Response to Strategy Unit, from
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Many thanks for the opportunity to respond to the National Alcohol Harm Reduction Strategy. If I had time I would respond to every one of your questions, but I do not, and I am sure that many others will be doing so. I will confine myself to the questions where I feel I would want to influence you most, which is primarily about the impact on families and children.

2. How far is alcohol misuse a mater of individual responsibility?

Most people who misuse alcohol live in families. Their misuse usually affects others in the family. This means that alcohol misuse is certainly not simply a matter of individual responsibility. (The same argument also applies to other areas of society: people are not solely individuals: they drive on our roads, they go to work, they shop, etc etc: and if they are misusing alcohol when they are undertaking any of these (and most other) activities, then their alcohol misuse transcends their individual rights to become intoxicated, as each individual has a potentially major impact on other individuals who may not be misusing alcohol.)

I will concentrate here on the family issues. The European Charter on Alcohol, published in 1995 and endorsed by all Member States of the European Union, states certain rights which the UK has therefore already signed up to. The ones that apply particularly to families are that:

- **All** people have the right to a family life protected from accidents, violence and other negative consequences of alcohol consumption.
- **All** people have the right to valid impartial information and education, starting early in life, on the consequences of alcohol consumption on health, the family and society.
- **All** children and adolescents have the right to grow up in an environment protected from the negative consequences of alcohol consumption.
- **All** family members of people with hazardous or harmful alcohol consumption have the right to accessible treatment and care.

These are rights which are generally not achieved in the UK.

Some estimates suggest there are 2-3 million problem drinkers in the UK[1]. If each one of these affects (say) 2 close family members, then there are around 5-6 million family members

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[1] Figures for the year 2000 (ONS, Psychiatric morbidity among adults, 2001) show that 26% of adults report *hazardous* drinking patterns (as measured by the AUDIT questionnaire, Babor et al, 1992), and about 7% show symptoms of *dependence* on alcohol (as measured by the SADQ, Stockwell et al, 1983). Men are much more likely to report both *hazardous* drinking behaviour and signs of dependence than women: for hazardous drinking, the rates were 38% of men vs 15% of women. Although these figures vary with age as well as gender, the prevalence rate for men never falls below 30% until the 60-64 age group, whereas the prevalence rate for women falls from around 30% for both the 16-19 and the 20-24 age groups to around 24% in the 25-29 age group, and to below 20% thereafter.

These figures represent a large growth since the previous survey of this type in 1993. At that time, the estimated rate of *alcohol dependence* was 47 per 1,000 population; the 2000 survey estimates it at 74 per 1,000 population (119 per 1,000 for men, 29 per 1,000 for women) (i.e. 7.4% of the entire adult population, almost 12% of the entire adult male population, and almost 3% of the entire adult female population). Furthermore, these figures are a low estimate, because of the usual problems of national household surveys with under-representation of younger single people, students, those living in institutions, and those with no fixed address, all groups with

struggling with the negative affects of the problem – this is close to 10% of the UK population.

A key issue to address is that for the most part the impact of alcohol misuse on the family, and on children, remains a hidden problem – due to the lack of help available, the negative view that many professionals have of family members as causative of the problem drinker's drinking, and of the guilt and shame that the family members often feel[2].

With regard to children, the problem can remain hidden because they may have nowhere to go or no-one to talk to (service provision is particularly lacking for children and there are issues around confidentiality, and how children access and attend services). The problem can also remain hidden because of parental concerns that they may lost their children/have them taken away if the situation at home is discovered. Often alcohol misusing parents fail to recognise that the problem drinking does have a negative impact on children.

The impact of alcohol misuse on the family is huge and reaches into every facet of human life – physical health, psychological health, employment, education, finance, relationships, social life. These effects can lead to a wide range of negative emotions and feelings – anger, shame, guilt, fear, embarrassment, despair, hopelessness etc. Generally family members are isolated, often lacking in social support, or much of a social life – due to the shame etc., or to friends losing contact with a family because of how they can behave.

The impact on children can be particularly problematic, and they may have particular treatment needs. They are frequently affected by the general family disharmony that comes with alcohol misuse: by rows, violence etc. Their health, schoolwork, friendships are frequently affected. They often have to take on far more responsible than they should be doing at their age: looking after drunk or ill parents, or caring for younger siblings. They may be too ashamed or not able to bring friends home or have a 'normal' childhood. Research indicates that problem drinking increases the risk of familial divorce and separation and is a contributory factor to around 40% of cases of domestic violence. Statistics suggest that alcohol plays a part in around a quarter of known cases of child abuse; and that there are high rates of removal into care in these alcohol-related cases. There is also some work showing that these problems can still affect the children when they are adults.

