

# Silent Voices

Supporting children and young people affected by parental alcohol misuse

September 2012



Championing Children and Young People in England

cRc

COMMUNITY RESEARCH COMPANY



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How i cope



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## Foreword

The misuse of alcohol by parents negatively affects the lives and harms the wellbeing of more children than does the misuse of illegal drugs. Yet too often, parental alcohol misuse is not taken as seriously, in spite of alcohol being addictive, easier to obtain, and legal. The effects of parents' alcohol misuse on children may be hidden for years, whilst children try both to cope with the impact on them, and manage the consequences for their families.

We are publishing this review to draw attention to what children say about the problem. It does not concern only child protection professionals, though alcohol abuse can put children's safety at sustained, serious risk. The problem affects large numbers of children who never come to the notice of children's social care. They should not need to do so if there are services to support them and their families at an earlier stage. There are powerful messages from children in this report which must be heard, and acted on. We are grateful to the children and young people who shared their experiences with us.

My recommendations are for policy makers and all those who commission and provide local services. The impact of parental alcohol misuse is a problem which must be addressed by health professionals, those in social care, treatment services, and others in the child's life. It requires a coordinated, collaborative approach. It is a problem with which parents must seek help, and one we all need to address. The children speaking in this report tell us our casual attitude to the harmful potential of drinking too much must change. If we act on what they say, we might prevent some children from losing their childhoods.

Jenny Clifton, Principal Policy Advisor (Safeguarding) at the Office of the Children's Commissioner (OCC), has steered this review to its conclusion. I am indebted to her, and to the researchers, for this insightful piece of work.



Dr. Maggie Atkinson  
**Children's Commissioner for England**

## **Community Research Company (CRC UK)**

The Community Research Company (CRC UK) provides evidence for change through research, evaluation and engagement. We are an innovative company specialising in service user led research and development. We offer individuals, groups and organisations training, support and insight to make a difference across all sectors, for all ages, public, private and third sector.

Jon Adamson worked as a researcher in local government for around ten years and subsequently for the National Youth Agency before co-founding CRC UK with Graham Fletcher in 2011. Graham is a qualified and experienced social worker and teacher with extensive experience in the management and strategic development of community services, criminal justice, youth offending and children, schools and family services.

CRC UK has a strong, proven track record in training and supporting young people to become researchers. We maintain an active network of associates including young researchers who contributed to this review.

## **Lorna Templeton**

Lorna Templeton is a senior social sciences researcher with over 15 years of experience. Her area of expertise is addiction and the family. Having worked previously for the National Addiction Centre in London and the Bath Mental Health Research and Development Unit (Avon & Wiltshire Partnership Mental Health NHS Trust and the University of Bath), Lorna has worked since 2010 as an Independent Research Consultant. Lorna has published several co-authored book chapters and authored/co-authored over 30 academic peer review articles. She is a Trustee of Adfam, the national umbrella organisation for families affected by alcohol and drug use, and a member of Alcohol Research UK's Grants Advisory Panel.

## **ABOUT THE OFFICE OF THE CHILDREN'S COMMISSIONER**

The Office of the Children's Commissioner is a national organisation led by the Children's Commissioner for England, Dr Maggie Atkinson. The post of Children's Commissioner for England was established by the Children Act 2004. The United Nations Convention on the Rights of the Child (UNCRC) underpins and frames all of our work.

The Children's Commissioner has a duty to promote the views and interests of all children in England, in particular those whose voices are least likely to be heard, to the people who make decisions about their lives. She also has a duty to speak on behalf of all children in the UK on non-devolved issues which include immigration, for the whole of the UK, and youth justice, for England and Wales. One of the Children's Commissioner's key functions is encouraging organisations that provide services for children always to operate from the child's perspective.

Under the Children Act 2004 the Children's Commissioner is required both to publish what she finds from talking and listening to children and young people, and to draw national policymakers' and agencies' attention to the particular circumstances of a child or small group of children which should inform both policy and practice.

As the Office of the Children's Commissioner, it is our statutory duty to highlight where we believe vulnerable children are not being treated appropriately and in line with duties established under international and domestic legislation.

### **OUR VISION**

Children and young people will be actively involved in shaping all decisions that affect their lives, are supported to achieve their full potential through the provision of appropriate services, and will live in homes and communities where their rights are respected and they are loved, safe and enjoy life.

### **OUR MISSION**

We will use our powers and independence to ensure that the views of children and young people are routinely asked for, listened to and that outcomes for children improve over time. We will do this in partnership with others, by bringing children and young people into the heart of the decision-making process to increase understanding of their best interests.

## Acknowledgements

We would like to thank the following individuals and organisations for their contributions to this review:

- Jenny Clifton: Principal Policy Advisor (Safeguarding), Office of the Children’s Commissioner.
- Cinzia Altobelli: Head of Therapeutic Services at Families Plus and Lead Practitioner for the M-PACT (Moving Parents and Children Together) Programme at Action on Addiction.
- Vivienne Evans OBE (Chief Executive) and Joss Smith (Director of Policy and Regional Development): from Adfam, the national umbrella organisation for families affected by alcohol and drug use.
- Professor Donald Forrester: the Tilda Goldberg Centre of Social Work and Social Care at the University of Bedfordshire.
- Sarah Hargreaves: Head of Division, Youth & Community, De Montfort University.
- Professor Judith Harwin: Centre for Child and Youth Research, Brunel University.
- Joanna Manning: Programme Manager, The Children’s Society in Nottingham
- Wendy Robinson: a leading practitioner, trainer and supervisor in the field of children and families, substance misuse and resilience.
- Emma Spiegler: Director of COAP – Children of Addicted Parents and People.
- Alex Stutz: Head of Policy, The National Youth Agency.
- Emma Pawson: National Families and Young People Manager, NTA.

We would also like to thank colleagues at WAM (particularly Nicola Crisp) and Nacoa (particularly Hilary Henriques and Cassie Ohlson) for their support and assistance with the consultation phase of this project. Also thanks to all the young people who participated in a focus group and shared their experiences and views so openly and honestly. The title of the report and many of the drawings in the text were given by the children and young people involved.

## Summary of the Key Findings and Recommendations from this Review

This is a Rapid Evidence Assessment (RAE) of the needs and experiences of children and young people<sup>1</sup> where there is *parental alcohol misuse* (PAM). The review considers the following six research questions:

1. What is known about the experiences of children and families where there is PAM and to what extent is this informed by the views of children and young people themselves?
2. What are the key wider issues associated with PAM (e.g. unemployment, domestic abuse, mental health) and how do they relate to risk/protective factors for children and families?
3. What is known about protective factors and processes in this population and how they can minimise risk/negative outcomes?
4. What is known about services, and their delivery, and the impact/benefit of such services for children (and families) where there is PAM and to what extent is this informed by the views of children and young people themselves?
5. What is the current policy context for children and families where there is PAM and how might it be improved?
6. Thinking about questions 1 to 5 above, what are the gaps in our knowledge about children affected by PAM, and services for these children?

The review is primarily led by what we know from children's direct input to research and policy development. The report focuses on publications covering England but also draws on work from elsewhere where it adds to our knowledge and is particularly pertinent to this review. Similarly, the emphasis is very much on parental alcohol misuse, but some studies and information from the wider field of substance misuse is also included. A number of key messages emerge for each of the six research questions:

### 1. Children's Experiences

1. The size of the problem - the number of children who are affected by/living with parental alcohol misuse - is largely unknown. However, estimates suggest parental alcohol misuse is far more prevalent than parental drug misuse and there is a need for greater emphasis on parental alcohol misuse as distinct from other substance misuse. There are no England/UK data on how many children are affected by FASD (foetal alcohol spectrum disorder).
2. There is a very broad range of experiences to describe how children are affected by parental alcohol misuse. The children's voice in describing their experiences is quite a strong feature in a lot of the research which has been done.
3. There is a gap in research which has explored the experiences and needs of specific groups of children affected by parental alcohol misuse. This includes: young carers, children from Black, Asian and Minority Ethnic (BAME) groups, children who experience a substance misuse related bereaved, children of prisoners, children who are cared for by others (such as grandparent or other kin carers, foster carers or adoptive families), children with FASD, and the young homeless.
4. Children draw upon a range of personal and other resources to cope and this changes over time. However, coping does not equal resilience and a greater understanding of coping in this population would be helpful.

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<sup>1</sup> For reasons of brevity the term 'children' will be used as a generic term throughout this report to refer to 'children and young people' and 'adolescents'.



5. Different levels of consumption (not just parents who are dependent drinkers) and particular styles of drinking (such as binge drinking) may affect children and it cannot be assumed that higher levels of consumption equates to greater harm. Similarly, the impact of lower levels than would incur intervention but which can still be harmful, is not well understood. Linked to this, a large number of parents will naturally reduce or cease problematic drinking but for some children problems may remain. Little research has been carried out in these areas.
6. There is a lot of overlap with research which has considered how children are affected by parental drug misuse. However, some research has suggested that there are some unique features of living with parental alcohol misuse and, given the dearth of alcohol specific research in England; this is an issue which warrants further investigation.
7. Children living with parental alcohol misuse come to the attention of services later than children living with parental drug misuse. Boys are less likely than girls to seek help and are more likely to come to the attention of services with regards to their presenting behaviour, for example through Youth Offending Services, than for the harm they are experiencing.

## **2. Wider issues**

8. Parental alcohol/substance misuse is strongly correlated with family conflict, and with domestic violence and abuse. This poses a risk to children of immediate significant harm and of longer-term negative consequences, which is magnified where both issues co-exist. However, there is a need for further research with children in these situations, and for a greater understanding of the role of gender where such issues co-exist.
9. There is clearly a complex inter-relationship with other wider issues where parental alcohol misuse exists. Some evidence suggests that parents felt that substance misuse problems were viewed in isolation and that other problems were inadequately managed.
10. It seems that children recognise the links between parental drinking and the presence of conflict, violence and abuse. However, young people did not necessarily see a link between alcohol (or drug) treatment and improvements in relationships. There is a need for further research to explore children's understanding of these issues and the relationship between them.
11. Parental substance misuse features prominently on the caseloads of social workers, although there is a need to understand why cases involving parental alcohol misuse seem to come to attention later and often follow a different pathway through social care. Moreover, there is a need to understand the experiences and needs of children who come to the attention of social care, but who are classed as 'in need' rather than 'at risk', as this is an area where much less work has been undertaken.
12. There is a lack of pre- and post-qualification training for social workers around substance misuse issues. The challenges faced by social workers with regards to alcohol and violence may be linked to their understanding about alcohol, associated decision making processes and underestimating the risk to children where alcohol is present.

## **3. Protective factors and processes**

13. There is a need to continue research to enhance our understanding of protective factors and processes, and their evidence of resilience, for children living with or affected by parental alcohol misuse.
14. There is a need for more longitudinal research to understand how protective factors and processes operate, and change, over time, and what this means in terms of understanding resilience.
15. Coping is not necessarily equated with healthy or positive outcomes, and therefore with resilience. Furthermore, a protective factor or process may not always be entirely positive as

it may mask other harms or be less helpful in the longer-term. There is a need for greater understanding of these issues.

16. There are some interesting findings from the research about the role of gender (both of the parent with the substance misuse problem and of the child) in understanding how children may experience and be affected by parental alcohol misuse; this is a complex issue and one which warrants further investigation.

#### **4. Services**

17. There is no clear picture of the number and range of services available to children (and families) affected by parental alcohol misuse.
18. The number of services, and evaluations of some of these, is growing. There is evidence of a range of ways in which children, parents and families seem to benefit from services and interventions. However, there is a need for research to consider the potential longer-term benefits of such support, to include comparison with control groups, and to assess cost-effectiveness.
19. It is unclear whether the potential benefits of services are driven by a particular model or intervention, or if it is the characteristics of the support, and the relationships between children, families and workers which guide change.
20. Interventions which operate with strengths based frameworks appear to be beneficial in engaging families and facilitating change. Some research has indicated the potential for the transferability of interventions developed for adults to younger populations (for example, Motivational Interviewing and the 5-Step Method).
21. Some services have demonstrated success in working with both hard to engage families and families who were previously unknown to services. However, families already known to a range of public services tend to dominate caseloads and a greater focus is needed to reach those children and families who are not already known to services.
22. Services need to be flexible in a range of ways – for example, not be time-limited, work in a range of (creative) ways, be prepared to offer support in the longer term, offer a range of things to children and families, and consider how to support children and families separately as well as working with family units.
23. The links between universal/specialist services, adult/children & family services and alcohol/drug treatment services are crucial. There are a number of benefits to partnership working, and some examples where this has been successful are linked to joint commissioning and planning, training, forums to bring practitioners together, jointly developed tools and policies and the lead professional role.
24. Workforce development is a critical issue, with particular emphasis needed on training social workers, schools and universal services (such as primary care, education and generic youth services).
25. Easy routes to accessing services, such as free and confidential helplines, are an important part of the support which this group of children need.
26. It can be very hard for children to talk about parental alcohol misuse; however, children have told us some of what they need in order to get help. Children want a patient, empathetic and sensitive approach, based on trust, in which someone who is helpful, caring and encouraging recognises their circumstances and takes the time to get to know them.
27. Services for children experiencing parental alcohol misuse need to extend beyond childhood and support young adults, many of whom need additional support with issues after parent(s) are receiving treatment and after they have left the family home.

## **5. Policy context**

28. Over the last 10 to 15 years there have been improvements in policy in terms of recognising and attempting to respond to children affected by parental substance misuse in the UK. Despite this, there remain major limitations to the progress made in respect to alcohol.
29. Addressing the lack of prevalence data in this area may serve to give greater policy recognition to the issue of parental alcohol misuse.
30. The current family-focused agenda does not address parental alcohol misuse at a strategic level. There is a lack of alcohol specific focus. Similarly, there is less recognition, and response, to alcohol misuse, compared to drugs misuse. The need for a campaign similar to Hidden Harm for alcohol has been championed before – by agencies including Turning Point, The Children’s Society and Alcohol concern – and may be beneficial.
31. The emphasis within policy on children at risk, and on the most vulnerable or ‘troubled’ families is welcomed. However, the number of children who can be affected by parental alcohol misuse is likely to be a far greater group and policy must achieve a finer balance to also consider the needs of all children who can be affected by parental alcohol misuse, many of whom will be ‘in need’.
32. Harms associated with parental alcohol misuse are not necessarily correlated with the level of alcohol consumption. Policy must ensure that it does not take a narrow focus on parents who are dependent drinkers, but that it considers how to best support all children who may be affected by a range of patterns of parental alcohol consumption, including dependent drinking but also, for example, binge or harmful drinking.
33. Parental alcohol misuse often co-exists with a range of other problems. For example, children may be more adversely affected by family disharmony, conflict and violence but children make very clear links between this and parental drinking. Greater integration of different areas of policy, to consider the issue of parental alcohol misuse and the development of a more consistent response across policy, is needed.
34. Policy has focused largely on young children; however, for many growing up with parental alcohol misuse problems may continue into their young adult life. Policy development needs to take a broad enough scope to encompass this.
35. In an ever changing climate it is unclear which Government department should take the lead with this issue, how Government departments should work together to develop the best response, or which areas of policy should be targeted in order to give the issue of parental alcohol misuse greater policy attention.

## **Recommendations from the Children's Commissioner:**

### **1. Policy recommendation**

That Government and local policy makers give as much attention to alcohol misuse as to drug misuse within policy programmes on parental substance misuse, focus alcohol policies on children and families and not just on health and crime issues, and address the problem of parental alcohol misuse directly through family and related policy programmes.

This will be demonstrated by the following:

- a. Policies and strategies at all levels focus more strongly on the wide group of children in need of support as a result of parental alcohol misuse and not only on those in need of protection.
- b. Policies and strategies take into account the impact on children who may be affected by a range of levels of parental alcohol consumption and not just dependent drinkers.
- c. In the development of policies and strategies at local and national level, the links between parental alcohol misuse and domestic violence are taken into account.
- d. Local Safeguarding Children's Boards and newly developing Health and Wellbeing Boards ensure that the issue of parental alcohol misuse is well understood in their local area and that the needs of children and families are addressed in planning and commissioning services, utilising the Joint Strategic Needs Assessment.

### **2. Practice recommendations**

We look to the Government to encourage local service commissioners and providers, including those in health, social care and other related services, to seek to find ways of improving the delivery of services on the basis of the findings of this report. This would include addressing the following:

- a. All those involved in working with children are vigilant about problems related to parental alcohol misuse and try to understand what may lie behind troublesome and apparent coping behaviour so that children may feel more encouraged to seek help and their needs are identified.
- b. All local areas seek to develop and build on existing effective approaches to inter-agency and partnership work and find ways to reach those children and young people not known to services.
- c. Services to children, both directly and together with their families, be increased and include earlier intervention and outreach, drawing on the research into effective approaches. Services should engage with children from the outset in order to respect their views and respond to their needs and should combine practical and emotional support.
- d. Relevant training for all professionals who engage with children is made available, both as part of basic professional training and of ongoing learning.

### **3. Research recommendations**

That there is follow up of the following areas in particular, together with the greater involvement of children and young people in research, service development and evaluation:

- a. Children's experience: the specific impact of parental alcohol misuse as distinct from other substance misuse; the impact on groups of children about whom little is known; the impact of different levels and patterns of consumption of alcohol by their families; how children are affected by a combination of parental alcohol misuse and domestic violence.
- b. Protective factors and resilience: longitudinal research which looks into how protective factors and processes operate over time.
- c. Meeting needs: further evaluative research into how services can benefit children and families; studies into how the response of universal services might be improved.

## Section One: Background

### Parental alcohol misuse: an emerging issue of concern

“I wish someone would tell *my* mum the impact it’s having on her family”  
(girl aged 12, supported by WAM project, Nottinghamshire)

“...it seems fair to suggest that as adults we have not yet created an environment that encourages children to talk openly to us about things that really bother them.....when we don’t listen to children it is not only that we fail to take on board information, feelings or experiences that the child wishes to communicate, but also that our lack of attention impacts on that child’s sense of self-worth, their ability to trust, their sense of safety, their connection to themselves and their connection to reality, and leaves children more vulnerable to abuse and neglect” (Robinson, 2008 p14-15)

“....gaining access to and communication with children [is] frustrating due to loyalty, secrecy and denial....children often revealed the impact on their lives much later, usually once they were no longer in the middle of the situation and when issues of safety and loyalty were not so critical.....actual communication with children, then, was seen to be difficult....” (Taylor & Kroll, 2004 p1126-1127)

Despite the interest given elsewhere, particularly in the United States through the ‘children of alcoholics’ movement, it is only relatively recently that England and the rest of the United Kingdom has given increased attention to parental alcohol misuse, both the devastating impact that this can have on children and the remarkable resilience which many children display in the face of such adversity. Box 1 summarises some of the published statistics in relation to this problem in England and the wider United Kingdom, a problem which has been identified as a public health, a social and a children’s rights issue. However, progress in this area in England (and the UK) remains very much a ‘work in progress’, with many arguing that far more work is needed, from research, practice and policy, and that parental alcohol misuse urgently needs equal, if not greater, attention than that which is given to parental drug misuse.

Hence, the starting point for this review is the recognition of the greater and specific attention that parental alcohol misuse demands. Moreover, coming from the Office of the Children’s Commissioner for England, a main driver for the review is the need for such a piece of work to be centred on the children themselves, something which also until relatively recently has been largely neglected in this field.

