

ALCOHOL PROBLEMS IN THE FAMILY

A report to the European Union





euro care



Cover photograph - **The Family maquette.** Bronze Laurence Broderick

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A joint project of EUROCARE and COFACE (Confederation of Family Organisations in the European Union). We are grateful to European Commission Directorate General V for financial support of the project.

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Introduction

Many reports have been written about the victims of alcohol abuse, primarily concentrating on the individual problem drinker. Less has been written on the 'forgotten victims' - members of the problem drinker's family, both spouses and children. Families of problem drinkers are families in distress. They are, as the report describes, 'fragile families' who need help.

Whilst millions of families within the EU are affected by the problem it is difficult to give an accurate assessment of its size. Perceptions of alcohol problems vary from culture to culture and, among those affected, it can often take the 'character of a shameful secret'.

Partly due to this perception, programmes and provision of services have on the whole been neglected. In areas of the Union, where they have been provided, they are patchy and under resourced. There tends to be little, if any, cooperation and co-ordination of action between the specialist alcohol agencies and the more generic family services, although the report shows there are isolated pockets where inter-agency cooperation is being developed. Examples of these appear in this report.

Indeed the fact that, through the support of the Commission, COFACE representing EU family organisations and EURO CARE representing alcohol services have joined together to produce this report shows that there is a growing awareness that tackling alcohol problems in the family is important if much family distress is to be alleviated.

Although politicians and the general public are rightly concerned about the harmful impact of illicit drug taking on society and the family, they need to recognise that they neglect alcohol problems at their peril. More families suffer from the consequences of alcohol abuse than from all other drugs combined.

Whilst all members of the working party have contributed to the report, we wish to acknowledge the extensive contribution of Andrew McNeill in his preparation of drafts and the writing of the final report. We are also grateful to Mr. Cees Goos and Dr. Peter Anderson of the World Health Organization for their assistance with the report. Our thanks also go to Directorate General V which contributed financially to the project.

William Lay
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Alcohol problems in the family

Families which experience problems with alcohol are fragile families. Harms related to alcohol are by no means restricted to drinkers themselves - those around them can also be damaged. The families of problem drinkers are particularly vulnerable to harm. A childhood in such a family can mean a childhood in distress: a distress which is often hidden to those outside the family and neglected by policy makers.

1. Quotations supplied by members of the working party from various sources.

THE CRIES OF THESE CHILDREN REVEAL WHAT IT IS LIKE TO BE IN A FAMILY WITH ALCOHOL PROBLEMS:⁽¹⁾

"Dad gets drunk every day, he hits me and mum ... he broke my arm once. If I have bruises he ... stops me going to school. He says if we ever tell anyone he will kill us ... I'm scared ... it's getting worse."

Girl

"Dad drinks and hits mum. I took an overdose last week. I want to die. I can't talk to mum it would only add to her problems ... It's all my fault."

Girl

"My mum beats me when she's been drinking."

Girl

"Please don't stop my mother smoking ... I would rather she smoked than drank"

Boy with alcohol foetal syndrome

"Sometimes it's hard. I can't run away because when there's trouble there will be no-one to run to for help."

Boy

"I told him (the father) not to drink any longer. And he said he would quit but he never did. And this was the only thing I did. I felt it was no use, whatever I did it was no use ... I had a feeling ... I thought he would stop if I told him ... I had thought about it for a very long time and I felt if he did not stop the very first time (I told him) he would not do it the next time either ... I felt bad, I realised I had to live with it for the rest of my life..."

Boy

"I cry ... she (the mother) says she will quit, but it never happens."

Girl

"If other parents knew about my father drinking, they might stop their children playing with me."

Boy

"Mum says Dad is drinking again. Dad says he isn't ... I'm confused. I'll just try harder to work it out."

Tasha, 7 (From NACOA Does this happen to you? leaflet)⁽¹⁾

1. The National Association for Children of Alcoholics, a UK charity addressing the plight of children growing up in families with parents who have alcohol or similar addictions.

ADULTS ARE ALSO HURT:

"I felt responsible for everything. I was constantly blaming myself for having chosen this partner and the consequent effect it had on my children."

Wife

"He is prepared to lose his family rather than stop drinking. He mustn't love us and I find myself wondering if he ever did or if all our life together was a lie. I feel sad and frightened and angry."

Wife

"I felt let down and I could not cope. I felt she had given up on all the plans we had made when we got married - given up on the kids and everything."

Husband

Problem Drinking

I made myself believe I was a good father taking my son to football. Now I admit I did it to have an excuse to have some beers ... He (the son) has more than once found me on the floor drunk and in coma. I do not know what it means to a child to see his father like that."

Problem Drinking Father, now abstinent

"The caller said he saw the two-year-old wandering down the road wearing a T-shirt, underpants and socks. The caller asked him where he lived and the child took him to a house 200-300 yards away. The front door was opened and a man and a woman were asleep on a sofa in a cigarette smoke-filled room which also smelled of alcohol. The child went to the woman, calling her 'Mummy' and shook her. She told him to 'bugger off'."

Neighbour

(Telephone call to a UK telephone help line run by the National Society for the Prevention of Cruelty to Children. Quoted in V. Lewis: Drunk in Charge. Community Care. 11-17 September 1997)

"My strongest childhood memory is one of fear. My father was a huge man and always angry... He would sit up drinking late at night. My brother, sister and I were terrified of being beaten..."

Tim, 53 (From NACOA Does this happen to you? leaflet) ⁽¹⁾

The importance of the family

Alcohol problems in families are important because families are important. The essential functions of the family are to meet the needs of its members for physical, psychological, social, and economic security and well being, and the provision of a satisfactory environment for the support, education and socialisation of children. All of these functions can be jeopardised by the problematic consumption of alcohol.

1. Franz Rothenbacher:
Household and Family
Trends in Europe: from
Convergence to Divergence.
Eurodata Newsletter,
Number 1 1995.

Any discussion of family problems must recognise that in the European Union the traditional patterns of family life are undergoing a process of change, and new family forms have come into existence⁽¹⁾. One aspect of this change is the growing 'nuclearisation' of the family, the disappearance from the household of those, such as grandparents, not members of the nuclear family of parents and children. Another trend - also more evident in some European countries than others - is the growth in living alone, divorce and in single parent families. Both of these developments have implications for family alcohol problems. One possible consequence is that there may be fewer people available in the household to lend support when things go wrong. Divorce and family break-up may be both cause and consequence of alcohol problems.

The paramount importance of the rights of the child to grow up in a safe and secure environment and in an atmosphere of happiness, love and understanding is enshrined in UN declarations, particularly the Convention on the Rights of the Child (see appendix 2).

The right to a satisfactory family life implies a right to assistance in the event of parental alcohol problems. The fact that children are likely to be affected by the problems arising from alcohol consumption was recognised by the WHO European Alcohol Charter signed by all member states of the European Union in Paris in 1995. Four of the five ethical principles of the Charter refer to the family:

1. *All people have the right to a family, community and working life protected from accidents, violence and other negative consequences of alcohol consumption.*
2. *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.*
3. *All children and adolescents have the right to grow up in an environment protected from the negative consequences of alcohol consumption and, to the extent possible, from the promotion of alcoholic beverages.*
4. *All people with hazardous or harmful alcohol consumption and members of their families have the right to accessible treatment and care.*

"I hate it when my Dad is drunk, but I do love him. I wish I could make it better but now I can't. Now when he gets drunk, I just call Grandma or my Uncle Jim and they come and look after me."

Jessie, 11 (From NACOA Does this happen to you? leaflet)

It is clear that all too often problematic alcohol consumption results in extremes of bad parenting and leads to the children (and the spouse) experiencing various forms of physical or emotional neglect or abuse. Just because these are tragic realities for so many people, it is important not wholly to identify child abuse and domestic violence with heavy or problematic drinkers. Heavy drinking and even alcohol dependence do not necessarily greatly disrupt family relationships nor result in violence or other forms of spouse or child abuse.

Moreover, in many cases where children suffer as a result of parental drinking, they continue despite everything to love their parents and to remain loyal to them. Equally many problem drinking parents "...had genuine concern for their children. (They) showed acute awareness of their children's hurt, although sometimes their preoccupation with drink made it hard for them to act on this remorse."⁽¹⁾

1. A. Laybourne et al
Children, Families and
Alcohol. University of
Glasgow 1995.

It is important, therefore, not to stigmatise the abusive drinker in a family. While spouses and children may require help in their own right, the main solution for a family suffering from alcohol problems lies with the abusive drinker and the help which can be given to him or her. The need for helping services for all family members including the drinker is a main theme of this report.

The nature of alcohol problems

For the purpose of this report, problem drinking is defined simply as any drinking which causes problems to the drinker or others. The focus of this report is the harm inflicted on other members of the family, particularly spouses and children, by the problematic consumption of alcohol.

Often, problem drinking is perceived wholly in terms of alcohol dependence or 'alcoholism'. We believe it is important to recognise that, while alcohol dependence causes very severe problems to the families of the drinkers, not all alcohol problems that affect families necessarily arise from dependence.

Essentially, there are three kinds of drinking behaviour that can lead to problems for the drinker and others: intoxication; regular excessive consumption; and alcohol dependence. With increasing degrees of magnitude, each state can involve a series of problems. They include drunken driving, accidents, violence, financial problems, absenteeism from work, psychological problems, disrupted relationships, alcoholic poisoning, other health problems.

Clearly, each kind of drinking behaviour can have an adverse impact on family members. Equally clearly, there are national and cultural variations in the relative importance of the different kinds of harm. In some populations problems relating to acute intoxication predominate and in others problems relating to sustained heavy drinking. Nordic countries provide an example of the first, France and Mediterranean countries of the latter. The diagnostic criteria of alcohol abuse and alcohol dependence are given in appendix 3.

1. Reported in chapter 3 of G. Edwards et al: *Alcohol Policy and the Public Good*. Oxford University Press 1994.

A survey of adverse social consequences of drinking⁽¹⁾ found that for each life-area investigated, the proportion of drinkers reporting experience of harm rose fairly steadily with increased volume of drinking, with no clear threshold of consumption below which problems were never reported. At an average level of consumption of 27g - 40.5g per day, around 10 per cent of drinkers reported experiencing harm in relation to their home life during the preceding 12 months. It is not known if similar results would be obtained in a different drinking culture, but the point here is that consumption at this level is greatly below that associated with alcohol dependence.

2. E. Österberg: *Alcohol Related Adverse Social Consequences within the European Union* in T. J. Peters (ed) *Alcohol Misuse: A European Perspective*, Harwood Academic Publishers 1996.

Some surveys⁽²⁾ have found that impairment of social relationships, including family problems, are more strongly related to frequency of intoxication rather than to the level of consumption as such.

Equally, family structures and relationships also exert a powerful influence on drinking behaviour and therefore the likelihood of experiencing alcohol (and other) problems.

The Scale of the problem

The population of the European Union is in the region of 371.5 million. There are 121.6 million adult males, 127.6 million adult females and 66.1 million children aged under 15. The population is divided into approximately 146 million households.

1. G. Edwards et al: *Alcohol Policy and the Public Good*. Oxford University Press 1994.

Any idea that in this population it is a rare occurrence to encounter a significant personal problem with alcohol is dispelled by the available evidence, incomplete though it is.⁽¹⁾ However, the scale of the problem depends entirely on how it is perceived and defined. Clearly, alcohol dependence is extremely likely to have an adverse effect on family members as well as the drinker, but it may not be perceived as a significant problem, by children for example, if it is not strongly disruptive of family relationships. Conversely, even occasional intoxication may pose severe problems to family members if, for example, it is associated with violence or parental incapacity.

The diverse range and severities of the social and health problems associated with alcohol makes it impossible to arrive at a precise estimate of the number of families and family members affected by them. How severe or persistent must an adverse consequence of alcohol consumption be in order for it to be perceived by family members as a problem for themselves?

Moreover, even where consequences of consumption such as violence, divorce and family break-up, and behavioural problems in children are clearly problematic for those involved, information is extremely limited and uncertain. The contribution of alcohol to such problems is not normally routinely assessed and recorded in official statistics.

The reality that underlies these difficulties is that everywhere alcohol problems in families tend to have a character of the shameful secret. The families themselves may be reluctant to volunteer the fact that their problems are alcohol related, and the health or social workers involved with them may not think or wish to ask. However, some information is available for some Member countries.

The population at risk

One way of assessing the potential scale of the problem is to estimate the population at risk of alcohol problems in relation to the prevalence of heavy drinking and alcohol dependence.

The large majority of European adults consume alcohol at least occasionally. In the EU as a whole non-drinkers comprise around one in ten men and one in five women, the proportions of non-drinkers being lowest in Denmark and highest in Ireland - 2.1% men and 6.1% women in Denmark and 24.5% men and 36.3% women in Ireland.⁽¹⁾ An unknown but probably substantial proportion of non-drinkers are ex-drinkers, some of whom stopped drinking as a result of experiencing alcohol problems.

1. H. Holder and G. Edwards, *Alcohol and Public Policy*. Oxford University Press 1995.

Heavy drinking and alcohol dependence

Substantial proportions of adult Europeans regularly consume excessive amounts of alcohol, i.e. quantities known substantially to increase the risk of experiencing health or social problems. Smaller but still substantial proportions of Europeans experience the signs and symptoms of alcohol dependence.⁽²⁾ In some countries

2. Unless otherwise stated, information provided by members of the working party. Information was not provided for Greece and Italy.

alcohol abuse and dependence may often result in the breakup of the family. In others, presumably those in which divorce/separation are less socially acceptable, high proportions of people even with severe alcohol problems remain married. For example, in Portugal around 70% of people treated for alcohol dependence are married. In Spain 66% of such patients are married, and 80% of them have an average of 2.5 children which is higher than the average of the general population. The number of people affected by problem drinkers is thus extremely large.

There is a lack of consistent terminology in the EU in regard to problematic alcohol consumption, and authoritative and consistent statistics of the numbers of problem drinkers or alcohol dependents are not available for the European Union as a whole. However, estimates have been provided by a number of member states.

In **Austria** there are around 1 million problem drinkers and 400,000 alcohol dependents. In **Belgium**, it is estimated that there are around 300,000 problem drinkers. Figures for **Denmark** show that 14% of men and 8% of women exceed the recommended consumption limits (252g and 168g pure alcohol per week for men and women respectively). In **Finland**, based on a screening test for alcohol problems, 22% of men and 5% of women are classed as “risky drinkers”. Around 250,000 Finns are alcohol dependent, equivalent to one in ten of all alcohol consumers.

29.5% of men and 11.1% of women seen by general practitioners in **France** are excessive drinkers (over 28 drinks per week for men and 14 drinks per week for women) who are at risk of alcohol-related disease or already ill. It is estimated that over 5 million French adults fall into this category. Two million French adults are alcohol dependent.⁽²⁾

2. Health in France 1994.
French High Committee on
Public Health 1996.

In **Germany**, around 16 per cent of 18-59 year olds (7.8 million) are drinking at ‘dangerous’ levels and altogether there are around 6.6 million problem drinkers. **Luxembourg** had around 9000 problem drinkers (out of a population of approximately 413,000). In **Portugal** there are an estimated 1,700,000 alcoholics and problem drinkers, that is, approximately 21% of the adult population. In **Spain**, there are around 3 million male and around 235,000 female problem drinkers or alcohol dependents.

In **Ireland** around 23 per cent of men and 5 per cent of women exceed the recommended ‘sensible limits’ of regular consumption, and 8 per cent of men and 2 per cent of women report signs of alcohol dependence.⁽³⁾

3. Smoking, Alcohol and
Drug Use in Cork and Kerry.
Southern Health Board.
1997.

In the **Netherlands**, up to 25 per cent of young and early middle-aged men and 2 to 3 per cent of women exceed the “sensible limits” of regular consumption.

In **Norway**, the normal estimate is that ten per cent of the adult population experience alcohol abuse or dependence, that is around 300,000 people.

In **Sweden**, 10 per cent of adult men and 3 to 6 per cent of adult women are “heavy drinkers”. There are an estimated 300,000 “alcohol abusers” of whom 50,000 to 100,000 are “heavy abusers”.

In the **United Kingdom**, 7 per cent of men and 2 per cent of women currently report symptoms of alcohol dependence.

If UK percentages are applied to the European Union as a whole, then there are around 8.5 million alcohol dependent adult men and around 2.5 million alcohol

dependent adult women. If on average, each problem drinker adversely affects only one other family member or other person, then 22 million people in the Union are either problem drinkers or adversely affected by another's drinking.

This is of course an extremely crude method of estimating the numbers of problem drinkers and those affected by them, and it clearly underestimates the scale of the problem. Firstly, the estimate is of those **currently** experiencing alcohol dependence: the lifetime prevalence of dependence is likely to be substantially higher. For the total adult population, the lifetime prevalence of alcohol abuse and dependence is more likely to be in the region of 14 per cent. This gives a figure of over 42 million adult Europeans experiencing alcohol abuse or dependence during some period of their lives. If the same assumption is made that each problem drinker affects adversely only one other person, then 84 million people are either problem drinkers or affected by another's drinking. In reality, problem drinkers are likely to affect adversely more than one other person.

Secondly, the UK level of alcohol consumption is significantly less than that of most other EU countries: the UK prevalence of alcohol dependence is therefore likely also to be relatively low. This affects the estimate of the number of children of problem drinking parents. A UK survey found that 4.1% of fathers (living with their partner and with children) have experienced alcohol dependence within the last year.⁽¹⁾

1. The Prevalence of Psychiatric Morbidity in Private Households. O.P.C.S. survey of psychiatric morbidity in Great Britain, Report number 1, HMSO 1995.

2. See page 61

In Finland, it is estimated that 12 per cent - one child in eight - has experienced harm from excessive parental use of alcohol.⁽²⁾ If the Finnish estimates are applied to the Union as a whole, then approximately 44.5 million people have grown up or are growing up in a problem drinking household. This number includes 7.9 million children aged under 15 presently living in a problem drinking household.

However, as Finland, like the UK, is one of the less heavy drinking nations in the Union, this figure is probably therefore also an underestimate. A Danish study shows that 7% of 13-19% year olds had at least one parent who had been admitted to a hospital with an alcohol-related diagnosis.⁽¹⁾

1. M. N. Christoffersen: Opvaekst med arbejdsløshed. Socialforsk-ningsinstituttet 1996.

Applying the Danish evidence to the total under-15 population of the European Union gives 4.5 million children living in households affected by alcohol. Since a large proportion of problem drinkers are never admitted to hospital or do not have their illness identified as alcohol-related, this must be taken as a low estimate.

On the basis of the Danish and Finnish estimates (7%, and 12% respectively), the numbers of children (aged under 15) of problem drinking parents is calculated for each member state. The authors are satisfied in taking the estimate based on the Danish medical survey as the lower and that based on the more socially based Finnish survey as the higher limit of the extent of the problem.

Even taking the lower figure, it is evident that there is a very considerable problem, with at least 4.5 million children throughout the European Union living in families adversely affected by alcohol. Almost certainly the actual figure is much higher, as suggested by the upper limit of 7.7 million.

Further indications of the scale of the problems are provided by such estimates as exist of the contribution of alcohol to marital problems such as conflict, separation and divorce and to child abuse and neglect. (See page 20 - 21)

Table 1 Estimates of numbers of children of problem drinking parents.

Country	Based on Danish estimate	Based on Finnish estimate
B	128,100	219,600
DK	66,500	114,000
D	917,000	1,572,000
GR	124,600	213,600
E	439,600	753,600
F	774,900	1,328,400
IRL	61,000	104,600
I	602,000	1,032,000
L	5000	8,600
NL	195,300	334,800
N*	61,000	104,000
A	101,500	174,000
P	125,300	214,800
FIN	67,900	116,400
S	117,600	201,600
UK	780,500	1,338,000
Total for the EU	4.5m	7.7m
*Norway		

“ When dad is hitting mum I try to help or me and my sister hide in the bedroom”

Boy

The older generation

1. The prevalence of Psychiatric Morbidity among adults living in private households. OPCS surveys of Psychiatric Morbidity in Gt. Britain. Report No1. HMSO 1995.

While this report is mainly concerned with the children and the partners of problematic drinkers, other family members can also be affected. In the UK, there is evidence that adults living with their parents are at raised risk of alcohol dependence. Adults living with a single parent appear to be at even greater risk.⁽¹⁾ Such parents, many of whom are elderly, may experience severe distress as well as practical difficulties.