A National Strategy has a responsibility to ensure that there is service provision to family members, including children, and to provide services that help family members in their own right. Historically service provision is lacking for family members; where there is help available it tends to focus on the drinker, and how the family member/family can help them to stop drinking. Even when the drinking has stopped, problems continue for the family as they adapt to a completely different way of family life to the one that may have existed for many years. One UK study a few years ago (Robinson & Hassell, 2000) identified only 14 services across the whole of the UK with specific remits to work with families and children.

6. Definition of alcohol misuse.

(The following is taken from my book: Velleman, 2001, *Counselling for alcohol problems.*) My own definition of an alcohol misuse is very simple: if someone's drinking causes

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high proportions of heavy drinkers. Nevertheless, because these surveys focus on households, they are of particular relevance to the impact of substance misuse on families.

[2] Key references to all the information in this section are Velleman & Orford, 1999 and Velleman, 2002

problems for him or her, or for someone else, in any area of their lives, then that drinking is problematic; and alcohol is being misused. If someone's drinking causes problems with his or her health, finances, the law, work, friends or relationships, then that drinking is problematic; if it causes problems for husbands, wives, children, parents, bosses, or subordinates, then that drinking is problematic.

There are many implications of such a simple definition. It means that whether or not someone has a drinking problem is not determined by fixed quantities of alcohol, or fixed timings, but instead is a matter of negotiation by the individual with him or herself, family, friends, work place, and society as a whole.

The idea of negotiation within context may be illustrated with a few examples:

- Within a marital context, it might be the case of a person who drinks one pint of beer a week but is married to a confirmed teetotaller: the one pint may cause problems, and will need to be negotiated within the marital context.
- Within an employment context, someone might drink half a bottle of wine during a business lunch, or might visit the pub at lunch-time with colleagues. In some contexts, such drinking has been negotiated as acceptable behaviour; yet the same drinking may cause severe problems within an industry which has introduced an alcohol-at-work policy which forbids drinking during the working day.
- Within the social context, forty years ago someone's ability to drive after drinking was determined by their ability to walk a straight line; now, someone's ability to drive after drinking has been re-negotiated by society such that it is determined by their blood-alcohol level, and if it exceeds a certain amount (and they are detected by the police!) they are automatically deemed unfit to drive, and will have their licence revoked.

Someone has an alcohol problem if their drinking causes them or anyone else a problem. This idea is gradually gaining acceptance, but there are still many phrases that are in common use, such as 'alcoholism', 'alcohol-dependence syndrome' (ADS), 'alcohol-related problems', 'social drinking', 'normal drinking', 'controlled drinking', and so on.

7. What drinking patterns should an alcohol harm reduction strategy seek to affect?

There is clear evidence that per capita consumption is linked to alcohol related harms at all levels of society. This means that a National alcohol harm reduction strategy should work to reduce (or at least stabilise) overall per capita consumption.

14. How do you define harmful drinking?

In exactly the same way I define alcohol misuse: see my answer to question 6, above.

16. Costs for the NHS .. indirectly

Again, I want to stress the impact on families. If the figures I give above (in answer to Q2) are correct, then some 5-6 million family members are struggling with the negative affects of the problem, close to 10% of the UK population. There is good evidence that these individuals have higher rates of GP consultation (Svenson et al, 1995), and greater levels of physical and psychological problems, leading to greater use of prescription drugs, etc. This is a major indirect affect which is not usually taken into account in such measures of costs to the NHS.

There are also huge costs to social services as well: if the latest research (eg Forrester & Harwin, 2002) is representative of the national picture, then around ¾ of child care social service cases are affected by maternal problem substance use (frequently alcohol). Harwin & Forrester (2002) describe families affected by chaos, violence, relationship break-ups (often single parent families), housing difficulties and unemployment, alongside clear concerns that present for the children, usually categorised as neglect. Furthermore, these cases cause higher than normal difficulties for social workers who try to engage with these families: they experience a lack of preparation & training, difficulties in dealing with denial (of families that their substance misuse is causing problems), problems with the threat of violence & threatening behaviour, and the lack of involvement of substance misuse professionals. Given the amount of time that this work takes, and the training that staff need, studies like this have major implications for social services resource utilisation and for social care costs.