**Box 1: Some statistics about alcohol misuse, parental alcohol misuse and the impact on children & young people**

- It is estimated that over 1.5 million people in England and Wales are alcohol dependent (DoH, 2010 in Turning Point, 2011).
- Over one million hospital admissions are alcohol related (NHS Information Centre, 2011 in Turning Point, 2011) and there were 8,790 alcohol-related deaths in the UK in 2010 (ONS, 2012).
- It is estimated that 30% of children live with an adult binge drinker, 22% with a hazardous drinker and 2.5% with a harmful drinker (UK, under 16 years - Manning et al., 2009).
- It is estimated that 79,291 babies under 1 year old in England live with a parent who is a problem drinker (Cuthbert et al., 2011).
- A study in Ireland found that almost one-in-ten children (9%) reported that “their parents’ alcohol use affects them hugely in a negative way” (ISPCC, 2010 p7).
- Nearly half of the adults who used Turning Point’s alcohol treatment services (5,326 of 12,248) were parents – 83% of whom worried that their drinking had affected their children (Turning Point, 2011).
- A study of nearly 300 social work cases going for long-term allocation across three London Boroughs found that there were concerns about parental substance misuse in 100 (a third) of the families (involving 186 children), and that violence was also present in about two thirds of the cases (Forrester & Harwin, 2006).
- In a study of 338 social work files from six English Local Authorities, domestic violence featured in 60% of the referrals, parental substance misuse in just over half (52%) of cases, and both issues were present in a fifth (20%) of cases (Cleaver et al., 2007)
- It is estimated that 2% of children (UK, under 16 years) lived with an adult binge drinker who also had ‘concomitant psychological behaviour’ (Manning et al., 2009).
- Over three quarters (78%) of young offenders who also misused alcohol had a history of parental substance misuse (or domestic abuse) in their family (Delargy et al., 2010).
- Evidence of parental substance misuse in 57% of serious case reviews (DCSF, 2008 in Turning Point, 2011) and of parental alcohol misuse in 22% of serious case reviews (Brandon et al., 2010).
- Census 2001 identified 175,000 young carers, although it is not known how many young carers are affected by parental alcohol/substance misuse.
- Between 1999-2009 nearly 40,000 children calling ChildLine raised the issue of parental (or other significant person) drinking (Wales et al., 2009 in Hill, 2011).
- ChildLine (April 2008-March2009): 4,028 children were concerned about parental alcohol misuse (21% of all callers) – 71% were girls, 60% aged 12-15 years and 20% aged 5-11 years (Mariathasan & Hutchinson, 2010).
- In 2011 there were 4,530 calls to the National Association for Children of Alcoholics (Nacoa) helpline. In addition the organisation received nearly 1,000 e-mails and over 75,000 hits to its website (Ohlson, 2011).
- 80% of adults think that parental drinking is a serious problem for children in the UK and 84% of adults agreed that parental drinking is as harmful to children as parental drug use (Delargy et al., 2010)

## Policy context

*“...any service development should aim to work with children and young people and not just for them. At the same time, children often do feel vulnerable and powerless, so adults have a responsibility to intervene. In terms of children’s rights.....children are entitled to provision, protection and participation” (Hill, Laybourn & Brown, 1996p165)*

Policy in England in this area has been largely driven by two overlapping areas of policy – drugs policy, and the children and families agenda. The major catalyst for change came in 2003 with the publication of the Advisory Council on the Misuse of Drugs report *Hidden Harm: Responding to the needs of children of problem drug users* (ACMD, 2003) and a subsequent progress report (ACMD, 2007) which noted that, for England, the Government had accepted 42 of the 48 recommendations made in the original report. Coupled with a growing focus from successive Governments on families over the same period (*Every Child Matters*, *Think Family*, *Respect*, and *Troubled Families*) the last ten years have seen substantial progress in recognising and supporting children affected by parental substance misuse. However, there are three major limitations to the progress which has been made.

First, there has been a greater focus placed on children who are at risk, particularly those known to child care services or who are the target of the Government’s family agenda (the 120,000 so-called ‘troubled families’ targeted by a new ‘payment-by-results’ fund of £448million over three years<sup>2</sup>). Attention has also been placed on learning from serious case reviews, including those which have received significant media attention (Brandon et al., 2011; Munro, 2011). This has meant that there has been less progress made in identifying and supporting the larger numbers of children defined as ‘in need’ and who are often not known to, or engaged with, services. Further, from a research and a children’s rights perspective, the voice of children experiencing parental alcohol misuse – in research and in policy development – tends to be the voice of those already receiving services, with the vast ‘hidden’ majority of children experiencing parental alcohol misuse still without a voice. Second, despite its greater prevalence, far less attention has been given to parental alcohol misuse, an issue that has often been subsumed within the wider drugs agenda. Despite a recommendation in the *Hidden Harm* progress report (ACMD, 2007) that children affected by parental alcohol misuse needed to be given specific attention, there has as yet been no *Hidden Harm* equivalent for alcohol (Hill, 2011). Third, given the common co-existence of alcohol with other problems such as domestic violence or mental health problems, opportunities have been missed for different areas of policy to work together to consider the best integrated response to children (and families) where there is parental alcohol (or drug) misuse.

Also of relevance to this review is the policy context underpinning the participation of children and young people in research – not just as subjects of research or recipients of services – which is enshrined in The United Nations Convention on the Rights of the Child (UNCRC). The UNCRC is an international agreement that protects the human rights of children under the age of 18. The UNCRC was ratified by the UN General Assembly in 1989 and the UK agreed to uphold all the rights listed in the Convention on the 16th December 1991. The following articles of the UNCRC are of particular importance for children’s participation in work around parental alcohol misuse:

- **Article 13** gives children and young people the right to receive and give information through speaking, writing, printing, art or any other form.
- **Article 17** gives children and young people the right to information, especially information that helps build social, spiritual and moral well-being, and physical and mental health.
- **Article 12** gives every child and young person the right to express and have their views given due weight in everything that affects them.
- **Article 33** pertains to children’s rights to protection from the use of narcotic and psychotropic drugs.

This provides some of the important legislative context in which children’s participation is embedded. In practice, children know their own needs best and are best placed to prioritise what is important to them. Programmes which effectively secure children’s genuine participation will lead to meaningful,

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<sup>2</sup>Announced by Communities & Local Government on 28<sup>th</sup> March 2012 ‘*Troubled Families: Top 10 areas are on board as Government is ready to go*’ <http://www.communities.gov.uk/news/newsroom/2118082> accessed March 2012.

informed, and evidence-based contributions that can help to influence and shape policy development and implementation. As summarised by UNICEF, (youth) participation:

- Leads to better decisions and better outcomes,
- Is an integral part of a democratic society,
- Strengthens young people's understanding of human rights and democracy,
- Promotes social integration and cohesion in society, and
- Encourages more young people to participate, by example.<sup>3</sup>

Considering these fundamental children's rights Olszewski et al. state that,

*"Research that focuses on the meanings and perceptions of drug and alcohol use from the perspective of children whose lives are in some ways exposed to these substances offers a way to understand their needs and to plan appropriate interventions" (Olszewski et al., 2010 p3)*

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<sup>3</sup> UNICEF Children & Young People: Participating in Decision-Making. A Call for Action  
[http://www.unicef.org/violencestudy/pdf/call\\_action.pdf](http://www.unicef.org/violencestudy/pdf/call_action.pdf)



## Section Two: Methodology

This review was completed by two lead researchers supported by a third person providing an overall steering role and responsible for quality assurance and the project delivery. The work was also supported by young researchers who had previously been trained and supported in research methods by CRC UK.

This review was conducted following a Rapid Evidence Assessment (REA) approach to synthesising current policy and research relevant to parental alcohol misuse. The REA approach involves the same level of rigour employed when searching, assessing and encapsulating relevant research and policy papers for a large systematic literature review. However, by agreeing sharply focused search parameters and limiting the searches and databases used, the process can be accelerated to deliver robust results within a more limited time/resource framework than might otherwise be achieved through the full systematic procedure. For this reason, the REA was the most appropriate methodology to achieve a good level of detail around research and policy development in recent years within a timescale of a couple of months.

Government Guidance (Civil Service) describes the REA as:

*A quick overview of existing research on a (constrained) topic and a synthesis of the evidence provided by these studies to answer the REA question....[to] provide a balanced assessment of what is already known about a policy or practice issue, by using systematic review methods to search and critically appraise existing research.*<sup>4</sup>

The primary difference between a full systematic literature review and a REA is that some limitations are put in place to limit the size of the review by narrowing or focusing down on some of the key search parameters. The key to ensuring a REA meets the aims and objectives of a review is clarity of focus and a shared understanding of the process. Davies (2003)<sup>5</sup> outlines the REA as a process of collating descriptive outlines of the available evidence on a topic, appraising that evidence, sifting out studies of poor quality and ultimately providing an overview of what the evidence is saying, plus a discussion of the identified gaps.

Using this as a starting point, Berry et al. (2011)<sup>6</sup> highlight that,

*The key to any REA therefore is: clarity regarding the subject matter and the aims of the work; a tightly structured approach to the selection of suitable data sources; the searching process (including well defined search criteria); and a clear and simple assessment process. In broad terms, the REA comprises four broad stages, namely:*

1. *Identification of the research question and agreement of definitions;*
2. *Search and selection process;*
3. *Quality assessment; and,*
4. *Synthesis of the findings from the selected papers.*

### Statement on quality assurance

This review draws on a broad range of over 150 relevant sources of literature. A time-scale of two months was set to complete this review and a Rapid Evidence Assessment was chosen as the most appropriate approach to take. By design and for reasons of expediency, this involved making some concessions around the scope of the review and the level of quality assurance undertaken. Thus, quality assurance of literature was not undertaken in fine detail but important information on the

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<sup>4</sup> More information is available from the Civil Service website, which can be accessed here:

<http://www.civilservice.gov.uk/networks/qsr/resources-and-guidance/rapid-evidence-assessment/what-is> accessed March 2012

<sup>5</sup> Davies, P. (2003) *The Magenta Book. Guidance Notes for Policy Evaluation and Analysis. Chapter 2: What Do We Already Know?* London: Cabinet Office.

<sup>6</sup> Home Office Research Report 52 (2011) *The effectiveness of partnership working in a crime and disorder context. A rapid evidence assessment.* Geoff Berry, Peter Briggs, Rosie Erol and Lauren van Staden. © Crown copyright 2011, page 3

sample and methodology is included for key references and highlighted where relevant throughout the report.

## Stages of the review

Looking at each of the four stages in turn, the successful completion of this review required setting out a common, shared understanding and an agreed, clear framework for the REA. This was achieved in consultation between the Project Team, lead OCC staff and an 'Expert Group' convened specifically for this review.

The four stages of the review are broken down as follows:

### **1. Identification of the research question and agreement of definitions**

As highlighted in the project brief, much of the research, policy agenda and service provision appear to address problems arising from both drug and alcohol misuse by parents.

This was an important aspect for consideration at the outset and throughout the project. Maintaining the focus on alcohol use (rather than a broader focus on all substance misuse) and the experience of, and needs of, children and young people were defining aspects of this review. Agreement of the research questions and relevant definitions was achieved through an initial project set-up meeting with the Office for the Children's Commissioner and, subsequently, through consultation with the 'Expert Group'. The Expert Group for this review was recruited through the existing network of contacts in this subject area held by the researchers and the Office of the Children's Commissioner. The Expert Group was consulted by email on the draft search strategy for this review and several responses were made which resulted in changes and further clarification of the search strategy (see Appendix 1). Table A summarises the scope of the review:

Table A: Scope of the review

Included in the review:	Outside of the scope of this review:
Focus on parental alcohol misuse and, where there would otherwise be a gap, reports covering alcohol misuse in the broader context of substance misuse.	References focusing only on illegal or prescription drug misuse by parents were not included.
The primary focus is on sources of information which include the direct voice of children and young people.	This review has a fairly narrow focus in terms of the policy agenda with a strong emphasis on parental alcohol misuse only.
The age range of children which the review will consider is 4 or 5 years (the lower limit of school age) to 18 years (the definition of a child as stated by the UN Convention on the Rights of the Child).	This review did not actively search for and review work relating to pregnancy and the periods around birth and immediately beyond or for work involving young adults aged 18 years or over.
Only English language literature has been included. Searching and review focused on published academic research, plus policy documents and evaluations from England.	Publications from outside England were not the main focus of the report but have been included where they met other criteria and provided something new. These were identified through the knowledge of the authors and expert group and through reference harvesting.
Consideration was given to issues relating to parents, the wider family and other wider issues (e.g. domestic abuse, mental health) in so far as they are identified within the review, which has its primary focus on children.	The literature around wider family issues – e.g. the current UK Government agenda on Troubled Families – was not explicitly searched and reviewed. Prevention literature is not included within the scope of this review.  Children's own substance misuse was not a key search criterion but is referenced where relevant.
Publications from the last ten years are included (2001 to early 2012).	Publications earlier than 2001 were not searched and reviewed but some references to publications earlier than this may be included where relevant.

The Expert Group met in March 2012 to discuss the overall scope and direction of the review, following which the six research questions were finalised:

1. What is known about the experiences of children and families where there is PAM and to what extent is this informed by the views of children and young people themselves?
2. What are the key wider issues associated with PAM (e.g. unemployment, domestic abuse, mental health) and how do they relate to risk/protective factors for children and families?
3. What is known about protective factors and processes in this population and how they can minimise risk/negative outcomes?
4. What is known about services, and their delivery, and the impact/benefit of such services for children (and families) where there is PAM and to what extent is this informed by the views of children and young people themselves?
5. What is the current policy context for children and families where there is PAM and how might it be improved?
6. Thinking about questions 1 to 5 above, what are the gaps in our knowledge about children affected by PAM, and services for these children?

A second meeting of the Expert Group was held in May 2012 to discuss the draft final report, key messages, conclusions and recommendations and the next steps for key stakeholders in the review.

## **2. Search and selection process**

Literature from UK sources from 2001 to 2011 were comprehensively searched for relevant articles, including published and 'grey' literature with the bulk of the searching focused on major electronic databases. A range of academic databases were searched along with other online resources – such as organisational databases like Adfam and the Childline NSPCC – plus ad-hoc access through reference harvesting and personal contacts in the field (the latter including some unpublished materials – see Appendix 1).

Searches for published service reviews, evaluations and other 'grey literature' were also conducted through Google searches. A blog post and forum theme were added to the Local Government Association Knowledge Hub<sup>7</sup> seeking examples of service delivery and evaluation from Local Authorities around the country.

Initial references were screened with duplicates and clearly irrelevant articles removed. The remaining references were reviewed in relation to the six research questions (as outlined above). Abstracts were reviewed for all references and whole articles, chapters and reports were accessed for the most relevant articles. Access to articles was obtained online and, where necessary, using the academic resources available through the library of De Montfort University.

It is likely that some references (published and unpublished) have been missed. Nevertheless, the authors believe that the work which has been identified and reviewed here, including the consideration of work from elsewhere in the United Kingdom and selective work from further afield, is highly representative of research in this field. It should also be noted that the library of research which is reviewed here could be considered very large for a rapid evidence assessment.

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<sup>7</sup> The Knowledge Hub forms part of the new integrated online offer from the Local Government Association (LGA) and provides tools to help people connect, share and learn from each other. The Knowledge Hub replaces the 'Communities of Practice or CoPs' which were closed in March 2012 with individual CoPs – e.g. 'child poverty' – migrated to the new system. For more inform see: <https://knowledgehub.local.gov.uk/> accessed March 2012.

### 3. Quality assessment

The Quality Assessment of the review was undertaken through an agreed process whereby relevant research papers are reviewed against a list of key criteria (as described in the previous section and, in more detail, in Appendix 1). The following different levels were identified for the documents reviewed:

- Level 1 – Based in England where children & young people have been directly involved.
- Level 2 – UK non-England, England/UK pre-2000 and international – where children & young people have been directly involved.
- Level 3 – Children young people’s needs and experience from other perspectives (e.g. parents, social workers, case-files, grandparents) (primarily England).
- Level 4 – Issues related to service delivery, practice and policy (primarily England).
- Level 5 – Consideration of wider issues.

Over 150 references have been included in this review.

### 4. Synthesis of the findings from the selected papers

The references generated through searching were reordered into tables which corresponded to the levels outlined above. Reading, quality assessment and subsequent synthesis of findings was divided between two lead researchers on the project. Where a text had been authored or co-authored by one of the lead researchers (Lorna Templeton) these were read for the review by the second researcher (Jon Adamson).

Young researchers trained and supported by CRC UK on previous research projects were recruited as young associates for this review. Two young researchers attended the Expert Group meeting held in March 2012 to enable them to develop an understanding of the scope of the review and how that scope had been agreed. Young researchers then led on interpreting the key findings of the review for young people and the design and implementation of focus groups with other children and young people based on a peer-to-peer model of consultation.

#### *Consultation on the research findings and next steps*

As a further check on the reality and credibility of emerging findings from the review four focus groups were held with children and young people with direct experience of living with parental alcohol misuse in April 2012. The National Association for Children of Alcoholics (Nacoa) in Bristol and the ‘What About Me?’ (WAM) project in Nottinghamshire each hosted two focus groups. A total of 23 young people were involved (see Table B).

Table B: Consultation with children and young people

	Focus Group 1	Focus Group 2
WAM	4 young people (3 female, 1 male aged between 14 and 18 years old)	6 children (all female, aged between 8 and 12 years old)
Nacoa	7 young adults (all female, and in their early to mid 20s)	5 young adults (4 female and 1 male, all in their early to mid 20s)

Ten children and young people took part in the WAM focus groups which were facilitated by a member of the research team and a young associate from CRC and lasted around an hour and a half. A total of 13<sup>8</sup> individuals participated in the focus groups organised with Nacoa, which lasted up to two hours. The Nacoa focus groups were facilitated by a member of the research team and a member of staff from the organisation. All those participating received a £10 High Street Voucher in acknowledgement of their time and contribution.

<sup>8</sup> The co-facilitator from Nacoa was also a young adult with experience of parental alcohol misuse; they participated in both groups and so the number of participants from Nacoa is one greater than that shown in Table B to reflect her involvement.

### **Section Three: Consultation with children and young people**

*"It's good to have someone there to talk to whenever you need it & they're not going to just tell anyone else. If there was one single thing I could change it would be to make (other young) people more aware that groups like this exist."*

*(male aged 17 supported by WAM Project, Nottinghamshire)*

*"I wish we had somewhere safe where we can go to quickly until things are better at home."* (girl aged 10 supported by WAM)

*"It's good to have friends to talk to but you can't always talk to friends about your problems and they can't always be around"* (female aged 14, supported by WAM)

As outlined in the Methodology section, four focus groups were arranged through two separate organisations: the National Association for Children of Alcoholics (Nacoa – based in Bristol), and a project supporting children and young people growing up with parental alcohol misuses - 'What about me?' (WAM) project in Nottinghamshire. The purpose of these focus groups was to enable children and young people to provide a 'reality check' of the emerging findings and key messages from the review, and to discuss potential next steps for the programme of work. The focus groups involved a total of 23 young people aged from 8 to mid-20s. Working with two different organisations, each with their own ethos and approach to the issue, allowed engagement with a range of young people, although the majority of participants were female and White British. The different age groups enabled researchers to explore issues around what is currently happening for younger children, how they respond to that and where they get support from, and to get some more reflective feedback from young adults.

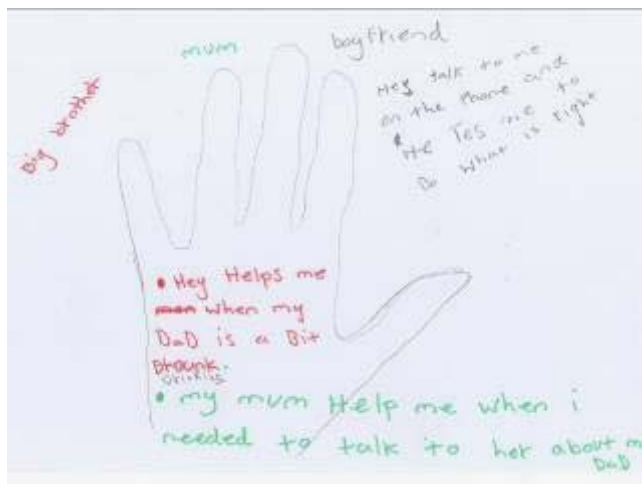
Focus groups with the younger participants were co-facilitated by young researchers who also helped design the sessions and ensure that they were pitched at the right level for the participants. These two focus groups explored how parental alcohol misuse affected their lives, how they coped with that, how they accessed support and what might improve things for them and other young people in their situation. Focus groups involved a range of activities across the different learning styles (including audio, visual and kinaesthetic - see appendix C for an outline session plan for the focus groups). The groups at Nacoa with young adults involved discussion (using flipchart paper to record the conversations) of the review's research questions and the emerging key messages from the review.

What arose from this consultation exercise is described below, reported separately for each organisation which facilitated and supported the groups. This is to reflect the distinction between the groups with a younger age group currently experiencing parental alcohol misuse (WAM project) and those who were older, young adults (early 20s) who were reflecting on their own experiences of living with, currently or in the past, parental alcohol misuse (Nacoa).

## Views of the participants from 'What about Me' (WAM)

### Accessing support

In the WAM focus groups participants were asked to draw around their hand and, at the end of each finger, to write the name of a person/s or organisation which has helped them or given them support. They were also asked to write a few words or draw pictures to show which people or organisations help and support them and to place a sticky-star next to the one that helps them most of all. Two examples of this are shown below.



What emerged from this exercise was that children, even at a young age (under 12) had identified different sources of support. This will be influenced by the fact that participants were recruited through an organisation which is already providing them with support. Most children identified five areas where they were supported but a few only identified one area. Support came from professionals, for example the WAM key worker, social workers and teachers as well as from family and friends. Younger children (under 12) identified more support from the extended family, including from grandparents, aunts and uncles, and from neighbours, while teenagers appreciated support from friends and boy/girlfriends. The potential for support to come from a wide range of sources concurs with our findings in the review.