Families as a cause of alcohol problems

Home and family are the child's first and primary source of concepts of what is normal or acceptable drinking. It is hardly surprising, therefore, that children normally follow their parents example. Light drinking parents tend to produce light drinking children, heavy drinking parents heavy drinking children. This is not, of course, invariably the case. Different generations can have their formative years in quite different drinking cultures and environments. Equally, some children of heavy drinking parents may reject their parents' example, perhaps precisely because of the problems associated with it, and, as adults, drink little or nothing.

While most of this report is concerned with problems caused to children by parental alcohol consumption, it is, of course, also the case that children's own consumption of alcohol can cause problems to themselves and to their parents.

Among 15-16 year olds in Europe, around 6 - 22 per cent of boys and girls report problems arising from their own drinking such as reduced performance at school and accidents or injury, and 17 per cent of girls and 20 per cent of boys report problems in their relationships with their parents due to their own drinking. The highest rates of such problems appear to be found in the UK and the Scandinavian countries, countries in which teenagers also report high frequencies of drinking to intoxication.⁽¹⁾

Family breakup and the youth culture

A major international study⁽²⁾ of the large post World War 2 increase in crime, alcohol and drug problems and other psychosocial disorders in young people, attributed this increase at least partly to the breakdown of family structures and values and the rise of youth culture. As well as the psychological stresses and strains experienced by young people as a result of family discord and breakup, their increased freedom and independence has tended to insulate young people from the influence of adults, in particular their parents, and to increase the influence of the peer group with its cultural values of 'sex, drugs and rock and roll'.

Other commentators have referred to the impact of youth culture in promoting the values of hedonistic self-centredness. This has been in the context of conformity to the peer group, thus fostering 'other-directed personalities' and undermining the psychological and moral achievements of individual autonomy. A particular aspect is that many people now remain in the youth culture for a prolonged period, with, these commentators suggest, debilitating consequences both for themselves and for society as a whole. These debilitating consequences include "juvenile delinquency, and (increasingly) serious crime, drugs and alcoholism, suicide, a frenetic preoccupation with sexuality, mental disorders, and the appeal of fanatical cults."⁽¹⁾

Family structures

A number of studies have found that children from 'non-intact' or 'non-standard' families (i.e. those in which the children are not living with both natural parents) have a raised risk of substance misuse as well as other problems. A Finnish study⁽²⁾ found that children from non-standard families, particularly where parents had divorced or one had died, were more likely to consume alcohol and showed an increased risk of drunkenness and experimentation with other intoxicants, suggesting the possibility of a raised risk of substance abuse problems in later life.

1. European School Survey Project on Alcohol and Other Drugs. The Swedish Council for Information on Alcohol and Other Drugs & The Pompidou Group at the Council of Europe 1995.

2. M. Rutter and D.J. Smith. Psycho-social Disorders in Young People. John Wiley & Sons 1995.

1. B & P Berger: The War Over the Family. Penguin Books 1983.

2. M. Isohanni et al: Teenage Alcohol Drinking and Non-Standard Family Background. Social Science & Medicine 1994 Vol 38 Number 11.

3. R. A. Johnson et al: The Relationship Between Family Structure and Adolescent Substance Use. US Dept. of Health & Human Services 1996.

A large American study⁽³⁾ also found evidence of the protective effect of intact families in regard to children's substance abuse. Adolescents living with both natural parents were significantly less likely to use alcohol, cigarettes and illicit drugs or to report problems associated with their use. For most substances, the highest risks of adolescent substance use, dependence and the need for illicit drug abuse treatment were found in 1) families with a father and stepmother and 2) families in which the adolescent was married and living with his or her spouse. High risks were also found in families where the adolescent lived with a father and no mother figure or lived with a mother and a non-relative.

4. Addiction Research Foundation. Ontario Drug Use Survey.

A Canadian study⁽⁴⁾ found that adolescents living in single parent or mixed marriage families had an elevated risk of problem or dangerous behaviour, although the highest risk was found in adolescents living with neither natural parent. Compared with children living with both natural parents, these children were seven times more likely to smoke cigarettes, five times more likely to use cannabis and eight times more likely to use other drugs, four times more likely to exhibit delinquent behaviour and three times more likely to drink heavily.

The Canadian study took family functioning into account as well as family structures. The measures included communication between parents and children, the amount of time parents spent with their children and whether the parents kept track of where their children were and what they were doing. When these factors were taken into account, the higher risks of substance abuse in children in single parent or mixed marriage families were reduced.

1. P. Miller: Family Structure, personality, drinking, smoking and illicit drug use: a study of UK teenagers. Drug & Alcohol Dependence 45. 1997. 121-129.

Studies in other countries have found similar results. For example, a UK study found that 15-16 year olds living with both parents were significantly less likely than those living with one parent to drink alcohol to intoxication, smoke cigarettes or use illicit drugs. However, the differences between two parent and one parent families were reduced when factors such as psychological symptoms and social support were taken into account.⁽¹⁾

These findings are of considerable significance. In the first place, it suggests that measures can be taken, in this case by parents, to protect children from a potentially adverse situation. This is a theme which will be discussed further in relation to the children of problem drinking parents.

2. D. Foxcroft & G. Lowe: Adolescent Drinking Behaviour and Family Socialisation Factors: A Meta-Analysis Journal of Adolescence 1991. 14. 255-273.

Secondly, the finding is consistent with the conclusions of other studies of adolescent drinking behaviour and the influence on it of family relationships.⁽²⁾ Adolescent drinking, including heavy drinking, has been found to be associated with low parental and family support and control. Support comprises behaviour which fosters in adolescents feelings of comfort, belonging and acceptance; control is a dimension of strictness as against permissiveness in the upbringing of adolescents. However, very high levels of control are also associated with heavy drinking by adolescents, drinking perhaps being chosen as a means of rebellion against parental or adult authority.

Children from single parent families may be at higher risk of substance and alcohol abuse, because, as well as any psychological repercussions from the divorce or separation itself, it is more difficult for one adult than two to provide adequate support and control.

Family breakup and adult drinking

Some commentators have referred to the protective effect of marriage and families in relation to alcohol problems among the adult partners as well as the children. Of course, where this protective effect fails to operate the consequent problems within families can be very severe indeed, and it is with these that this report is mainly concerned.

However, the evidence is clear (in some countries at least) that for the majority of people, forming stable relationships, marriage, and producing children are literally sobering experiences. Adults, especially men, who are married and/or living in stable partnerships tend to drink less than those who are single, separated, divorced or widowed. The pattern is more complex in women. It is also unclear whether the pattern in men is consistent throughout Europe.

There are numerous reasons why single and newly separated people are more likely than others to be relatively heavy drinkers. Most obviously, they tend to be freer of other commitments and responsibilities; to have more disposable income and leisure time; and they may seek company in bars and other places where drinking is one of the main activities.

Single people who acquire new families or stable relationships tend to decrease their alcohol consumption again. Of course, in some cases, heavy or problematic drinking is the cause of the divorce or separation. However, in the UK, researchers have suggested that high rates of separation and divorce (the highest in Europe) may be an underlying cause of a current rise in alcohol related deaths and disease at a time when consumption levels appear to have been generally stable.⁽¹⁾

The prevalence of alcohol dependence tends to follow the prevalence of heavy drinking in relation to family status. In the UK the lowest risk of alcohol dependence is found in couples with children. The highest risks are found in single people, adults living with one parent and, especially significantly for this report, single parents with children. It is worth noting that in a UK study, unmarried and post-marital groups also had high rates of neurotic disorders in general, as did single parents and people living on their own.⁽²⁾

There is evidence that divorcees of all ages and both sexes are at greater risk of premature death than married people. This has been shown for every country with accurate health statistics.⁽³⁾ For men between the ages of 35 and 45 the risk is doubled.⁽⁴⁾ Psychiatric consequences of marital breakdown include affective and anxiety disorders, para-suicide and misuse of alcohol. Divorcees, especially men, have higher mortality from cardiovascular and cerebrovascular disease, cancer, suicide and accidental death.

The strong association between marital breakdown and subsequent ill health both mental and physical has led some to argue that divorce as such should be a key target in strategies for improving public health.⁽⁵⁾ (See below for the effects of divorce on children.)

Parental separation in childhood and problem drinking in adulthood

A UK study found that higher levels of alcohol consumption, heavy drinking and problem drinking were found for those who had experienced parental divorce in childhood. The increased risk became apparent between the ages of 23 and 33. The

1. J. Chick: Evidence Suggesting Increasing Health Damage in Scotland Related to Alcohol. Health Bulletin 1997.

2. Health Psychology: 1996 March 15 (2) 94-101.

3. R. H. Coombs: Marital Status & Personal Well-being: A Literature Review. Family Relations 1991:49:97.

4. O.P.C.S. Mortality Statistics. HMSO 1989.

5. J. Dominian et al. Marital Breakdown & the Health of the Nation. London. One Plus One 1991.

1. S. Hope et al.
The relationship between
parental separation in child-
hood and problem drinking
in adulthood, *Addiction* Vol
93 Number 4 April 1998

same effects were not found for later parental divorce or parental death.⁽¹⁾

Marriage and divorce in the EU

The potential significance of these findings is clear, given that if present trends continue, almost one in three marriages in the European Union will end in divorce. There are also fewer marriages.

2. Eurostat.
See appendix 7.

In the EU, divorce has risen from 11 per cent of marriages in 1970 to 30 per cent in 1995; marriages have fallen from eight per 1,000 inhabitants in the 1970s to 5.1 per 1,000 in 1995. Belgium and Sweden are the most divorce-prone countries, with more than half of marriages likely to end in divorce. Finland, England and Wales and Denmark have rates of 49 per cent, 45 per cent and 41 per cent respectively. The divorce rate is lower in the Mediterranean countries, and lowest in Italy, where fewer than one in 10 of marriages ends in divorce.⁽²⁾

The causes of increased rates of marital breakdown and the growth of single parent families are, of course, both complex and controversial. A number of factors have been identified including cultural changes, such as the growth of feminism and the decline of religion; social factors such as the welfare state; economic factors such as the growing participation of women in the labour force and, in consequence, increased financial independence, and technological factors such as improved methods of birth control.

3. A Giddens. *Sociology*.
Blackwell 1989.

Another factor is divorce law reform which, presumably, has been both cause and consequence of changing attitudes to marriage and increasing rates of divorce. Since 1970, divorce has been legalised in Italy, Lichtenstein, Spain, Portugal and Ireland. Almost all EU countries have made divorce easier by reducing the number of years of prior separation and simplifying the procedures, and virtually everywhere in the Union divorce is now obtainable 'by mutual consent'.

Across the Union, therefore, hundreds of thousands of children now experience parental divorce. In the UK, it is estimated that around 40 per cent of the present generation of children will experience parental divorce or separation before they are 18.⁽³⁾

Alcohol as a cause of family problems

1. P. Steinglass et al: The Alcoholic Family. Hutchinson Education. 1988. This section also leans heavily on the work of Richard Velleman, especially his paper Alcohol Problems in the Family, Institute of Alcohol Studies 1993.

It has always been known that problematic drinkers cause problems not only to themselves but also to their spouses, children, parents and other family members.

However, fully to understand the impact of problematic drinking on the family, it is necessary to go beyond a list of specific problems and to see how problematic drinking can affect the structure and functioning of the family as a system of relationships.⁽¹⁾ This has been described in the following terms:

The family as a whole

i) Roles

Problematic drinking can change the roles played by family members in relation to one another and the outside world. As a family member develops a drink problem, the old division of labour may break down. The problem drinker may cease to perform his or her previous functions as a breadwinner or in relation to the support and supervision of children, household chores or recreational activities. These functions are therefore either not performed or performed by another, often the spouse. However, a particular pattern that has been observed is that a child, particularly the eldest child, may be forced to adopt adult roles and responsibilities, for example, in doing the housework, or acting as a surrogate mother or father. He or she may also be forced to assume a kind of emotional responsibility for the family.

ii) Routines

The problem drinker's behaviour is likely to become unpredictable and disruptive, impairing the family's capacity to plan activities in advance or to stick to familiar routines. It may become impossible to be sure whether the problem drinker will return home at the proper time, or appear at school to collect the children, or, what state he or she will be in, in the presence of the child's friends. Uncertainty and anxiety are therefore constant features of life in a problem drinking family,

ii) Rituals

Family gatherings such as a Christmas or birthdays, designed to celebrate and integrate the family, may be particularly subject to disruption, either because of the absence of the problem drinker, or, perhaps much worse, their presence. This problem is encapsulated in a comment made by one of the children of problem drinking parents interviewed by Margaret Cork in one of the first studies of the subject 'The Forgotten Children' - "Dad spoiled every Christmas I can remember because he smashed the tree."

ii) Social life

This has two aspects: activities within the family and the family's relationship to the outside world. Activities, particularly recreational activities within the family are likely to be restricted as the drinker becomes unwilling or unable to participate, or the other family members themselves choose to avoid activities out of fear of the behaviour of the drinker.

The unpredictable, disruptive and often drunken behaviour of the drinker is likely to be regarded by family members as acutely embarrassing and shameful. The ten-

dependency is to keep the problem a secret from the outside world. Divulging the nature of the problem to others may be regarded as an act of betrayal or disloyalty. This makes it difficult or impossible to invite others into the family home, or, given the norms of hospitality, to accept invitations from others. The family tends to become increasingly socially isolated. Activities and relationships outside the home may come to be severely restricted. Where family members do still engage in activities and relationships outside the home, these are likely to be kept rigidly segregated from life at home.

In either case, family members may be unable to explain to others the real reasons for what is happening. A particular feature of this inability is that family members, often the spouse, are put in the position of having to tell lies in order to prevent the truth becoming apparent. For example, it may be the spouse who has to make the excuses for her partner's repeated absences from work. In this way the spouse may unwittingly protect her partner from the consequences of his own behaviour. Many commentators have referred to this tendency to collusion and cover-up and the way in which it may serve to perpetuate the drinking.

ii) Finances

Money spent on alcohol is not available for other purposes. An alcohol problem may impair or destroy the drinker's capacity to earn a livelihood. Reduced earnings or unemployment are not infrequent consequences of drinking problems and these, naturally, affect the other members of the family and can have all sorts of repercussions. Holidays may have to be forgotten; it may become impossible for children to be sent on school trips; the rent may not be paid.

ii) Communications

Communications within the family can be disrupted both by what is said and what is not said. In the early stages, the drinker may refuse to talk about the problems, and the spouse may also be reluctant verbally to confront his or her partner or discuss it with the children. In a Danish study⁽¹⁾, children said they could remember their parent's alcohol problems from when they were as young as 4-5 years old, usually several years before the problem was discussed by and between their parents.

Alternatively, or at a later stage, alcohol and drinking may come to dominate the conversation as well as the rest of the life of the family. Communication between the spouses may also be alcohol dominated. Even where the drinking itself is not addressed directly, there are likely to be conversations, often turning into arguments and recriminations, about the consequences of the drinking.

Given the way in which alcohol problems can affect the dynamics of the family, it is hardly surprising that the international research evidence is consistent in regard to the adverse impact on individual members of the family.

Alcohol, marital problems, and domestic violence⁽¹⁾

Not all member states are able to provide figures on these subjects. In **Ireland**, the national marriage guidance service (Accord), says that 11% of clients identified alcohol abuse as the primary presenting problem (1997). However, figures available from the Cork Counselling Service show a much higher level of up to 25% (1994-1996). In the **United Kingdom** it is estimated that persistent alcohol problems double the risk of divorce/separation and it has been stated that 1 in 3 divorce petitions

1. Reported in *Alcohol, Health and Society*. WHO Paris 1995.

1. Unless otherwise stated, figures below provided by members of the working party.

cite excessive drinking by a partner as a contributory factor. However, this latter claim is of doubtful reliability.

2. Health in France 1994. French High Committee on Public Health 1996.

As far as domestic violence is concerned, in **France** it is stated that alcohol is a determining factor in many social problems, ranging from job problems to criminal behaviour (violent attacks, rape, child abuse and marital violence)⁽²⁾ but statistical information appears to be lacking. In Ireland 17.5% of men attending Cork Domestic violence treatment programme stated that they had been treated for alcohol or drug abuse. Figures from the **Netherlands** show that in 30% of cases of violence against wives or partners, the assailant is drunk at the time of assault. There are, in that country, around 15,000 drunken assaults on wives or partners each year. In **Portugal**, 16% of cases of violence against women are alcohol or drug related (the majority being associated with alcohol).

The 1996 British Crime Survey found the following in relation to domestic violence:

VIOLENCE INVOLVING ALCOHOL AND/OR OTHER DRUGS (%):			
	Offender under influence of alcohol	Offender under influence of drugs	Offender under influence of drugs or alcohol
Domestic violence	32	13	38

Problems for individual family members

a) The non-drinking spouse

The spouse has to cope with the bewildering unpredictability and frequent unpleasantness of life with a problem drinker. The more serious an alcohol problem, the less able a person is likely to be to perform competently, or at all, the various roles and responsibilities of a spouse and parent.

2. R. Velleman: Alcohol Problems in the Family. IAS 1993.

More than one third of problem drinkers receiving treatment cite marital conflict as one of the main problems caused by drinking. In the UK, the divorce rate is twice as high in marriages complicated by alcohol problems as in those without alcohol problems.⁽²⁾ Marital conflict may take a violent form, and there is much evidence to show that domestic violence and alcohol are often associated. While problem drinking is neither a necessary nor a sufficient cause of domestic violence, high proportions of perpetrators of domestic violence are either problem drinkers or under the influence of alcohol at the time of the assault. Equally, high proportions of victims of violence are also under the influence of alcohol at the time of the assault.

There also appears to be an association between problematic drinking and child abuse, including incest. The connection between child abuse and alcohol abuse "may take the form of alcohol abuse in parents or alcohol intoxication at the time of the abuse incident."

1. NCADI. USA 1995

An American review⁽¹⁾ concludes that alcohol consistently "emerges as a significant predictor of marital violence." Alcoholic women have been found to be significantly more likely to have experienced negative verbal conflict with spouses than were

non-alcoholic women. They were also significantly more likely to have experienced a range of moderate and severe physical violence.

Studies have shown a significant association between battering incidents and alcohol abuse. Further, a dual problem with alcohol and other drugs is even more likely to be associated with the more severe battering incidents than is alcohol abuse by itself.

2. R. Velleman: *Alcohol Problems in the Family*. IAS 1993.

The spouse may be affected by relationship difficulties not only with his or her partner but also with the children. Most obviously, as the drink problem comes to dominate the lives of everyone in the family, the non-drinking parent may simply have less time and emotional as well as material resources to devote to the children. The non-drinking parent may have to assume the whole responsibility for disciplining the children, and it may well be the non-drinking parent who has to give the children the bad news that, for example, they cannot invite friends to the house or that there is no money for them this week. It is reported that, ironically and poignantly, children, especially perhaps young children, who cannot see behind the surface, may at times resent and blame the non-drinking parent as much or more than the drinking parent.⁽²⁾

The non-drinking parent is thus likely to experience an acute conflict of interests and loyalties between her partner and her children and to feel guilty for neglecting someone whichever course she takes. It is also reported that spouses, perhaps especially women, may blame themselves for their partner's drinking problem believing that they are in some way its cause.

1. S Brown: *Safe Passage: Recovery for Adult Children of Alcoholics*. John Wiley & sons 1992.

"My husband always told me if I were a better wife, more loving, sexually responsive and less demanding, he wouldn't need to drink so much. I spent years trying to be that better wife, but his drinking didn't change."⁽¹⁾

A note on co-dependency.

Much of the self help literature written for the spouses of problem drinkers is focused around the concept of "co-dependency". Until relatively recently co-dependency was a term used in the addiction field to describe the "enabling" behaviour of the partners of problem drinkers. The term "enabling" refers to all of the many ways in which spouses compensate for or cover up the destructive behaviour of their drinking partners, possibly facilitating continued drinking.

2. D. Treadway (1990), *Codependency: Disease, Metaphor or Fad?* Family Therapy Networker, 14, (1) 39-42.

3. T. Gierymski & T. Williams (1986), *Codependency: Journal of Psychoactive Drugs*, 18(1), 7-13.

4. L.S.Brown (1990, Winter), *What's Addiction Got To Do With It: A Feminist Critique of Codependence*. Psychology of Women, 17, 1-4.