There are large scale costs associated with other areas of life too: impact son the employment sector, the education sector, etc. Some crude examples relate to eg children's truancy from school or other family member's missed days from work, in order to care for drunk or ill alcohol misusing relatives.

18. How effectively do you think that those at risk are identified?

Not very! Most professionals shy away from asking questions about alcohol, and many of those that do, do so in a perfunctory way. When it is done well (eg Smith et al, 2003), it can be very effective.

35. Domestic Violence

There is some good evidence on this, recently reviewed in Journal of Substance Use (the paper by Leonard on 'Domestic Violence and alcohol: what is known and what do we need to know to encourage environmental interventions' and a commentary on that paper me: Leonard 2001a,b; Velleman 2001b).

One point I make in my commentary is that child abuse is often left out of 'domestic violence' statistics, and it should not be: there is a significant involvement of alcohol misuse in many child abuse cases.

36. Which children are most vulnerable?

All children are potentially at risk. Some are more resilient than others (due to their coping or their support, whether there is violence, how stable their family life is, and some intrinsic characteristics that they can possess: Velleman & Orford, 1999); yet all will suffer as a result of parental problem drinking (or the drinking of another key family member). These problems can persist when the children are themselves adults, trying to raise a family etc.

A key question is whether or not there is work that can be done to promote resilience, rather than reduce risk? This is a similar approach to health promotion versus harm reduction. A key answer is 'yes'. Work can be undertaken on all the known risk factors, and on all the known resilience factors, to promote positive resilience and reduce risk. This does not need to involve work with the problem drinking parent if they are unwilling to engage.

37. Other vulnerable groups.

The key other vulnerable group is other family members, and in fact, other members of the community who are not misusing alcohol. All family members can be and often are affected, as are many other people in the community: friends, work colleagues etc.

39. Joined up working

As is often the case, this is about more, and better, communication and joint-working between professionals/agencies/organisations. For example, between adult substance misuse services, CAMHS, other child services, social services, primary care, domestic violence agencies, mental health services, non-statutory alcohol agencies etc. etc. Often services and professionals have very different views about alcohol problems, how they are caused, how they are best treated, the language that they use. This can negatively affect family members and how they engage with services.

Linked to this, services often do not communicate with each other, and are not happy with sharing information, even if this may be in the best interests of the family as a whole. Often, the alcohol problems and their impact on the family cannot be treated in isolation. Some work around confidentiality, protocols around sharing information etc. would be most helpful. This may be of particular concern where there are child protection concerns or activities.

Confidentiality
The biggest issue here for children is one of confidentiality. Under some circumstances, children in families disrupted by alcohol can try to access help from Child and Family Counselling services (or Child & Adolescent Mental Health Services) within the NHS. However, these services can only offer help ('treatment') with parental consent. The issue is rarely addressed of how a child who wants help because of the behaviour of one or both parents, can ask for that help, if the agency needs to tell the parents and ask them for consent to 'treat' the child!?

Youth Services, Voluntary Agencies such as the Children's Society, and a limited amount of in-school counselling services do exist, but access for younger children is limited, and most have to follow the same statutory procedures outlined above which would necessitate informing the parents of the fact that they have been approached by the child.

Confidentiality, therefore, is a significant barrier to providing help. If there is a statutory obligations meaning that if a child approaches an agency for help, the parents must be notified, this will put off many children from seeking help. In some circumstances, similar statutory obligations mean that child protection procedures might be invoked, even if this was in opposition to the expressed wishes of the child in question, who simply wanted to discuss their situation with an informed and helpful adult.

This necessity to breach confidentiality is linked to the 1989 Children Act (HMSO, 1992). This Act was meant to ensure that the welfare of the child was paramount, and that children's needs and rights would be protected. One of the central ideas of the Act is that of parental responsibility, which leads on to the importance of working in partnership with parents. *Unfortunately, for those children who have reason to fear their parents, this is not workable.* Hence the essential problem of confidentiality: children need to know that they can access confidential help, without their parents being informed, and without child protection

procedures being invoked against their wishes. Such children should be enabled to get help if needed, and this should be kept confidential unless and until the child agrees that informing the parent or invoking child protection procedures is a realistic and sensible option.