The support which participants identified that they got, and which they wanted most of all, was to be able to speak to someone when they needed to and to be listened to. This was true for a key worker, a family member, partner or friend. Two other important factors which were not strongly evident in the reviewed literature but which the younger children talked enthusiastically about helping them were their pets and the role of humour and play with their siblings. Almost all of the children said it helped having a pet that they could talk to and stroke and which made them feel happy. While sibling care and support is also highlighted in the literature, it was particularly the role of play and humour – largely with siblings but others too – which children said was 'the best thing' in life and which helped them to cope with other 'bad things'. All the teenagers in the WAM groups, and most of the younger children, talked about how much they valued someone who could make them laugh and smile. The importance of having fun, as well as receiving specific support, is mirrored by findings from evaluations of services and interventions which are discussed later in this review.

Teenage participants in the WAM sessions were also asked to brainstorm and rank the potential barriers to accessing support and produced the following list (ranked 'biggest barrier' to least):

1. Lack of confidence.
2. Lack of personal direction (explained by young person as not knowing where to go to get any help).
3. Parents finding out.
4. Feeling comfortable enough/at ease with someone to tell them.
5. Worried about brother/sister.
6. Didn't want school friends/acquaintances to know.
7. Fear of it going further, for example to the police.

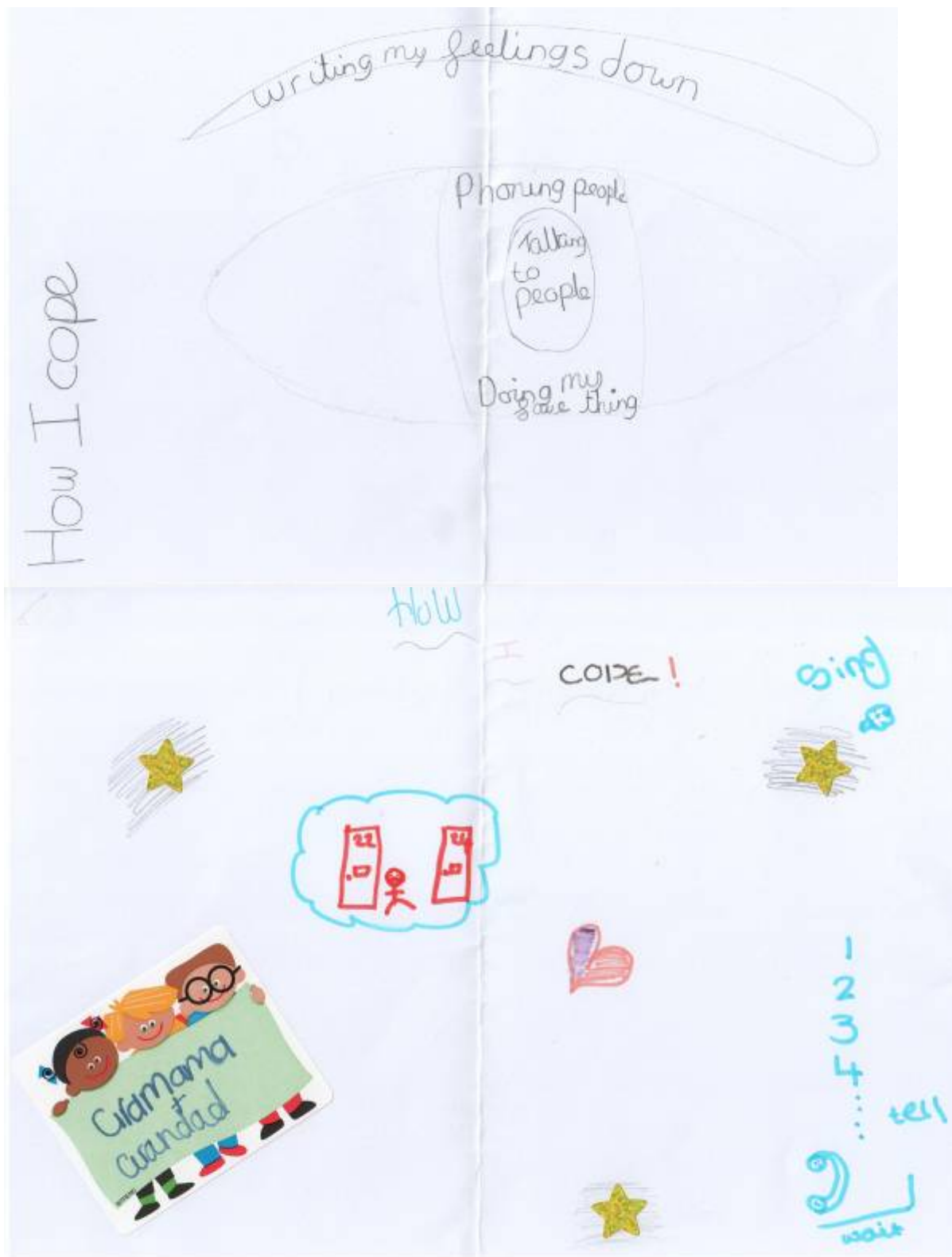
Again this was broadly in line with what emerged from the review, except for children's fear that others, particularly the police or social services, might find out about the problems which seemed to be a bigger barrier for children and families in some of the literature which was reviewed. Discussions took place around the initial decision to seek help from a professional service and what opportunities there were for that. There was a mixed response regarding teachers with one participant describing a very positive experience of confiding in a teacher and being able to access support, whilst two others had a very negative experience. One teacher had invited the child's parents in to a meeting at school to discuss their drinking despite the child very clearly indicating they did not want this course of action. Another young person said that their teacher had advised her parents that she was accessing support from WAM, again contrary to her wishes. Thus, participants were reticent to recommend speaking to a teacher to access support. Participants had initially sought support from WAM through word of mouth and information on leaflets and liked it that they could make contact through text message. One girl commented,

*It took me about an hour to get the courage to send the text. It was better than having to speak to someone and explain everything while I was in the corridor [at school] and other people could listen to what I was saying.*

### **Coping/resilience**

In the WAM focus groups with younger children (aged 8 to 12 years) discussion took place around 'coping' and 'getting by' but more complex issues of resilience were not explored (although this was part of the Nacoa focus groups with young adults described below). The young children participating in focus groups completed drawings or wrote on paper how they coped with the parental alcohol misuse and these were placed in an envelope. A few examples of these are provided below:





The drawing in the centre of the sheet above depicts one young girl going to a neighbour 'where it's safe' and to get help. Another girl said that, "I need somewhere safe to go quickly when mum starts drinking and cutting herself but where can I go?" Escaping difficult situations when parents are drinking is identified through the literature and in this review. However, this existing research tends to focus more on retreating to bedrooms or friend's houses rather than neighbours or safe places in the community which were mentioned in the WAM sessions.



Those participants who chose to write down how they coped in words (rather than drawing pictures) mentioned talking to their WAM key worker, phoning people and writing a diary. One young girl said that,

*I won't tell anyone but I write in my notebook and show it to my social worker. My parents found my book and they were so angry, they said that I had let them down by writing it for everyone to read.*

The uncertainty around drinking patterns and parental behaviour was another important issue evident in the review and backed up by the focus groups. One girl wrote,

*I think when I was 3 my mum started to drink and have drugs my mum got better some days but not all days and now I am 10 now and they is more but it make me upset (girl in WAM focus group, aged 10)*

### **Group work and peer support**

The focus groups at WAM were the first time in which young people supported through the project had come together as a group. Most of those taking part had enjoyed the opportunity to be together with other children who were experiencing similar things to them. A girl in the younger group said "It's been great coming here tonight; I never knew all these other kids had the same problems as me to put up with". This was also a strong finding which will be discussed later in the review.

In the focus group with teenagers it emerged that peer to peer support was something which participants thought would be useful to receive, and also to provide. In responding to a question about what they would advise someone else in a similar situation to do, all participants would offer them some form of support through sharing their own experiences and what they have found to be helpful. One male responded said that this would,

*...turn a positive into a negative: things you've seen etc you can share with them and say 'look, it's not that bad, you can get through it'. Give them advice that other people have given you and that helped.*

He went on to say that he also thought that talking to someone else about their problems would also help the individual providing support to understand their life better too. Peer to peer support or mentoring does not feature largely in the review and this may be an area worth further exploration, including the possibilities of online forums (for example, 'CyberMentors' developed by Beatbullying).

### **Box 2: additional messages from younger children consulted on the review**

The following key messages were either not evident in the literature reviewed in the section which follows, or were given much greater importance by children:

- The role of **play and humour** – mainly with siblings but also with friends and other family members – was very important in how children coped with the sometimes difficult circumstances of their family life.
- Having a **pet** who they could care for, stroke and talk to was important for almost all of the small sample of children consulted on this review.
- Having '**somewhere to go**' when things were difficult at home (parent drinking, shouting/angry or self-harming were all cited) was a primary concern for children. Older children – teenagers – sought respite with friends, both on the streets and at friends' houses, while younger children went to neighbours or tried to contact grandparents.

- Children really enjoyed taking part in the focus groups. None of the children had done any group work previously and they all wanted to meet up again, suggesting **group work** may be of great benefit in terms of understanding what is happening in their life and particularly the reassurance that they are not alone and can seek and receive support.

### ***Reflections from Nacoa participants***

There were four broad themes which emerged from the focus groups with Nacoa as being most important to the participants. The participants discussed talking and silence, how alcohol is perceived by others (and what this means in terms of how the 'children of alcoholics' are viewed), coping and resilience, and support. A summary of the key issues raised by the participants under each of these broad themes is listed below.

#### *Talking and silence*

- Many children keep what they are going through 'inside'. There is a range of reasons for not talking about parental alcohol misuse, including difficulties in identifying people of trust who problems can be shared with, blame, shame and stigma.
- Some children are uncertain of what 'it' (the problem) is and so they do not know what to talk about or who to talk to. Some children can feel very overburdened by the problem, or have lived with it for many years, and feel that they just do not know where to start in terms of talking about it.
- One way in which children cope is by covering up their emotions and being very guarded about this and what they share with others.
- Children do not always want support from other people to be about talking about the problems, and some do not want to be pushed in to talking about things. Children need to know that 'talking support' is available but opening up and talking needs to be on their terms.
- This is a group of children who may have had to grow up quickly to manage what they are dealing with; in terms of support from others they want this to be recognised and for professionals to talk to them in more respectful, adult, ways.
- The Nacoa participants were young people who had been 'silent' about their problems (and were therefore largely invisible) for years, and who had not sought help or talked about the problems until their late teens/early 20s.

#### *How alcohol, and how 'children of alcoholics' are perceived*

- Children do not want to be patronised and seen as victims.
- Children do not want to have an identity that is based on being the 'child of an alcoholic'; they want to be viewed by other, as more than this.
- Participants were critical of societal attitudes to alcohol and its focus on drunkenness. Alcohol is usually portrayed in such a way that its misuse is not seen as wrong, whereas other drugs are illegal and all use is seen as 'bad'.
- Participants were also critical of the media representation of alcohol, with its focus on drunkenness as a positive and fun activity (which rarely has harms associated with it). The groups also felt that media portrayal of alcohol is focused towards certain groups – in

particular they felt that little attention was given to the use and misuse of alcohol by 'middle class' groups. The groups were also critical of alcohol advertising and compared this to the ban on smoking advertising.

- Overall, there is a need for wider education and awareness raising around alcohol.
- Some of the young people talked about the benefits to understanding 'alcoholism' as a disease. They felt that approaching the topic from this angle might be a better approach to take in schools, rather than giving simplistic messages about units and harms associated with drinking.

#### *Coping and resilience*

- Coping may not be healthy and does not necessarily mean survival or resilience.
- Younger children in particular may not realise that they are 'coping', they are simply living with what they think is normal and doing what they have to do to 'get by'.
- Children can have great pride in 'surviving' their experiences, and they made links between this and their wish to not be patronised or seen as victims by others.
- Older children and young adults may be better able to reflect on their experiences and through this understand more about coping.
- The role of and support from other family members (particularly the 'other' parent and siblings) is important.
- Some participants talked about their experiences in relation to their own use and non use of alcohol.
- Despite their experiences the participants agreed that they would not change anything about their childhoods as their experiences have helped to shape who they are. One young person said, "I wouldn't change any of it" while another said, "I wouldn't change any of it for the world".

#### *Support*

- Support should not just be about talking.
- The participants in both groups talked in some detail about schools. There were mixed views but a consensus that they are very important. They offer praise and support to children (which may be missing at home); they offer an escape from what is going on (meaning some would not necessarily want to access support through schools); and they offer the chance for adults to be proactive in identifying and offering support. There needs to be much more done generally by schools in terms of alcohol education and awareness, and to advertise services. Children do not necessarily want to be 'singled out' for help.
- There is a need for support for young people when they are older (e.g. late teens/early 20s); this relates to the age of the majority of the participants when they accessed help and started talking about what the problems. Both groups felt there was a gap in help for this age group.
- Support needs to be available in the longer-term and should also not be time limited – things are not necessarily okay because you seem okay and because you are older.
- The participants talked about whose responsibility it is to engage with children and young people. They felt that it is the responsibility of others (not the responsibility of children) but that the support which is available and offered needs to be led by the child – what they want, when and if they want to talk.

- This group of people hadn't accessed help other than Nacoa. They talked about what they gained through Nacoa, including the benefits of telephone support and of subsequently going through the Nacoa training to be a volunteer.
- Trust appears to be a key element of support and getting help.
- Some of the participants had grown up with negative views (imposed on them by others) of social services (and other NHS services) – they were often very much seen as 'baddies', and this was often a reason for why children kept silent about their experiences.

Finally, at the end of each focus group supported by Nacoa the lead researcher asked the participants, "if there was one key message that you would want to give to the Children's Commissioner for England about this issue what would that message be?" The responses are given in Box 3. Overall, the experiences and views of this group of young people mirrors many of the key findings and messages to come from the main review.

**Box 3: One key message for the Children's Commissioner**

- It's not the child's problem. It's not the child's responsibility to get help. It's a societal issue, society is responsible for future generations.
- We lost our childhoods and we had to grow up quickly.
- Appreciate the complexity and individuality of children.
- It's got to be the child's decision to speak, but we need to let them know it's okay to speak.
- Children have a poor and negative understanding of services like social services and the NHS, so this influences children's views of such services.
- There is too much formality in services, which are too driven by responsibility and remit. Services need to be more human. A child may not tick all the boxes for a service but you can still help them. Services also need to be more flexible in terms of the ages of children they can help.
- It doesn't stop when you leave the situation, it doesn't ever stop.
- Don't patronise us/children of alcoholics. Don't see us as victims. We will just retreat further in to our shells.
- There needs to be more education for everyone about what it's like for us.
- Change the public perception towards alcohol, particularly how it's portrayed in the media. Denial is a large part of what we live with, and this seems to be mirrored by society and Governments which deny the size of the problem and the way in which alcohol problems can affect children and families.

## Summary

What was clear from both groups, but less apparent in the review of literature, was that children and young people experiencing parental alcohol misuse want support and help but they do not want that support to always be focused on 'the problem'. Younger children participating in focus groups supported by the WAM project emphasised the importance of playing with siblings, humour and looking after pets in helping them cope and get on with their lives. Young adults participating in the focus groups at Nacoa were clear that they wanted to know that 'talking support' was available but that they did not want support to always involve them having to talk to different people about the problems. They did not want to be defined as 'children of alcoholics'. They did not want to be pushed into talking about things and wanted the availability of support and the option to talk to be on their terms. While they felt it was the responsibility of others to engage with children and young people they felt that this should be led by the child.

One interesting area, which was also less apparent from reviewing the literature, was the positive aspects which some young people could ultimately derive from having to deal with parental alcohol misuse. Young adults participating in the focus groups at Nacoa spoke of their 'great pride' in surviving their experiences and of not wanting to change anything about their childhoods because it made them who they are now. The strong attachments which many children continue to have to their parents despite the difficult circumstances in which they have lived was evident in some literature (e.g. Forrester & Harwin, 2004) and was also a powerful theme to emerge from the consultation with children and young people.

With the broad range of ages and backgrounds of children and young people consulted in the focus groups it was clear that children sought support from different sources of support from a very young age and that they adapted and changed this over time as they, and their environments, changed. Children seek support from services, and others, at different times in their lives and for different reasons and the need for flexibility of service provision in regard to this was of paramount importance to the young people participating in consultation on this review. While this may not be an entirely new finding, the emphasis placed on this requirement for flexibility in service provision – and the previous point about support services not solely focusing on discussing problems all the time – are given a greater priority by children than that which emerged from the review of literature.

While the review findings showed that not much is known about what children think about the various models of understanding alcohol problems – see section 4, research question 1 – participants in the Nacoa focus groups discussed the benefits of understanding 'alcoholism' as a disease, particularly in the approach taken in schools. This was something which the expert group picked out as a potential new area to explore.

## Section Four: Review Findings

*"My brother who is ten says he wants to end it all, my mom also says she wants to die. She really needs to talk to someone but there is no one? I am not getting any sleep. I am scared what I will find when I wake up or what might happen whilst I am sleeping" (girl aged 10 supported by WAM Project, Nottinghamshire)*

### Introduction

This section of the report describes the main findings in relation to the research questions, though inevitably there may be some overlap between the sections. The review will discuss each of the research questions in turn, before concluding with a consideration of the strengths and gaps from the work which has been reviewed.

A central focus for this review has been literature which directly considers the views of children. Tables C, D and E in Appendix B summarise the main references in this area which have been included in the review. The tables provide information on the authors, year of publication, sample of children involved and other key details about each study. Table C summarises research in England, while Table D summarises work which has been undertaken elsewhere in the United Kingdom as well as international research in this area. Table E summarises research which has been undertaken, primarily in England, to evaluate services or interventions for children (and families) affected by parental alcohol/substance misuse.

Overall, research directly involving children in England with experience of parental alcohol misuse is fairly sparse. Even broadening the focus beyond England to the UK and internationally, the direct views of children are only captured in relatively low numbers, often in the context of work undertaken around the broader impact of substance misuse as a whole. Much of the research focuses on qualitative work with children or secondary data analysis (e.g. of helplines/website). There are few longitudinal studies, few which focus on the experiences of Black, Asian and Minority Ethnic (BAME) groups and no examples of peer-led research projects.

## **Research Question 1: What is known about the experiences of children and families where there is parental alcohol misuse, and to what extent is this informed by the views of children and young people themselves?**

“Alcohol misuse is frequently a family secret that remains undisclosed, and children’s voices, all too often, go unheard” (Turning Point, 2011)

“Alcoholism is hidden because it’s legal – it’s swept under the carpet” (girl in Delargy et al., 2010)

“They think it’s normal. They think it’s happening to everybody. They don’t know how bad it is. They just accept it. They have no one to turn to about it and they feel helpless” (ChildLine Counsellor: Mariathasan & Hutchinson, 2010)

### **Introduction**

Overall, there has been a great deal of research, particularly within the last 10-15 years, from both the United Kingdom and further afield, which has considered how children are affected by parental substance misuse. Significantly, this has included an increased focus on listening to what children have to say about their experiences and needs, as well as considering the perspectives of others, mainly parents or a range of professional groups. There have been a number of literature reviews in this area, including from England (e.g. Gorin, 2004, Kroll, 2004, Tunnard, 2002<sup>9</sup>), Scotland (Templeton et al., 2006; Barnard & McKeganey, 2004), Ireland (Horgan, 2011), Australia (Burke et al., 2006) and New Zealand (Girling et al., 2006). A European study has also summarised what is known across 18 EU countries about children affected by parental alcohol problems, commenting on similar shortcomings in several areas across the continent (Harwin et al., 2010).

In England, there has been a small amount of research which has specifically considered the experiences of children living with parental alcohol misuse, from the viewpoint of children themselves. Thus, it is important that this section of the review is also informed by work which has been undertaken elsewhere and that research which has explored the impact of parental alcohol (and drug) misuse on children from the perspectives of others, particularly parents and professional groups, is also considered. It is interesting that there are a small number of recently completed research studies which have employed creative methods to talk to children about their experiences (Hill, 2011; Holmila et al., 2011; Wall & Templeton, 2010; Fraser et al., 2009; Gilliver, 2007), and at least one study which published a separate report of its findings aimed at young people (Bernays et al., 2011).