5. S.C. Anderson (1994) *A Critical Analysis of the Concept of Codependency*. Social Work, vol.39, Number 6, 677-684.

In more recent times, "co-dependency" has been defined as a "pattern of painful dependence on compulsive behaviours and on approval from others in an attempt to find safety, self worth and identity".⁽²⁾ More enthusiastic adherents have described co-dependency as a primary disease, present in every member of an addictive family, often worse than the disease itself, with its own physical manifestations. It is viewed as a treatable diagnostic entity.⁽³⁾ Although men can theoretically be co-dependent, the literature refers almost exclusively to women.

Although it is clear that many people have been helped by their involvement in the co-dependency movement by finding ways to understand how they get pulled into a set of behaviours and become part of a destructive system, the concept itself raises broader social questions and needs to be critically evaluated. According to some, the concept of co-dependency, although seductive, may be dangerous.⁽⁴⁾

In her paper, "A Critical Analysis of the Concept of Co-dependency"⁽⁵⁾, Anderson

raises the following criticisms of the co-dependency movement.

1. J.W.Walters: The codependent Cinderella who loves too much ...fights back. *Family Therapy Networker*, 14 (4). 1990.

2. T. Gierymski & T. Williams (1986), *Codependency: Journal of Psychoactive Drugs*, 18(1), 7-13.

3. J.W. Wetzel (1991), *Universal Mental Health Classification Systems: Reclaiming Women's Experience. Affilia*, 6(3), 8-31.

- Its tendency to conceptualise interpersonal behaviours as addictions, thus trivialising the truly addictive behaviours associated with chemical dependency. (1)
- The failure of the co-dependency movement to differentiate between severe pathologies and relatively minor problems and to acknowledge the many resources and coping strategies of families coping with problems of addiction. (2)
- The pathologising of behaviours strongly associated with female qualities such as excessive caretaking of others and putting the needs of others first in order to protect relationships.
- The failure to recognise spouse's behaviour as a culturally conditioned response of an over functioning person in relation to an under functioning person.

Anderson quotes Wetzel's⁽³⁾ summary of the themes shared by most successful women's programmes. These include consciousness raising regarding gender roles; addressing the right of every woman to live without domination, to be treated with respect, and to be paid equitably for her work; restructuring the family such that home maintenance and child care are shared with men on an equal basis; teaching women that both personal development and social action are essential for positive change in their lives; and teaching women how to analyse and develop policies and legislation, always beginning with the personal and generalising to the global, so that the connection becomes clear.

The results

The spouse of the problem drinker is therefore under severe psychological strain, and it is not surprising that the psychological problems reported for the spouses include anxiety, depression and low self-esteem. The indications are that spouses of problem drinkers are themselves heavy users of health and social services, and may be prescribed, and perhaps get into difficulties with medications such as tranquilisers. It is reported that some spouses themselves get into difficulty with alcohol, perhaps through using alcohol to cope with stress or as a result of the misguided strategy of drinking with the partner in the hope of exercising some control over his or her consumption. Where the non-drinking partner is employed, his or her own work performance or attendance may suffer as a result of the difficulties experienced at home.

Excluding cases in which the drinker dies, there are essentially three possible outcomes to the relationship: the partner continues drinking problematically and the spouse continues to live with the partner and the problem; the partner ceases to drink problematically; or the relationship ends. The outcome will depend not only on factors of individual personality and circumstance but also on cultural and social factors. For example, it has been reported that men married to problem drinking wives are more likely to seek a divorce than women married to problem drinking husbands. This pattern may be changing as it becomes easier for women to find employment and to live independently following divorce. Similarly, alcohol-impaired marriages may be more likely to survive in countries where neither the legal system nor social *mores* facilitate easy divorce.

b) Children

In a few jurisdictions, the association between problem drinking and bad parenting is regarded as so strong that evidence of a parental alcohol problem is assumed to be evidence of child neglect. The New York Family Court Act states:

'...proof that a person repeatedly misuses a drug or drugs or alcoholic beverages...shall be prima facie evidence that a child of or who is the legal responsibility of such person is a neglected child except....when such person is voluntarily and regularly participating in a recognised rehabilitative programme.'

Alcohol problems vary in nature, severity and persistence. Moreover, how badly a child is affected by parental problems is likely to depend, amongst other factors, on the child's age at the time they develop. The child under five is particularly vulnerable to diminished physical care whereas the older child may be more vulnerable to psychological damage. This is not to say, of course, that the younger child does not suffer psychological damage, merely that its situation does not allow it to detach from the abusive parent in the way an older child can do by simply leaving the family home.

Everything revolves around Mum's drinking. We pretend it's not happening. I can't stop thinking about what's happening at home when I'm not there. Sometimes I think I'm going mad."

Paul, 15 (From NACOA Does this happen to you? leaflet) ⁽¹⁾

As has been described, in the worst cases the world of the child of a problem drinking parent is likely to be bewildering, unpredictable and threatening.

1. B & P Berger: *The War Over the Family*.

The possible adverse effects of a problem drinking parent may be seen in relation to Erikson's concept of the importance of trust for the development of a healthy personality: the child must be able to trust the love of the adults who care for him, and he must also be able to trust in the fact that they will continue to be around in the future.⁽¹⁾

The child may experience various forms of neglect and feel abandoned by both parents; it may fear that the drinking parent may die, or that the non-drinking parent may leave; it may have a restricted capacity to make or sustain friendships; to be the victim of verbal or physical aggression; to be a witness to conflicts, perhaps violent conflicts, between his or her parents, and may experience the break-up of the family.

1. R. Velleman: *Alcohol and the Family*. IAS 1993.

"To the child, it can feel as if everyone in his or her world is full of anger, bitterness and pain, with no-one offering warmth, love or support."⁽¹⁾

The child may be forced to take on adult roles and responsibilities and in this very real sense be deprived of their childhood. A particular feature that can arise is that the child, like the spouse, comes to believe that he or she may be to blame for the problems the family is experiencing.

2. S. Brown: *Safe Passage: Recovery for Adult Children of Alcoholics*. John Wiley & sons 1992.

"Mom always reminded us, not too nicely, that we were the cause of the family's strife. If we didn't fight so much, or if we got better grades, she wouldn't feel so upset all the time. I grew up knowing one thing for sure: I'd cause some problem today, though I couldn't determine how, why, or what."⁽²⁾

The Results

1. R. Velleman: Alcohol and the Family. IAS 1993.

Many studies have been carried out in numerous countries of the children of problem drinking parents. These show consistently that they are at increased risk of a range of problems during childhood.⁽¹⁾ These can be grouped under three main headings:

- i. **Anti-social behaviour:** children of problem drinking parents are at raised risk of aggressive behaviour, delinquency, hyperactivity and other forms of conduct disorder.
- ii. **Emotional problems:** these include a wide range of psycho-somatic problems from asthma to bed wetting; negative attitudes to their parents and to themselves, with high levels of self-blame; withdrawal and depression.
- iii. **School environment:** the problems include learning difficulties, reading retardation; loss of concentration; generally poor school performance; behavioural problems such as aggression and truancy.

2. Information provided by ABS.

A Spanish study⁽²⁾ shows a statistically significant impairment among children of alcoholics in many areas, including:

- anorexia and other eating disorders;
- body development;
- language and communication skills;
- nightmares, insomnia, and nocturnal restlessness;
- a higher rate of depressive symptoms;
- disturbed behaviour patterns;
- anxiety-related disorders and phobias;
- performance on the Weschler Intelligence Scale.

3. S. Kork: What are the problems for children? in Alcohol Problems and the Family. Conference Report IAS 1995.

In the UK, a social worker with a children's telephone help line⁽³⁾ has summarised what children of problem drinkers tell the counsellors about their experience:

- having to take responsibility for their parents
- feeling embarrassed and ashamed of their parents, not being able to take friends home
- problems at school
- being bullied
- being preoccupied, lack of concentration
- afraid of what they may find every time they return home
- witnessing arguments and fights

- feeling guilty and responsible for their parents' behaviour
- feeling hopeless, helpless, irritable, nervous, depressed, let down, disappointed, confused, lonely, anxious, angry and resentful.

1. S. Wegscheider. Es gibt doch ein Chance. Hoffnung und Heilung für die Alkoholikerfamilie. 1998.

It is sometimes suggested that in the problem drinking family, children may be affected differently, and come to play different roles, according to their birth order. In one theory, the first born child is the 'hero' of the family (taking over adult roles and responsibilities); the second is the 'scapegoat' or rebel (relationship problems, delinquency); the third is the invisible or 'lost' child (demands little from other family members, always takes a back seat) and the fourth is the 'joker' (immature and demanding).⁽¹⁾ It is unclear, however, how well founded such typologies are.

Abuse and neglect

Parental alcohol consumption can have adverse effects on children even before they are born.

Foetal alcohol problems:

Foetal alcohol syndrome is defined in terms of the following:

- Foetal growth retardation
- Central nervous system involvement (neurological abnormalities, developmental delay, intellectual impairment, head circumference below the 3rd centile, brain malformation).
- Characteristic facial deformity

Other, lesser abnormalities, affecting all systems in the body, have been described and are referred to as foetal alcohol effects.

2. Royal College of Obstetricians & Gynaecologists: Guideline: Alcohol Consumption in Pregnancy. Nov 1996.

Foetal alcohol syndrome is relatively rare with reported incidence of 1.7 per 1,000 and 3.3 per 1,000 live births in Sweden and France⁽²⁾, respectively. It is reported that every year in Germany around 2000 children are born with foetal alcohol syndrome.⁽³⁾

3. Information from DHS, Germany.

The syndrome is not seen consistently in infants born to women who are heavy consumers of alcohol and occurs only in approximately one third of children born to women who drink about 2 gms per kilogram of body weight per day (equivalent to approximately 18 units of alcoholic drink per day). The differing susceptibility of fetuses to the syndrome is thought to be multifactorial and reflects the interplay of genetic factors, social deprivation, nutritional deficiencies, tobacco and other drug abuse, along with alcohol consumption.⁽²⁾

The incidence of foetal alcohol effects may be much higher than foetal alcohol syndrome. Some studies have suggested that children born to mothers who have on average as little as one to two drinks per day, or who may occasionally have up to five or more drinks at a time, are at increased risk for learning disabilities and other cognitive and behavioural problems. However, it is difficult to establish the frequency of a birth defect that is hard to identify at birth and may be confused with other health problems.⁽²⁾

1. Information supplied from members of the working party.

Other child abuse⁽¹⁾

Information is not available from every member state as to the relation between alcohol problems and child abuse, but, for those able to supply such figures, it would seem that it is not unusual for half the number of cases to involve alcohol. In the **Netherlands**, whilst 17% of child abuse cases had alcohol addiction as a contributory factor, between 30 and 50% of children registered with Boards of Child Protection had parents who were excessive drinkers. In **Norway**, it is believed that alcohol is involved in 60-70 per cent of cases of child abuse and neglect. In Lisbon and Porto in **Portugal**, 49% of incidents of physical or emotional abuse towards children involve alcohol, whilst estimates for **Italy** suggest a figure of 50%. 12.9% of children taken into care in **Ireland** - as opposed to all cases of child abuse - had parents who were assessed as addicted to alcohol or other drugs. A 1992 study in **Spain** showed that 30% of cases of child abuse or neglect met the criteria for parental alcohol abuse or dependence.

More detailed figures are available for the **United Kingdom**. In the period 1995-1997 the following numbers of children under 18 years (England/Wales and Northern Ireland) and under 16 years (Scotland) were placed on child protection registers as having been abused or neglected or at considerable risk of abuse/neglect:

Table 2. UK: Children placed on child protection registers.

Year	Country	No's registered	No's registered per 1000 of under 18 population
1996	Scotland	2,479	2.1
1997	England	32,369	2.9
1995	Wales	1,668	2.5
1996	N Ireland	1,551	3.0

A survey of case loads of child care social workers identified 28 per cent of cases in which alcohol was thought to be contributory factor. In child protection cases, the percentage of referrals involving alcohol ranged from 30 to 60 per cent.⁽¹⁾

Table 3. UK: Percentages of alcohol involved cases of child abuse.

	Manchester	Kingston-Upon-Thames	Dundee	Powys (Wales)
% of child protection referrals involving alcohol	30%	30%	37%	60%

Devon County Council in an analysis of needs and services carried out in 1996 identified 15% of all children and young people looked after away from home as having

either alcohol problems themselves or as the children of adults with an alcohol problem. If the data outlined above are replicated throughout the U.K. a total of 30% of all registered abused and neglected children (a figure of approximately 11,500) could be suffering, at least in part, because of alcohol misuse. Since only 64% of children, on average, referred to a child protection case conference are actually registered the numbers severely abused and neglected are considerably higher.

Further confirmation of the problems experienced by children in families misusing alcohol comes from two major child care charities in the U.K. The National Society for the Prevention of Cruelty to Children, the largest charity working exclusively with abused and neglected children, analysed 2,234 calls received by their help line for a 4 month period to 31.12.97. This showed that 23% of child abuse or neglect calls involved the misuse of alcohol.

In a report published in November 1997 by 'Childline', a free national children's help line, 3,255 children who spoke about parental alcohol misuse were shown to have been counselled in a twelve month period from 1.4.95 to 31.3.96. This survey shows that alcohol misuse was an issue across almost the entire range of problems which children cited, including running away, violence in the home, physical abuse and

Table 4. UK: Parental alcohol misuse and problems for children.

Main Problem	% of children who said that alcohol misuse was a factor
Domestic violence	21%
Physical abuse	15%
Family relationships	7%
Running away	7%
Homelessness	7%
Parents divorced/separated	5%
Sexual abuse	4%

poor family relationships.

The cycle of abuse

There is considerable evidence in regard to the way in which abusive behaviour in one generation produces abusive behaviour in the next. An obvious example is the increased risk of problem drinking in children of problem drinkers. Physical, including sexual, abuse appears to follow a similar pattern. In particular, while alcohol abuse in a parent or other may be associated with child sexual abuse, there is also evidence that, especially among women, childhood sexual abuse is associated with problem drinking later in life.⁽¹⁾

Variations in the experience of problems

Children of problem drinking parents are at raised risk of problems, but not all such children experience problems at the same level of severity. Some do not appear to experience any significant problems even while they are children, let alone as adults.

Research suggests⁽²⁾ that some of the main factors influencing the likelihood of experiencing problems and thus the degree of negativity of the child's experience are:

1. B. Miller: *The Interaction Between Alcohol, Drugs and Family Violence*. NIDA Research Monographs 1990.

2. R. Velleman: *Resilient and Un-Resilient Transitions to Adulthood: The Children of Problem Drinking Parents*. In *Alcohol Problems in the Family*. IAS Conference Report 1995.

Violence: witnessing violence even when not its target greatly increases the child's risk of experiencing the kind of problems described above.

Marital conflict: even non-violent marital conflict appears substantially to increase the likelihood of children experiencing severe problems.

Separation, divorce and parent loss: this also appears to be another major factor affecting the negativity of the child's experience.

Inconsistency and ambivalence in parenting: this is implicit in the above, and related to the unpredictability of life in a problem drinking household. Much research suggests that, especially in their earlier years, children have a strong need for structure, for things to be familiar, stable and thus predictable.

Problems in later life

The evidence is clear that the children of problem drinking parents can have very disturbed and unhappy times as children, though this is not inevitable. But do the emotional and other problems persist into later, adult life? In many cases they do. Evidence for this is provided by the United States, where there is a large social movement of adults who experienced parental alcoholism in their childhoods, and a formal association, Adult Children of Alcoholics (ACA). There are also helping services for children, one of the aims of which is to reduce the risk of problems continuing into later life. In the USA there is the National Association For Children of Alcoholics (NACoA).

Some children have significant problems that persist into later life and affect their lives as adults. However, the available evidence is limited and is primarily concerned with the question of whether children of problem drinkers themselves become problem drinkers, and with the persistence of clinically definable psychological or other problems.

The available evidence does not necessarily answer the question of whether adult children of problem drinking parents escape from their experience entirely unscathed. Careers may be damaged if achievements at school were less than they would have been had the parental alcohol problem not existed.

1. J. Orford and R. Velleman:
Childhood and Adult
Influences on the
Adjustment of Young Adults
with and without Parents
with Drinking Problems.
Addiction Research 1995.

A UK study⁽¹⁾ found that a minority of children of problem drinkers had problems continuing into early adulthood. Compared with a control group of young adults from non-problem drinking families, they were more likely to have misused alcohol or other drugs themselves, and a proportion were found to have a more negative adult adjustment - to be more depressed, more anxious, to have relationship difficulties, to leave home early and, generally, to be more dissatisfied with their lives. A common finding is that some children of problem drinking parents find difficulties in later life in making and sustaining close, adult relationships.

In the UK study, the bad outcomes were more likely to occur in children both of whose parents had an alcohol problem, and if the problematic drinking occurred in the home rather than elsewhere.

However, the most significant finding was that the strongest predictor of psychological problems in early adulthood was not having a problem drinking parent, or

even two problem drinking parents, but family disharmony. In families which managed to remain intact and relatively harmonious despite the alcohol problem (a small group), the children appeared to emerge largely undamaged. In contrast, children from disharmonious families were more likely to experience problems as young adults, whether it was alcohol or some other factor that was the cause of the disharmony.

Family disharmony as a cause of problems in later life

There is a large scientific literature on the effects on the children of parental divorce and separation. The evidence suggests that parental divorce has 'a moderate, long-term negative impact on adult mental health.'⁽¹⁾

The impact on the health of children of divorced parents can be severe, with a higher risk of ill health from the time of parental separation until adult life: children under five when their parents divorce are especially vulnerable.⁽²⁾ There is also evidence that children from divorced families grow up to show a higher risk of premature mortality across the life span. One study suggests that the higher mortality risk for men may be partially explained by the fact that men who have experienced parental divorce are more likely to have failed marriages, to be less educated, and to engage in fewer service activities. Women who experience parental divorce may smoke more and be more likely themselves to divorce, both of which predict higher mortality risk.⁽³⁾

A note on genetic factors

Alcohol problems tend to run in families and through the generations. First degree relatives of alcoholics are two to seven times more likely than the general population to develop problems with alcohol sometime in their lifetime (Merangas, cited in 9th Special Report 1997). Numerous investigations have attempted to discover why this should be. Clearly, one possible explanation is a form of 'social contagion' whereby problematic drinking is learned behaviour and, for a variety of reasons, children and others come to imitate the behaviour of the problem drinker.

Another possible explanation is that there is a genetic basis to problem drinking. While it is unlikely that genetic factors alone can explain the great variations in the prevalence of alcohol dependence from one country or society to another, or in the same society over time, the consensus of scientific opinion is that genetic factors do play a part. Studies of families, twins, adoption and genetic markers have shown that genetic factors are involved in relation to alcohol consumption (total amount and frequency); complications experienced (physical, social and psychological) and dependence. However, it is 'the balance between environmental and genetic factors that is important. It is not genetic factors on their own that make someone an alcoholic or problem drinker.'⁽⁴⁾

This is illustrated in a British study of young adults. A biological vulnerability from an alcohol dependent parent was neither sufficient nor necessary for the participants in this study to develop alcohol dependence as a young adult, although there was an increased risk. There also appeared to be strong protective effects of positive family relationships on the potential negative effects of a family history of alcoholism, a theme discussed further below.⁽⁵⁾

Implications

1. P.L.Chase-Lansdale, A.J.Cherlin and K.E.Kiernan: The Long Term Effects of Parental Divorce on the Mental Health of Young Adults: A Developmental Perspective. *J Pers Soc Psychol* 1997 Aug 73 (2) 381-391

2. A.Sims: Marital Breakdown and Health. *British Medical Journal*, 22nd Feb 1992.

3. J.S.Tucker et al: Parental Divorce: Effects on Individual Behaviour and Longevity.

4. Dr C. Cook: Genetic Aspects of Alcohol Related Problems at the conference "Alcohol Dependency - Meeting the Challenge" Edinburgh November 1995.

5. E.M. Hill et al: Young Adult Children of Alcohol Parents: Protective Effects of Positive Family Functioning. *British Journal of Addiction* 87, 1992.

