were gathered. Seventy per cent of the initial sample were re-interviewed again in 2001 (Wave 3). Final reports on Waves 1, 2 and 3 were delivered to the Department of Health. A number of papers have been published or are in press; two successful PhDs have

resulted from the project; and results have been presented at a number of national and international conferences.

The Development and Preliminary Evaluation of a Package for use in General Practice in Working with Close Family Members of People with Alcohol and Drug Problems (The first Primary Care Project, PCP1)

Supported by the Mental Health Foundation, and The West Midlands Regional Health Authority (January 1997 to June 1998).

Despite recent advances in ways of treating addiction problems in general practice, developing better ways of responding to the needs of close family members has been neglected. The PCP projects have been collaborations with colleagues in Bath. A ‘package’ of written materials, training and support for workers in general practice has been developed. The package, based on a stress-strain-coping-support perspective on the circumstances faced by relatives, provides illustrations of relatives’ experiences and expressed needs based on our previous research, and offers brief ‘training’ and consultations to enable primary health care workers to feel confident in supporting and counselling relatives. Results of PCP1 were very encouraging. Thirty- six primary health care professionals (GPs and health visitors being the largest groups) worked with a total of 38 close relatives during the period of the study. The interventions were followed by reduced symptoms, and reduced engaged and tolerant coping by relatives, and improved confidence and optimism in carrying out this kind of work amongst the primary health care professionals. Results were published.

A Randomised Comparison of Two Levels of an Intervention to Work with Close Family Members of People with Alcohol and Drug Problems in Primary Care (The second Primary Care Project, PCP2)

Supported by the NHS Executive West Midlands Research and Development fund and the Alcohol Education and Research Council (January 2000-December 2002).

Based on the findings of our first primary health care project, the 'package' tested in that project has been submitted to an experimental comparison with a simpler, self-help manual only intervention. As before, outcomes for the family members, and primary care professionals' attitudes and confidence, have been assessed. In addition, an economic analysis is being carried out in collaboration with the University of York's Centre for Health Economics. A total of 170 primary care professionals were involved in this cluster randomised trial (62 GPs, 70 health visitors and 38 practice nurses) who between them recruited 143 family members (just over 50% partners or spouses, a little under a third parents, with smaller groups of sons or daughters, siblings and others). Results are currently being analysed and will be submitted for publication during 2003.

The Combined Psychosis and Substance Misuse Programme (COMPASS)

Supported by a grant from the Department of Health to Northern Birmingham Mental Health NHS Trust (January 1998 onwards).

Part of this grant has been made available to Northern Birmingham Mental Health NHS Trust Research and Development Unit, and our research group is contributing to management, supervision and support for research aspects of the programme. People who have combined problems of psychosis and substance misuse have been identified as a group with special needs that are often not easily met by existing specialist services. The aim of the programme is to assess needs, to assist services in meeting them, and to evaluate the success of the programme. Several papers and an edited book on the setting up of the programme have been published. The programme has been evaluated using a quasi-experimental design in which mental health team staff are trained in two phases, one early and the other delayed, and results are currently being analysed.

A Systematic Review of Longitudinal Studies on the Impact of Drug Use on Young People

Supported by Department of Health, in collaboration with other universities and NHS Trusts in Wolverhampton, Bristol and London (January – December 2001)

Over 6,000 journal articles and other items were systematically reviewed and rated according to a set of criteria reflecting research adequacy. It was found that the methods that had been employed varied widely so that results were difficult to compare. Very few studies had employed a rigorous, longitudinal design, and hence it was not possible to conclude that a causal relationship had been established between youthful cannabis use and problems later in life.

South Birmingham Study of Managing Psychological Problems in General Practice

Supported by South Birmingham Mental Health Care NHS Trust research and development to School of Health Studies (Nursing) (July 1998-December 1999).

Although this project is not directly about alcohol, drug or addiction problems, the ways in which psychological problems (other than severe mental illness problems) are dealt with in general practice is highly relevant to our group. This project was carried out in collaboration with the School of Health Studies (Nursing) and the academic department of Psychiatry, employing a research worker (Jennifer Smith) based in the School of Health Studies. A number of focus groups were carried out with GPs; interviews were held with GPs and practice nurses across South Birmingham; and questionnaires were completed by three groups of mental health specialists (CPNs, psychiatrists, and clinical psychologists). A final report was delivered to the Trust and a paper is in press in a primary care journal.

The British Gambling Prevalence Survey

Supported by a grant from GamCare to the National Centre for Social Research (1999-2000)

In terms of psychological theories of addiction gambling is of particular interest because no ingestible substance is involved. Our group has therefore welcomed the opportunity to extend our activities into the field of gambling and gambling problems. This was the first British national survey aimed at establishing the prevalence of problem gambling in the UK. It was made possible by a grant from GamCare (the national non-government organisation in Britain in the gambling field) to the National Centre for Social Research which is one of the country's leading social survey organisations. Our group provided the academic support for this study. The main sample consisted of a representative household sample of nearly 8,000 individuals who completed a standard questionnaire in their homes in the later part of 1999. That main study was supplemented by a small qualitative study of 17 people identified at the survey stage as having probable gambling problems. These studies are of considerable national importance in the light of current Government proposals to liberalise gambling regulations in Britain. Two reports were delivered to GamCare, a book reporting the results within the context of the literature on gambling and problem gambling in Britain is in press, and a paper has been accepted for publication.