### **What is the size of the problem?**

*“Across the four nations [of the UK], there is no systematic collection of prevalence data on children affected by parental drug and alcohol misuse” (Hill, 2011 p1)*

There has been little work which has attempted to estimate how many children may be affected by parental alcohol/substance misuse. A major European study in this area (Eurocare and Coface, 1998) extrapolated an estimate for the UK from estimates elsewhere in Europe. Despite limitations with such an approach (Harwin et al., 2010), the work nevertheless suggested that between 780,000 and 1.3 million children were living with an adult’s alcohol misuse. Cleaver et al. (2011) suggested that the prevalence of parental mental illness, parental substance misuse, domestic violence and learning disability are all very similar.

Until relatively recently only very broad efforts have been made to estimate how many children across the UK may be affected by parental substance misuse. This reflects a wider lack of consideration of how many families/adult family members are affected by someone else’s alcohol or drug misuse (Copello, Templeton & Powell, 2009). More recently, there have been efforts, both at a UK wide and

<sup>9</sup> This report focused on alcohol; Tunnard has also written a review which focused on parental drug misuse (2002), which has not been included in this review.

at a local level, to more accurately estimate the size of the problem (Duffy et al., 2010; Manning et al., 2009; Percy et al., 2008; Hay et al., 2005; Murray & Hogarth, 2003), although it is generally recognised that such calculations are under-estimates and that there has been more focus on drug misuse. This means that we still lack a clear picture (both for England and the UK) of how many children may be affected by parental alcohol misuse (Harwin et al., 2010). Despite the lack of a specific focus on alcohol it has been suggested in at least one report that there are five times as many children affected by parental alcohol misuse than by parental drug misuse (Turning Point, 2006). One study which estimated the number of children of problem drug users in Cheshire and Merseyside suggested that there are between 14,517 and 24,552 such children (Duffy et al., 2010) which, according to Turning Point's statement, would place the number of children affected by parental alcohol misuse in the same area between 72,500 and over 120,000.

The most recent study to estimate the numbers of children living with substance misusing parents, considering both alcohol and drugs, employed data from several UK household surveys – the Health Survey for England, the General Household Survey, the National Psychiatric Morbidity Survey, the British Crime Survey and the Scottish Crime Survey (Manning et al., 2009 – see Box 4). These estimates suggest that the 'number of children living with substance misusing parents exceeds earlier estimates', such as those presented in the Hidden Harm report (ACMD, 2003) (Manning et al., 2009). If it is assumed that such calculations are under-estimates – for example, because of caution applied with the mathematical assumptions, or because it is recognised that there will also be large numbers of children affected by parental alcohol or drug misuse but who are not living with those parents – then the size of the problem is a substantial one.

#### **Box 4: Estimates of Children living with Parental Alcohol Misuse (UK, under 16 years)**

- 30% live with at least one parent who is a binge drinker (between 3.3-3.5 million children); (Binge drinking: 6 or more units on a single occasion for women; 8 for men.)
- 8% live with at least two binge drinkers (just over 950,000 children);
- 4% live with a lone parent who is a binge drinker (just under 460,000 children);
- 22% live with a hazardous drinker (over 2.5 million children); (Hazardous drinking: a pattern that increases the risk of harmful consequences to the user or others)
- 2.5% live with a harmful drinker (298,988 children) (Harmful drinking: results in consequences for physical and mental health.)
- 6% live with a dependent drinker (over 700,000 children);
- 4% live with a problem drinker who has co-existing mental health problems (approximately 500,000 children);
- Around 79,000 babies under 1 in England are living with a parent who is classified as a 'problematic' drinker ('hazardous' or 'harmful'). This is equivalent to 93,500 babies in the UK.
- Around 26,000 babies under 1 in England are living with a parent who would be classified as a 'dependent' drinker. This is equivalent to 31,000 across the UK.
- In Scotland, 2.5% of children live in households where there was violence between adults when at least one adult had been drinking (over 24,000 children).

(taken from Manning et al., 2009)



Other work has considered how many people in alcohol/drug treatment are parents. A three month audit in one London Borough reported that 20% of clients from the three specialist drug and alcohol treatment services were parents, 43% of whom had current child social care involvement (Nagle & Watson, 2008). While only covering one London Borough, these findings suggest that over half of the children of these clients were currently not known or 'hidden' to social services. It is now a requirement in England for treatment providers (drugs and alcohol) to record, as part of their returns to the National Treatment Agency for Substance Misuse how many of their clients are parents and to establish basic details, including living arrangements, for any children who are identified. Finally, one specific area where more attention has been given to estimating the size of the problems is in reviewing the cases of social workers in children's social care, and this is discussed separately later in the review.

Overall, however, there is a dearth of work which has considered the numbers of children who are affected by parental alcohol misuse (and who can be affected at all levels of consumption, not just parents who are dependent drinkers). Tackling this gap is a key first step in understanding the size of the problem and developing the most appropriate practice and policy response to what is believed to be a very significant issue.

### **Experiences of children**

*"...many children understand their parents' drinking and the resulting diminished parenting capacity as contributing to their own problems and unhappiness"*  
(Wales et al., 2009 p41)

This section of the review will summarise at a general level what is known from children themselves about how children are affected by parental alcohol/substance misuse before considering a number of issues in more detail. It has been highlighted that for England, as well as across Europe as a whole, there is a lack of empirical research in this area (Harwin et al., 2010), but there are many strengths about much of the work which has been undertaken and two things are immediately striking from the research: the young ages of many of the children who are exposed to parental alcohol (or drug) misuse and for how many years children have been exposed to these problems. A European study (including England), which talked to 45 young people aged 12-18 years about living with domestic violence and parental alcohol misuse, reported that the young people had been exposed to maternal alcohol misuse for an average of 5 years and to paternal alcohol misuse for an average of 6.5 years (Velleman et al., 2008). A study in Northern Ireland, involving 23 young people aged 12-17 years reported that the young people had been living with parental substance (mainly alcohol) misuse (and/or parental mental health problems) for 3-14 years (Templeton, 2011). Velleman & Orford's retrospective study with young adults who had grown up with parental drinking reported that in many cases the problem had "...persisted throughout most of the participant's childhood years" (Velleman & Orford, 1999 p218). Burke et al.'s literature review in this area is just one piece of work which has highlighted that, "...the longer the child has been exposed to parental alcohol misuse, the greater the impact may be" (Burke et al., 2006).

What is also apparent from the research is the range of ways in which children are affected by parental alcohol misuse. Looking across the research included in this review, Box 5<sup>10</sup> summarises the extent of this experience. Kroll's review identified 12 key issues which she felt captured the experience of these children, before highlighting six issues to discuss in more detail; namely, denial, distortion and secrecy; separation and loss; family functioning; conflict and breakdown; violence, abuse and living with fear; role reversal, role confusion and the child as carer; what children say they need (Kroll, 2004). Barnard & McKeganey's (2004) review highlighted the uncertainty and unpredictability which children faced through living with a problem which is, "...characterised by cycles of relapse and recovery" (p553), both of which can affect children in very different ways. Hill's qualitative thesis with 30 children aged 9-20 years in Scotland who were living with parental alcohol misuse discusses the issues of emotions, silence, trust and stigma at length (Hill, 2011). Children

<sup>10</sup> Box 5 informed by : Bernays et al., 2011; Cleaver et al., 2011; Hill, 2011; Houmoller et al., 2011; Clay & Corlyon, 2010; Delargy et al., 2010; Kroll & Taylor, 2010; Fraser et al., 2009; Sawyer, 2009; Templeton et al., 2009; Wales et al., 2009; Velleman & Templeton, 2007; Burke et al., 2006; Girling et al., 2006; Murphy & Harbin, 2006; Turning Point, 2006; SCIE, 2005; Bancroft et al., 2004; Barnard & McKeganey, 2004; Bell & Sim, 2004; Corbetter, 2004; Forrester & Harwin, 2004; Gorin, 2004; Kroll, 2004; Taylor & Kroll, 2004; Barnard & Barlow, 2003; Kroll & Taylor, 2003; McKeganey et al., 2002; Tunnard, 2002; Alcohol Concern, 1997; ChildLine, 1997; Hill, Laybourn & Brown (1996).

who talked to ChildLine in Scotland about parental alcohol misuse talked regularly about family breakup and losses such as a parent losing their job or losing their health:  
*".....the 'double loss' where a child's relationship with their non-drinking parent is affected or damaged by the other parents drinking....children understand events such as separation, bereavement and other kinds of loss as acting as triggers to parental drinking or escalating alcohol use"* (Wales et al., 2009 p36)

A significant feature of many children's experience is that the parental substance misuse is often highly correlated with family disharmony and/or conflict (including domestic violence and abuse). Furthermore, some research has suggested that children can be more affected by this family disharmony than by the drinking or drug use itself (Turning Point, 2006; Gorin, 2004; Kroll, 2004; Tunnard, 2002; Velleman & Orford, 1999; Alcohol Concern, 1997). This issue will be discussed in more detail later in the review, an overview only is given here. One of the earliest studies conducted in this area with children of 'alcoholic' parents (conducted in Canada: Cork, 1969), reported that 98 of the 115 children who took part in the study (85%) "....said that fighting and quarrelling between their parents was their main concern" (Tunnard, 2002 p15). Evaluation of calls to ChildLine and Nacoa indicate that children who disclose that they are living with parental alcohol (or drug) misuse often have another major problem which is troubling them and which is the initial reason for why they made the call (most commonly physical abuse, violence or family breakdown), with the parental substance misuse only emerging as an additional issue later in the conversation (Ohlson, 2011; Mariathasan & Hutchinson, 2010; ChildLine, 1997).

#### **Box 5: Children's Experiences of Parental Alcohol/Substance Misuse**

- Experiencing conflict between wanting others to know, wanting to keep the family 'secret' and being fearful of others knowing or finding out;
- Living with a problem which is often apparent (despite parents efforts to keep it hidden), but which may not be fully understood by children, and which is kept hidden and a secret;
- Missing out on childhood; experiencing isolation and a lack of social skills;
- Children can be affected at all stages of, and in all areas of, development. Immediate and longer-term effects of in utero exposure to alcohol/drugs;
- Normalising their experiences, playing down how bad things are and protecting parent(s);
- An awareness that parent(s) view their misuse as more important than their child(ren);
- Experiencing strong emotions – worry, love, loyalty, fear, anxiety, loss, sadness, isolation, depression, anger, frustration, guilt, shame, stigma, embarrassment;
- Parents' inability to care (physically and emotionally) for children and meet their basic needs, often associated with neglect. A wide range of ways in which parenting capacity and attachment can be affected, can also include increased risk of sexual abuse;
- Impact on family functioning, relationships and everyday family lives, including children feeling let down or blamed for what is going on;
- Social, behaviour and conduct problems (includes offending, anti-social behaviour, aggression, responding inappropriately to discipline, boundaries etc.), can also include increased sexualised behaviour;
- Affected by co-existing issues – including polydrug use, domestic violence/abuse and mental health problems, and exposure to risky behaviours associated with the misuse;
- Presence of (often multiple) stressors which can heighten risk e.g. financial problems, poverty, housing problems, social exclusion, unemployment;
- Experiencing, or being concerned about, loss, separation, bereavement – can include issues relating to contact with parent(s) and the fear of being removed;
- Impact on physical health (includes sexual health, eating disorders and injuries related to violence, abuse or neglect), emotional development, well-being and mental health;
- Attendance and performance at school, relationships with teachers and peers. Lack of parental support in children's education. Children can be victims of bullying, or be bullies;
- Taking on caring or other responsibilities at home; inappropriate levels of concern and responsibility for parent's welfare and the family; being a young carer;
- Maintaining love, loyalty and attachment to parent(s), regardless of their behaviour and how much these ties were tested.

Analysis of calls to ChildLine across Scotland found examples of multiple negative impacts of the experiences of children where there is parental alcohol misuse, including “severe emotional distress, physical abuse and violence and a general lack of care, support and protection” (Wales et al., 2009 p9). Most children described ongoing assaults, with the vast majority relating the violence to when a parent was drunk or had been drinking. Children also said that they often feel isolated within their own home – due to ongoing abuse, verbal aggression and conflict, feeling unloved and uncared for – and isolated outside of the home – due to difficulties/absenteeism from school, bullying, difficulties in making friendships due to caring responsibilities, low self-esteem and coping with the stigma of parental alcohol misuse (Wales et al., 2009).

The review will now consider in more detail a number of issues related to children’s experiences. There has been a small amount of longitudinal research undertaken in this area, and this will be discussed in the section on protective factors and resilience.

### **Coping**

Despite living with a problem which they may not be able to name or understand, and which is often confusing, distressing and frightening, children are not “passive victims” (Hill, Laybourn & Brown, 1996 p164). Rather, they go to extraordinary lengths to come up with their own solutions, often a combination of practical, physical and emotional strategies, to cope with what they are living with and/or exposed to (e.g. Holmila et al., 2011). One researcher suggested that the term ‘getting by’ may better capture this concept in relation to children living with parental alcohol or drug misuse (Hill, 2011). It is therefore important that coping is not equated with resilience, something which will be discussed in later sections of this review and which emerged from the consultation work with young people.

In her literature review Gorin suggested a typology of four broad categories to capture how children cope with parental substance misuse (and other family problems covered in the review), namely avoidance & distraction; protection & inaction; confrontation, intervention & self-destruction; and help seeking & action (Gorin, 2004). Avoidance and (emotional) detachment strategies were particularly common in Velleman & Orford’s sample of young adults interviewed retrospectively about growing up with parental drinking (Velleman & Orford, 1999). However, rather than falling into one or another category, it is more often the case that coping dilemmas for children are more complex, affected by a range of variables, including the severity and complexity of their circumstances. Hence, children rarely adopt just one strategy and will most likely face coping as an ongoing struggle to know what to do for the best, or by using strategies which they actually report as being less effective (Templeton, 2011; Velleman et al., 2008). Worryingly, some of the young people in one small study, and the young adults in another study, talked about their own use of confrontation and aggression/violence, including child to parent violence, as a way of coping (Templeton et al., 2009; Velleman & Orford, 1999). Many children will be faced with supporting or protecting others in the family, such as siblings or even adult family members, and this will affect how they are able to look after themselves. Some coping strategies adopted by children, such as anger, aggression, truancy, anti-social behaviour or challenging authority, can make it much harder for them to engage with services as they are viewed in relation to their presenting behaviour rather than the reality that such actions may be masking (Ofsted, 2011a).

A common strategy for children is to talk to someone else, usually a friend or family member, but studies suggest that many children make very careful and considered decisions about who to seek such support from and are highly selective with their choices (something which was evident in our own consultation with children), meaning that it may be quite some time before children actively seek such support (Houmoller et al., 2011; Velleman et al., 2008; Gorin, 2004). An evaluation of Nacoa’s helpline suggested that nearly one half of callers were currently not talking to anyone else about their problems (Ohlson, 2011). Hill’s research with 30 children in Scotland further highlighted that children also make clear decisions about how they talk about parental alcohol misuse, discussing five strategies used by the children in her study: ‘knowing’ about alcohol, using the third person, using a hypothetical scenario, talking about a collective experience, and talking about their own lives in terms of the implied impact of their parent’s alcohol use (Hill, 2011 p107). Holmila et al.’s Finnish study, which collected data from 70 children using a web-based questionnaire, emphasised that, “.....the experience of children’s own agency must be understood, respected, and supported, and seen as a resource; empowering the children might be extremely important for their well-being and health” (Holmila et al., 2011 p185).

### **Groups of children**

One critique of research in this area is its homogeneity and lack of attention to how different groups of children may experience and be affected by parental substance misuse (Hill, 2011; Templeton et al., 2006; Tunnard, 2002). Therefore, it is recognised that there is a dearth of research which has investigated particular groups of children to consider what may be different or similar in terms of their experiences and their needs from services and other forms of support. Such groups of children include siblings, young carers, those cared for by grandparents or other kin carers (or by, for example foster or adoptive carers), children in the care system or living in a residential establishment such as a children's home, children affected by a substance misuse related bereavement, children of prisoners, and the young homeless. Research which has considered these groups of children is summarised below.

There has been very little research which has considered siblings, other than one Scottish study (not included in this review) which considered the impact on siblings of having another sibling with an alcohol or drug problem (Barnard, 2005). A small number of studies have included sibling pairs or groups, but the extent to which similarities and differences between siblings have been considered is variable (Houmoller et al., 2009; Templeton et al., 2009; Backett-Milburn et al., 2008; Bancroft et al., 2004). For example, age, older siblings caring for younger siblings, seeing siblings as role models, and how siblings find ways to cope together have all been identified as important (Houmoller et al., 2011; Backett-Milburn et al., 2008). Another common theme from this research is the potential for siblings to serve as important sources of support. One area where the issue of siblings has been considered is in supporting siblings groups or keeping siblings together when they enter the care system and how such issues should be taken in to account when making placement decisions (Bell & Sim, 2004). Bell & Sim (2004) discussed a number of issues in relation to this, including the needs of siblings of different ages, relationships between siblings as a result of their experiences, siblings being affected by separation where older siblings have been caring for younger siblings, and siblings viewing foster siblings differently to birth siblings.

A substantial volume of research has been undertaken into the impact of parental substance misuse and, similarly, into young carers, but little research has been undertaken into the needs and experiences of children who fall into both groups, let alone with a specific focus on alcohol. Indeed as definitions of 'young carers' vary, in some cases in Australia, for example, young people providing a caring role for someone misusing substances are explicitly excluded from research, policy and practice debates and may even be ineligible for carer support and assistance (Hill et al., 2009 cited in Moore et al., 2010; Odyssey Institute of Studies, 2004).

A small qualitative study in Canberra, Australia focused specifically on those children who care for a parent with an alcohol or other drug issue and how their needs and experience may differ from other carers (Moore et al., 2010). While the level of care was similar to their caring peers, the 'expanse' of the caring role for children where there was parental alcohol misuse was much greater. Children reported responsibility for:

- emotional support – listening/worrying on day-to-day basis;
- financial support – contributing/managing finances, seeking financial aid;
- household tasks – cooking, cleaning, shopping;
- safety and monitoring – preventing or dissuading drinking/drug use, arranging transport, removing items that could cause harm/self-harm;
- personal care – giving medication, assisting with washing whilst intoxicated (children envisaged personal care tasks increasing in the future due to the health consequences of alcohol and drug abuse); and
- caring for siblings – food, love, comfort, emotional support, protection from parents and others.

Overall, Moore et al. reported that it was the emotional care which children spoke about 'most poignantly' but that it was manifest in a more complicated and complex relationship than a simple reversal of the parent-child roles (Moore et al., 2010). Christie's study with young carers in Scotland identified that the group which seemed to be the most affected were those living with parental substance misuse or mental health problems (Christie, 2007<sup>11</sup>).

<sup>11</sup> It was not possible to access Christie's full PhD thesis so the references to it here are taken from the abstract which was available on the Index to Theses website.

Other studies have identified positive impacts of young carers who are well supported by services targeted specifically for them, including skills development, increased maturity, independence and understanding of illness and a strong bond with relatives (Early et al., 2007 cited in Moore et al., 2010; Carers Australia, 2002; Banks et al., 2002). However, this was not the case for young carers of a parent misusing alcohol or drugs who, admittedly based on a small sample, “did not generally feel that they had become stronger or more resilient as a result of their experiences... in contrast they had little confidence, poor self-esteem and limited hope for the future” (Moore et al., 2010 p171).

Of particular note for this review is that young people were ‘ambivalent’ about being given the label of ‘young carer’, found it ‘unusual or uncomfortable’ and of ‘little relevance’ to them (Moore et al, 2010). The authors concluded that the label of ‘young carer’ was “an adult-centric notion forced onto young people who would never define themselves in this way” (Moore et al., 2010 p173). Christie’s PhD thesis with young carers in Scotland also found that this group did not understand the term or apply it to their own situations. However, it was also acknowledged that some way of identifying these young people is an important factor in securing support. The aforementioned bullet-list of responsibilities facing young carers of substance misusing parents is a close match with issues commonly raised by children living with parental alcohol misuse. Identification with such a caring role – by children themselves and by services – could be a means of reaching and accessing support services. If children of parents who misuse alcohol do not see themselves as ‘young carers’ then this may prevent them from seeking, and receiving, support from services for young carers. Children’s sense of agency, their ability to bring about change in their circumstances – discussed elsewhere in this report – is an important protective factor.

The issue of children affected by parental alcohol/substance misuse who are cared for by grandparents or other kin carers has received increased attention in recent years, although there has been little English/UK based research which has considered this issue specifically or which has included the views of children themselves. It is recognised that approximately 140,000 children are cared for by grandparents as a result of parental alcohol/substance misuse, and that this is a group of grandparents who face increased hardships as a result of the additional burden which is placed upon them (Grandparents Plus, 2011; Barnard, 2007). It has also been reported that grandparents (or other carers in the extended family) can become involved where problems are particularly serious – for example, a quarter (26%) of the children in Forrester & Harwin’s two year follow-up of 100 families (186 children) where parental alcohol misuse was a feature at allocation were being cared for by the extended family (Forrester & Harwin, 2007).