The findings of genetic research have two main implications for the subject of this report. Firstly, further progress may lead to improvements in the treatment of problem drinking and alcohol dependence. Secondly, genetic research and knowledge may help in relation to the prevention of problem drinking and dependence. Given that the biological offspring of problem drinking parents appear to be at increased risk of becoming problem drinkers themselves, then they are a group with special needs for educational or other interventions.

Protective factors and ‘resilience’

1. J. Orford and R. Velleman: *Childhood and Adult Influences on the Adjustment of Young Adults with and without Parents with Drinking Problems.* *Addiction Res* 1995.

It is already clear from the foregoing that there are some factors that serve to protect the psychological well being of children in adverse circumstances and which reduce the likelihood of their experiencing continuing problems in adulthood.⁽¹⁾ There are also factors that can protect the well being of the spouse of the drinker. It is of course important for these factors to be identified because they suggest measures that can be taken within families and by helping agencies to mitigate the worst effects of the alcohol problem.

In relation to the children, the most obvious protective factor is a cohesive relationship between the parents. If this can be maintained despite the alcohol problem, the children are at greatly reduced risk of suffering harm.

A second factor is cohesive family relationships. Even if a cohesive parental relationship is not maintained, the risk to children is reduced if family cohesion and activities are maintained. A particularly important factor appears to be that what are described above as family rituals are maintained, especially during the heaviest drinking years. Another factor is whether the family of origin of the non-drinking parent maintains family rituals at a high level.

A third element is the other (non-drinking) parent: if he or she is able to provide a stable, supportive environment, the risks of a negative outcome for the child(ren) are reduced.

2. R. Velleman: *Resilient and Un-Resilient Transitions to Adulthood: The Children of Problem Drinking Parents.* In *Alcohol Problems in the Family.* IAS Conference Report 1995.

A further important factor is suggested to be a cluster of psychological characteristics in spouses and children known as ‘planning’ or ‘deliberateness’⁽²⁾. Essentially, this is the opposite of an attitude of fatalistic helplessness. It includes the ability psychologically to distance oneself from adverse circumstances and to formulate coping strategies. It also encompasses the ability to think through situations and alternative possibilities, and to come to deliberate decisions about the best courses of action to take.

‘Deliberateness’ is evident in the pattern of ‘selective disengagement and re-engagement’ that some commentators have identified as a means of coping by children of problem drinking parents. Examples are a child’s efforts to disengage from the disruptive elements of family life and to engage with others outside the family. At a later stage in the life cycle, deliberateness may be evident in the choices and decisions made by the now adult child of a problem drinking parent in relation to forming a family of his or her own, by consciously planning how to be the same or different from their family of origin.

It is suggested that the presence or absence of these factors help to explain why some alcohol impaired families are ‘transmitters’, that is, transmit the problems to the next generation, while in others the cycle is broken. They also help to explain why many children brought up in otherwise highly problematic family environments do not appear to suffer a lasting adverse impact. The optimistic finding here

is that having to cope with adversity can strengthen people as well as damage them.

What is being done ?

In regard to helping services currently available to family members, it is impossible to generalise across the whole European Union. There is a very wide assortment of services and approaches to alcohol problems, although the indications are that in a number of EU countries, helping services for family members are scarce. In some, for example Portugal, such services as do exist are provided by NGOs which are permanently in a precarious financial situation.

All EU countries provide services for children in relation to family problems, and all EU countries have helping and treatment services for alcohol problems.

However, a common theme to emerge is that specialist alcohol services may provide little or no help to family members, whereas specialist helping services for family problems may not be trained or equipped to identify or deal with alcohol problems.

A related theme is that there is often little collaboration on individual cases between alcohol service organisations on the one hand and family service organisations on the other.

Other obstacles to treatment

The majority of problem drinkers never receive formal treatment but make their own individual decisions to stop drinking or reduce their consumption to less harmful levels. Often, these decisions appear to be at least partly a result of social pressure from others, especially their families. It is equally clear that many of those who do receive formal treatment do so only after considerable delay. Often, perhaps typically, people who have problems with alcohol are reluctant to admit the fact to others or even to themselves.

An additional element here is the way in which the problem drinking family tends to keep its own secrets. Children, out of a strong sense of loyalty may be unwilling to tell any outsider about what is happening. In some cases, and as illustrated in the first quotation in this report, children may be threatened to keep quiet. This silence acts as a major obstacle to children receiving help.

However, the element of violence should not be overstated. The majority of children of problem drinking parents may need help and support, but they do not need protection from parental violence. Ironically, this can itself act as an obstacle to children receiving help. Where children are suffering or at risk of violence, social and health services are normally under an obligation to take action to protect them. Where there is no risk of violence children may not come to the attention of helping services or, if they do, be seen as needing help. As described earlier, children may be unwilling to ask for help themselves. Adults too may share this reluctance and again one reason for this is fear of the consequences, particularly where children are concerned. Many problem drinkers, especially women, who are also parents may well fear that seeking help from a treatment agency will result in their children being 'taken away'. It appears that this fear is aroused especially by statutory agencies.⁽¹⁾

This is a complex and difficult area and there are no simple solutions. Part of the answer may be the provision of telephone helplines which children can contact 'safely' in the sense that they are anonymous. Another part of the answer (dis-

1. T. Brisby et al: *Under the Influence. Coping with parents who drink too much.* Alcohol Concern 1997.

cussed below) is better education and training to enable professionals such as teachers and social workers who encounter children to recognise the signs of family alcohol problems.

One of the issues involved in such situations is that of confidentiality, and the limits placed on the flow of information about clients from one agency to another. Clearly, in order for some problem drinkers to seek or agree to treatment, assurances may have to be provided in regard to confidentiality and the likely consequences for their children. There is an argument that it is better for helping agencies to confront them directly and explicitly. One option is to provide clients with a written statement of agency policy in regard to confidentiality and child protection. An example is given in Appendix 5.

Alcohol services

In all EU countries there are alcohol treatment services provided by the state in hospitals and clinics. These services vary within as well as between countries and provide varying amounts and kinds of help to family members. There are also private treatment facilities which often provide advice and support to family members, including group therapy and counselling.

Non-governmental including self-help organisations are the main providers of helping services both to problem drinkers and their families.

Probably the best known such service is Al-Anon and Al-Ateen, which is present in all EU countries. Al-Anon is undoubtedly of enormous help to many people, but it may be either inappropriate or inaccessible for many others. One consideration is that Al-Anon is based on a specific model of problem drinking which may not be equally relevant to everyone.

Other international organisations providing services in several EU countries are the Good Templars and the Blue Cross, both of which are highly oriented to the families of problem drinkers. Vie Libre is active in France and Belgium.

Telephone helplines

These are available in an number of member states. There are alcohol problems helplines and general helplines for children and young people.

Drinkline

The UK helpline was launched in 1993 since when over 155,000 callers have contacted the agency. The service operates seven days a week. The service has been supported financially by the Department of Health. However, at the time of writing the future of this service is in doubt.

Around 60 per cent of the calls received are from drinkers wanting information, advice or help for themselves, and around 37 per cent are from concerned others. Partners, relatives and friends call for information and advice for the drinker or for guidance for themselves about coping or living with a problem drinker.

Alcohol problems helplines are also provided in Austria, Denmark, Finland, Germany, Greece, Luxembourg, Netherlands, Norway, Portugal and some regions of Spain.

General helplines for children and young people are provided in Austria, Denmark, Finland, Germany, Ireland, Netherlands, Norway, Portugal and the UK.

Other examples of helping services⁽¹⁾

Denmark

In 1992 the Egmont Foundation in co-operation with the Health Authority of Copenhagen implemented a three-year inter-disciplinary intervention project "Prevention of congenital alcohol damages in children born in Copenhagen". Thus the alcohol research fund of the National Board of Health has granted financial support to a 3 year PhD study of the development of alcohol exposed children from 0 to 2 years of age together with a grant for a 3 year research project on the further development of these children from 2 to 6 years of age.

The project was established within the framework of the Family Centre at Hvidovre Hospital and The University Hospital (Rigshospitalet) in an integrated co-operation with the midwife centres, the maternity wards and the children's wards of the two hospitals and in close co-operation with the alcohol department at Hvidovre Hospital and the primary social and health sector.

The aims of the project were:

1. To prevent congenital alcohol damage in children.
2. To provide children exposed to alcohol with the best possible conditions for development.
3. To prevent serious alcohol problems in the childhood environment.
4. To gather more knowledge about the influence of alcohol on the physical, psychological and social development of children.
5. To test new methods for early identification of pregnant women and infants who are in a risk group due to alcohol.
6. To develop and test interdisciplinary and cross-sectorial intervention models for early intervention.

Information about the project:

The leaflet "alkohol og fosterskade" (Alcohol and teratogenicity) prepared by the Egmont Foundation and Sundhedsstyrelsen (The National Board of Health) was sent to all pregnant women in Copenhagen. At the first pregnancy examination a structured questionnaire concerning the consumption of alcohol and other substances was completed.

Before the project began and during its first few months the problem of alcohol and pregnancy was widely publicised through the media and educational training was provided to professionals in the field.

Inter-disciplinary treatment

Families expecting a child were offered treatment and support adapted to the specific requirements of the individual pregnant woman and her family. The intervention extended over quite a long period of time, comprising pregnancy, birth, the neonatal period, the maternity leave period and the first three years of the infants life. The treatment took place according to the usual practice of the Family Centre with continuity in treatment, contacts and in close co-operation with general prac-

tioners, visiting nurses, social authorities, public alcohol clinics and drug treatment programmes, and other relevant professionals outside the hospital.

Simultaneously with the intervention a systematic investigation of the physical, psychological and social development of the alcohol exposed children was carried out. The children followed a fixed examination programme regularly by a doctor and a psychologist until the age of three. In all the infants cases detailed background information dating back to early pregnancy is collected for further evaluation and research purposes.

Supplementary Projects

Over a 2 year period The Directorate of Health decided to intensify the effort towards pregnant women and families with alcohol problems in a local area (Copenhagen North-West) in connection with the Healthy Cities project supported by the National Board of Health. The Directorate of Health also decided to implement a pilot project on the isle of Amager aiming at the same risk group. Both pilot projects formed part of the work of the Family Centre.

During the project period the expertise of the Family Centre was been used in various contexts and discussions concerning the problem area: children and pregnancy in alcohol families, for instance in the planning of Healthy Cities financed by the National Board of Health and the Alcohol Plan for Prevention and Treatment of the Directorate of Health together with the work group of the National Board of Health concerning Children in addicted families.

Permanent establishment

When the original project ended in May 1995 the work continued in the Copenhagen hospital system.

Finland: A fragile childhood

A Fragile Childhood is a prevention, training, treatment and research campaign which attracts attention to the situation of the children in alcohol families. The project began in 1986, and it is a joint venture of the main Finnish alcohol treatment organisation, A-Clinic Foundation, the Finnish Alcohol Monopoly ALKO and the City of Helsinki.

The basic idea is to present the child's perspective of, and experiences with, his or her parent's use of alcohol. The main target groups are families with small children, teen-age and adult children of alcoholic parents and professionals in social and health care.

The basic concept is the "alcohol family", which expands the scope from alcoholic families to all families where alcohol or other drugs are used in a way that is harmful to children's development. The idea is that the children are in need of the most urgent help and care in an alcohol family.

The Fragile Childhood project has now been running over ten years in Finland. The project has produced a large amount of tools and materials and trained professionals. The project uses both traditional and the most modern methods of prevention. The project has produced research, self-help material, group activities, training and information. For example, the awareness training programme is the largest of its

kind in Finland. Also a supportive telephone systems and a professionals' network have been developed.

The three part series of postcards and posters of the project was awarded the title of "The Best Health Education Product of 1992" in Finland. In 1998 in Lyons, France, the project won an Honorary Laureate in the First European Health Education Award.

1. Source: Else Christensen. Nordisk Alkohol & Narkotikatidskrift Vol 14 1997.

Sweden; help for children⁽¹⁾

Since 1989, Ersta Vandpunkten (run by Ersta Diakonisallskap, a deaconal institution within the church of Sweden working with social welfare, health care, and education in Stockholm) has offered structured group work for children of alcoholics.

This work is inspired by the American programme, Children Are People Too, which is based on the Minnesota model. The American model has been reworked and adapted to Swedish conditions.

Ersta offers groups for younger children (in the 6-8 age group), slightly older children (9-12 years) and youths (13-17 years). Each of the groups meets, under the leadership of a trained group leader and an assistant, 15 times over 15 consecutive weeks, and follows a predetermined programme.

Ersta has four basic principles for this work:

- 1) to change hopelessness into hope, and to get children to realise their limitations with regard to affecting their parents' alcohol addiction;
- 2) to have children openly share their experiences. This means increasing the children's awareness of themselves and of others, and breaking the concealment of alcohol addiction;
- 3) to introduce a rhythm, regularity and structure via the programme, as a counter-balance to everyday life in an alcoholic family; and
- 4) to support the children in recognising their own rights and personal limitations, again in understanding of the fact that this can be a problem for children of alcoholics.

These four principles are converted into a programme for the 15 meetings, such that there is a fixed course for each individual group which takes the children's age into consideration.

Theoretical assessment is made in appraisals of every 3-4 sessions, based on Piaget's developmental psychology. The programme for the individual sessions is evaluated on the basis of Piaget's developmental stages, in order to see whether the children are, formally and logically, sufficiently developed to understand what is being communicated.

An evaluation project concluded that the programme works. Something positive happens to the children, and they learn a large number of the things which are formulated in the founding principles. It was suggested, however, that there were a few places where revisions to the material used should be made, so that it better matched the children's level of development.

Italian clubs - caring for drinkers, their families and the community

Clubs for alcoholics undergoing treatment were introduced in Italy by Prof Vladimir Hudolin in the late seventies. The project began in the north-east region of Italy, where there is a high level of wine production and also a high incidence and prevalence of alcohol-related problems. It was supported and promoted by certain hospitals which were commencing educationally-oriented residential programmes. They provided therapeutic communities for alcoholics, which included the participation of the whole family in the education and treatment programme.

Alcoholics and their families who completed the one month educational programme formed the first clubs for alcoholics undergoing treatment. Subsequently, in the Veneto region, the programmes were supported by local community services particularly the drug addiction service.

The transition from a predominantly hospital-related approach to a more definite community one was accompanied also by a modification of the very concept of alcoholism. In fact, when programmes first began, reference was made to alcoholism as an illness, but in the mid-Eighties the concept of lifestyle was introduced.

This remains the philosophy around which the Italian Association of Clubs for Alcoholics Undergoing Treatment is organised. Alcoholism is a lifestyle, which involves the whole family and which is deeply rooted in the culture of the local communities where the clubs and their families live and work. The fundamental objective is therefore not to cure an illness, but to modify lifestyles and the culture that supports them.

Currently about 2000 clubs are spread over the whole of Italy. However, about 50 per cent of the clubs are concentrated in the north, where the programmes are better organised and are all supported by public funding.

In the areas where the programme is most developed, the distribution of clubs is one to every 2000-3000 inhabitants. The ideal ratio is, in fact, one club for every 2000 inhabitants. This ratio is considered ideal, since it permits easy access to clubs, enabling the clubs themselves to establish roots in the local culture.

The family approach introduced by the primary health care system of Clubs includes:

The involvement of the whole family

Family training and education through the following model

1. training programme:

- a. training for general population and workers in primary health care
- b. sensibilisation week for community health workers
- c. brief courses of 2-3 days for community health workers
- d. sensibilisation course of 2 days for teachers
- e. sensibilisation course of 2 days for the family planning centres

2. community programme for alcoholics and their families in the local network of the clubs of treated alcoholics

3. territorial school of alcoholology: one every 15.000-20.000 inhabitants

- a. 4 meetings of 2 hours each for general population
- b. 10 meetings of 1 hour each for families with alcohol related problems

c. 1 half a day meeting for families of the clubs of treated alcoholics

4. specific programmes:

a. alcohol, ecstasy and young people

b. alcohol and women

c. alcohol counselling and general practitioners

d. alcohol and the workplace

e. alcohol and prison

f. alcohol and multi-problematic situations

Treatment and Prevention

Treatment of alcohol problems

1. G. Edwards et al: *Alcohol Policy and the Public Good*. Oxford University Press 1994.

Treatment is a vital component of the total policy response to alcohol problems and there is ample evidence to show its value.⁽¹⁾ All EU countries provide specialist treatment services for alcohol dependent drinkers. Some of these also provide help to family members. It is also clear that across the European Union provision is patchy and that there are countries and regions where people experiencing problems, from their own or, especially, another's drinking, find it difficult to obtain any specialist assistance.

2. W. Miller: *The Effectiveness of Alcohol Treatment. What Research Reveals, in Treating Addictive Behaviour*. 1986.

Research evidence suggests that treatment is effective in the sense of being better than no treatment, although no one approach to treatment has been clearly shown to be generally superior to the others. There is evidence that forms of treatment which involve family members have better outcomes than those that do not.⁽²⁾

3. *The Pattern and Range of Services for Problem Drinkers. Report by the Advisory Committee on Alcoholism. DHSS and the Welsh Office*. 1979

Yet, for a variety of reasons, the reality is that only a minority of problem and alcohol dependent drinkers ever attend a specialist treatment service. Many problem drinkers do not seek or need formal treatment programmes, preferring, as a result of a range of personal and social factors, family pressure perhaps being one, to make their own individual decisions to stop or reduce drinking. However, most problem drinkers (and members of their family) do come into contact with a range of primary health care and social welfare systems as well as employing organisations. Here the contribution of alcohol to a presenting problem could be recognised and action taken at an earlier stage than is often the case. Because of these factors it has been found helpful to distinguish between primary and secondary level services.⁽³⁾

The primary level includes primary health care teams, personal social services, and some non-governmental agencies. The secondary level includes psychiatric units and services, other medical and specialist alcohol treatment agencies. It is suggested that proper service provision be facilitated by an appropriate division of labour and cooperation between the primary and secondary levels.

The main tasks of workers at the primary level are to:

- identify problem drinking
- acquire an adequate knowledge of the help required by the problem drinker and the family
- give this help so far as it lies within their scope
- know when and where to seek expert help
- provide continuing support before, during and after any period of specialist treatment
- provide adequate follow-up

The main tasks of workers at the secondary level are to:

- provide specialised knowledge, advice and support to those working at the primary level

- interview problem drinkers and family members as a consultative service providing a second opinion
- accept problem drinkers into secondary care i.e the direct involvement of specialists in the provision of treatment and care
- provide specialised treatment and care, such as medical or psychiatric assessment and intensive social support including, where necessary, residential accommodation. (Pattern and Range of Services)

Brief Interventions

1. G. Edwards et al: *Alcohol Policy and the Public Good*. Oxford University Press 1994.

There is evidence from many countries on the effectiveness of brief, mainly educational interventions in primary health care settings with heavy or problematic drinkers, especially men.⁽¹⁾ Brief interventions are a form of secondary prevention aimed at helping those already drinking at hazardous or dangerous levels to stop drinking or reduce their consumption. Experience shows that brief interventions are successful in reducing heavy drinking with all the benefits that implies for the individuals concerned and those around them, particularly their families. They are unlikely to be a method for dealing with the dependent drinker.

2. B. Ritson: *Community and Municipal Action on Alcohol*. WHO Regional Publications European Series No. 63 1995.

The WHO has provided a list of skills which Primary Health Care workers should ideally possess.⁽²⁾ While the WHO is referring primarily here to doctors and nurses, the list is also relevant to social workers, probation officers and others in social services.

- 1 a knowledge of the prevalence of hazardous and harmful alcohol consumption, and of related physical, psychological and social problems;
- 2 a knowledge and appreciation of the effects of patients' alcohol problems on their partners and families;
- 3 an awareness of the patient's attitude to alcohol;
- 4 the ability to identify the various physical, psychological and social indications of a drinking problem;
- 5 the ability to communicate accurate information on alcohol and alcohol-related problems, in an appropriate context, to patients or their relatives;
- 6 the considerable skill needed to distinguish between low-risk, hazardous/harmful and dependent levels of alcohol consumption;
- 7 the ability to manage the physical consequences and complications of acute intoxication;
- 8 the ability to take an accurate drinking history;
- 9 the ability to recognise signs of alcohol-related disease;
- 10 the ability to interpret laboratory results accurately;
- 11 the ability to choose an appropriate management plan, that is, brief advice/intervention or referral to appropriate colleagues or clinics; and
- 12 the ability to direct and manage patient detoxification at home.