Interventions with children

Children of problem drinkers have high rates of problems themselves, The severity and duration of these problems for children are amenable to intervention. Some of the most immediate areas for intervention are that:

? *those working with children should be made aware of the signs of parental problem drinking or drug-taking* – currently, such children are not routinely assisted by helping agencies, or underlying problems of parental substance misuse are not recognised. Workers should be made aware of potential signs in children such as behavioural disturbance, anti-social behaviour, emotional difficulties, school problems, ‘precocious maturity’, or difficult transition from childhood through adolescence.

? *family disharmony is a prime focus for intervention, even if the parental substance misuse itself is not amenable to change*

? *a knowledge of ‘protective factors’ can help guide behaviour change* – it is possible that helping agencies can work with parents to ‘build-in’ or incorporate protective factors into their familial life. For example, work could be conducted with non-problem drinking parents to encourage them to provide a stable environment, or work could focus instead on other adult figures outside of the nuclear family, ensuring that there is at least someone who can provide the necessary stabilising influence (Velleman, 2001c).

? *Some interventions do exist and do work in helping family members*. These range from brief interventions within primary care (Copello et al., 2000a, b), through to solution-focussed brief interventions (e.g. Watts, 2000), to more extensive family based interventions (reviewed by Velleman & Templeton, 2002, and including working within a family systemic approach, unilateral family therapy, cooperative counselling, the use of community reinforcement training and of social networks) to more specific therapeutic work with the children of substance misusing parents (Harbin, 2000).

It is clear that there is much that can be done to help, but the lack of services for the children and other family members of problem drinkers (and problem drug-takers) shows that, to a very large extent, they are the forgotten and ignored victims of alcohol or drug misuse.

40. How much can these groups be dealt with by mainstream services, how much by specialists?

Generic services

The research group I co-lead have developed effective brief interventions within primary care of intervening with families suffering with someone else’s alcohol misuse (Copello et al., 2000a, b). Over the years we have developed a unique theoretical approach that has been translated and evaluated as a brief intervention, shown to be effective when used by primary health care professionals with family members. It is possible (although yet to be tested) that a similar approach would also be effective within primary social care: social services.

Clearly, the development of brief interventions within primary health & social care is a cost effective way of delivering services to large numbers of people. Primary care is often first port of call for many family members. However, identification is difficult and it often remains a hidden problem, partly because of how family members feel, but partly because primary health care professionals are wary of what to do and of how best to intervene if they do ask questions and then uncover major problems. Such questions are only asked if the questioner has some idea of how best to respond! This underlines again issues of lack of

knowledge, lack of training, and lack of services available for family members. If primary health and social care colleagues do not know what to suggest or where to send family members for help (especially if there are other difficulties such as mental health issues, violence, child behaviour problems, etc) then they simply will not ask and uncover the problems in the first place.

It is clear that brief interventions can work for many families. However, there may be a need to screen for suitability for a brief intervention as opposed to something more intensive.

<u>Specialist Substance Misuse or specialist Child & Family services</u>
Both these services could provide help to family members, but both rarely do, other then in the case of substance services who are starting to more commonly provide help for spouses (although still rarely for children).

A good first step would be for each team or service working with alcohol misusers to appoint or select one member to specialise in work with children. This individuals could set up cross referral systems, and joint working, with school counselling and child psychology and psychiatry services. They should adopt the role of ensuring that the children of clients using the alcohol service are monitored, assisted and their problems addressed.

An equal first step would be to do the reverse in generic services dealing with children: to ensure that there is at least one staff member in each generic team or service dealing with children appointed to develop training and procedures to clarify whether alcohol played a major role in the problems which led to the child being originally referred. Generic services for children need to be aware that many difficulties presented by children may have parental alcohol problems as an underlying causative factor. Often such parents will resist discussing this, and staff within children's services may need training in raising the topic in an unthreatening manner (Velleman, 2001a).

<u>Specialist services for family members of people with alcohol problems</u>
Such specialist services do exist. Two interesting examples are the Family Alcohol Service in London (run by NSPCC and ARP) who have been visited by the Strategy Unit, and Option 2 in Cardiff.

The FAS approach is around joint-working, working with the whole family, having a multi-disciplinary team, having a model that identifies and builds upon family strengths.

In summary

People with drinking problems often claim that their misuse does not affect their families. There is copious research which demonstrates that this is not true: that living with a problem drinker can and does affect other family members, particularly children, in many negative ways. Families can influence each other positively, as when partners influence each other to moderate their drinking, or children learn about sensible drinking, rather than being given an example of inappropriate use. When the influence is negative, however, it is very powerful indeed, able dramatically and adversely to affect the lives of all family members, sometimes over quite long periods of their lives. It is imperative to develop services which adequately help these family members. The National Alcohol Harm Reduction Strategy should have a lot to say about this.