Given the lack of specific research in this area, work in England (Orford, 2012; Templeton, 2012<sup>12</sup>; Kroll, 2007) and Scotland (Barnard, 2007, 2003), as well as work by Adfam (2011, 2006) and Mentor UK (2010, 2009)<sup>13</sup> are therefore useful contributions to understanding this issue although Kroll highlighted a lack of research which has considered alcohol specifically (Kroll, 2007). Templeton’s study involving 21 grandparents explored three key dilemmas which they faced in relation to caring (formally or informally) for grandchildren because of parental substance misuse: their own dual identities as both parents and grandparents; maintaining (or not) bonds between grandchildren and their parents, and communicating with their grandchildren about the parental substance misuse (Templeton, 2012). Both this study and one in Scotland which included 20 grandparents (and one aunt) emphasised that, “...*these grandparents and other relative carers were unequivocal as to the importance of having taken on the care of children*” (Barnard, 2007 p102). While it is recognised that grandparent/kin carers can be protective factors for children (e.g. Barnard, 2007; Kroll, 2007), some of the work in this area has sounded a note of caution that, because of the complexities surrounding the ways in which substance misuse can affect families and intra-family relationships, this should not be assumed (e.g. Kroll, 2007) and that careful assessment and ongoing support (for both children and their kin carers) is often required.

As highlighted elsewhere, the prevalence of parental substance misuse within children’s social care, and the complexity of these cases, is an issue that has received greater attention in the literature. However, again, there is limited research which has considered this from the child’s perspective and

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<sup>12</sup> There was also a final report and a research briefing from this study; only the published article has been included as a reference in this review.

<sup>13</sup> There have been numerous outputs from this study, the references included here are therefore selective. For more information on this project see <http://www.eukinshipcarers.eu/>

there has been little research which has considered specific groups of children within this, such as those who are placed with foster carers or in residential homes. Forrester & Harwin (2004) interviewed 26 children about their experiences of being in care; the majority of the children came from families where there was parental substance misuse. What struck them was the strong attachments which many of the children held to their parents, despite the situations they had lived in and what they had been exposed/subjected to. Phillips considered the stories told by 18 families, who had experience of adoption or fostering of children affected by parental substance misuse (Phillips, 2004), while other chapters in Phillips book presented the stories of parents who adopted an 11 year old child and of a young girl who was adopted (both in Phillips, 2004). The families talked about the information they received (or not) on substance misuse, the positives and challenges in caring for these children, the needs (short- and long-term) that they and the children needed post-placement, and the impact of contact with the birth parent(s) both on children and also their foster or adoptive carers.

There are a number of other groups of children who may have very specific experiences of, and needs associated with, living with parental alcohol/substance misuse. This includes, for example, children who experience a substance misuse related bereavement, children who have a parent who is also in prison, and children who are homeless. The most recent evaluation of Nacoa's helpline indicated that a quarter of callers also raised the issue of prison, while a quarter also discussed bereavement, suggesting that these are common issues also affecting this group of individuals (Ohlson, 2011). Unfortunately, however, there has been very little research with these, and other, groups of children. Overall what is clear is that there is a dearth of research which has considered the experiences and needs of a wide range of groups of children who are affected by parental substance misuse. They are all areas where further research is needed.

### ***Gender, age and ethnicity***

It is possible to pull out some key issues which the research has raised in terms of the experiences and needs of children according to three key variables, namely their gender, age and BAME status. These three issues will all be considered separately below.

With regards to age, the work of Cleaver and colleagues is particularly useful in considering, for three age groups (under 5's, 5-10 years, 11 years and over), the key risk and protective factors that are faced when living with a range of family problems, including parental substance misuse (Cleaver et al., 2011). McInnes & Newman's local study suggested that younger children may be more affected in terms of school attendance and developmental delays, while older children may be more affected through being young carers, being more isolated or themselves misusing substances (McInnes & Newman, 2005). An Iranian study of opium and heroin-dependent parents noted parental strictness being replaced over time by parents' indifference towards their children (Pisaraee, 2007). An American study of parental drinking and children's use of health care, focused on children under 12 years old, reported that parental drinking was positively associated with higher attendance of children (particularly girls) at both paediatricians and emergency rooms (Balsa & French, 2012).

Other research has suggested that age may influence how children cope with parental substance misuse. For example, Gorin's review suggested that older children are more likely to externalise their feelings and how they are affected, are more likely to themselves use alcohol or drugs problematically, and are more likely to skip school (Gorin, 2004). On the other hand, younger children are more likely to be affected by the higher levels of dependence that they have on their parent(s), and are also more likely to "...believe that they can influence their parent's behaviour than older children" (Gorin, 2004 p41), what Kroll & Taylor termed 'magical thinking'. Forrester & Harwin's research in social care has suggested that children living with parental alcohol misuse (compared with drug misuse) tend to come to the attention of social workers at an older age, and that this may influence how they are affected as well as their welfare outcomes in the longer term (Forrester & Harwin, 2007 & 2006). Additionally, one local study suggested that there is a lack of support for younger children, with workers believing that younger children were less affected by the substance misuse or were too young to hold the knowledge about parental substance misuse which would enable them to engage with services (McInnes & Newman, 2005). However, in a Finnish study analysing responses from 70 children to a web-based questionnaire, Holmila et al. (2011) found that, 'even younger children appreciate individual support, therapy and information from understanding adults or peers' (Holmila et al., 2011 p185). One report highlighted that "...children's most persistent

plea is for more age-appropriate information to help them understand what is going on in the family” (JRF, 2004).

In terms of gender, the findings from research are somewhat mixed as to whether there are differences between girls and boys in terms of coping and seeking support. Some research has suggested that girls are more likely to internalise, experiencing problems such as eating disorders, anxiety and depression, whereas boys are more likely to externalise and, hence, exhibit behaviours such as aggression, confrontation or hyperactivity (e.g. Burke et al., 2006; Gorin, 2004; Velleman & Orford, 1999). While this difference may mean that boys are more likely to come to the attention of services, it appears to be the case that girls are more likely to approach services for help (Ohlson, 2011; Mariathasan & Hutchinson, 2010; Wales et al., 2009; JRF, 2004). Given the importance of a sense of agency with regard to children’s response to parental alcohol misuse the much lower proportion of boys seeking help and support, compared to girls, is an area of concern.<sup>14</sup>

The research included in this review identified some other interesting characteristics in relation to gender. A large survey (just under 10,000 respondents) of children’s behaviour and attitudes towards teen and parental alcohol use in Ireland found differences in their perceptions of parental alcohol misuse, with a higher proportion of boys agreeing that it was okay to drink alcohol and become drunk in the presence of children and to consume more than five alcoholic drinks in one sitting (ISPCC, 2011 p6). Higher numbers of boys also reported binge-drinking and ‘being drunk’. Two other differences which have been highlighted are that the risk of poor outcomes for girls increases the longer they are exposed to the problems (Velleman & Templeton, 2007), and that being a boy is one of the predictors of poorer welfare outcomes for children whose cases are placed for allocation within children’s social care (Forrester & Harwin, 2007).

With regards to ethnicity, there is far less research which has considered this issue. The majority of the research which has been conducted has considered the experiences of ‘White’ children. A rare example of research which has considered ethnicity is from Mayer (2004) who draws upon the experiences of children attending the Children’s Society’s STARS Project (for children living with parental substance misuse), indicating that approximately one quarter of the 160 children who had engaged with the service in a two year period (2002-2004) were from Black, Asian and Minority Ethnic (BAME) groups. Mayer highlights that many children from black or mixed heritage have experienced “significant bullying, often of an extreme nature” (Mayer, 2004 p158), and goes on to list the following themes as relevant to work with this population of children:

- Children have unclear ethnic origins;
- Differing ethnic identities within sibling groups when considering permanent placements;
- Stereotypes of racial groups;
- Issues of ethnic identity within family placement;
- Experiences of racism and violence amongst black and dual heritage children and young people who are affected by parental substance misuse. (Mayer, 2004 p150)

A study in the Sikh community that involved 24 wives, ten male drinkers and seven (young adult) daughters (Orford, 2012<sup>15</sup>) discussed how the experiences of the wives and daughters might challenge the expected stereotypes and that many of the themes to emerge from the study are not necessarily different to those seen in other cultural groups of families affected by substance misuse (Orford et al., 2005). However, the increased importance of support from the extended family may be an important nuance to take from another piece of research in this area. Forrester & Harwin’s follow-up study (of 100 families going for long term allocation in social care) reported that being a substance misusing parent who was a first generation immigrant was a predictor of a child remaining at home at the two year follow-up point (Forrester & Harwin, 2007). Furthermore, this group of parents were more likely (a third compared with 7% of the other families) to have reduced their alcohol or drug misuse, with the authors suggesting that the presence of a non substance misusing parent, coupled

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<sup>14</sup> The Office of the Children’s Commissioner has commissioned a report into ‘Recognition and telling: developing earlier routes to safety for children and young people’. This report will be published in 2012 and will be of relevance to the next steps with regards to this issue of low numbers of boys seeking help/support where there is parental alcohol misuse.

<sup>15</sup> This chapter draws upon Sekhon’s PhD Thesis which was completed in Birmingham 2000 and which (because of its date) has itself not been included in this review.

with support from extended family, may have played a part in this finding. However, as with the Forrester & Harwin study, Cleaver et al. (2007) also noted that there were low numbers of families from BAME groups in their sample. They explored the possible reasons for this apparent under-representation (focusing on the Asian community) in children's social care, listing services lacking understanding and ethnic sensitivity, institutional racism, families in BAME communities being reluctant to engage with services where support may come from non-Asian workers, and ignorance and embarrassment from these families/communities about seeking help (Cleaver et al., 2007).

A study in the United States suggested that there may be a higher prevalence of parental alcohol misuse amongst some BAME groups (Ramisetty-Mikler & Caetano, 2004). Using survey data from the 1995 National Alcohol Survey (n=4925) and data from the US 2000 Census they estimated that overall, 11.6 million children (16%) were exposed to an adult with alcohol problems and 3% were exposed to an adult with alcohol dependence (all children). A higher proportion of black and Hispanic children – 19% compared to 14.5% of white children – were exposed to an adult with alcohol problems and significantly higher proportions of black (5.2%) and Hispanic (4.9%) children were exposed to an adult with alcohol dependency compared to white children (2%).

Overall, it has been recognised that there is a need for greater understanding of how culture may influence the experiences and needs of groups of children in England and that greater cultural sensitivity is needed.

*“...ethnic and cultural context in which children live will also affect the extent to which they feel able to talk to professionals or are indeed given permission to do so” (Kroll, 2004 p137)*

*“The importance of culturally sensitive interventions with this group must therefore be recognised as a priority area for service development” (Mayer, 2004 p149)*

Mayer also recommends that all professionals who engage with children from any BAME group who are affected by parental alcohol/substance misuse should have the relevant training, awareness and support to be able to explore issues of race and culture with children; it is not something which should be an 'add on' or left to specialist workers (Mayer, 2004). No doubt, facilitating engagement with the local communities themselves, and with other community and specialist organisations which support BAME groups/children, will be important in terms of progress in this area.

### ***Perspectives of parents***

*“Children need to explain to parents how [harmful] use is, how it makes them feel. Then they will stop, they will listen to kids more than they will listen to them [professionals]” (8 year old girl in Fraser et al., 2009 p857)*

There has been a reasonable amount of research, both in England and elsewhere, which has investigated, from the perspectives of substance misusing parents, how children can be affected (Rhodes et al., 2011; Kroll & Taylor, 2010; Redelinguys & Dar, 2008; Barnard, 2007; Pisaree, 2007a, b; Meier et al., 2004; Barnard & Barlow, 2003; McKeganey et al., 2002). One survey found that 80% of adults thought that parental drinking is a serious problem for children in the UK, with 84% agreeing that parental drinking is as harmful to children as parental drug use (in Delargy et al., 2010). Over three quarters (83%) of 100 parents with alcohol problems surveyed by Turning Point said that they were worried about how their drinking had affected their children, with just over half saying that their drinking prevented them from caring adequately for their children and a quarter admitting they had used their children as a reason for why they drank (Turning Point, 2011).

Overall, one message to take from research in this area is that parents often hold a high level of understanding about the range of ways in which their children are affected by their substance misuse and the impact that their misuse has on their parenting (Turning Point, 2011; Fraser et al., 2009; Mitchell & Burgess, 2009; Barnard & Barlow, 2003; McKeganey et al., 2002). Mitchell & Burgess's review of interventions for families affected by parental substance misuse found that parents understood the impact on children through exposing their children to risky environments/activities, including violence, and a diminished capacity to engage emotionally with their children (Mitchell and Burgess, 2009). An Iranian study based on qualitative interviews with 41 opium- and heroin-dependent parents noted a sharp decline in the quantity and quality of communication with children in families where there is substance misuse (Pisaree, 2007). Parents in a survey by Turning Point identified stress, anxiety, concerns for their parents' health and welfare, and taking on caring responsibilities, as all ways in which their children had been affected (Turning Point, 2011).



However, despite this awareness about the impact of their substance misuse which parents may hold, at the heart of the research in this area is an underlying debate as to whether substance misusing parents are capable of good, or 'good enough' parenting, and whether "...the only response that can meet the needs of these children is to take them into care as soon as possible" (McKeganey et al., 2002 p242). It has been questioned whether this group of parents are able to do more than meet their children's most basic needs (and whether even this can be achieved), which is often interpreted at a physical and practical level, often therefore omitting the capacity of parents to meet the basic emotional needs of their children (Sawyer, 2009; Turning Point, 2006; McKeganey et al., 2002). An interesting finding from this research is that many of these parents do go to quite considerable lengths to keep their misuse a secret from children, but that despite their best efforts to conceal their misuse, parents are often also able to recognise that their behaviour is negatively affecting their children (as noted above). While parental substance misuse, "...does not always or necessarily result in poor parenting ...the research literature provides limited insight into how some families are able to manage this" (Mitchell & Burgess, 2009 p27).

Often children realise that something is going on, and both see and understand more than parents realise (e.g. Houmoller et al., 2011; Barnard & Barlow, 2003), but the heightened secrecy often attached to substance misuse, coupled with the priority which children see their parents giving to something which is, to all intents and purposes hidden from them, adds to their confusion, distress and lack of understanding. Barnard & Barlow's study with 36 children (and parents) in Scotland highlighted the lengths that children will also go to in order to support their parents in keeping the substance misuse a secret, going on to say that children can be doubly affected through living with a problem that is not acknowledged by parents (Barnard & Barlow, 2003). An interesting finding from one English study, which collected data over a five year period from over 60,000 drug using parents (roughly split between those who lived or do not live with their children), was that those drug users who had their children living with them demonstrated fewer risky behaviours than parents whose children lived elsewhere (Meier et al., 2004). Eight risk indicators were assessed, covering both drug misuse (including daily alcohol misuse) and social environment. Overall, these parents used drugs less, their living environments were more favourable (a profile recognised by the authors as similar to the adults who did not have children), and they were least likely to have two or more indicators of risk. However, limitations to this work include the focus on adults already engaged in treatment, and a lack of comparison with parents who were misusing alcohol to explore whether the same findings would hold true.

Another study with 29 drug using parents (alcohol in a small number of cases) reported that strategies of 'damage limitation', involving normalcy, secrecy and ambiguity, were common, serving to protect both parents and their children (Rhodes et al., 2010). Importantly, the study also differentiated between parents who tended towards damage qualification (often associated with attempting to achieve 'good enough' parenting) and those who had shifted towards damage acceptance, with the latter narrative more closely associated with a recovery journey. Such an understanding has important potential for understanding how to engage parents in drug treatment – and perhaps also alcohol treatment – and how to approach the topics of parenting, family life and how their children have been affected. It is possible that earlier intervention with parents could make the initiation of such conversations a little easier and could maximise their subsequent engagement, retention and completion of treatment – as well as, of course, contributing to the earlier identification of children who are in need of support.

Hence, an important finding from research in this area is that for some parents it is their children who are a major motivation for them engaging in treatment (Fraser et al., 2009; Scaife, 2007; Mitchell and Burgess, 2009; Meier et al., 2004). Nearly half (43%) of the 100 parents in a survey by Turning Point were trying to resolve their alcohol problem "because they want to give their children a better life" (Turning Point, 2011). Parents in another study expressed remorse for how their behaviour had affected their children, with many wanting to improve relationships and/or resume caring responsibilities with their children (Fraser et al., 2009). Meier et al.'s study also identified children, particularly those who lived with their parents, as a possible protective factor for such families because of the motivation it can give parents to seek help and minimise the risk that their children are exposed to (Meier et al., 2004).

Finally, research has identified the need for a more gender oriented understanding of parental substance misuse; in terms of the gender of the parent who is misusing alcohol or drugs, the

child[ren] who are affected (Sawyer, 2009; Scaife, 2007; Burke et al., 2006; McMahon & Rounsaville, 2002; Velleman & Orford, 1999) and the co-existence of other issues such as domestic abuse/violence which are known to be 'gendered' (Velleman et al., 2008; Bancroft et al., 2004). It has also been recognised that research has tended to focus on maternal substance misuse, partly because children in such situations are more likely to be living with their mother, but that this has been at the exclusion of understanding the impact of paternal substance misuse for both children and fathers. For example, the 38 young people in Bancroft et al.'s study in Scotland (alcohol misuse featured for 22 of them) reported different experiences through living with maternal compared with paternal substance misuse (Bancroft et al., 2004). This issue will be discussed again in the section of the review which considers protective factors and resilience.

### **Contact**

*"...they often wanted to love their parents, despite everything, and complete rejection of a parent seemed to be very hard and quite unusual"* (Bancroft, et al., 2004, p4)

Another issue which has been highlighted in the research in this area is that of contact between children and their parents (who have the alcohol or drug problem), particularly when they are temporarily or permanently removed from their families. A finding from some of the research in this area is the strong bonds and attachments that many children have with their parents, despite what they are exposed to and how they are treated. There is evidence of children remaining fiercely loyal to, and protective of, their families and family values (Templeton, 2012; Hill, 2011; Backett-Milburn et al., 2008). Meier et al.'s study (2004) also highlighted that parents with drug using children demonstrated fewer risk indicators than parents whose children were in care or adults who had no children.

This all therefore raises significant questions and challenges for those caring for these children (such as grandparents or other kinship carers, but also others such as foster carers or adoptive parents) when considering the issue of contact with the drug or alcohol using parent(s). There are also challenges when a child who has been fostered or adopted wishes to find out about and/or make contact with their birth family and how this should be managed. Even when the circumstances indicate that contact between children and their parent(s) would perhaps not be the best outcome for the child, the ties which children hold to their family suggest that the situation is more complex than this and at least some contact could be supported. Moreover, while the extended family can be supportive, it should also be recognised that problems and poor relationships within families where parental substance misuse is an issue can undermine the support which the extended family can offer. Some of the research in this area, with grandparents, foster/adoptive carers or professionals engaged with children/families in the care system, as well as the views of children themselves, supports this. Nevertheless, this whole issue adds to the already complex decision making processes which face professionals and families/carers in this area. It is important, however, that the children's voice is heard throughout this whole process and in the decisions which are made about contact.

### **Alcohol**

*"...there are similarities and differences between substances in the ways in which they impact on children.....similarities generally relate to the prioritisation of substance use over child welfare.....differences in impact on children are related to factors that are substance-specific"* (Forrester & Harwin, 2011 p33).

*"...social workers and other agencies need to take alcohol more seriously if we are to improve outcomes for children"* (Forrester & Harwin, 2007 p1530)

Despite there being a dearth of alcohol specific research (certainly compared with work which has considered drug or substance misuse), and a lack of work which has considered parental alcohol misuse from the perspective of children, there are a number of points which can be pulled out from the work reviewed here which strongly support the need for a greater emphasis on parental alcohol misuse as distinct from other substance misuse (see Box 6).

A study in Scotland interviewed 38 children aged 15-17 years who were affected by parental substance misuse – alcohol featured for 22 of them (Bancroft et al., 2004). The young people discussed some of the ways in which they felt living with alcohol differed to living with drugs. This included parents being: more emotionally 'invasive', more prone to harming themselves, more likely to be violent, more likely to cause problems at family or public occasions, and more often being absent

from the home because they drank outside of the home or were away on benders or binges (Bancroft et al., 2004).