An intervention strategy usually involves identifying cases, screening for those who are to be referred elsewhere, careful assessment, intervention and follow-up.

Family members

In regard to families presently affected by alcohol problems, the most obvious conclusion of the foregoing is that family members need help in their own right, both to help them cope with the present situation and, especially in the case of children, to reduce the risks of psychological and other problems continuing into adult life.

WHO primary health care project

The WHO is presently supporting an international project designed to help families cope with alcohol and drug problems.

The rationale of the project is as follows:

- When someone is taking alcohol (or drugs) excessively the close relatives are victims of chronic stress which can lead to physical or mental ill-health.
- Relatives are highly involved and active in reacting and responding to what is going on.
- Some of the ways in which relatives cope are better than others for reducing the risks of ill-health for themselves.
- Some of the ways in which relatives cope are better than others for influencing drinking or drug use in a desired direction.

1. Table 5 B. Ritson: Community and Municipal Action on Alcohol. WHO Regional Publications European Series No. 63 1995.

Table 5.

World Health Organisation: A basic strategy for early intervention⁽¹⁾	
1 Detect early problem	● Socially stable individuals at earlier stages of drinking have a better prognosis
2 Conduct a systematic assessment	<ul style="list-style-type: none"> ● Determine quantity and frequency of alcohol use ● Measure degree of alcohol dependence ● Check medical status and psychosocial functioning ● Note alcohol on breath
3 Engage in brief intervention	<ul style="list-style-type: none"> ● Review assessment findings with patient and family intervention ● Give feedback on mental or physical effects of drinking (e.g. raised gamma glutamyl transferase, mean corpuscular volume, carbohydrate deficient transferrin) ● Set drinking goals (abstinence or moderation) ● Set goals in other key areas ● Emphasise responsibility of the patient and family for working on goals ● Refer (if needed) to other agencies/professionals
4 Provide self-help manuals if available, or write down agreed plan	<ul style="list-style-type: none"> ● Have patient keep a daily drinking diary follow-up ● Monitor physical indicators of heavy drinking ● Review progress on goal attainment
5. Conduct periodic follow-up	

1. J. Orford: Drug and Alcohol Review Vol.13 No.4 1994

- Exactly what ways of coping are better depends upon a relative's circumstances.
- Primary health care workers can help relatives find ways of coping that reduce the risks to their own health, and at the same time help reduce excessive alcohol or drug use.⁽¹⁾

An obvious aim of intervention with the family is to build on whatever strengths and protective factors remain and to foster resilience. An important element of this is supporting the non-drinking parent in his or her relationships with the children.

Another aim is to help the family cease responding to the drinking problem in such a way that they (unwittingly) help to perpetuate it.

In regard to the content of helping programmes, suggestions include:

- Specific help in relation to stress management, assertiveness and self-esteem.
- As an important element of the problems facing family members is the uncertainty and unpredictability of life with a problem drinker, there is an obvious need for education about alcohol problems to increase understanding of what is going wrong and why.
- Help and advice in regard to coping strategies.
- Means to provide children suffering in families with alcohol problems with opportunities to discuss their feelings, fears and hopes. They should have access to someone able to befriend them and provide support in an environment where they feel safe. The spouse of a problem drinker can find help from specialist clinics and this is often the prelude to the acceptance of treatment by the drinker. Children, on the other hand, are excluded from this kind of service because systems do not exist to guide them towards it. A register of clinics or counselling services willing to offer help to children should be available to relevant authorities such as social services, GPs and schools.

The overall level of alcohol consumption

There is a mass of evidence that the levels of alcohol related harm in any population are correlated with the overall level of alcohol consumption: higher per capita consumption tends to be associated with higher levels of harm, lower consumption with lower levels of harm.⁽²⁾ The benefits of reduced national consumption are demonstrated by France during the period 1980- 1992. As can be seen, this reduction was accompanied by reduced numbers of people drinking excessively.

Between 1981 -1991, alcoholism and cirrhosis (15-64 years) fell by 33% in men and by 36% in women; deaths from road accidents (5-64 years) fell by 14% and cancers of the upper airways fell by 19% in men, but rose by 8% in women.⁽³⁾

A partial explanation of this pattern is the fact of heavy drinking increasing both the likelihood and the severity of harm and the particular and consistent finding that populations with lower mean consumption tend to have lower proportions of heavy drinkers: those with higher mean consumption to have higher proportions of heavy drinkers.

There is no good reason why harm to families should depart from this pattern.

2. G. Edwards et al: Alcohol Policy and the Public Good. Oxford University Press 1994.

3. Health in France: 1994 General Report. High Committee on Public Health. Ministry of Health and of Social and Urban Affairs. Paris 1996.

Table 6.

Trends in excessive consumption by adults (% of the population) ⁽¹⁾			
	3-4 drinks per day	5-8 drinks per day	9 drinks or more
1980-1981			
Women	7.3	2.1	0.0
Men	22.9	16.8	4.8
1986-1987			
Women	4.1	1.1	0.2
Men	20.2	15.4	3.7
1991-1992			
Women	4.1	0.9	0.1
Men	20.2	12.7	3.2

1. Table 6 Health in France: 1994 General Report. High Committee on Public Health. Ministry of Health and of Social and Urban Affairs. Paris 1996.

Everything else being equal, low consumption countries would be expected to have relatively low levels of harm to families: high consumption countries relatively high levels of harm.

2. Table 7. Calculated from Eurostat population statistics, and conservation statistics from B.L.R.A Statistical Handbook 1998.

It is important for Member States governments to recognise, therefore, that actions or inactions that result in increased national consumption are likely to increase problems for families as well as other kinds of health and social problems. Conversely, policies that reduce alcohol consumption are likely to benefit families.

Table 7.

Litres of pure alcohol a year sold to average person over 15. 1996 ⁽²⁾			
France	14.9	Netherlands	9.9
Austria	13.4	Greece	9.3
Portugal	13.2	Italy	9.1
Germany	12.9	UK	8.9
Belgium & Luxembourg	12.4	Finland	8.2
Denmark	12.3	Sweden	7.9
Spain	11.2	Norway	5.0
Ireland	9.9		

3. E. Österberg: Alcohol Related Adverse Social Consequences within the European Union in T J Peters (ed) Alcohol Misuse: A European Perspective, Harwood Academic Publishers 1996.

However, and as stated above, it is also clear that per capita consumption is not the only factor influencing the level of harm: patterns of consumption also seem to play an important role. Indeed, some surveys have found a stronger relationship between family problems and frequency of intoxication than the level of consumption as such.⁽³⁾

Fortunately, there is good evidence that there are methods available for controlling alcohol problems. One relates to the price of alcohol.

Price and tax as system of control

4. G. Edwards et al: Alcohol Policy and the Public Good. Oxford University Press 1994.

Within the EU, studies of the effects of price changes on alcohol consumption have been carried out in Belgium, Denmark, Germany, Finland, France, Ireland, the Netherlands, Portugal, Spain, Sweden and the UK. Similar studies have also been undertaken in North America.⁽⁴⁾

The main conclusions of these studies are:

- Alcohol behaves basically like other commodities - if prices go up, consumption goes down, and if prices go down consumption goes up provided other things remain unchanged.
- The effects of price changes are enhanced or reduced by any concurrent changes in disposable income.
- Price elasticities are not the same for all times and places or for all beverages. In particular, the traditional beverage of choice (wine in wine producing countries etc) tends to be less price elastic than other beverages.
- Normally, increases in alcohol taxes increase Government revenue.
- Heavy and even alcohol-dependent drinkers are influenced at least as much if not more than lighter drinkers by price changes.

This last finding contradicts the claim often made by representatives of the alcohol industry that higher alcohol prices only penalise responsible, moderate consumers while having no effect on heavy and problematic drinkers. It also challenges the claim that price increases only impose an additional burden on the families of problem drinkers.⁽¹⁾

1. *Alcoholic Beverages and European Society*. Amsterdam Group 1993.

There is no good evidence that alcohol taxes bear more heavily on the poor.

The most recent scientific review of these issues concludes:

“The contention that alcohol taxation is irrelevant to public health is factually unsustainable. The evidence is clear: other things being equal, a population’s consumption of alcohol will, to a usually significant degree, be influenced by price. Moreover, given that heavier as well as lighter drinkers are affected, price changes are likely to translate into changes in the prevalence of alcohol problems.”⁽²⁾

2. *G. Edwards Alcohol Policy and the Public Good*. Oxford University Press. 1994.

It is worth noting at this point that the European Commission has already accepted the principle that alcohol taxes have a public health dimension. The original proposed minimum tax rates on alcohol products were increased by 10 per cent to allow for the health aspect; the Commission has stated that it will allow each member country to determine its own level of taxation on substances that may influence the nation’s health and the Commission’s White Paper on “Growth, Competitiveness and Employment”, commenting on the need to reduce budget deficits, states:

“An increase of excise duties on tobacco and alcohol provides a source of additional budget revenue and a means of preventing widespread social problems, and can help social security budgets to make savings (by reducing the need to treat cancer and alcoholism)”.

The strategies for action agreed at the 1995 Inter-Governmental Paris conference “Health, Society and Alcohol” included to “Promote health by controlling the availability, for example for young people, and influencing the price of alcoholic beverages, for example, through taxation.”

This was agreed and endorsed by the health ministries of all 49 member states of WHO European Region, and including all but one member state of the European Union.

Physical and legal availability

1. Alcohol - Less is Better.
WHO Regional Publications
European Series No. 70 1996.

There is a considerable amount of evidence to show internationally that increasing the physical and legal availability of alcohol tends to encourage increased consumption, and conversely that restrictions on availability tend to reduce consumption and related problems.⁽¹⁾ Availability here refers to the location and density of outlets, hours of sale and licence and service restrictions such as the legal drinking age.

Restrictions or lack of restrictions on availability presumably reflect the culture and requirements of the different countries and it is not being suggested here that there is a blue-print that could or should be imposed across the whole of the European Union.

What is being suggested is that, particularly in the northern states where the current trend appears to be towards de-regulation of the alcohol retail system, there is a clear danger that increased availability will result directly or indirectly in increased consumption and related problems, including harm to families.

Existing restrictions may therefore be seen as safeguards which it may be unwise to remove.

The legal age for purchase and consumption

The above consideration applies with particular force to the question of the legal age for purchasing and consuming alcohol. There is no uniform set of age limits across the Union (see appendix 3) and the different limits presumably reflect cultural differences in attitudes to drinking by children and young people.

There is an argument often heard in northern countries that it is preferable for parents to introduce their children to alcohol at an early age and in the family setting. It is widely believed in northern countries that this is what happens in the wine producing countries and that such an introduction to drinking helps prevent alcohol abuse.

2. B. Grant & D. Dawson: Age at Onset of Alcohol Use and its Association with DSM-IV Alcohol Abuse and Dependence: Results for the National Longitudinal Alcohol Epidemiologic Survey. *Journal of Substance Abuse* Vol. 9 1997.

These assumptions are false because historically the wine producing countries have had the highest levels of alcohol consumption and harm. Consistent with this, evidence from the northern countries themselves suggests that early regular drinking increases rather than reduces the risk of heavier drinking and of alcohol problems later in life. A recent American study⁽²⁾ found that children who begin regular drinking by age 13 are more than four times as likely to become problem drinkers than those who delay drinking until 21 or older. A German study⁽³⁾ also found that early initiation into alcohol use is associated with increasing risk of experiencing alcohol abuse or dependence.

3. C. Nelson & H-U Wittchen: DSM-IV alcohol disorders in a general population sample of adolescents and young adults. *Addiction* Vol 93 No 7 July 1998.

The implication of these studies is again that existing restrictions on drinking by children, both those imposed by parents and those imposed by the state, are safeguards which it would be unwise to weaken or remove. Indeed, there is a clear case for strengthening the existing safeguards.

4. J. van Reek et al: Alcohol Consumption and Correlation Among Children in the European Community. *International Journal of Addiction* 29 (1) 1994.

Interestingly in this context, it appears that French attitudes have changed, and parents are now less likely than both their predecessors and their British contemporaries, to provide their children with alcohol at a young age.⁽⁴⁾ Similarly, in Spain, there has been discussion of the desirability of postponing the onset of regular

drinking and the Regional Government of Galicia is reported to have introduced new legislation, classing alcohol and tobacco as drugs and raising the minimum purchase age for alcohol and tobacco to 18. The age level for the rest of Spain is 16. In the Netherlands, there is also debate regarding the possibility of raising the legal age for purchase of alcohol to 18.

Controls on drink driving

1. Reducing Traffic Injuries Resulting from Alcohol Impairment. European Transport Safety Council. Brussels January 1995.

Clearly, measures that reduce casualties from drinking and driving benefit families as well as society at large. Every year in the European Union around 45,000 people are killed and 1.6 million injured in road traffic accidents. Around 19 per cent of injury accidents and 22 per cent of serious and fatal accidents are alcohol related. (1)

Such deaths and injuries can, of course, have devastating effects on families. In some countries, victim families have been at the forefront of campaigns against drinking and driving, and have played a crucial role in raising public awareness of the issue.

Another important component of countermeasures against drink driving is appropriate management, including treatment, of 'high risk offenders' - those drivers identified as possibly being problem drinkers. In modern, motorised societies, a common indicator of a developing alcohol problem is a conviction for drinking and driving. The normal pattern is that as countermeasures against drinking and driving succeed, large numbers of ordinary social drinkers stop drinking and driving and an increasing proportion of those who continue to drink and drive are habitual heavy or problem drinkers. This pattern is particularly evident in the northern European countries, where around one third of those convicted of drinking and driving show biochemical evidence of problem drinking. There is also ample evidence to show that problem drinkers are particularly dangerous drivers and are responsible for a disproportionate number of road crashes, deaths and injuries. (2)

2. J. Dunbar et al: Drinking and Driving: Success of Random Breath Testing in Finland. BMJ 11 July 1987.

The essential principle of 'high risk offender' schemes is that drivers who come into this category are disqualified from driving until and unless they can convince the authorities that their drinking habits are no longer a danger to other road users. High risk offenders may be required to undergo a treatment programme.

High risk offender schemes thus provide a means of social intervention into drinking problems at a relatively early stage and, given the importance of the driving licence in modern society, provide a strong incentive for the drivers concerned to arrest the development of the problem or to begin a process of recovery. While the need to improve road safety may provide the principal rationale for such schemes, by providing a means of preventing or treating alcohol problems they also directly benefit family members.

Education / rehabilitation schemes for convicted drink drive offenders are already established in the northern part of the Union (for example Germany, Sweden, the UK) but appear to be virtually unknown in the south.

Workplace alcohol programmes

Similar arguments apply to problem drinking policies in workplaces. While alcohol problems can be associated with unemployment and social exclusion, the majority of problem drinkers appear to be in gainful employment. It is estimated that

1. M.Nilson-Giebel: *Drinking Practices of Specific Categories of Employees*. WHO Europe 1990.

between 10 and 30 per cent of employees in Europe may be considered to have alcohol problems.⁽¹⁾ Indeed, some industries and occupations are at raised risk of alcohol problems, and such problems can of course severely impair work performance, productivity and safety. Workplaces thus provide a particularly appropriate setting for identifying and tackling alcohol problems and the benefits of doing so extend to the home and families of the employees concerned.

Alcohol advertising and sponsorship

The European Alcohol Charter states that “All children and adolescents have the right to grow up in an environment protected from the negative consequences of alcohol consumption and, to the extent possible, from the promotion of alcoholic beverages.”

2. G.B. Hastings et al: *Is Alcohol Advertising Reaching The People It Shouldn't Reach?* Health Education Journal Vol 51/1 1992.

Most Advertising Codes prohibit the specific targeting of minors, but the ubiquity of alcohol advertising ensures that it can hardly be missed by them. Indeed, the evidence is that even young children are aware of alcohol advertisements and tend to remember them.⁽²⁾ Manufacturers further reduce the chances of young people failing to get the message by sponsorship of sports teams and events and music concerts having particular appeal to the young.

3. B.A. Christiansen et al; *The Differential Development of Adolescent Alcohol Expectancies May Predict Adult Alcoholism*. Addictive Behaviours. 10-3 1985.

There is also evidence that underage drinking and the likelihood of alcohol problems in later life are closely related to positive expectations of benefit from alcohol use, precisely the expectancies advertising is designed to encourage.⁽³⁾

4. C.Godfrey: Chapter 9 of G Edwards & M Lander. *Addiction; processes of change*. Oxford Medical Publications 1994.

The results of scientific studies of the effect of advertising on total alcohol consumption and harm have been mixed. Some have found evidence of an effect, though a relatively small one when compared with factors such as price and income. On the basis of these studies it is suggested that a 10 per cent decrease in advertising could result in up to a 1 per cent decrease in consumption.⁽⁴⁾ Such studies cannot reliably be used to forecast the effect of a major change of policy such as the introduction of a ban on alcohol advertising. However, other studies⁽⁵⁾ have suggested that countries with broadcast advertising bans have lower levels of alcohol consumption.

5. H. Saffer: *Alcohol Advertising Bans and Alcohol Abuse: An International Perspective*. Journal of Health Economics. 10. 1991.

There is therefore evidence to support the strategy for alcohol action proposed by the European Charter that each Member State “implement strict controls, recognising existing limitations or bans in some countries, on direct and indirect advertising of alcoholic beverages and ensure that no form of advertising is specifically addressed to young people, for instance, through the linking of alcohol to sports.”

Education and information

The scientific evidence suggests that, often, education and information alone are of limited effectiveness and that educational strategies need to be combined with other measures, especially those which have a direct impact on the drinker's environment.⁽⁶⁾ However, it may also be argued that education and information are required in order to win public acceptance of these other measures.

6. G. Edwards *Alcohol Policy and the Public Good*. Oxford University Press. 1994.

Moreover, the issues with which this report is concerned are ones which, in the words of the Portuguese participants, tend to provoke a strong ‘ostrich response’.

“We can summarise the situation in regard to alcohol problems and the family in Portugal in some keywords: indifference, ignorance, and shame to speak out. Even

in the governmental and non-governmental organisations surveyed, let alone the general public, we observed a tendency to prefer not to recognise the problems, and the majority were ignorant of the terrible extent of the problems and sufferings.”

Clearly, the Ostrich response is not unique to Portugal: throughout the Union there is a need for increased awareness of the nature and scale of the problems on the part of the public and politicians as well as organisations and individuals concerned with family welfare.

Schools

Schools have an important role to play in the provision of education and information about alcohol and alcohol problems. The evidence suggests that school alcohol education programmes can increase knowledge and affect attitudes but are of limited effectiveness in regard to changing behaviour. They should not therefore be regarded as a panacea.⁽¹⁾ However, there is also evidence that educational programmes are more likely to affect behaviour if they are based on peer-led approach and are designed to increase social skills - the development of strategies to deal with anticipated drinking situations and to resist social pressure to drink.⁽²⁾

However, the potential importance of schools extends beyond classroom teaching to the concept of the school as a health promoting environment, of which a comprehensive alcohol policy is one component. Schools are also employing organisations and there are benefits for them too in workplace alcohol policies. There is also the question of the policy of the school towards the availability and consumption of alcohol on its own premises and at school functions. Lastly, in view of the possible adverse effects of parental problem drinking on children’s school performance and attendance, there is an obvious need for school disciplinary and pastoral care systems to be sensitive to the possibility of parental alcohol problems and equipped to take constructive steps to deal with the issues.

Family influences

There are clear implications for society and for policy makers. The findings in relation to family structures and alcohol problems suggest that policies that support the stability of marriage or at least stable relationships between adults may also have beneficial effects in relation to alcohol problems. Conversely, policies that undermine such stability may, indirectly, promote alcohol problems.

There are also clear implications for parents, the most obvious being the importance of providing a good example. In addition, the likelihood of experiencing alcohol problems is reduced by adequate parental support and control during childhood and by delaying the onset of regular drinking preferably until the late teens.

1. G.Edwards et al: Alcohol Policy and the Public Good. Oxford University Press 1994.

2. C.Perry et al: WHO Collaborative Study on Alcohol Education and Young People. Outcomes of a four pilot study. International Journal of Addictions 24 (12) 1989.