Gambling and Problem Gambling Amongst Clients of Alcohol and Drug Services, and Staff Attitudes Towards Working with Gambling Problems

Supported by a grant from GamCare to Aquarius Action Projects (July 2001-June 2002)

As part of the work of a specialist part-time gambling worker (Sylvie Boulay), employed by Aquarius and funded by the national organisation GamCare, a survey was carried out of all staff employed by the non-statutory alcohol agency Aquarius and the Northern Birmingham NHS Addictive Behaviours Centre, and all clients attending those services during one sample week. Our group provided research support for that work. Compared to a matched sample from the British Gambling Prevalence Survey, clients of alcohol and drug services reported more gambling of forms known to be associated with problem gambling, and gambling on four or more types of activity, and more often obtained scores on a problem gambling screening scale that indicated the likely existence of a gambling problem. With the exception of a sub-scale reflecting adequacy of present skills and knowledge to work with gamblers, staff of alcohol and drug services responded positively to a standard scale assessing attitudes towards working with clients with gambling problems. A report on this work has been submitted for publication.

Drinking by Second and Subsequent Generation Ethnic Minority Sample

Supported by a grant from Alcohol Concern to Aquarius Action Projects (1999)

This project was carried out in Birmingham and Leicester in 1999 under a grant from Alcohol Concern (the lead national non government organisation in the UK in the alcohol area) to Aquarius Actions Projects (the leading non-statutory organisation providing services for people with alcohol problems in the West Midlands). Along with Dr Mark Johnson of De Montfort University, Leicester, our group provided academic support for this project. Data were collected by BMG Research (a Birmingham based market research firm). The aim of this project was to collect up-to-date information about the drinking and possible drinking problems of second generation members of British ethnic minority groups. It was thought that existing data on the drinking of ethnic minorities might now be out-of-date and not applicable to those born and brought up in this country. A quota sample of nearly 1700 participants was involved, comprising those who identified themselves as Black, Indian Hindu, Indian Sikh, Indian Muslim, Pakistani, and Bengali. A report on the project has been published by Alcohol Concern, and a journal paper has been

accepted. This work has helped to raise awareness about the possibility of alcohol problems amongst members of ethnic minority groups, and has been influential in the setting up by the Alcohol Education and Research Council of a task force on the subject.

Evaluation of the Impact on Health of the New Deal for Communities Initiative

Supported by a grant from West Midlands NHS Regional Executive to the University of Birmingham (April 2001-March 2006)

This represents another new departure for our group. The focus is the Government's urban regeneration scheme, New Deal for Communities, which has provided funds in 39 of the most deprived neighbourhoods in England in order to tackle issues in the areas of: worklessness, health, education, crime and community safety, and housing and the environment. In collaboration with the Department of Public Health and Epidemiology at the University of Birmingham, our group is evaluating the impact in the area of health of NDC programmes in six communities in the West Midlands: two in Birmingham plus one each in Coventry, Sandwell, Walsall and Wolverhampton. Our group is responsible for collecting data in the form of household interviews and focus groups which we hope will illuminate the process whereby NDC impacts (or not) on residents' health. Although risks for alcohol and drug problems are undoubtedly important elements in the whole picture of health in NDC communities, that is not the principal focus of this work which relates more closely to our group's interest in community psychology.

Community Responses to Drug Issues

Supported by a grant from the Birmingham Drug Action Team (January-December 2003 with possible extension to December 2004)

Given the current emphasis on and investment in mobilising community responses against drugs in the UK it is important to review current evidence and develop rigorous evaluation methods. The aims of this project are: to prepare a review of community responses to drug issues internationally but with special emphasis on

Europe; to construct a comprehensive inventory of community responses in the city of Birmingham (previous work has identified over 70 community organisations addressing drug issues in the city, including those working with young people, parents and carers, vulnerable groups, people with housing problems, and members of ethnic minority groups); and to provide a detailed description and preliminary evaluation of two of those community based projects.

Family Coping with Drinking Problems in Sikh Men
Carried out with Student Grant Support for Apninder Ahuja (formerly Sekhon) from the Alcohol Education Research Council (October 1994 to September 1997). PhD awarded 2000.

The Cultural Appropriateness of Services for Alcohol Problems in the West Midlands, with Special Attention to Spirituality
Carried out with Student Grant Support for Asesha Morjaria from the Alcohol Education and Research Council (October 1997 to September 2000). PhD awarded 2001.

A Study of Exercise Dependence in Women
Carried out by Rachel Cox for the Clinical Psychology Doctorate Degree (1997-99). ClinPsyD degree awarded, 1999.

A Study of Motivation for Abstinence amongst Methadone Maintenance Patients
Carried out by Margaret Reid for the Clinical Psychology Doctorate Degree (1997-99). ClinPsyD degree awarded, 1999.

A Study of the Content of Dreams During Alcohol Detoxification
Carried out by Sarah Simpson for the Clinical Psychology Doctorate Degree (1997-99). ClinPsyD degree awarded 2000.

The Development and Testing of a Psychological Intervention to Aid Detoxification from Alcohol in the Community
Carried out by Catherine Paula for the Clinical Psychology Doctorate Degree (1998-2000). ClinPsyD degree awarded 2000.

A Qualitative Study of the Decisions of People with Alcohol Problems to Enter Treatment

Carried out by Dorothea Tsogia for the Clinical Psychology Doctorate Degree (1998-2000). ClinPsyD degree awarded 2000.