#### **Box 6: Thinking about parental alcohol misuse**

- There has been little prevalence research which has considered the size of the problem, yet recent data indicate that it is a significant problem that far exceeds the extent of parental drug misuse. The Manning study is also important because it considers different levels of consumption, including binge-drinking.
- One study found that children were more likely to witness their parent's problem drinking than drug misuse but did not see this as problematic ".....parents who had a problem with alcohol drank it more openly in front of their children, but also tended to deny that it was a problem at all" (Bernays et al., 2011 p9).
- Children living with parental alcohol misuse are thought to be more at risk of problems than children with parents who do not have alcohol problems or children living with parents with other problems.
- Research conducted within the care system suggests that parental alcohol misuse is more common in the lives of children in care, is more likely to exist alongside violence, is less likely to involve workers from substance misuse services, and is more likely to come to the attention of child care services when children are older. This group of children are also more likely to experience poorer welfare outcomes.
- In one study parental alcohol misuse was related to the later initiation of care proceedings, within 9 months for cases involving parental drug misuse but later than this in nearly two thirds of cases which involved parental alcohol misuse.
- Social workers appear to find alcohol misuse (and/or domestic violence) particularly challenging to work with. For those children who were removed from their families, this tended to happen later, and those who were removed were more likely to be in temporary placements. However both groups seemed to experience poorer welfare outcomes.

(Bernays et al., 2011; Manning et al., 2009; Forrester & Harwin, 2007; Forrester & Harwin, 2006; Hayden, 2004; Tunnard, 2002; Alcohol Concern, 1997; Harwin, J. et al., 2003)

In Scotland in 2006 a Think Tank (a partnership between the Arberlour Child Care Trust and the Scottish Association of Alcohol and Drug Action Teams) brought together 35 participants (commissioners, managers and practitioners) to debate the differences between parental alcohol misuse and parental drug misuse. The resultant report includes a summary table of the key similarities and differences, acknowledging that while some of these similarities and differences are clear-cut, others are less so (Russell, 2006). The summary table is reproduced in Table F (Russell, 2006 p6).

Table F: Similarities and differences between parental alcohol and drug misuse

Similarities	Differences
<ul style="list-style-type: none"> <li>• (leading to) problem behaviour and dependence</li> <li>• stigma</li> <li>• poor health (mental and physical)</li> <li>• absence - physical and emotional neglect</li> <li>• of children</li> <li>• reduced parenting capacity</li> <li>• unpredictable behaviour</li> <li>• inconsistent parenting</li> <li>• self-centredness</li> <li>• association with criminal activity</li> <li>• unsafe environment (people and places)</li> <li>• relationship and family breakdown</li> <li>• children's emotions</li> <li>• "learned" behaviour for children</li> </ul>	<ul style="list-style-type: none"> <li>• legality</li> <li>• perceptions ( of others)</li> <li>• attitudes of society – social/cultural</li> <li>• acceptance</li> <li>• attitudes/approach of services</li> <li>• cost and accessibility</li> <li>• types of crime – drugs/theft, alcohol/ violence</li> <li>• alcohol link to domestic violence</li> <li>• more varied socio-economic status</li> <li>• alcohol a greater cost e.g. NHS</li> <li>• coverage by the media</li> <li>• visibility of children less with alcohol</li> </ul>
<p>When the problem is at its worst, it is accompanied by a chaotic lifestyle.</p>	

The Think Tank report concluded that:

*“Although there are some distinct differences, there are many similarities in characteristics which mean that parental alcohol and drug use have a similar impact on children’s physical, emotional, and social development and well-being.....What does make a difference for the child is the more tolerant approach of society to alcohol arising from its cultural and legal acceptability. This influences policy making, planning and the approach of services. That approach has a direct impact on the child as it leads to delays in identification of problem parental alcohol use, delays in assessing the effect on the child and delays in intervention”* (Russell, 2006 p19)

In response to this the report highlights the need to be mindful of, and to challenge, such public perceptions in the design and delivery of services, and that this would be facilitated by improving awareness and co-ordination between both specialist and universal services (Russell, 2006).

Four further issues are relevant when considering the specific impact of parental alcohol misuse on children, and the implications this has in terms of identifying and supporting those in need of help, although these were issues which did not emerge strongly from the literature reviewed here. First, is the significant influence that the family, especially parents, has on how children develop ‘knowledge, attitudes, expectations and intentions’ about alcohol use (Velleman, 2009) and the impact that this may have on children where parental consumption is heavy and/or problematic. Second, there has been limited research which has investigated how different levels of consumption (not just parents who are dependent drinkers) and particular styles of drinking (such as binge or episodic drinking) may affect children. Furthermore, it is not right to assume that greater harm is equated with higher levels of consumption or less harm with lower consumption. Third, and related to the previous point, not much is known about what children think about the various models of understanding alcohol and alcohol problems, such as the disease model or social theories about alcohol misuse, and how the views they hold may influence their experiences or coping strategies in terms of living with parental alcohol misuse. However, in the consultation with young people carried out to support this review, the disease model of understanding alcohol misuse was considered by young adults experiencing parental alcohol misuse to have benefits over simplistic messages about units and harms associated with drinking. Fourth, it is recognised that a large number of adults ‘naturally’ reduce or cease problematic alcohol consumption without the need for treatment or other support or intervention. There has been no research which has explored this group of families, how children may be affected, and whether, for some of these children, problems may remain even if the alcohol problem has been resolved. All are areas where further research is required to enhance our understanding of the specific ways in which children may be affected by parental alcohol misuse.

Finally, it is worth drawing attention briefly to two further issues of specific interest to alcohol – foetal alcohol syndrome and children’s own use of alcohol.

### **Foetal Alcohol Syndrome/Foetal Alcohol Spectrum Disorder**

There are no English or UK data on how many children may be affected by foetal alcohol spectrum disorder (FASD), a pattern which is repeated across most of Europe (e.g. Harwin et al., 2010). In their Canadian study Premji et al. (2006) carried out a systematic review of research-based interventions for children and youth with FASD. They described the difficulty in establishing prevalence rates and found that estimates ranged from 0.5 per 1,000 population in the general population (May & Gossage, 2001) to as high as 42.9 per 1,000 population in a high-risk South African community (May et al., 2000; both cited in Premji et al., 2006). In Denmark the rate of FASD was thought to be around 1.4 to 1.6 per 1,000 births but based on analysis of the 1966 cohort in Christoffersen's longitudinal study "the problem may be significantly larger" (Christoffersen, 2002 p12).

While it is outside of the scope of this review to consider in detail this group of children it is important to highlight that this appears to be a group of children who are particularly affected by this group of disorders and that this has implications for their relationships with parents, other family members/care givers and professionals (Plant, 2004). Plant (2004) discussed that this is a group of children who are identified/diagnosed late, who are more likely to be removed from their birth families, and who often have specific lifelong needs because of the damage they have experienced. FASD can be diagnosed throughout an individual's life although it is usually diagnosed in childhood (Bertrand et al., 2005), at a mean age of eight years old (Astley et al., 2000), and only a very small percentage of children are diagnosed before they are six years old (Streissguth et al., 1996: all cited in Premji et al., 2006). Burnell & Vaughan, as part of their work at a service for children who had been removed from their birth families and placed with foster or adoptive families, also considered the differences for those children who had a background of parental alcohol misuse and those who had a background of parental drug misuse, writing that:

*"...hypothetically, children born to alcohol-misusing mothers will have a propensity towards an ambivalent attachment style, compounded by behavioural problems and learning disability resulting from neurological and physiological damage caused by alcohol in utero"* (Burnell & Vaughan, 2004 p291)

However, it has also been highlighted that foster or adoptive carers are often not aware that they are caring for a child with FASD and this has implications for the care they can provide and the impact on them of taking on such a child. Finally, a systematic review of literature concluded that, due to "....a lack of scientific rigour ...no conclusions can be drawn with regards to effective interventions for children and youth from birth to 18 years who are affected by a FASD", and that there is "a dire need to conduct rigorous intervention research in this area" (Premji et al., 2006 p394).

### **Children's own use of alcohol**

While also not considered in detail as part of this review, it is important to acknowledge that there is a substantial library of research which suggests that children with parents with alcohol problems are more likely to experiment with alcohol, to drink from an earlier age, to develop problems, to use alcohol consumption as a coping strategy and hold inappropriate views about alcohol (e.g. Turning Point, 2006). The same has been reported in terms of using/misusing drugs and experiencing mental health problems. Cuijpers, in his review of prevention programmes for children of problem drinkers, highlights the need for further research of prevention programmes for this group of children and discusses the gaps which need addressing (Cuijpers, 2005).

Ronel and Levy-Cahana (2011) conducted a qualitative study in Israel involving interviews with nineteen adolescents growing up with parental drug misuse and now all themselves either dependent on psychoactive substances or in recovery. An important subjective risk factor highlighted in the study was a wish to identify with the parent by means of drug use. The participants described a desire to identify with their parents and to get closer to them, perceiving an intimate relationship having been taken away from them by drug use. One participant recovering from substance misuse haven grown up with both parents dependent on substances described the following conversation with his mother,

*"She asked me then – 'why do you touch [drugs]?' and I said – 'I wanted to know what feeling it gave you that you loved it so much and could give me up'"* (male aged 20 in Ronel and Levy-Cahana, 2011 p612)

There is some evidence that substance misusing parents recognise the risk of their behaviour being taken on by their children. For example, an English survey of 66 in-patients (largely males with alcohol problems) reported that 41% were worried that their children might develop their own problems with alcohol or drugs (Redelinghuys & Dar, 2008).

On the other hand, a European study by the European Network for Children Affected by Risky Environments within the family (ENCARE, 2011) found that children who had experienced parental alcohol misuse were no more likely than the control group to use tobacco or illegal drugs (the latter being rare in both groups). With regards to alcohol use (including episodes of binge drinking) more young people had never drunk alcohol in the affected group than in the control group. Another European study reported that the young people they recruited said that they drank alcohol frequently, but experienced low levels of drunkenness (Velleman et al., 2008). There is evidence therefore that their parents' experiences can also act as protective factors for children against the use or misuse of alcohol (or drugs) (Velleman & Orford, 1999). For example,

*"My parent's drinking....I guess it did me a favour in one way....made me not want to be like them, do something positive with my life. I knew I didn't want to turn out like that, on the social and everything. I got my exams and got a job straight after school"* (girl, 18 in Turning Point, 2006 p11)

It should be highlighted that there is an apparent lack of experimental research in this area in the UK, certainly compared to elsewhere such as the United States. A rare example is a study which investigated the attentional bias for alcohol-related information in 15 young people (aged 15-20 years) with alcohol-dependent parents, compared with another 15 young people who did not have an alcohol-dependent parent (Zetteler et al., 2006).

Overall, parental alcohol misuse is seen as a much bigger problem than parental drug misuse. While there are claims that children affected by parental alcohol misuse are, or should be, more visible to professionals (Kroll, 2004), it appears to be a problem that (largely because of social acceptance of alcohol and stigma attached to its misuse) remains in fact largely hidden and which, as a result, means that children often come to the attention of services much later.

### **Key Messages**

1. The size of the problem, the number of children who are affected by/living with parental alcohol misuse, is largely unknown. However, estimates suggest parental alcohol misuse is far more prevalent than parental drug misuse and there is a need for greater emphasis on parental alcohol misuse as distinct from other substance misuse. There are no England/UK data on how many children are affected by FASD (foetal alcohol spectrum disorder).
2. There is a very broad range of experiences to describe how children are affected by parental alcohol misuse. The children's voice in describing their experiences is quite a strong feature in a lot of the research which has been done.
3. There is a gap in research which has explored the experiences and needs of groups of children affected by parental alcohol misuse. This includes: young carers, children from Black, Asian and Minority Ethnic (BAME) groups, children who experience a substance misuse related bereavement, children of prisoners, children who are cared for by others (such as grandparent or other kin carers, foster carers or adoptive families), children with FASD, and the young homeless.
4. Children draw upon a range of personal and other resources to cope and this changes over time. However, coping does not equal resilience and a greater understanding of coping in this population would be helpful.
5. Different levels of consumption (not just parents who are dependent drinkers) and particular styles of drinking (such as binge drinking) may affect children and it cannot be assumed that higher levels of consumption equates to greater harm. Similarly, the impact of lower levels than would incur intervention, but which can still be harmful, is not well understood. Linked to

this, a large number of parents will 'naturally' reduce or cease problematic drinking but for some children problems may remain. Little research has been carried out in these areas.

6. There is a lot of overlap with research which has considered how children are affected by parental drug misuse. However, some research has suggested that there are some unique features of living with parental alcohol misuse and, given the dearth of alcohol specific research in England; this is an issue which warrants further investigation.
7. Children living with parental alcohol misuse come to the attention of services later than children living with parental drug misuse. Boys are less likely than girls to seek help for themselves and are more likely to come to the attention of services with regards to their presenting behaviour, for example, through Youth Offending Services, than for the harms they are experiencing.

## Research Question 2: What are the key wider issues associated with parental alcohol misuse and how do they relate to risk/protective factors for children and families?

*"...in many of these families [where one or both parents misused alcohol], children witness significant domestic abuse and interparental violence, and suffer a much greater incidence of physical violence and emotional abuse themselves....most young people told us that it was extremely difficult to cope with this environment" (Velleman et al., 2008 p404)*

*"In general, there appeared to be a strong institutional tendency towards under-responding to alcohol and drug misuse.....a pervasive sense that social workers did not know how to work with parental alcohol or drug problems.....[they had] minimal training and often had limited supervision and support.....a toxic cocktail that is almost certain to produce poor practice" (Forrester & Harwin, 2011 p116)*

### Overview

There are a number of issues which most commonly co-exist alongside parental alcohol/substance misuse, as well as a number of family and individual stressors which can add to the complexity faced by children and their families, and which cumulatively can increase the risk for harm. For example, an evaluation of the national Nacoa telephone helpline reported that young callers were concerned about a range of issues in addition to the alcohol misuse, including relationship problems, mental well-being, abuse, suicide, bereavement, eating problems, self-harm, and drugs (Ohlson, 2011). Moreover, the young people who accessed Nacoa also reported facing a number of issues associated with abuse (including physical, emotional, sexual, rape, domestic violence, bullying, and neglect) and a number of issues associated with mental health (including anxiety, fearfulness, loneliness, stress, and depression).

The most common issues to co-exist alongside substance misuse are domestic violence and mental health problems, while the common stressors most associated with these families include unemployment, financial problems and poverty, homelessness and housing problems, and social exclusion. This section of the review will consider two major issues in more detail. The first is that of family disharmony and conflict/violence, an issue which was touched upon briefly earlier in the review. The second issue is that of children who come to the attention of child and family social care because of parental alcohol/substance misuse, and often other problems as well. Issues relating to practice with these children and families will be discussed later in the review.

### Family Disharmony and Conflict/Violence

*"When assessing the impact on children whose parents are misusing alcohol or substances and are living with domestic violence, no one issue can be addressed without acknowledging the accumulation of disadvantages brought about by adult behaviours....Research suggests that both parental domestic violence and substance misuse individually increase the risk posed to children, not only of immediate significant harm, but of longer-term negative consequences. If the two factors are experienced together the danger is compounded and consequently the risk of harm is significantly increased" (Evans, 2006 p65 & 74)*

While the high correlation of domestic abuse with alcohol problems is widely recognised and it is also accepted that children living in such situations are at increased risk of problems, there has been little research which has considered how young people may be affected through living with co-existing domestic violence and parental alcohol misuse. These experiences were explored in a European study which included 45 young people aged 12-18 years from five European countries (including England) (Templeton et al., 2009; Velleman et al., 2008; Velleman & Reuber, 2007). Young people were asked to complete a battery of measures, including the CAST (Children of Alcoholics Screening Test), the Conflict Tactics Scale (CTS), the Youth Self-Report (YSR) and KIDCOPE (in England qualitative data were collected from eight young people [Templeton et al., 2009], with questionnaire data from five of them included in the study's main quantitative analysis [Velleman et al., 2008;



Velleman & Reuber, 2007]). The findings showed that many of the children were exposed to high, and often extreme, levels of violence between their parents (the authors also commented on the gender interaction within these findings). Furthermore, while the children were exposed to lower levels of parent-child physical violence, this violence could often be extreme and, moreover, children were exposed to high levels of parent-child psychological aggression. In addition, over one-third of the sample had scores on the YSR which indicated clinical or borderline levels of problems, with just under one-third of the young people having current or past experiences of engagement with mental health services.

It has been highlighted in the research that children are at greater risk when more problems are present, with, as already noted, family disharmony and conflict/violence strong predictors of risk (Cleaver et al., 2011; Evans, 2006; Kroll, 2004; Tunnard, 2002; Velleman & Orford, 1999). It has also been highlighted that parental alcohol misuse is commonly associated with violence in cases allocated to social workers (Cleaver et al., 2007; Forrester & Harwin, 2006). However, one English study, albeit with a small sample of eight children living with domestic violence and parental alcohol problems, suggested that in fact young people may be more affected by the alcohol misuse:

*“...the young people spoke more about the impact of the drinking....[they] gauged recent key events in their lives alongside whether or not their parent had been drinking, not the aggressive or violent incident”* (Templeton et al., 2009 p147)

This would be an interesting issue which would benefit from further research. Is it the case that some children clearly identify the link between their parent’s drinking and the violence (parent-parent or parent-child) and believe that if the drinking stops then the violence will also reduce or cease? What does this tell us about children’s understanding of the relationship between parental alcohol misuse and violence and abuse? This hypothesis has some support from another aspect of the research, and also from our consultation with children and young people – when this group of young people were asked what they wished for the future, in almost all cases their wishes related to wanting their parent to stop drinking. A recent study by Galvani included focus groups with 14 young people (aged 10-15 years old) in three English locations to explore their views on the relationship between alcohol, drugs and domestic abuse (Galvani, 2010). The findings led Galvani to recommend that there is a need for more education of young people on the relationship between substance misuse and domestic abuse. Additionally, Galvani also highlighted that the young people did not necessarily see a link between alcohol (or drug) treatment and improvements in relationships, which is an important message for services to take on board.

Historically, it has been very hard for alcohol treatment and domestic abuse agencies to work together, and for partner agencies to fully consider and meet the needs of children and families where the co-existing issues of alcohol misuse and domestic abuse are present. The challenges of practice in this area have been identified (Galvani, 2006). However, in recent years there have been some examples of work which has been undertaken to facilitate improved working in this area. Three such examples are briefly summarised below.

1. Embrace Project (Alcohol Concern). This three year project (funded by the Big Lottery) worked with nine adult alcohol treatment services across England, to support them to develop a more family-focused approach to their clients, to also consider the needs of children and other family members, and to take account of domestic violence and abuse throughout their work. A number of reports, training and other resources were produced<sup>16</sup>.
2. Stella Project. This organisation aims to address the overlapping issues of domestic and sexual violence, drug and alcohol use, and mental health, thereby supporting services in their response to survivors, their children and perpetrators. The project offer training, consultancy and resources, as well as undertaking specific projects in this area<sup>17</sup>.
3. Action on Addiction (a leading England non-statutory drug and alcohol treatment provider) and CAADA (Co-ordinated Action Against Domestic Abuse) have developed an intensive training

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<sup>16</sup> See <http://www.alcoholconcern.org.uk/alcohol-concern-in-action/projects/embrace> for more details.

<sup>17</sup> See <http://www.avaproject.org.uk/our-projects/stella-project.aspx> for more details.

course (accredited by the University of Bath) to support professionals who work with the victims of domestic abuse (and how their children may be affected) who are also experiencing substance misuse<sup>18</sup>.

### ***At the heavy end***

*“...the issues of alcohol, domestic abuse, drugs and mental health come up again and again in serious case reviews”* (Laming, 2009 in Delargy et al., 2010 p8)

*“...it is simply not feasible for social workers or policy-makers to consider PSM as ‘somebody else’s problem’, or as an issue that specialists will be able to deal with.....social workers need to be better prepared for working with substance misuse”* (Forrester & Harwin, 2006 p332-333)

Several studies have highlighted the high incidence of parental substance misuse in childcare social work, although it has equally been recognised as an issue which is under-estimated and unrecognised (Hayden, 2004). Cleaver et al. suggested that the rate of parental problems (including parental substance misuse) in social care is greater than that seen in the general population (Cleaver et al., 2011), while Forrester and Harwin noted that, “...the more serious the level of concern the higher the proportion of cases that involve parental substance misuse” (Forrester & Harwin, 2004 p119). A national survey in England of over 600 social workers and social care practitioners suggested that alcohol featured prominently on caseloads (Galvani et al., 2011). Reviews of child social care serious case reviews have also highlighted that parental alcohol/substance misuse are issues which feature prominently (Munro, 2011; Ofsted, 2010, 2011), with one report highlighting that babies under one year old and over 14 years old featured disproportionately in the nearly 500 cases which were reviewed (although it is unknown for how many cases parental alcohol/substance misuse was an issue) (Ofsted, 2011a).