What should be done?

Members of the working party were invited to provide a brief statement concerning their own country and to make recommendations for the future.

Austria

It is important to make available helping networks for those affected by alcohol problems and their families.

In regard to prevention, there should be:

1. Action to strengthen the personality of the child ('make the children strong') by information and awareness programmes aimed at the population as a whole:

- by training for parents, teachers, and others who care for the young
- by direct measures aimed at family members

2. Legislative measures in relation to:

- marketing practices, for example the three cheapest drinks for sale in a bar should be non-alcoholic; prohibition of sales to the underaged
- child protection
- alcohol taxes

3. A lobby for children in relation to:

- Child and youth advocates, who should be present in every federal state of Austria, with a standardised free telephone hotline (similar to Swedish Ombudsman).
- Other lobbies with religious or political backgrounds should address issues of family alcohol problems, particularly in regard to alcohol problems.

4. Measures of support on a community level

In our view, a basic consideration is that information and awareness programmes should be positive rather than negative. It is unwise to campaign against alcohol, particularly by creating unenforceable laws and preferable to make available sensible alternatives so that people have their free space in which, in the context of what is legally permissible, they can experiment and develop.

Hans Kohler, Krankenhaus Stiftung Maria Ebene

Belgium

- Front line mental health care workers and general practitioners should have better knowledge of alcohol related problems and the effects of alcohol abuse on family life. Specific training on alcohol related problems should therefore be provided during their basic education.
- Training programmes for treatment of alcohol abuse should be developed and put into practice.

- Research should be carried out on the effectiveness of different treatment strategies. Attention should also be given to strategies for getting more abusers into therapy.
- More long term and broadly oriented health education is necessary; not only on the effect of alcohol for the individual, but also on the consequences for family life.
- Family members of the alcohol abuser should be more systematically invited into therapy.
- More government funds should be provided for research, prevention and treatment of alcohol related problems.

Erwin De Bisscop, AZ Sint-Jan

Denmark

Children in families where the consumption of alcohol inflicts harm on the children have to be more visible in the work with prevention and treatment. Not only as members of the family system but also as children who are at risk of developmental problems (health and development). Therefore any contact from the treatment and prevention system to these families must explicitly include questions on the well being of the children. The children cannot always wait for their parents to stop the problem drinking. If the parents are helped first and then the children, the children may grow up before they can get help. Therefore any action to treat/help the families must include specific and direct help/treatment to minimise developmental problems on behalf of the children (who need help in their own right).

It is important that the work can start when the parents get in contact with the alcohol treatment system. To find the best way to do it experimental work (project) should be designed - carried through and evaluated. The results could be collected in an European documentation - data base open to all interested organisations/persons.

The workers in the alcohol treatment system should be taught a better knowledge on children, their health and development.

The front line professionals should have knowledge about alcohol, alcohol related problems and alcohol inflicted harm to children as part of their basic curriculum.

The WHO list of skills (see page 41) could provide the basis of an education and training programme.

Else Christensen, Joint Council on Child Issues

Finland

There are aspects needing particular attention:

- The changes in family structures and role models within the family. It is important to study their impact on substance abuse from multidisciplinary perspectives.

- The impact of postmodernity. The movement from life time working careers to short term employment coexisting with high unemployment rates creates new conditions for substance abuse. Meanwhile, the traditional pattern of heavy drinking at weekends still persists, thus creating conditions for higher substance abuse levels. There is still insufficient knowledge of the impact of these factors.
- The traditional way of moderating consumption of alcohol through pricing policy is becoming increasingly difficult as a result of Finnish membership of the European Union and the move to harmonise alcohol taxes. Lower prices of alcohol may significantly increase consumption and lead to rising substance abuse problems within families.
- It is of the upmost importance that the indications of family alcohol problems are discovered and dealt with as early as possible. This means, among other things, that the early signs of substance abuse will be noticed by social and health care workers and other professionals as well as family members.

Finnish Centre for Health Promotion

France

Knowledge of the problems posed by alcohol within the family setting is insufficient.

It would be advisable to:

- put into place research for the study of these problems
- encourage the giving of information and training to professionals working in the family setting and in particular GPs, paediatricians, social workers and midwives.

The risks of heavy drinking during pregnancy should become a topic for a prevention programme with a national campaign and local action.

A telephone line specialising in alcohol problems within the family and with free access should be set up.

Pierre Fagniot, Délégation Régionale de Prévention de l'Alcoolisme

Germany

The development of special helping services for alcohol dependents and those affected by alcohol is essential. The family should be included in counselling and therapeutic efforts because:

- all family members are affected psychologically, socially and often also physically by the effects of alcohol dependency
- directly or indirectly, the dependency of an individual family member is supported or maintained by misplaced support, apathy or self-interest

- there exists a danger of a co-dependency for the partner or the children
- parental alcohol dependence may serve as an example for the children

From a point of view of family systems, it should be emphasised that chronic alcohol dependency is an expression of a disturbance in the relationships of the whole family system. Moreover, initially up to 90 per cent of those who go to special advice centres looking for help are the partners of the problem drinker.

Special help for children and young people

It is an urgent requirement that special helping services for children and young people, be extended to support alcohol dependent families and to children and young people with their own alcohol problems. There are large numbers of helping services for children and young people in Germany (children's advice centres and care lines etc), especially in the larger population centres. These helping services are publicised by means of posters, notices, listings in the telephone book and in the yellow pages. Indeed, in all localities there are free guides which provide information on public and private helping services. Such helping services should also be publicised in schools and kindergartens.

Family services

It is essential to improve and extend the facilities of advisory and therapeutic institutions for adults, young people and children with special problems such as separation, divorce.

Helping services for alcohol dependents

Different specialised helping services (such as marriage guidance, addiction counselling and family helping services) should be available in large numbers. At the request of the person seeking help these services should complement one another and work together. There should be special, trained counselling teachers, school psychologists and drug education teachers who can be approached by children and young people.

Special training and further education for authorised helping services

Special training, experience and knowledge about alcohol problems should be made available to everyone who is involved in helping services.

Political Measures

Alcohol problems are of political significance in society. The combating of alcohol problems must take place on various levels and form part of health and social policy.

Maria Braun, Familienbund der Deutschen Katholiken in der BRD.

Greece

The first consideration is that the alcohol consumption problem is increasing and that Greece is a Mediterranean country, where leisure time is associated with the

idea of “innocent” alcohol consumption.

The fact that alcohol looks “innocent” compared to other addictive substances means that we have to create some measures such as:

- 1) We have to aim through special units to inform and sensitise target groups such as students, prisoners etc.
- 2) Establish special services and units and day care centres specialised in alcohol on an individual level and team of consultants for parents, children and relatives.
- 3) Other public policies such as a) high taxes and b) control advertising towards drinking etc.
- 4) The training of experts who work with alcohol problems.
- 5) The collection of statistical and other information about alcohol problems.

All of the above would be facilitated by the creation of a national alcohol information centre responsible for the collection and dissemination of information and raising of public and professional awareness.

Vasiliki Sakki, Family and Child Care Centre

Ireland

The special place of the family in the Irish Constitution should be honoured by a greater willingness on the part of politicians and government agencies to acknowledge the (increasing) harm caused to families by alcohol abuse and in recognition of this, a greater commitment to funding agencies and initiatives to support families experiencing this trauma.

All health and social care professionals should receive significant (compulsory) education and training in all aspects of problem drinking, sufficient to enable them to competently undertake brief interventions and feel empowered to undertake a therapeutic commitment to the problem drinking clients and their families they meet in the course of their work.

Sheila Lyons, Stanhope Alcohol Treatment Centre

Italy

The Italian Eurocare organisations, in relation to the project *Alcohol Problems in the Family* first of all recognise the need to work for outlining a national profile on the subject. There is a clear lack of available information in our country, which is absolutely necessary in order to implement an action plan to cope with alcohol problems in families.

Secondly, they believe that an effective way to answer the suffering of families with alcohol related problems is the experience of the Clubs of Alcoholics in Treatment. The methodology was introduced in Italy by prof. Vladimir Hudolin at the end of the

1970s, and it has proved its value for the Italian families since then. The methodology is mainly family-oriented, and the role of families through their involvement within the Clubs methodology is fundamental. Briefly, the Clubs are multi-family communities imbedded and well rooted in the local community. The idea of treatment of alcohol related problems underlying this methodology is based on shifting the focus from therapy to lifestyles changes, from the individual to the family, from self-help groups to multi-family communities.

Franco Marcomini

The Netherlands

- 1) There is clearly a shortage of information. What is needed is an extensive research programme, preferably EU-wide, allowing comparisons both over time and between countries. A particular need is research into the effects of help and treatment for problem drinkers and their families.
- 2) In The Netherlands, helping services for children of problem drinkers are weakly developed. For children of drug addicts a lot more is being done. Only in a few organisations is a helping service for children part of the structure of the offer to people asking for help. We recommend that all professional treatment organisations for alcohol and drugs problems adopt helping services for children as an integral part of their offer to people asking for help. Part of this offer will be system therapy for a whole family.
- 3) In a number of regions there exist “partner-relatiegroepen” (partner-relation groups). This means mixed groups consisting of couples (the drinkers plus their partners), plus problem drinkers without their partners, plus partners without their drinking partners. There is close interaction between the problem drinker and his (her) spouse. Therefore, it is desirable that if both want to cope with their problem, there is opportunity for both to participate in the same therapy group. Thus we recommend that all Dutch helping organisations expand their services and accept also partner-relations groups as an integral part of their offer to people asking for help. Of course it is necessary that all existing group therapies for alcohol addicts and the group therapies for the partners of the drinkers will be continued.
- 4) We recommend that Dutch professional prevention workers employed by the organisations for alcohol and drug problems pay more attention to the teachers of primary schools, who see their pupils daily. The prevention workers may instruct the teachers how to detect pupils who are children of drinking parents, how to give the pupils help and how to refer them to professional treatment.
- 5) In the last 5 years the Dutch authorities have cut expenditure on the ambulatory alcohol helping services. We recommend that the authorities undo all these cuts, with the consequence that the services for alcohol clients and their family will be extended again.
- 6) We recommend that the Dutch government increase the amount of money available for alcohol problems treatment and prevention. As the yield of the excise duties on alcoholic drinks amounts to 1.58 milliard guilders, we recommend that this money- or at least a substantial part of it- be spent on treatment and prevention services. Additional funds for treatment services could be

raised from social security premiums (AWBZ). Additional funds for prevention could be raised from greater contributions from the municipalities.

Maarten Otto, STAP (Stichting Alcohol Preventie)

Norway

First of all it should be stated that family and children are the areas that problematic alcohol drinking normally affects first of all. When a persons consumption shows on the liver, it normally has affected the family for 10-20 years.

It should be stated that not all of this affection can be scientifically proved harmful. But also stressed that most scientists agree that the large majority of it is harmful - especially for children.

It is therefore strong evidence to ask the governments to give first line service health and social workers better resources to detect and take action in this area of problems. This ought to be done both in terms of giving better competence around the problems as well as better budgets.

There are also many families that are discovered by school or in kindergarten through the relationship between the teacher and the child. This number could be exceeded by giving more teachers competence on the subject.

And last - but not least - it is of course important to continue to educate the broader public of what risk their drinking may represent for their children.

Kalle Gjesvik, Avholdsfolket Landsråd

Portugal

We could summarise the situation of alcohol and family in Portugal in some keywords: indifference, ignorance, shame to speak out. In the governmental and non-governmental organisations we surveyed for this project we observed a strong "ostrich policy". Some actually know but do not want to recognise the problems; most are not even aware of the terrible extent of the problems and suffering.

Children are victims of abuse and neglect; wives are beaten and ill treated; there are high numbers of widows and orphans of cirrhotic husbands and fathers; and there are handicapped people who are victims of heavy drinking drivers. These are but the tip of the iceberg.

With such an extent of family problems known and estimated, how can it be understood that so few research projects have been undertaken in this area?

We think that one explanation is in our drinking tradition. To recognise problems in this area is shameful and "out of fashion". Only a few governmental and non-governmental organisations are concerned with research on alcohol and the family. Professionals' concern focuses almost exclusively in the areas of treatment and aftercare.

We think that the following lines of action must be implemented in Portugal:

- 1) A nation-wide project of information to increase awareness of the risks and harms of alcohol abuse for families, pregnant women, children, teenagers and heavy drinkers themselves. To reach most families this action has to be carried out through the mass media.
- 2) A production of clearly and scientifically presented leaflets and brochures are necessary to implement education on alcohol use and abuse in families.
- 3) This public information campaign should be accompanied by these legal measures:
 - a To raise the legal age for children and teenagers to enter bars unaccompanied to buy and consume alcoholic drinks. These measures must be enforced with penalties to owners and barman who serve them.
 - b To regulate the labelling and marketing of alcopops and designer drinks as alcoholic drinks and to indicate in a very visible way that they are alcoholic beverages and to indicate the amount of alcohol they contain.
 - c To regulate and forbid the functioning of school bars and cafeterias for children and teenagers with alcohol drinks available.
 - d To regulate advertising of alcohol beverages so as to prevent the presentation of them as not harmful and with no risks.
- 4) To programme a nation-wide plan of scientific research projects to collect and publish data on alcohol and the family focusing mainly on alcohol involvement in family violence and child abuse problems. This is still a very strongly hidden and taboo problem without a public recognised contour to be met with adequate preventive measures.
- 5) To fund more adequately the non-governmental organisations who have proved to be efficient in carrying out prevention programmes on alcohol problems. The non-governmental organisations have to be better supported financially and associated to programmes dealing with items 1,2,3 and 4 of this statement. This would help to improve the results they already achieve.

This funding would permit non-governmental organisations to keep some full-time professionals active in research, production of material, family counselling and aftercare for treated alcohol dependent people.

Aires Gameiro, SAAP

SPAIN

The widespread use of alcohol is causing not only a large number of alcohol dependents and alcohol-related illnesses and deaths but also significant harm to the whole of society and especially to those closer to the problem drinkers, namely their children and spouses.

These problems for the family include amongst others, foetal alcohol damage, child abuse and neglect, seriously disturbed family relationships and domestic violence. To cope with this situation, the following action ought to be undertaken:

- A permanent information system managing selected basic indicators is needed

to assess and monitor the alcohol-related harm in society. These indicators should not be limited to health data, such as alcohol dependents in treatment, illnesses or death, but has to incorporate family harm related indicators, such as attributable cases of child abuse and neglect, other problems caused to children, violence against women, number of children orphaned from alcohol-related deaths etc.

- The main categories of professionals involved in the prevention, early detection or intervention on the above mentioned family alcohol-related harm should receive basic training during their compulsory training period in their school or university. We refer to social workers, psychologists, police officers, physicians, teachers, nurses and others. Even if this is already being done in a number of universities, the situation is very irregular / variable and the provision of basic training is not guaranteed in many places.
- The relatives (and specially the children) affected by the behaviour of a problem drinker should be guaranteed the appropriate social and psychological support. In Spain, that support can come from alcohol services, the mental health network, social services or other agencies. In many cases the appropriate care is already being provided, but in too many others no cost-free appropriate assistance can be found. In others different kinds of services are badly coordinated.
- The prevention of alcohol-related harm has to be the main priority and not only on paper. As an example, there is in Spain a big and growing concern about violence against women, and measures are being taken for the support of the victims and the punishment of the aggressors. But nothing is being said about the prevention of such phenomena, eg through early coping with the alcohol abuse which is the root of so many cases of violence.
- None of the above points will be made possible without the participation and commitment of the national, regional and local authorities. In the same vein, the NGOs both from the alcohol and the family sectors have to be deeply involved in the reduction of alcohol related harm for the children and families, both through their own preventive and caring programmes, and through lobbying the authorities to fulfil their commitments as the voice of the civil society they aim to be.

Xavier Ferrer, Acción para- el Bienestar y la Salud (Action for Health and Social Welfare)

SWEDEN

The Children's Ombudsman

We believe that a useful means of helping children from problem drinking families is the institution of the Children's Ombudsman, as practised in Sweden.

Swedish children and young people up to the age of 18 have an Ombudsman of their own, the Children's Ombudsman, referred to in Swedish as "Barnombudsmannen" (BO). The main task of the Children's Ombudsman is to safeguard the rights and interests of children and young people as laid down in the United Nations Convention on the Rights of the Child. The Children's Ombudsman was established in 1993 by an Act of Parliament and the Ombudsman is appointed by the government every sixth year. The Agency is under the supervision of the Ministry of Health and Social Affairs.

The UN Child Convention - an important platform

The area of responsibility of the Children's Ombudsman covers in principle all issues concerning children and young people. The foundation of the work is the United Nations Convention on the Rights of the Child. As soon as an issue is regulated under the Convention, it comes within the area of competence of the Children's Ombudsman. However, issues falling outside the scope of the Convention can also be taken up if they involve the rights and areas of interest that the Children's Ombudsman monitors.

The Children's Ombudsman is an independent non-political body, but this does not mean that the agency takes a neutral position. Its task is to promote the rights of children and young people. This means that the Children's Ombudsman represents the interests of a particular group as opposed to individuals in public and civil society.

Representing children and young people

One of the most important tasks of the Children's Ombudsman is to represent children and young people. The aim of our work is that young people themselves will be able to make their voice heard and gain respect for their views. We obtain their views on issues that concern them through a number of questionnaires and studies, from letters and via the telephone as well as the internet. We also visit schools, school recreation centres and other places in which there are children and young people. Children and young people can also call our special phone information line called, BO Direct. There they can address questions on their rights and get advice on where and how they can get help to deal with different problems. The Children's Ombudsman has the power to classify any information received concerning the situation of a particular individual as secret.

Working on a general level

The Children's Ombudsman works at a strategic level on issues concerning the rights and needs of children and young people. This means that the Children's Ombudsman monitors the application of the Convention for all Swedish children as a group. Among other things, we make recommendations on changes in legislation in order to bring about greater conformity between the Convention and Swedish law. We work to ensure that the municipalities in Sweden use the Convention as the basis for all their activities concerning children and young people.

The Children's Ombudsman does not exercise any supervision over other authorities, nor does it intervene in individual cases. However the Children's Ombudsman can take an individual case as its starting point for interpreting the Convention from a Swedish perspective. This is done in order to give greater prominence to principles which could form the basis of different standpoints, recommendations and proposals for change. The Children's Ombudsman acts as a consultative body in the process of drawing up legislation covering the care of children and young people.

Shaping and influencing public opinion

Some of the most important tasks of the Children's Ombudsman is to participate in public debates, shape opinion on important issues and influence the attitudes of politicians, decision makers and the general public on issues concerning children and young people. We do this through a wide range of activities, such as writing articles, lobbying commissions and arranging conferences and seminars.

Co-operation and disseminating knowledge

We co-operate closely with other public authorities and organisations dealing with issues affecting children and young people at different levels in society. In some cases this may involve creating a common approach on a specific issue, in other cases the aim may be to achieve a common view and strategy on a range of different issues involving children and young people.

We follow and compile reports on the latest knowledge, statistics and research on children and young people, we take initiatives to promote research and spread this knowledge to special target groups.

Main issues of the Children's Ombudsman

Since the working area concerning the needs and rights of children and young people is so broad, it is necessary that we continuously review priorities to determine which areas of society should be focused on at different points in time.

At present we focus our activity on five principal areas:

- The United Nations Convention on the Rights of the Child: information, implementation and application
- Children in vulnerable situations, such as bullying and sexual abuse.
- The influence of children and young people in school and society.
- Conditions of children and young people: legally, politically and socially
- Co-ordination and development of public activities covering the safety of children and young people.

Karin Israelsson, National Temperance Council of Sweden

UK

Front line professionals - social workers, health visitors etc should receive training on the effects of alcohol misuse on families as part of their core professional training and in-service.

The Child Protection mechanism is currently being "refocused" away from identifying and registering children at risk of significant harm to a concentration on providing help to "Children in Need". This should help in identifying children affected by alcohol misuse. Our statement should urge authorities to include children affected by alcohol misuse as children in need, identifying the misuse of alcohol as a specific factor in the child's vulnerability. In this way they would begin to see (& hopefully respond) to the scale of the problem.