References cited above

Babor, T, de la Fuente, J., Saunders, J. and Grant, M. (1992) *AUDIT: The Alcohol Use Disorders Identification Test: Guidelines for use in Primary Health Care*. Geneva: World Health Organisation.

Copello, A., Orford, J., Velleman, R., Templeton, L. and Krishnan, M. (2000a) Methods for reducing alcohol and drug related family harm in non-specialist settings. *Journal of Mental Health*, **9**, 329-343.

Copello, A., Templeton, L., Krishnan, M., Orford, J. and Velleman, R. (2000b) A treatment package to improve primary care services for the relatives of people with alcohol and drug problems: feasibility and preliminary evaluation. *Addiction Research*, **8**, 471-484.

European Charter on Alcohol (1995) World Health Organisation. Copenhagen:WHO

Forrester, D. & Harwin, J. (2002) Picking up the Pieces. Community Care 12-18 December 2002, p36-37.

Harbin, F. (2000) Therapeutic work with children of substance misusing parents. In Harbin, F. and Murphy, M. (Eds.) *Substance Misuse and Child Care*. Lyme Regis: Russell House.

Harwin, J & Forrester, D (2002) Parental Substance Misuse and Child Welfar: A Study of Social Work with Families in which Parents Misuse Drugs or Alcohol, First Stage Report to the Nuffield Foundation.

HMSO (1992) *Children Act Report - presented to Parliament by the Secretaries of State for Health and for Wales.* London; HMSO.

Leonard, K. (2001a) Domestic Violence and alcohol: what is known and what do we need to know to encourage environmental interventions. *Journal of Substance Use*, **6(4)**, 240-250.

Leonard, K. (2001b) Response to Critiques of 'Domestic Violence and alcohol: what is known and what do we need to know to encourage environmental interventions'. *Journal of Substance Use*, **6(4)**, 254-257.

ONS (Office for National Statistics) (2001) *Psychiatric Morbidity Among Adults Living in Private Households*. London: Office for National Statistics.

Robinson, W. & Hassell, J. (2000) *Alcohol Problems and the Family: From Stigma to Solution*. London: ARP and NSPCC.

Smith, A et al, 2003, A RCT of a brief intervention after alcohol-related facial injury. *Addiction*, **98**, 43 – 52

Stockwell, T., Murphy, D. and Hogson, R. (1983) The severity of alcohol dependence questionnaire: its use, reliability and validity. *British Journal of Addiction*, **78**, 145-155.

Svenson, L. et al (1995) Individuals with a chemical-dependent family member. Does their health care use increase? *Canadian Family Physician,* **41**: 1488-1493.

Velleman, R. (2001a) *Counselling For Alcohol Problems*, 2nd Edition. London; Sage (Counselling in Practice Series).

Velleman, R (2001b) Invited Commentary on 'Domestic Violence and alcohol: what is known and what do we need to know to encourage environmental interventions' by Kenneth Leonard. *Journal of Substance Use*, **6(4)**, 251-253.

Velleman, R. (2001c) Working with substance misusing parents as part of Court Proceedings. *Representing Children*, **14**, 36-48.

Velleman, R. (2002) The Children of Problem Drinking Parents: An Executive Summary. *Executive Summary series; Centre for Research on Drugs & Health Behaviour*, **Executive Summary 70**, 1 - 5. Published on line:

http://www.med.ic.ac.uk/divisions/64/execsumm.asp (for index of Executive Summaries)

http://www.med.ic.ac.uk/divisions/64/execsum70.pdf (for pdf version of this Executive Summary)

Velleman, R. and Orford, J. (1999) *Risk & Resilience: Adults who were the Children of Problem Drinkers.* London: Harwood.

Velleman, R. & Templeton, L. (2002) Family interventions in substance misuse. In: T. Peterson & A. McBride (Eds) *Working with Substance Misusers: a guide to theory and practice*, London: Routledge, Chapter 10, pp 145-153.

Watts, P. (2000) Solution focussed brief therapy used in a substance misuse setting. In Harbin, F. and Murphy, M. (Eds.) *Substance Misuse and Child Care*. Lyme Regis: Russell House.

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