English research has made a significant contribution to understanding the extent of parental substance misuse within social care, and of the challenges this presents to practice (Forrester & Harwin, 2011, 2007, 2006; Fraser et al., 2009; Forrester, 2008; Cleaver et al., 2007; Hayden, 2004). Table F in Appendix B summarises the key findings, in terms of prevalence, from these studies, attempting to also pull out what these studies tell us about parental alcohol misuse. Unfortunately, there has been a lack of research in this area which has been able to involve children directly to explore their experiences of the social care system; this has been identified as a challenge by several authors. One of Ofsted’s reports on serious case reviews focused on the invisibility of children and the need to more prominently consider the children’s voice (Ofsted, 2011b).

In addition to the research summarised in Table F, some of these studies have also reported that families who are experiencing parental substance misuse are also at greater social disadvantage (for example, unemployment, living in temporary accommodation and having housing problems) when compared with families (also referred to social workers) where parental substance misuse was not an issue (Forrester & Harwin, 2006). Similarly, Forrester & Harwin reported that their sample of families where there was parental substance misuse, when compared to the families in their study where there was no parental substance misuse, had a higher incidence of other problems alongside the parental substance misuse, including learning difficulties, mental illness, violence, ill health or disability, criminal convictions, being a first generation immigrant, and having been in care/known to social services as a child. As was discussed earlier, while it is important to state that there is no clear, linear causal relationship here, there is clearly a complex inter-relationship of other wider issues where parental alcohol misuse exists.

Some of the work in this area has also raised the important point that many of these families had a different experience of the social care system. First, it has been highlighted by some studies that children living with parental alcohol misuse tend to come to the attention of care services much later than do those living with parental drug misuse and the study of the Family Drug and Alcohol Court (FDAC) has found later court intervention in alcohol cases. (Forrester & Harwin, 2011; Burnell & Vaughan, 2004; Harwin and Ryan (2007). In the 2003 study of care plans by Harwin, it was noted that parental alcohol misuse was ‘less seriously regarded than drug abuse or mental health problems’ (p144). Also, in one study, nearly one third (62%) of children who were subject to care proceedings and 40% who were placed on the child protection register were from families with parental alcohol misuse, compared with 25% of the children who were categorised as children in need (Forrester &

<sup>18</sup> See <http://www.actiononaddiction.org.uk/Family-Support/Professional-Development.aspx> for details.

Harwin, 2006). Earlier research from Forrester and Harwin reported that, in line with other research in the area, parental alcohol misuse was strongly associated with the re-referral of a closed case to social services (Forrester, 2004), and was more likely to be associated with difficulties with previous social work involvement (Forrester & Harwin, 2004). Further studies have linked parental substance misuse with non-co-operation with children's services, which triggered care proceedings (Masson, J et al., 2008). The Masson care profiling study found that alcohol misuse was a concern of children's services for 25.3% of all the mothers,

A number of studies have identified the substantial challenges that social workers face in working with families affected by parental substance misuse. A qualitative study with 40 practitioners discussed five dilemmas for practice raised by the range of adult and child care workers they recruited (Taylor & Kroll, 2004) – namely,

1. Accessing families and gaining trust such that work could move forward;
2. Building bridges to support improved working practices between adult and child services;
3. Confidentiality and cross-agency communication;
4. Limitations to the assessment process meaning that workers could often not gain the full picture for a family; and
5. Challenges in accessing and working directly with children.

A decade later it seems that these are dilemmas which are still facing a wide range of professionals working in mainstream or specialist services in this area.

A later study by Kroll & Taylor interviewed children, parents and professionals for their study (Kroll & Taylor, 2010). The parents felt that they tended to be viewed in isolation as drug misusers and that other problems were inadequately managed. The children raised several issues from their contact with social workers – that they and their families were offered too little too late, not enough was done to keep families together, children were not taken from families soon enough (when that was required), high staff turnover meant that there was inconsistency with their social workers, there was poor management of contact when children were separated from parents, and foster carers ill-equipped to manage these children who came in to their care.

*“we wanted them to help our mums, not take them away from us”* (Kroll & Taylor, 2010 p195)  
*“they just left...kept moving on....they think it doesn't affect children but it does....if you are going to be a social worker make sure you are committed”* (Kroll & Taylor, 2010 p195)

This dichotomy between separation from the alcohol misusing parent and keeping the family together was also identified in a Finnish study by Holmila et al. (2011) who found that children sought separation from the alcohol misusing parent in some cases, but also thought it was important to recognise the importance of family ties. One suggestion from children was that the, “...possibility for a temporary stay outside home should be more easily available for minors” (Holmila et al., 2011 p185). However, it should be highlighted that there is evidence from other research with children and parents who have found intervention and support from social workers legitimate, appropriate and helpful. The issue of contact was also discussed earlier in this review.

Fundamentally, however, significant challenges remain in supporting social care to improve their practice with this group of children and families who feature so prominently on their caseloads. A national study of social work students identified the lack of specific training during qualifying and post-qualifying social workers training programmes, and also reported that students felt that they lacked knowledge and confidence to work with substance misuse (Galvani & Hughes, 2008). The Munro Review of child protection also highlighted the need for social workers to have greater knowledge in this area (Munro, 2011). The particular challenges that social workers seem to face when working with alcohol and/or violence have been highlighted by others, with Forrester commenting that parental alcohol misuse is one issue which appears to be linked to poorer decision making by social workers, in particular an under-estimation of the risks to children (Forrester, 2004). The lower levels of working with other services, most notably primary care and substance misuse professionals, when parental substance misuse is present, has also been highlighted (Forrester & Harwin, 2007 & 2006; Cleaver et al., 2007).

## Key Messages

1. Parental alcohol/substance misuse is strongly correlated with family conflict, and with domestic violence and abuse. This poses a risk to children of immediate significant harm and of longer-term negative consequences, which is magnified where both issues co-exist. However, there is a need for further research with children in these situations, and for a greater understanding of the role of gender where such issues co-exist.
2. There is clearly a complex inter-relationship of other wider issues where parental alcohol misuse exists. Some evidence suggests that parents felt that substance misuse problems were viewed in isolation and that other problems were inadequately managed.
3. It seems that children recognise the links between parental drinking and the presence of conflict, violence and abuse. However, young people did not necessarily see a link between alcohol (or drug) treatment and improvements in relationships. There is a need for further research to explore children's understanding of these issues and the relationship between them.
4. Parental substance misuse features prominently on the caseloads of social workers, although there is a need to understand why cases involving parental alcohol misuse seem to come to attention later and often follow a different pathway through social care. Moreover, there is a need to understand the experiences and needs of children who come to the attention of social care, but who are classed as 'in need' rather than 'at risk', as this is an area where much less work has been undertaken.
5. There is a lack of pre- and post-qualification training for social workers around substance misuse issues. The challenges faced by social workers with regards to alcohol and violence may be linked to their understanding about alcohol, associated decision making processes and underestimating the risk to children where alcohol is present.

### Research Question 3: What is known about protective factors and processes in this population and how they can minimise risk/negative outcomes?

*“Despite the fact that children can be surprisingly resilient in the face of adversity, and that it is tempting to rely on this in a range of situations, children have their limits and it is clear that, for many children of substance misusing parents, these limits are sorely tested” (Kroll, 2004 p137)*

*“It is the worse kind of dichotomy. In one sense they are tough and coping and on the other hand they are really vulnerable because they are dealing with things that they have no skills to deal with” (ChildLine Counsellor: Mariathasan & Hutchinson, 2010)*

#### **Understanding resilience**

*“Interventions to build resilience are not concerned with developing something unusual; they are concerned with enabling young people to develop a characteristic that is inherent in basic human adaptational systems” (Velleman & Templeton, 2007 p84)*

*“A really good life is being safe and being able to trust yourself” (child in Moe et al., 2007 p392)*

It used to be the case that the only outlook for children living with problems such as parental alcohol (or drug) misuse was a bleak one with children at risk of a wide range of problems in both the short- and the long-term. However, the last decade or so has seen the introduction of a welcome alternative viewpoint; namely, that it is not necessarily a foregone conclusion that these groups of children will be as adversely affected as might be expected. Many children, borne out by the accounts from children in their own words and the word of others, seem to be ‘resilient’. Moreover, there is an increased understanding (based on both generic literature in this area [not reviewed here, but see e.g. Werner, 1987] as well as work which has specifically considered children affected by parental substance misuse) of a set of protective factors and processes, which operate at individual, family and environmental levels, and which can ‘buffer’ children from the negative effects of their family circumstances thus minimising the likelihood of negative outcomes.

Before continuing, it may be useful to offer a common definition of the key terms under consideration in this section. A protective factor or process reduces or prevents the impact of a risk factor, while a resilience factor or process is something which supports a child to avoid the harms often associated with a risky environment. The presence of a resilient factor can be evidence of resilience, which can be defined as “a universal capacity which allows a person, group of community to prevent, minimise or overcome the damaging effects of adversity” (Grotberg, 1997 p7 in Sawyer, 2009 p4). Forrester & Harwin also discuss recovery factors, in line with the recovery agenda which is prominent in England, which they define as, “...those that help children who have experienced harm to overcome it as they mature and become adults” (Forrester & Harwin, 2011 p43).

Reviewing a broad range of issues including parental mental illness, economic hardship, teenage mothering, chronic illness, delinquency and criminality, and childhood maltreatment, Masten reported a convergence of findings indicating ten protective factors that play a role in the development of childhood resilience (Masten, 1994 cited in Moe et al., 2007 p383).

1. Effective parenting.
2. Connections to other competent adults.
3. Appeal to other people, particularly adults.
4. Good intellectual skills.
5. Areas of talent or accomplishment valued by self and others.
6. Self-efficacy, self-worth, and hopefulness.
7. Religious faith or affiliations.
8. Socioeconomic advantages.
9. Good schools and other community assets.
10. Good fortune.

Given the co-existence of parental alcohol misuse with those issues reviewed here by Masten (1994) it seems that many of these 'protective factors' will also be applicable to children growing up with parental alcohol misuse. Table G summarises, from a number of studies, what is currently known about the protective factors and processes which might support resilience for this group of children. It is important to highlight that, while children who have grown up with parental alcohol problems may be at increased risk of negative outcomes, research has also suggested that these children are also more likely to do well and be high achievers (Forrester & Harwin, 2011), which complicates our understanding in this area about the nature of protective factors and processes and the development of resilience.

Table G: Protective Factors and Resilience

Individual	Family	Community/environmental	Evidence of resilience
<p>A sense that one's own efforts can make a difference; a belief in self-help                      Personal or 'inherent' qualities e.g. expression of feelings, knowledge, life choices – overall individual temperament and intelligence                      A child's own coping skills – ability to think about and make decisions about coping and an internal locus of control                      A child's view of themselves                      A sense of self-strength relative to the substance-dependent parent                      Plans for the future/ yearning for a better future                      Early and compensatory experiences &amp; a good relationship with the primary carer in the first years of life                      Positive opportunities at times of life transition                      Perceptions of 'substance abuse' behaviour                      Aversion to parent's dependence                      Not taking drugs or drinking                      Achieving a balance between supporting the parent(s) and looking after themselves</p>	<p>Open acknowledgement of the alcohol (or drug problem)                      Small family size, larger age gaps between siblings                      A supporting and trusting relationship with another (non substance using) adult in the family ...or the extended family (usually uncles, aunts or grandparents)                      Parental self-esteem                      Consistency with everyday family life – such as social life, rituals, roles and routines – families spending time together                      Adequate finances and employment opportunities                      Constructive coping styles and deliberate parental actions to minimise adversity for children                      Receiving treatment (parents)                      Openness and good communication                      A knowledge of 'protective' factors                      Low levels of family conflict – absence of domestic violence/abuse and cohesive parental relationships                      Parenting style – such as clarity about family rules, which are appropriately and consistently enforced                      A wish to protect siblings from substance dependence</p>	<p>Cultural connectedness, values and identity                      Support from an adult – such as a teacher or neighbour                      Strong friendships, including with those who a YP can talk to about the problems at home                      Community engagement and supportive social networks                      Positive school experiences and influences; opportunities through education and employment</p>	<p>Deliberate planning by the child that their adult life will be different                      High self-esteem and confidence                      Good self-efficacy                      Skills and values that lead to good use of personal ability                      A good range of problem-solving skills and an ability to deal with change                      Feeling that there are choices                      Feeling in control or own life                      Previous experience of success and achievement</p>

(Bernays et al., 2011; Cleaver et al., 2011; Ronel & Levy-Cahana, 2011; Sawyer, 2009 – Chapter 3; Moe, Johnson & Wade, 2007; Velleman & Templeton, 2007 & 2006; Bancroft et al., 2004; Tunnard, 2002; Velleman & Orford, 1999; Alcohol Concern, 1997; Werner, 1986)

Overall, there has not been a great deal of research into protective/resilience factors undertaken specifically with children living with parental alcohol/substance misuse. Three important studies which have been conducted in this area are from Scotland (Backett-Milburn et al., 2008; Bancroft et al., 2004), the United States (Moe et al., 2007) and Israel (Ronel & Levy-Cahana, 2011).

Moe et al.'s American study carried out qualitative interviews with 50 children 'of alcoholics', including one question specifically on resilience (Moe et al., 2007). Three themes emerged from children's comments about what is important with regards to resilience. First, in terms of substance misuse behaviour, children talked about the need for themselves and their parents to be free of drugs. Second, children held clear perceptions about the substance misuse behaviour, including not feeling guilty about their parent's drug/alcohol misuse, the important role of treatment and recovery, and parents as role-models (both negative and positive). Finally, children talked about internal resources, centred on their ability to express their feelings, knowing the truth about their parent's addiction and recognising the different choices, attitudes and activities which can encourage a sense of resilience. Based on these findings, the authors identified three ways in which practitioners can help support children to develop their own characteristics of resilience; namely, providing children with a venue in which to express their feelings, educating them about substance misuse, and showing them that there are other ways to live (Moe et al., 2007).

Longitudinal research in this area also has an important contribution to make, although there have been a very small number of such studies. Two of the studies which have been conducted in this area have been undertaken in England. The first is Velleman & Orford's 'Risk and Resilience study' (summarised below: Velleman & Orford, 1999; Orford, 2012). The second is the Family Life Project, which interviewed some of the 50 children in their study on up to four occasions over a roughly year long period (Houmoller et al., 2011). Two other longitudinal studies which are important to this area were undertaken in Hawaii (Werner & Johnson, 2004; Werner, 1986) and Denmark (Christoffersen, 2002). Werner's longitudinal study in Hawaii involved nearly 700 children who were born on the island in 1955 and who were followed up at ages 1, 2, 10, 18 and 32 years – 65 of this cohort had an 'alcoholic' parent (Werner & Johnson, 2004; Werner, 1986). Christoffersen (2002) carried out multivariate logistic regression analysis of a large national database of two cohorts of children born in 1966 (n=84,765) and in 1974 (n=69,623) - analysis covered a 15 year period taking the 1996 cohort up to 27 years old and the 1973 cohort up to 20 years old.

Velleman & Orford's study was retrospective; where 164 young adults (aged 16-35) who had grown up with a parental alcohol problem (the 'offspring' group) were interviewed on two occasions roughly 12 months apart (Orford, 2012; Velleman & Orford, 1999)<sup>19</sup>. The study also involved a comparison group of 80 young adults, with 89% of the full sample of 244 interviewed on both occasions. The study allowed the authors to come to a number of conclusions, some of which will be briefly summarised here, based on a starting point of understanding that the offspring group had lived with an unacknowledged alcohol problem which had persisted for many years and affected individual and family life in a very wide range of ways.

*"What characterised most of the offspring group in the present study was a parental problem that had persisted throughout most of the participant's childhood years, as often as not untreated as far as the child was aware, and often unacknowledged openly.....despite the family disruption or spoiling of family life with which it was often associated"* (Velleman & Orford, 1999 p218).

Velleman & Orford reported that family disharmony and conflict were common and prevalent, and were more likely to be associated with problems and negative outcomes for the children/young adults in the offspring group, concluding that childhood family disharmony is an important mediator for this group of families. However, the authors also highlighted that there was substantial variation in how children were affected by their childhood experiences, coming to the important conclusion that not all such children will suffer from adjustment or other problems in the long-term. The authors also discuss the influence of gender on their findings, suggesting that, while a child may have more negative experiences because of maternal drinking, it is also the case that maternal drinking tends to have a

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<sup>19</sup> There have also been a number of published articles from this study, but they pre-date the 1999 book so only the book has been used to inform this review.



later onset, is less damaging for the mother-child relationships and does not affect overall family life to the same extent as paternal drinking.

Two common, and related, findings which seem to have emerged from the research in this area are the importance (in the short- and the long-term) of a supportive relationship with another adult and an absence of conflict in the family. One American 33-year longitudinal study found that, for the adult male children of problem drinkers in their study, it was the combination of a drinking father with a poor relationship with their mother that was a greater predictor of harm than the father's problem drinking itself (West & Prinz, 1987 in Tunnard, 2002). Hence, having a strong relationship with the non-substance using parent or, more broadly, the support of one confidant, has been identified as important. Ronel and Levy-Cahana's qualitative study with 19 young people in Israel of subjective risk and protective factors for children of substance-dependent parents found that perceptions of a strong non-substance-dependent mother could reduce the risk-factor of the perceived power of the substance-dependent father (2011). The Kauai Longitudinal Study on Hawaii reported that, by age 32 years, those who coped effectively with the trauma of parental alcohol misuse had significantly larger numbers of people in their support networks than those who had problems coping (Werner & Johnson, 2004). This was more so for daughters, although the whole sample described a wide range of people in their network who they could turn to. Werner & Johnson discuss the continuity over the life course between internal protective factors and sources of support. Finding new ways of facilitating children accessing such additional support is an important way of increasing resilience.

However, despite this advancement in knowledge, there is much that we still do not understand about this area and how it might specifically benefit children affected by parental alcohol/substance misuse. For example, resilience is a dynamic process, which is an interaction between an individual and their environment that is therefore open to influence. Yet, we do not know enough about how protective factors and processes operate at different points in time – for example, what may be a protective factor for an 11 year old may not be for a 17 year old or for an adult - or how such factors and processes operate for different children in a range of situations (e.g. Backett-Milburn et al., 2008; Bancroft et al., 2004). Christoffersen found that the short-term consequences of parental alcohol misuse are stronger than the long-term consequences as, “when other confounding factors, usually associated with parental alcohol abuse, were incorporated into the model, the correlations between parental alcohol abuse and long-term consequences fade away” (2002 p23). A study in Scotland with 38 15-27 year olds reported that while the young people discussed a range of things which helped them and which may contribute to resilience, “...the protective factors thought to promote ‘resilience’ were seldom in place for them unconditionally and without associated costs” (Backett-Milburn et al., 2008).

It is also the case that the presence of some protective factors (such as doing well at school) may in fact mask other aspects of the child's experience which continue to negatively affect them and which may be linked to risk. In other words, coping and apparent resilience may not always be positive or associated with healthy outcomes (Velleman & Templeton, 2007 & 2006) and it is not a safe assumption to believe that, ‘once a child is okay then they will always be okay’ (Kroll & Taylor, 2003 in Sawyer, 2009) or that a child who outwardly appears okay is coping well.

*“Even though I was having them problems at home I didn't let it show in school. I'd still come in and do my work and act like a normal kid....I didn't let it show at all and I didn't say anything”* (young person in Bernays et al., 2011 p11)

A useful concept in understanding the difference between coping and resilience comes from Grotberg, who suggested that children draw from three sources of resilience, commonly referred to as 'I HAVE, I AM, I CAN'. Box 7 summarises the key components of each of these features. Ideally, a child needs to be able to draw upon at least several of these features to build resilience. On the other hand, coping focuses more on a child's ability to independently manage difficult situations, and to make decisions and adaptations to the circumstances which they face. Given the secrecy usually associated with parental alcohol misuse, and often reduced support from parents, the opportunity for children to draw upon the features identified by Grotberg in order to build resilience may be reduced. As such the features identified by Grotberg can be used to support intervention with children and families.