Penny Stanley-Evans, Barnardos Scotland

Conclusions and recommendations

It is clear that the problematic consumption of alcohol affects millions of families, and thus millions of children and adults across the European Union, causing harm and misery on a scale which dwarfs the problems associated with illegal drugs. Despite this, national governments often devote more resources to campaigns against illegal drugs. Likewise, combating illegal drugs is written into the Treaty of Rome but there is no special EU campaign against the far larger problem of alcohol misuse.

1. M.Bobak & M.Marmot:
East-West Mortality divide
and its potential explanations. B.M.J. 17/2/96

It is worth noting at this point that Eastern European countries, including those seeking membership of the European Union have high levels of alcohol consumption and harm. In most of these countries the situation appears to be worsening.⁽¹⁾ The entry of Eastern European countries into the European Union will thus result in additional millions of EU citizens affected by alcohol problems.

For a substantial minority of the affected children, the problems continue into their adult lives and, indeed, some children of problem drinking parents themselves become transmitters of the problems to the next generation.

The difficulties experienced by family members go beyond individual unhappiness to health and social problems that affect, and are an economic burden upon the whole society. Unknown but necessarily large amounts of public money are expended in all member states each year on health and social services in dealing with the consequences of alcohol problems in families.

And yet, in no member state do family alcohol problems appear to be accorded the importance that they actually deserve. All member states promote often very high profile public awareness programmes on the dangers of drunken driving: none promotes any remotely similar awareness programme about the dangers of drunken parenting.

Across the Union there are some treatment and helping services for family members but provision is patchy and, undoubtedly, there are many people, particularly children, who currently have no real access to help or support.

A particular problem identified is that alcohol treatment services may not be prepared or equipped to deal with the family aspects of the problem, while family treatment services may not be prepared or equipped to deal with alcohol problems.

However, while more and better helping services are a priority crisis intervention alone is of limited value to society however much it may benefit individuals. The main task is to prevent problems reaching crisis point or, preferably, from occurring at all. There is also the question of how and by whom helping services should be funded.

Partly because of lack of information, it has not been possible to explore in this report the question of the economic costs of family alcohol problems to society. The issue of funding treatment services should be seen in this context and, as suggested above large sums of public money are already being expended on dealing with the consequences of family alcohol problems. It makes sense therefore to allocate some resources to addressing and treating the problems that produce the consequences. New money is likely to be required. An obvious source is revenue from

alcohol sales. In member states where alcohol taxes are low it is unlikely that they are sufficient to cover the economic costs of alcohol problems including family problems. As well as raising excise duties a special levy could be placed on alcohol sales to fund treatment and prevention services.

In some member states family alcohol problems are at least on the public policy agenda, although occupying only a relatively minor place. In Denmark, for example, family alcohol problems have been the subject of some recent Government-supported investigations and reports.

In the UK, the Minister for Public Health has made a recent statement about the needs of children of problem drinking parents. She commented that under present arrangements it is not always clear who is responsible for providing services for the children of problem drinking parents. However, she gave an assurance that the needs of children and families will be taken into account in the national strategy on alcohol misuse now being prepared.⁽¹⁾

1. Tessa Jowell MP, speaking at NSPCC / Alcohol Concern Conference, London 16th July 1998.

In Germany an alcohol action plan was adopted by all the Federal States in 1997. The action plan includes a commitment to "...the improvement in the protection of children and young people from the negative consequences of alcohol use" However, it is unclear whether this commitment relates to the negative consequences on children of parental alcohol consumption. In 1993, the German DHS developed a model programme "Working with Children of Addicts" However, due to a lack of funds little progress was made. In Ireland the national policy on alcohol refers to the family aspects of the problem, although without discussing them in any depth.

Norway has a comprehensive alcohol policy and a white paper produced by the Department of Social Affairs in 1991/92 includes a lengthy discussion of the family aspects of the problem. In this white paper children of problem drinking parents and other family members are listed as two out of eight areas of particular attention in the future.

In Finland, the national policy on alcohol includes the following reference to the family aspects of the problem:

One of the aims of the whole alcohol policy is to safeguard and support the activities of the family unit.

(One family in six has suffered from inappropriate alcohol use. One child in eight has had negative experiences as a result of the parent(s) drinking.)

Objectives are:

- *to increase the professionalism and co-operation between schools, social, health, youth workers and police.*
- *to provide further education for those persons dealing with children.*
- *local authorities to establish the post of a co-ordinator who deals with all matters relating to children and their problems (psychological, physical, schools, nurseries, etc). The postholder must have alcohol problem knowledge.*
- *serious consideration should be given to establish special 'sobering-up' places for children and young people.*

In most member states, however, we have been unable to find any explicit reference to the family aspects of the problem in national policy or any authoritative statement by government ministers recognising the existence of the problems and the need to do something about them.

It is not surprising, therefore, that there is much that is not known. As has been made clear in this report, lack of information makes difficult even a rudimentary estimate of the size of the problem. In a number of member states there appears to be a lack of statistical information about the involvement of alcohol in cases of child abuse and related social problems. Earlier in this report, this lack of knowledge was described in terms of the 'ostrich response' and it does not require an excess of cynicism to believe that a lack of information can on occasion be extremely useful and convenient: so long as the true scale of a problem remains unknown it has no real existence in relation to public policy, and Governments and others are spared the unwelcome necessity of having to do something about it.

Children and the non-drinking parent may here be paying the price of the clear difference in public attitudes towards problems associated with alcohol and those associated with the illegal drugs. When problems occur with illegal drugs, the tendency is to blame the drugs; when problems occur with alcohol, the tendency is to blame the drinker. As one of the quotations at the beginning of this report illustrates, the drinkers family are likely to experience the problem of guilt by association. Blaming the individual drinker diverts attention from the social and economic factors that encourage the problematic consumption of alcohol.

In reality, alcohol problems in families are affected by the same factors as affect alcohol problems in general: at both the individual and the population level, the likelihood of experiencing such problems increases with the amount of alcohol consumed and with the frequency of intoxication. Policies that increase alcohol consumption are thus likely to increase family alcohol problems, problems that can impair and destroy families.

Equally, family influence and family break-up can increase the likelihood of alcohol and other substance abuse problems in both adults and children. For these reasons, policies that reduce alcohol problems are likely to strengthen and support families, and policies that strengthen and support families are likely to reduce alcohol problems.

In regard to substance abuse by children and teenagers, it is becoming increasingly clear that, in the words of a recent report, "If society intends to provide young people with an environment which helps them not to take illicit drugs (or abuse volatile substances), or to reduce the harms which they do, the climate of awareness and belief on alcohol and tobacco must be seen as part of that context."⁽¹⁾

This is because there is clear evidence that early use of licit drugs increases the risk of developing patterns of illicit drug use at a later stage. The majority of people who have used illicit drugs have previously used tobacco and alcohol. Similarly those who have never smoked or consumed alcohol rarely report use of illicit drugs. The tendency to demonise such "dance drugs" as ecstasy or amphetamines whilst condoning the use of alcohol is therefore dangerous. "Young people live in a society which heavily advertises alcohol and tobacco, and where they are readily and lawfully accessible, and the advertising of "alcopops" has on occasion seemingly been targeted at young people and has at times veered towards open encouragement of drunkenness."

It follows that “When setting up drug prevention policies consideration will often need at the same time to be given to the place of alcohol, tobacco and volatile substances in the scheme of things. Drug prevention policies which ignore licit drugs lack credibility.”⁽¹⁾

National Governments should:

- Establish improved systems of research and monitoring to obtain more complete and reliable information about the contribution of alcohol to divorce, family break-up, child neglect and abuse and other family problems and to assess the economic costs of these problems.
- Formulate and implement coherent national policies for reducing alcohol-related problems. National policies should make explicit reference to family alcohol problems.
- Ensure that national alcohol education programmes provide information not just about alcohol and health but also about alcohol as a potential social problem and the ways in which alcohol can disrupt social and, especially, family relationships.
- Require local health and social service authorities to draw up plans for tackling alcohol problems and, in particular, for meeting the needs of family members including children. This will involve specifying the ways in which they will make best use of specialist alcohol services, including those provided by NGOs.
- Ensure that schools and other institutions and professionals having contact with children are provided with the education and training necessary for identifying and supporting children from problem drinking families.
- Ensure that a free telephone help line is available for children. It is probably unrealistic to propose a special, dedicated helpline for the children of problem drinking parents: however, alcohol helplines (such as those available in Denmark and the UK) should be geared up to dealing with enquiries from children as well as adults and, similarly, general helplines for children should be geared up to deal with calls concerning alcohol problems.
- Ensure that the bodies responsible for the education and training of social workers and other professionals having contact with families and children, and their accreditation, receive appropriate education and training about alcohol problems, methods of intervention and the needs of family members.

The European Commission should:

- Encourage member states to improve the collection of information in regard to family alcohol problems, coordinating such investigations (perhaps through the European Observatory on National Family Policies) and, on the basis of the results of such investigations, supporting a programme to ascertain the economic costs of family alcohol problems in the European Union.
- Utilise the existing Health Promotion Programme as a vehicle for disseminating information about alcohol in general and family alcohol problems in particular.
- In view of the fact that for many young people, alcohol, tobacco and illicit drugs are all part of the same domain, extend drug awareness campaigns to include alcohol and tobacco.

- Continue to promote workplace alcohol policies and anti-drink driving campaigns, the latter paying particular attention to the management of the 'high risk offender'.
- Ensure that the Union's other policies, particularly those on taxation and the single market do not undermine efforts to reduce alcohol problems.
- In view of the generally worsening situation in Eastern European countries seeking membership of the Union, begin to collect and disseminate, in cooperation with international agencies such as WHO, information on ways of tackling family alcohol problems.
- Together with member states cooperate with and financially assist non-governmental organisations to a) raise the level of public awareness about alcohol and family problems, b) develop appropriate information and helping services and c) encourage the spread of practice in order that all citizens of the Union are able to have access to the help they may require.

Non-Governmental Organisations

- Specialist alcohol agencies should designate a member of staff to be responsible for family and children's services.
- These agencies should also ensure that adequate training is provided to staff in relation to child development and the family aspects of alcohol problems.
- Specialist family agencies should ensure that adequate staff training in alcohol problems is provided.
- COFACE and EURO CARE should cooperate in the field of alcohol problems in the family by setting up a joint working party at European level which would meet on a regular basis to take stock of developments and decide on and carry out joint initiatives.
- COFACE and EURO CARE should encourage their members at national, regional and local community level to seek cooperation with each other to develop a network of appropriate information, support and counselling services for families suffering from alcohol problems.

Appendix 1

COFACE: RECOMMENDATIONS adopted by the Administrative Council on 13th May 1992 following the Seminar 'Families and Alcohol' held in Dublin, 2nd-3rd April 1992

1. The Problem

The development of the use and abuse of alcohol and the dramas it generates must be analysed both in social and economic terms, and in the context of human relationships within and between families.

On behalf of the people and families directly concerned, on behalf of those faced with the ravages of this drug, whose very banality makes it all the more harmful and also on behalf of all families, COFACE, having discussed the subject during its seminar "Families and Alcohol" which was held in Dublin on 2nd and 3rd April in conjunction with the ICA, one of its member organisations, is anxious to put forward various thoughts, recommendations and claims.

COFACE wants to address them to all the bodies concerned: not only to national and local public authorities but also to opinion formers, to cultural leaders, to managers in trade and industry, to medico-social bodies, to any relevant organisation and to families brought together and operating under the umbrella of the family associations in the 12 countries of the EC.

The alcoholic cannot be held solely responsible for his/her illness any more than his/her family can, but both the alcoholic and his/ her/family have to be involved in the healing process.

2. Recommendations

Consequently,

1. it is essential that right from an early age children are given a real "education for life" in which the following topics are discussed: health, diet, the dangers of taking toxic substances, ... with a view to promoting a positive attitude towards their health and welfare;

2. this education must be undertaken by all those in the child's immediate entourage (teachers etc.) in close collaboration with families. This must also stimulate dialogue between children and adults so as to identify any problems;

3. an education of this kind must also include information about the various structures available, so that each individual knows who to talk to, where to get information or find support. This kind of education should not be mistaken for some of the media propaganda which tends to be sensational rather than educational, and can actually lead to alcohol consumption;

4. the family is particularly affected by the impact of alcohol on young people. For this reason, the attitude and behaviour of parents are on-going aspects of their children's education;

5. the information campaigns must show that on the one hand one can be a victim of alcohol without being an alcoholic and on the other show that alcoholism should not be considered as a vice but as an illness.

6. treating an alcoholic requires that the family be involved in the work of the therapists. Family therapy may make it possible to modify the behaviour of the whole family and give each member of the family the support he/she needs;

7. in addition to its purely statistical findings, research today looks into the various forms of domestic alcoholism and their impact on the various age groups: women, the underprivileged, immigrants etc.; likewise, innovative methods of therapy must be evaluated on an on-going basis;

8. *the fight against alcoholism cannot be effective as long as non-alcoholic drinks are more expensive than alcoholic ones. Alcohol advertising should not be allowed to use the euphoric effects of alcohol as a sales ploy, but on the contrary should be required to point out the dangers of alcohol abuse;*

9. *it is important to encourage research into alcohol substitutes (non-alcoholic beers etc.) rather than to prohibit alcoholic drinks;*

10. *but it is even more important that there be a real move against alcohol of the same proportions as that against other drugs. This can only be done satisfactorily if families' living conditions are taken into consideration and there is an effective fight against poverty, isolation, exclusion, etc*

3. COMMITMENT

The family associations have an important part to play in this; together with all the families and other partners, they have an informative and educational role, and must be involved in the setting up of support networks.

COFACE undertakes to promote these recommendations by including them in a policy of solidarity which can only be effective if the EC and Member States provide the financial support necessary for its development.

Appendix 2

The United Nations Convention on the Rights of the Child

The United Nations Convention on the Rights of the Child was passed unanimously by the U.N. General Assembly on 20th November 1989. It is binding on all those countries which agreed to ratify the Convention and all European member states are signatories.

The Convention, which consists of 54 Articles, is important for many reasons not least because it is an international Human Rights instrument which takes account of the wide range of beliefs, values and traditions of the world's population. (Nigel Caldwell — Defence for Children International).

Progress on implementing the Convention is being monitored by a Committee who received a national report from each States Party two years after ratification and will receive further reports from States Parties thereafter each five years. Key Principles of the Convention are:

1. That all the rights guaranteed by it must be available to all children without discrimination of any kind. (Article 2)
2. That the best interest of the child must be a primary consideration in all actions concerning children. (Article 3)
3. That children's views must be considered and taken into account in all matters affecting them. (Article 12)

The Convention throughout, promotes the child's right to family life (Articles 5,8,9,16,18,29,42) and also covers other issues that indicate a need for help and assistance to be given to children and young people who are affected by alcohol misuse:

4. Information and material aimed at the promotion of his/her social, spiritual and moral well-being and physical and mental health. (Article 17)
5. Take measures to encourage regular attendance at school (Article 28.e)
6. Take all appropriate measures to promote physical and psychological recovery and social reintegration of a child victim of any form of neglect, exploitation or abuse (Article 39).

Appendix 3

Diagnostic criteria of alcohol abuse and alcohol dependence

The Diagnostic and Statistical Manual (DSM-IV) of the American Psychiatric Association establishes criteria for the diagnosis of substance dependence and substance abuse. The criteria for substance dependence are:

(1) tolerance as defined by either of the following:

- (a) a need for markedly increased amounts of the substance to achieve intoxication or desired effect
- (b) markedly diminished effect with continued use of the same amount of the substance

(2) withdrawal, as manifested by either of the following:

- (a) the characteristic withdrawal syndrome for the substance
- (b) the same (or closely related) substance is taken to relieve or avoid withdrawal symptoms

(3) the substance is often taken in larger amounts or over a longer period than was intended

(4) a persistent desire or unsuccessful efforts to cut down or control substance use

(5) a great deal of time is spent in activities necessary to obtain the substance, use the substance, or recover from its effects.

(6) important social, occupational or recreational activities given up or reduced because of substance use.

(7) continued substance use despite knowledge of having had a persistent or recurrent physical or psychological problem that is likely to have been caused by the substance

The criteria for substance abuse are:

A A maladaptive pattern of substance use leading to clinically significant impairment or distress, manifested by one or more of the following, occurring at any time during a twelve month period:

- (1) recurrent substance use resulting in a failure to fulfil major role obligations at work, school or home
- (2) recurrent substance use in situations in which it is physically hazardous
- (3) recurrent substance-related legal problems
- (4) continued substance use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance

B The symptoms have never met the criteria for Substance Dependence for this class of substance.

There is also the concept of **alcohol-related disabilities**. These are subdivided into social disabilities (eg impaired social relationships), psychological disabilities (eg anxiety depression) and physical disabilities (eg liver damage).

Appendix 4

Country	Drinking Age	Purchasing Age
Austria		Age limit for drinking in public. 9 states - spirits age is 18 8 states - wine/beer is 16 Lower Austria - 15
Belgium		16
Denmark		15 in shops (introduced summer 1998), 18 in restaurants and bars
Finland		20, but 22 per cent abv alcohol can be sold to over 18s
France		16, but drinks are split into categories
Germany		Beer/wine - 16 Spirits - 18
Greece		18 for buying in public places
Ireland		18
Italy		16 - sales to under 16s prohibited with threat of arrest and penalty, especially if drunkenness involved
Luxembourg		16
Netherlands		Beer/wine - 16 Spirits - 18
Portugal		16
Spain		Most regions (eg Madrid) 16, in some 18 (eg Basque country)
Sweden		18 in restaurants and grocery stores (medium strength) 20 in liquor stores (state-run shops) Light beer (2.25 abv) has no restrictions
UK	5	16 in pubs/restaurants with meals 18 otherwise

Source: Eurocare Liquor Licensing Questionnaire 1996

Appendix 5

ALCOHOL RECOVERY PROJECT (ARP), UK CHILDCARE SERVICES

Why we work with children

Alcohol misuse damages the family system not just the drinker. Intervention and support targeted at the children of people with drinking problems can help reduce the likelihood of permanent damage.

A high proportion of problem drinkers come from families where parents and/or siblings already have an alcohol problem. Family work may help to break this cycle.

Some parents using ARP need to bring their young children if they are to use the service. Many are seriously troubled by feelings of guilt and inadequacy as parents and greatly benefit from specialist help in strengthening their relationships with their children.

Summary

ARP runs children's services including creche sessions staffed by experienced children's services workers, at some of the counselling centres, (shopfronts), and runs Wellmeadow House, a rehabilitation project for women with drink problems and their young children. The children's services on offer include creche services, individual work and small group work.

Aims of the childcare service

- To increase access to ARP's services for parents with a drink problem.
- To run regular good quality creche sessions at the counselling centres to enable problem drinkers with children to use ARP's services.
- To offer help to children whose parents have a drink problem.
- To hold individual parenting skills sessions to help clients strengthen their relationships with their children.
- To provide childcare expertise within the guidelines of ARP's Alcohol Services Manual. This includes running creches, parenting skills and play therapy sessions and educational workshops.
- To provide the childcare expertise at the women and children's scheme, Wellmeadow House (a residential rehabilitation unit for women and children affected by alcohol problems)
- To operate a child protection procedure for use by all ARP staff when information is obtained directly or indirectly, which indicates that a child may be at risk

Children's services workers as full members of the social work team

The position of the children's services workers in ARP's staffing structure is complex. The children's services workers are attached to the social work teams and the line manager is the senior social worker. Overall management responsibility for ARP's childcare services rests with the Area Assistant Director and the senior social workers are thus accountable to her in childcare matters.

Confidentiality

All clients bringing children to the service are given a statement about ARP's creches and a statement on confidentiality. The creche statement explains that children's services workers are full members of the social work team. It states

As well as running play activities and providing general care for the children while parents or carers are using the services, the children's services worker is also part of the social work team. Within the social work team there is an exchange of information about clients although the information is confidential to the team.

If information about a child is disclosed to a social worker or a children's services worker by the client or the child which implies that the child is at risk it may be necessary to break that confidentiality and share the information with the appropriate agencies. Should this be the case the worker would consult you first if at all possible.'

While staff are keen to reassure clients with children that the service is there to support them, it is essential to raise the issue of confidentiality from the outset, in order to avoid the danger of collusion with unacceptable behaviour later on. Most mothers attending ARP expect that the issue will be raised and some may be relieved that it has been brought out into the open.

The range of children's services on offer

Emerging needs have dictated that we place more emphasis on tailor-made services for individual children and their parents. Creche sessions are still held but they form only part of a wider range of children's services. The current children's service falls broadly into the following categories:

- Crisis assessment and intervention service for statutory bodies.
- Tailor-made services for individual children and their parents
- Creche sessions
- Family work.
- Parenting work for clients while their children are absent.

Children's services at Wellmeadow women and children's house. A description now follows:

Crisis intervention and assessment service for statutory agencies

There is an acute gap in social services expertise and provision which ARP is in an ideal position to fill. We have developed a crisis assessment and intervention package to meet this gap.

Tailor-made services for individual children and their parents

- Three way parenting skills sessions are held between childcare worker, parent and child. These deal with issues such as learning how to play, discipline and listening skills. Techniques include modelling, observation and feedback.
- Individual play sessions are held between childcare worker and child. The child is able to express his/her feelings and the worker can explore difficult areas and offer encouragement to the child. The information from such sessions is then fed into work with the parent.
- Counselling/discussion sessions are offered to older children of ARP clients who often have confused feelings of loyalty and resentment towards drinking parents and benefit greatly from help in their own right. The Women's Alcohol Centre has taken a lead in developing this work.

Creche Sessions

The option of running regular creche sessions to coincide with the women's sessions held at the shopfronts is available according to demand and staff availability. While creches now comprise a minor part of the overall range of children's services they nevertheless remain valuable.

The timing and frequency of the creches is kept under review and may vary in accordance with demand and the availability of staff. The child/staff ratios are determined partly by the age of the children. The maximum permitted is five children to one staff member, with a lower ratio for babies and toddlers. This means that parents are sometimes required to ring to check creche spaces are available before attendance. On occasion it is necessary for a social worker to assist the children's services worker in order to meet the staff/child ratio requirements.

Family work

On occasion the children's services worker has an invaluable role in family counselling sessions run jointly with ARP social workers. The child(ren) may or may not attend these sessions. The child's needs and perspective can be reflected by the children's services workers while at the same time helping the parent(s) rebuild damaged relationships with their children.

Parenting work

When needed a parents' support group is run which includes the following categories of women: women who have lost their children permanently; women who hope to be reunited with their children; and women who currently have care of their children but do not yet want their children to get involved with ARP's children's services.

The group is run by the Children's Services Worker and a social worker and functions partly as a bridge between adult services and children's services. It is a way of building up trust in ARP's children's services, of preparing for transition back to parental duties and of coming to terms with feelings of failure as a parent.

Children's services at Wellmeadow House

The children's services worker carries out duties at the Wellmeadow House. The house programme includes structured group play sessions; three way parenting skills sessions, parent group and individual work with child and worker.

Recording and documentation

Children's services workers contribute to case discussion and their observations form an integral part of the clients reviews.

Creche diaries are completed by the children's services worker after each creche session and records are kept of all individual and 3 way sessions and small group work. Accident forms are completed when necessary. In addition there are specific child protection procedures to be followed if there is any cause for concern about non-accidental injury or indication that a child may be suffering from 'significant harm' or neglect.

Appendix 6

EU PER CAPITA ALCOHOL CONSUMPTION BY COUNTRY (TOTAL POPULATION)

Country	1976	1986	1990	1991	1992	1993	1994	1995	1996
Luxembourg	11.2	11.9	12.2	12.5	12.4	12.5	12.3	12.1	11.8
Portugal	14.1	11.2	10.1	11.6	10.7	10.7	10.8	11.0	11.2
France	16.2	13.2	12.6	11.9	11.8	11.5	11.4	11.4	11.1
Denmark	9.2	10.0	9.9	9.9	9.8	9.7	9.9	10.0	10.0
Austria	11.2	10.0	10.4	10.6	10.0	10.1	9.8	9.8	9.8
Germany	11.7	10.5	10.6	10.8	10.8	10.4	10.2	9.9	9.8
Spain	13.7	11.6	10.8	10.7	10.2	9.9	9.7	9.5	9.3
Ireland	7.5	6.7	7.6	7.8	8.1	8.3	8.6	9.2	9.1
Belgium	10.2	10.3	9.9	9.4	9.6	9.6	9.2	9.1	9.0
Greece	8.3	7.3	8.6	8.6	8.5	9.1	9.0	8.8	8.7
Italy	12.4	10.0	9.1	9.0	9.0	8.8	8.6	8.0	8.2
Netherlands	8.4	8.6	8.1	8.2	8.2	7.9	7.9	8.0	8.0
UK	7.1	7.4	7.7	7.4	7.3	7.3	7.5	7.3	7.6
Finland	6.3	6.9	7.7	7.5	7.2	6.8	6.6	6.8	6.7
Sweden	6.4	5.5	5.5	5.5	5.4	5.3	5.4	5.2	4.9

Source: World Drink Trends 1997

Appendix 7⁽¹⁾

1. European Observatory on National Family Policies - A synthesis of National Policies in 1995 and in 1996

TOTAL DIVORCE RATE AND CRUDE DIVORCE RATE, VARIOUS YEARS

Country	Total divorce rate				Crude divorce rate			
	1970	1980	1990	1995	1970	1980	1990	1995
Belgium	0.10	0.21	0.31	0.55	0.7	1.5	2.0	3.5
Denmark	0.25	0.40	0.44	0.41	1.9	2.7	2.7	2.5
Germany	0.17	0.25	0.29	0.33	1.3	1.8	2.0	2.1
Greece	0.05	0.10	0.09	0.17	0.4	0.7	0.6	1.1
Spain	N/A	N/A	0.08	0.12	N/A	N/A	0.6	0.8*
France	0.11	0.22	0.32	0.38	0.8	1.5	1.9	2.0*
Ireland	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Italy	N/A	0.03	0.08	0.08	N/A	0.2	0.5	0.5
Luxembourg	0.10	0.26	0.36	0.33	0.6	1.6	2.0	1.8
Netherlands	0.10	0.25	0.30	0.37	0.8	1.8	1.9	2.2
Austria	0.18	0.26	0.33	0.38	1.4	1.8	2.1	2.3
Portugal		0.08	0.12	0.16	0.1	0.6	0.9	1.2
Finland	0.17	0.28	0.43	0.49	1.3	2.0	2.6	2.7
Sweden	0.23	0.42	0.44	0.52	1.6	2.4	2.3	2.6
UK	0.16§	0.39§	0.42§	0.45§	1.1	2.8	2.9	2.9*

§ Scotland and Northern Ireland are not included.

* Provisional data

BIRTHS OUTSIDE MARRIAGE: VARIOUS YEARS

Live births outside marriage as a % of all live births

Country	1970	1980	1990	1995
Belgium	2.8	4.1	11.6	15.0
Denmark	11.0	33.2	46.4	46.5
Germany	7.2	11.9	15.3	16.1
Greece	1.1	1.5	2.2	3.0
Spain	1.4	3.9	9.6	10.8*
France	6.9	11.4	30.1	37.2*
Ireland	2.7	5.0	14.6	22.7
Italy	2.2	4.3	6.5	8.1*
Luxembourg	4.0	6.0	12.8	13.1
Netherlands	2.1	4.1	11.4	15.5
Austria	12.8	17.8	23.6	27.4
Portugal	7.3	9.2	14.7	18.7
Finland	5.8	13.1	25.2	33.1
Sweden	18.6	39.7	47.0	53.0
UK	8.0	11.5	27.9	33.6

* Provisional data

COUPLE HOUSEHOLDS IN EU COUNTRIES: NUMBER OF CHILDREN UNDER 18

Country	% With 1	% With 2	% With 3	% With 4	% With 5/5+
Belgium	44.9	37.4	13.2	3.4	1.2
Denmark	43.7	43.56	9.9	2.3	0.7
Germany	41.9	42.5	12.0	2.3	1.4
Greece	38.7	49.4	10.0	1.7	0.3
Spain	44.5	43.6	9.7	1.8	0.4
France	41.1	40.2	13.7	4.0	1.0
Ireland	25.0	33.6	25.2	9.8	6.5
Italy	45.0	39.9	11.9	2.6	0.6
Luxembourg	42.9	37.5	17.0	2.3	0.3
Netherlands	29.4	49.1	17.2	3.3	1.1
Austria	-	-	-	-	-
Portugal	50.3	36.4	10.2	2.2	0.9
Finland	-	-	-	-	-
Sweden	-	-	-	-	-
UK	37.3	43.2	14.4	3.3	1.9

- missing data

Appendix 7 continued

DISTRIBUTION OF HOUSEHOLDS BY TYPE

Country	one person	Married couple no children	Cohabiting couple no children	Lone parent with children	Married couple with children	Cohabiting couple with children	Complex1	Other undefined
Belgium	28.1	21.9	3.2	7.1	32.8	2.6	3.6	0.7
Denmark	44.8	18.9	7.5	5.0	17.7	4.8	1.2	0.1
Germany	33.9	23.9	3.2	4.6	28.7	1.1	4.3	0.4
Greece	19.5	21.3	0.6	4.2	39.0	0.1	15.0	0.3
Spain	12.8	17.0	0.8	6.8	47.7	0.9	13.2	0.7
France	28.0	21.8	4.1	6.8	31.0	4.0	3.9	0.4
Ireland	21.7	12.5	0.6	9.6	44.5	0.7	10.4	0.1
Italy ³	22.2	20.5	<0.1	6.4	39.6	0.1	9.7	1.6
Luxembourg	26.0	21.5	4.1	4.6	31.6	1.6	10.4	0.2
Netherlands*	32.5	—	23.4	—	4.7	—	29.7	—
Austria -	-	-	-	-	-	-	-	-
Portugal	13.5	17.7	0.2	7.2	46.5	0.7	13.6	0.5
Finland -	-	-	-	-	-	-	-	-
Sweden -	-	-	-	-	-	-	-	-
UK	27.8	23.1	3.9	7.9	28.4	2.0	6.4	0.6

1 Households with and without children

2 Households with and without children

3 Due to a misinterpretation of the question in Italy, results related to cohabitation are likely to be wrong for this country.

* The question related to cohabitation was not asked in The Netherlands.

- Missing data.

The 'Other' category includes all those not covered by the household types specified including households with children over the age of 18 years. European Observatory on National Family Policies - A synthesis of National Statistics 1995.

LONE PARENT HOUSEHOLDS WITH CHILDREN: NUMBERS OF CHILDREN UNDER 18

Country	% With 1	% With 2	% With 3	% With 4	% With 5/5+
Belgium	57.9	30.6	10.4	0.6	0.5
Denmark	64.8	29.4	4.9	0.9	-
Germany	62.1	30.3	5.1	1.3	1.5
Greece	62.7	36.4	-	-	0.9
Spain	55.7	37.6	4.6	1.0	1.2
France	63.2	25.1	8.7	2.8	0.3
Ireland	40.7	32.0	17.8	5.2	4.4
Italy	65.6	22.9	6.5	2.7	2.3
Luxembourg	68.2	28.6	3.2	-	-
Netherlands	52.4	40.1	6.2	1.3	-
Austria	-	-	-	-	-
Portugal	52.1	37.9	8.7	1.0	0.4
Finland	-	-	-	-	-
Sweden	-	-	-	-	-
UK	50.2	34.5	10.7	3.8	0.7

- missing data

Source: Eurostat - initial results from the European Community Household Panel.

European Observatory on National Family Policies - A synthesis of National Statistics 1995

ESTIMATES OF THE PREVALENCE OF LONE-PARENT FAMILIES FROM VARIOUS SOURCES

Country	Lone parent with children under 16 as % of all families with children under 16 1994	Lone parent families as a % of all families with children	Lone parent families as a % of all families with children 1990/91	Lone parent families with child/ren under 15 as % of all families with children under 15	Lone parent families with child/ren under 6 as % of all families with children under 6	Lone parent families with child/ren under 15 as % of all families with children under 15
				1990/91	1990/91	1990/91
Belgium	13.7	11 (1992)	21	15	15	9
Denmark	18.8	19 (1994)	18	20	14	-
Germany	12.5	19 (1992)	19	15	14	10
Greece	6.7	11 (1991)	11	6	3	3
Spain	7.1	7 (1991)	13	-	-	2
France	13.0	12 (1990)	16	11	8	9
Ireland	17.0	11 (1993)	18	11	9	7
Italy	7.3	6 (1992)	16	-	-	4
Luxembourg	7.8	7 (1992)	19 ¹	12	11	6
Netherlands	10.0	16 (1992)	16	12	11	7
Austria	-	15 (1993)	19	-	13	9
Portugal	8.4	13 (1991)	13	9	6	4
Finland	-	16 (1993)	19 ²	-	10	12
Sweden	-	18 (1990)	18 ²	-	14	-
UK	19.6	21 (1992)	22	19	19	18
Source:	<i>ECHP 1994</i>	<i>Bradshaw et al, 1996a</i>	<i>Eurostat, 1995</i>	<i>EC, 1995b</i>	<i>EC, 1995b</i>	<i>Eurostat, 1996b</i>

1 Only families with children aged under 25 years are included

2 Only families with children under the age of 18 are included

- Missing data

LONE MOTHER AND LONE FATHER FAMILIES AS PERCENTAGE OF ALL FAMILIES WITH CHILDREN

(Most Recent Data)

Country	Lone Mothers (% Of All Families With Children)	Lone Fathers (% Of All Families With Children)	Lone Fathers As % Of Lone Parents	Lone Parents With Children As A % Of Households With Children §
Belgium (1992)	9.7	1.2	12	13.2
Denmark (1990)	16.2	2.4	13	17.7
Germany (1992)	16.0	3.0	16	6.2
Greece (1990/91)	8.7	2.2	25	5.6
Spain (1981*)	4.8	0.7	13	5.8
France (1990)	11.4	1.8	14	12.5
Ireland (1993**)	9.5	1.1	10	12.3
Italy (1991)	5.3	11.0	17	7.5
Luxembourg (1992)	6.0	1.2	17	7.8
Netherlands	13.5	2.4	15	10.7
Austria (1993)	13.4	1.9	12	-
Portugal (1991)	11.3	1.8	14	7.0
Finland (1993)	13.9	1.9	13	-
Sweden (1990)	15.3	2.7	15	-
UK (1991)	19.1	1.8	9	18.7

* Madrid area only

** Excludes all children over 15 years

Source: Bradshaw et al 1996 and §Eurostat, initial results from ECHP

European Observatory on National Family Policies - A synthesis of National Statistics 1995

Appendix 7 continued

HOUSEHOLDS WITH CHILDREN UNDER 16 YEARS ⁽¹⁾: DISTRIBUTED BY HOUSEHOLD TYPE

% of households with children under 16 years

Country	Simple households			Complex and "other / undefined" households	
	Lone parent	Married couple	Cohabiting couple	Lone parent	Other
Belgium	12.8	74.6	8.1	0.9	3.6
Denmark	18.4	57.8	22.2	0.4	1.2
Germany	11.5	79.7	4.4	1.0	3.4
Greece	4.0	76.7	0.5	2.7	16.2
Spain	3.0	77.6	2.3	4.1	13.0
France	11.7	70.4	14.0	1.3	2.6
Ireland	10.0	75.6	1.8	7.0	5.6
Italy ⁽²⁾	4.6	75.7	0.1	2.7	17.0
Luxembourg	5.4	73.6	5.5	2.4	13.2
Netherlands*	9.9	—	85.5	0.1	4.6
Austria	-	-	-	-	-
Portugal	4.6	75.1	1.7	3.8	14.8
Finland	-	-	-	-	-
Sweden	-	-	-	-	-
UK	16.4	68.0	7.4	3.2	5.0

Source: Eurostat, initial results from ECHP

1 Only those households for which relevant information is available are included

2 Due to a misinterpretation of the question in Italy, results related to cohabitation are likely to be wrong for this country.

* The question related to cohabitation was not asked in the Netherlands

- Missing data

CHILDREN ⁽¹⁾ LIVING IN HOUSEHOLDS: DISTRIBUTED BY FAMILY TYPE

% of children living in:

Country	Simple households			Complex and "other / undefined" households	
	Lone parent	Married couple	Cohabiting couple	Lone parent	Other
Belgium	10.7	79.0	6.3	0.5	3.5
Denmark	14.5	63.6	19.9	0.3	1.7
Germany	9.6	82.1	4.1	0.7	3.5
Greece	3.0	79.5	0.4	1.8	15.4
Spain	3.1	80.5	2.0	3.1	11.2
France	9.4	75.1	11.2	1.1	3.2
Ireland	8.7	80.5	1.2	4.9	4.7
Italy ⁽²⁾	4.4	79.3	0.1	1.8	14.5
Luxembourg	4.2	76.0	3.6	1.5	14.7
Netherlands*	8.2	88.2		<0.1	3.5
Austria	-	-	-	-	-
Portugal	5.3	75.4	1.8	3.2	14.3
Finland	-	-	-	-	-
Sweden	-	-	-	-	-
UK	14.7	71.6	5.8	2.4	5.4

Source: Eurostat, initial results from ECHP

1 Children: less than 16 years

2 Due to a misinterpretation of the question in Italy, results related to cohabitation are likely to be wrong for this country.

* The question related to cohabitation was not asked in the Netherlands

- Missing data

The 'Other' category includes all those not covered by the household types specified including households with children over the age of 18 years. European Observatory on National Family Policies - A synthesis of National Statistics 1995

EUROCARE

EUROCARE was formed in 1990 as an alliance of voluntary and non-governmental organisations representing a diversity of views and cultural attitudes and concerned with the impact of the European Union on alcohol policy in Member States. It now has 36 member organisations in 12 member states of the Union and 7 associate member organisations in 6 non-EU countries.

EUROCARE is an acronym for European Council for Alcohol Research Rehabilitation and Education. In 1993 the members agreed that the working title of the organisation should be EUROCARE - Advocacy for the Prevention of Alcohol Related Harm in Europe.

Member organisations are involved in the provision of information to the public; education and training of voluntary and professional community care workers; the provision of workplace and school based programmes; counselling services, residential support and alcohol-free clubs for problem drinkers; and research and advocacy institutes. Some member organisations work in all of these fields, but most are involved in only one or two areas.

The aims of Eurocare:

- Provide a forum for non-governmental European Union organisations and institutions working in the field of alcohol prevention.
- Establish, where possible, common ground and purpose among members of the European Union.
- Provide a regular exchange of information.
- Foster among its members an understanding of social, cultural, economic and political responses to the use of alcohol throughout Europe.
- Facilitate the collection, collation, analysis, dissemination and utilisation of data on alcohol consumption and related harm within the EU and other countries.
- Develop alcohol prevention and rehabilitation strategies and programmes appropriate to the needs of individuals and their environment.
- Stimulate a wide range of alcohol education and training programmes for special target areas such as the workplace, schools and social and health care organisations.
- Seek co-operation with appropriate international agencies.

COFACE

Set up in 1958 as a European Action Committee within the International Union of Family Organisations (IUFO), COFACE gradually acquired its autonomy. In 1979 it became a non-profit making international association under the name of Confederation of Family Organisations in the European Community.

COFACE is a non-political and non-denominational organisation made up of national family organisations of either a general or specific nature. COFACE now has 75 member organisations in fourteen Member States of the European Union. This represents several million parents and children.

COFACE is open to all national organisations representing families or active on family issues.

COFACE's aims:

- Numerous decisions taken at European level directly affect families, ie in the economic and social fields, consumer affairs, the environment, education, housing and health care, rural development etc.
- The impact of Community policies on families is such that there is a need for the shaping of a European family policy. Such a policy can be defined as the family dimension to be incorporated into the economic, social and cultural policies drawn up at European level.
- With a view to promoting such a policy, COFACE works in three complementary directions:
 - as a spokesperson for family organisations, it liaises with the European authorities in all sectors relating to the rights and interests of families;
 - it informs national organisations of developments in the European Union, and encourages greater awareness of the Community dimension;
 - it organises exchanges of ideas and experiences as well as mutual aid between family organisations in different countries.
- COFACE's action has contributed to the development of Community policy in areas such as the promotion of consumer interests, social protection, the fight against social exclusion, programmes promoting the integration of disabled persons, and the promotion of health and education. Family policy is therefore progressively being given a place in the field of European initiatives. COFACE is committed to furthering this.

COFACE works on behalf of families in a Union which it would like to see at the service of its citizens.

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