## Box 7: Building Resilience – I HAVE, I AM, I CAN<sup>20</sup>

### I HAVE

People around me I trust and who love me, no matter what  
People who set limits for me so I know when to stop before there is danger or trouble  
People who show me how to do things right by the way they do things  
People who want me to learn to do things on my own  
People who help me when I am sick, in danger or need to learn

### I AM

A person people can like and love  
Glad to do nice things for others and show my concern  
Respectful of myself and others  
Willing to be responsible for what I do  
Sure things will be all right

### I CAN

Talk to others about things that frighten me or bother me  
Find ways to solve problems that I face  
Control myself when I feel like doing something not right or dangerous  
Figure out when it is a good time to talk to someone or to take action  
Find someone to help me when I need it

### **Considering resilience in meeting children's needs**

*"...even where children appear to be functioning well, support should be made available"* (Turning Point, 2006 p24)

It is more widely recognised that meeting children's needs should involve a balancing act (depending on a range of variables, including the level of actual or potential risk) between reducing risk and targeting the individual, family and environmental strengths and values believed to be associated with the protective factors and processes that might facilitate resilience. Other factors, such as age, gender and ethnicity also need to be taken in to account. There are a range of generic and specific sets of guidance and other resources which have been developed to support practice in this area (e.g. Sawyer, 2009; Newman, 2002; Gilligan, 2000). However, it also needs to be recognised that an individual approach to this work is maintained within a broader framework of what is understood about protective factors and resilience:

*"...parents and young people are concerned about protecting themselves, and each other, from a range of harms.....and their prioritisation of risks and harms are likely to be experienced differently"* (Houmoller et al., p65)

There are a number of services and interventions which have incorporated ideas about resilience in to their models, with evidence (albeit largely qualitative and short-term) indicating that such a response can target some of the protective factors/processes, thus potentially building children's resilience (this will be included in the next section of the review). However, there is a need for more large scale longitudinal and evaluative research in this area.

Another interesting issue, discussed earlier in this review and where further research and greater understanding is needed, is whether children are in fact at greater risk if they live with, or are separated from, the misusing parent(s). One English study suggested that drug misusing parents who had their children living with them displayed fewer risk indicators, drug or environment related

<sup>20</sup> Taken from <http://resilnet.uiuc.edu/library/grotb95b.html#chapter1> – accessed 11th June 2012.

(Meier et al., 2004), although it is unclear how such findings might apply to a sample of alcohol misusing parents. Nevertheless, Meier et al. (2004) pose the question of whether children are exposed to different (and greater) risks through separation from their parents (despite separation reducing the impact of direct risks associated with exposure to drug misuse) and whether the ties between parents and children can serve as a protective factor:

*“The fact that many higher-risk users do not live with their children may remove some of the direct negative effects of parental use. However, parental absence may contribute to new problems.....Children living in a drug-using home are developmentally at risk and disadvantaged....but the large number of children not living with their drug-using parent(s) may be a different and hitherto unrecognised disadvantage”* (Meier et al., 2004 p960)

Additionally, some authors have called for a more gender sensitive approach to understanding risk and protective factors, from both the perspectives of children and their parents (e.g. Scaife, 2007). For example, as was noted earlier, it seems that there are some differences in how girls and boys cope with parental substance misuse (and the behaviours which may mean they are more or less likely to come to the attention of services), and in also their actions to seek help from others. Having a greater understanding of such gender differences would help inform the development of services/interventions for these children, and when gender might be an important issue to consider in terms of the response.

Scaife’s review, which does not include alcohol, considered risk and protective factors for children in relation to both maternal and paternal drug misuse (Scaife, 2007). Her conclusions are summarised in Table H. The role of parental gender in understanding risk, protective factors and resilience has also been highlighted by others (Burke et al., 2006; Templeton et al., 2006; Bancroft et al., 2004; McMahon & Rounsaville, 2002; Velleman & Orford, 1999). For example, Burke et al.’s review indicated that children’s development can be more adversely affected by maternal alcohol misuse, whereas children can be more affected in the longer-term by paternal alcohol misuse (Burke et al., 2006). Burke et al. also noted that maternal alcohol misuse can influence a mother’s emotional availability to her child, emotional problems more common for these children, while paternal alcohol misuse is more likely to affect children when associated with violence, resulting in a greater likelihood of anti-social or conduct problems for children (Burke et al., 2006). Some authors in this area have called for greater attention to be given to father and fatherhood in understanding parental substance misuse and its impact on children and their parents (Scaife, 2007; Templeton et al., 2006; McMahon & Rounsaville, 2002).

Table H: Maternal and Paternal Risk and Protective Factors

Maternal drug misuse		Paternal drug misuse	
Risk factors	Protective factors	Risk factors	Protective factors
Effects of misuse during pregnancy	High levels of concern about child welfare	Impact of non-residency on children and their relationships with fathers	High levels of motivation to care for their children
Heightened feelings of shame and rejection	Increased likelihood of engaging with treatment – particularly if there is a supportive partner	Violence/abuse more common	Strong emotional attachment to children
More likely to be living with the mother (more likely a lone parent) so increased probability of daily exposure to drug misuse	Efforts to protect children from drug misuse	Men may not support women who wish to seek treatment	Maternal presence to help buffer children from substance misuse
Parenting style more likely to be disciplinarian or authoritarian			
Increased social isolation of this group of mothers			

### **Key Messages**

1. There is a need to continue research to enhance our understanding of protective factors and processes, and their evidence of resilience, for children living with or affected by parental alcohol misuse.
2. There is a need for more longitudinal research in this area to understand how protective factors and processes operate, and change, over time, and what this means in terms of understanding resilience.
3. Coping is not necessarily equated with healthy or positive outcomes, and therefore with resilience. Furthermore, a protective factor or process may not always be entirely positive as it may mask other harms or be less helpful in the longer-term. There is a need for greater understanding of these issues.
4. There are some interesting findings from the research about the role of gender (both of the parent with the substance misuse problem and of the child) in understanding how children may experience and be affected by parental alcohol misuse; this is a complex issue and one which warrants further investigation.

#### **Research Question 4: What is known about services, and their delivery, and the impact/benefit of such services for children (and families) where there is parental alcohol misuse and to what extent is this informed by the views of children and young people themselves?**

*“Children are more used to being told what to do by adults, so they often expect this from the counsellor. What children can discover from talking to a counsellor is that they themselves often have good ideas, internal resources and solutions, and once they have been heard, and have had their feelings understood and acknowledged, they feel more able to think about what they might do and who might help them.....their capacity to do this can be easily overlooked by adults” (ChildLine, 1997 p44)*

*“The children we spoke to were often so busy looking after others that they did not realise they may need someone to help themselves” (Turning Point, 2006 p19)*

*“I didn’t know whether I had the right to contact services once mummy stopped drinking” (Child in Alcohol Concern, 1997)*

*“Quite often children feel they are stuck in the situation. But they really don’t want the family unit broken up. They love their family and don’t want any harm to come to them” (ChildLine Counsellors: Mariathan & Hutchinson, 2010)*

*“It’s been great coming here tonight [ to focus group]. I never knew all these other kids had the same problems as me to put up with!” (Girl aged 10 supported by WAM Project)*

#### **Introduction**

There are three key issues to pull out in considering this section of the review. First, is how hard it can be for many children to talk about their experiences of living with parental alcohol (or drug) misuse. As a result, it has been recognised in the research literature that many children do not talk to anyone about their problems, particularly while they are still experiencing them and when they may be at their most severe (e.g. Gorin, 2004). Second, many services are not set up, either on their own or in partnership with other agencies, to have the time, patience, flexibility and creativity which are needed to build a trusting and safe space for children to feel that they can talk about issues which are often secret and which require courage to begin to explore. Many of the children in Hill’s study in Scotland wanted workers to take time to know them as children first, rather than seeing them solely as a child affected by their parent’s alcohol problem, and to use this time to build the trusting relationship which would facilitate children opening up about their personal circumstances (Hill, 2011). Several studies have identified that something many children would like is the opportunity to meet other children living with similar problems. Children and young people participating in two of the focus groups carried out to support this review had come together as a group for the first time, found it to have been a very positive experience and were keen to meet up again.

Third, while there has been quite a of work which has considered what children (and families) need from services, and about the challenges faced by services (particularly children’s social care) in identifying and supporting this population, there has been far less work which has explored how services benefit children (and families) and how the response can be developed. As will become clear there is a particular lack of work which has considered, from the perspectives of children themselves, how they benefit from services, both in the short- and the long-term. This is not surprising, given that this area has only started to receive increased attention, at least in the UK, over the last decade or so. It is also not surprising that there has been bias towards the work of social workers and professionals engaged with families who come under the social care umbrella.

Moreover, there are further limitations in terms of the research which has been undertaken in this area. For example, there are no known systematic reviews (or meta-analyses) in this area.

One recent systematic review considered psychological interventions with families of alcohol misusers (Templeton, Velleman & Russell, 2010). Although the focus of this review was on adult family members, a small number of studies which included children were considered, with brief discussion of how such interventions can also support children and families, and the limitations of the work in this area. In terms of evaluation research focused on interventions and services to this population, there is a lack of experimental or quasi-experimental studies, and of research generally which investigates how services and interventions compare with other (or no) support, and how services help in both the short- and the long-term. Given that the development and evaluation of services for these children (and their families) is relatively new this is not surprising, nevertheless it is an area which needs attention in order to increase understanding and inform ongoing developments.

This section of the review will consider four main issues:

1. What is known about the availability of services to this group of children, and the usage of services by children;
2. What children affected by parental alcohol/substance misuse say they need;
3. An overview of evaluation research (from England and the rest of the UK) which has been undertaken in this area, and a summary of key findings from this group of studies;
4. A wider discussion of issues relating to practice in this area and where future attention could be directed to enhance the response to these children and their families.

#### **Availability of services and children's use of them**

*"Children and their families are still living with the pain and disruption of alcohol misuse without adequate support"* (Turning Point, 2006 p4)

*"Almost twice the number of children were counselled by ChildLine about their parents alcohol misuse than about drug misuse"* (Mariathasan & Hutchinson, 2010 p2)

Ultimately, there is no clear picture of how many services (specialist or universal) there are, within England or across the wider United Kingdom, which wholly or partly work with children affected by parental alcohol (or drug/substance) misuse. A 2004 review of services for children and families affected by parental alcohol misuse identified 59 services across the UK which offered some response to children and families, with 78% of respondents (sample size unclear) feeling that their response to these groups was inadequate (Williams, 2004). A later survey, which focused on drug misuse only, had responses from 141 services across 127 English Drug Action Teams, with 82 services from 63 areas which "...could be confirmed as undertaking direct work with children and young people whose parents misused drugs...large areas of England, including major counties and large conurbations, had either limited or no provision" (Clay & Corlyon, 2010 p180). A 'postcode lottery' of services has been suggested in terms of supporting children (and families) affected by alcohol (Turning Point, 2006) or drug misuse (Best, Homayoun & Witton, 2008). Even though no known recent surveys of services for children and families have been undertaken (in England or elsewhere in the UK) which have considered alcohol, it is likely that the services which do exist do not match either the identified need or what is implied in terms of 'hidden harm'.

In terms of the profile of children who access the services which are available, there is also very little research which has been conducted in this area. Of relevance are two reports of use of the ChildLine confidential telephone helpline and a third report which explored the characteristics of callers to the Nacoa (National Association for the Children of Alcoholics) helpline. These three pieces of work are summarised below, followed by some key findings which seem common from them.

- a. Evaluation of ChildLine data – 4,028 callers (April 2008-March 2009 – 21% of all callers to ChildLine) who talked about parental alcohol misuse (report also considered 2,284 callers in the same time who talked about parental drug misuse) (Mariathasan & Hutchinson, 2010).
- b. Evaluation of Nacoa – in 2011 there were 4, 530 calls to the helpline, nearly 1,000 e-mails received and over 75,000 website hits (Ohlson, 2011).
- c. Evaluation of ChildLine data – 3,255 callers (April 1995-March 1996) where parental alcohol misuse discussed during the call (ChildLine 1997).

From the above studies the following seem to be key findings.

- A third of callers are aged 12-18 years (Nacoa); 75% aged 11-15 years with the youngest child aged four years old (ChildLine, 1997); 60% aged 12-15 years (20% aged 5-11 years) (Mariathasan & Hutchinson, 2010).
- 80% of callers female (Nacoa); 78% (ChildLine, 1997); 71% (Mariathasan & Hutchinson, 2010).
- High percentage of callers are from lone parent families (ChildLine, 1997).
- The majority of people are calling about a parent with an alcohol problem. For nearly a third of callers the mother is the problem drinker (Nacoa); 40% of callers to ChildLine were calling about a mother having an alcohol problem (ChildLine, 1997). A fifth of callers to Nacoa said that both parents had an alcohol problem.
- In about 10% of cases the caller themselves has an alcohol problem (Nacoa). 306 children who talked about parental alcohol misuse also talked about their own alcohol or drug misuse (Mariathasan & Hutchison, 2010).
- Many children are not calling to talk about 'just' parental alcohol/substance misuse. Their situations are often far more complex than this and, as has been highlighted elsewhere, children often call to discuss another issue (or issues) with the substance misuse emerging later in the call.

One of the points above relates to the fact that children seem more likely to seek help about a mother with an alcohol (or drug) problem. This has also been noted by other research in this area (e.g. Turning Point, 2011; Wales et al., 2009; Christoffersen, 2003) although one study of calls to ChildLine from across Scotland reported that roughly equal numbers of call were about mothers and fathers drinking, with a small number calling about both parents (Wales et al., 2009). Despite drinking patterns showing greater numbers of men drinking harmfully in comparison to women, Wales et al. (2009) suggest that the similar numbers of calls about mothers and fathers may be a reflection of the greater role by mothers in providing childcare and hence that, "children experience a more direct impact of any reduction in their mother's parenting capacity in comparison to the fathers" (Wales et al., 2009 p23). Patterns of behaviour with regards to alcohol consumption may also differ by parental gender with mothers more likely to be at home. In the same study of callers to ChildLine it was reported that children often talked about mothers drinking excessively in the house, whereas for fathers the emphasis was on their returning home drunk (Wales et al, 2009). A longitudinal study in Denmark also found a clear distinction between the impact on children of maternal and paternal alcoholism (Christoffersen, 2002 p23). The 'long-term reactions' – described as drug addiction, mental illness, suicide, violent crime – were more severe where there was maternal alcohol misuse than paternal. This distinction was also evident for short-term disadvantages in childhood – described as premature death, abuse, neglect, residential care, family dissolution – where the risks were significantly increased to a higher level if the mother abused alcohol rather than the father.

Overall, what such evaluations suggest is that services such as helplines are used by a not insignificant number of children and that accessing such free and confidential helplines is an important part of the support which this group of children need. Another interesting finding from the most recent evaluation of Nacoa's helpline is that nearly two thirds of callers are over 18 years old (Ohlson, 2011), indicating the importance of ongoing support to those affected by parental alcohol misuse when they are adults. Apart from the work discussed above, however, there is little else which is known about children's use of services other than the use of social care services which was discussed earlier.

### ***What children say they need***

*"No-one has ever asked me how I feel in any of this"* (young person in Templeton et al., 2009)  
*"[I'd like the group to be called] Secret Lives, because we can talk about what is really going on at home"* (child aged 9, in Wheeler, 2006 p28)

There have been several studies which have listened to children to establish what they need and want in terms of support from professionals/services and others. The English Family Life Project,

which involved 50 children, summarised throughout their report the key messages which came across from the children they spoke to (Bernays et al., 2011). These messages are summarised in Box 8.

**Box 8: Messages from young people about what they want**

- Recognise that even by keeping the drugs and alcohol hidden, I still know that something is going on;
- Don't just deny it or get angry when I ask them about their problems with drugs or alcohol, but instead try to talk to me about it;
- Realise that the denial and the hiding makes it more difficult for me to trust them, but also to trust other people;
- Understand that their use has a big effect on my life and that I worry about being bullied or feeling awkward and embarrassed because of it;
- My parents told me that they loved me and showed me that they cared for my by: asking how my day was; encouraging me to do my homework; and asking me to be home by a certain time;
- My parents and siblings understood that I loved them but needed to care for myself;
- People understood that I am affected by my family, but they do not define who I am. I am an individual. Don't pre-judge me on the basis of others in my family;
- My family and other people helped me to understand that looking after myself is not being selfish;
- People supported me so that I wouldn't have to worry about being bullied;
- Teachers were clear in telling me that they knew what was going on, to avoid confusion and having to guess what they know;
- Teachers received more information as to what situations like mine really feel like every day;
- Support services gave me time to get to trust my keyworker and allowed me to get back in touch with them if things got hard again.
- (taken from the Family Life Project - Bernays et al., 2011 pages 13, 19 & 26)

In addition, research in this area has indicated that there are a number of things which children want and need when they seek help from services. Some of the key findings from this research are summarised in Box 9.



### Box 9: What children need<sup>21</sup>

- Children want their circumstances to be recognised by someone who is helpful, caring and encouraging. The work requires patience, sensitivity and empathy.
- Someone taking time to know the child and work at their pace, not just focusing on the parental substance misuse.
- Support can be about more than talking about the parental alcohol misuse. It can also be about talking about other things, not talking at all, or engaging in fun or other diversionary activities.
- Having practical help when it is needed.
- It can be very hard for children to talk about what is going on. Children need time to develop a relationship of trust, and to feel safe; they also need to understand confidentiality and what will happen with the information they share with others.
- Having consistency and reliability in the workers that they get help from – staff turnover, getting to know new workers, having to repeat their story (to new workers or to workers from different services) can be challenging for children.
- Professionals who understand the concerns held by many children about being separated from their parent(s) and who often remain extremely loyal to their parents.
- Being involved in future decisions made about their situations
- Meeting/wanting to meet other children living with similar experiences – they may derive comfort and strength from others who have similar experiences.
- Facilitating children to understand that the problems are not their fault.
- Having professionals who really understand what is going on for them, rather than just being aware on the surface of the parental alcohol/substance misuse.
- Being able to provide (accessible) information about alcohol (and drugs) – to be able to understand alcohol-related behaviour, addiction, treatment, relapse etc.
- Some children, particularly younger children, can have a simplistic view that they just need their parent to stop drinking and this can influence what they want from services.
- Children may need help with a number of other issues that they can also be struggling with in addition to the alcohol/substance misuse.
- Support often needs to continue when the parent is in, or has completed, treatment.

<sup>21</sup> Informed by: Bernays et al., 2011; Templeton, 2011; Clay & Corylon, 2010; Kroll & Taylor, 2010; Mitchell & Burgess, 2009; Templeton et al., 2009; Wheeler, 2006; Gorin, 2004; Kroll, 2004; Tunnard, 2002; ChildLine, 1997; Hill, Laybourn & Brown, 1996.

On seeing the range of things that children need by way of support and the challenges faced by those delivering services it is not surprising that it is proving extremely hard to get the response right – a response which is safe and structured yet which offers flexibility and can be individualised and responsive to the range of needs which different children will have. It is worth remembering that children may be invested in maintaining a family secret, and be fearful that the family will be broken up, which can affect their help seeking. Issues related to practice will be discussed in more detail later in the review. First, the next section will consider the key findings from evaluation studies which have been undertaken in this area.

### ***How services help***

In line with the growth of services in this area in recent years, there has also been an increase in the amount of evaluative oriented research which has been conducted. This section of the review will consider the services which have been included (because an independent evaluation has been completed), the children and families that they supported, the ways in which the interventions benefitted children, parents and families, and some broad issues which relate to development, delivery and sustainability. Table D in Appendix B summarises the studies known about in this area. It should be acknowledged that the number of services will of course be greater than those listed in Table D, but the table summarises services where known evaluations have been completed and where published papers or reports are available.

### *Overview of the services*

Table E shows that across England, and also including two examples of work from Wales and Northern Ireland, there are 18 services for children<sup>22</sup> (some also including their families) where there is a published evaluation (usually a report and/or summary document). There are five published articles from this group of work (Templeton, 2012; Templeton, Novak & Wall, 2011; Wall & Templeton, 2010; Forrester et al., 2008; Taylor et al., 2008). While this is clearly a small sample to consider, and the number of services for children and their families is far greater, there is nevertheless much learning to come from this body of work and this will be considered below. However, one immediate gap to highlight is the dearth of evaluative research of the efficacy of services for children and families in this area (Harwin et al., 2010; Mitchell & Burgess, 2009). Services need to be supported to introduce formal research and evaluation procedures to their work, to work in partnership with academic and other local partners to undertake this work and, finally, the resources are needed to encourage this work. It is possible that there is quite a bit more unpublished evaluative research in this area, which was not identified for this review, in which case efforts are needed to ensure such work is published and disseminated widely.

There are a number of strengths and limitations to the studies summarised in Table E. First is the increase in work in this area, the efforts that have been taken to include the views of children in such evaluations and the strength in the volume of qualitative data that is available and with the creative methods which some evaluations have employed. However, in terms of limitations, many of the studies are based on small samples, rarely include any follow-up (exceptions are Families First, FDAC and Option 2), and are also limited by a lack of quantitative outcome data (exceptions are CoreKids, Breaking the Cycle and some of the Comic Relief projects). Furthermore, there is often a lack of data from younger children and much of the research in this area is based on pilot work and on unpublished research reports. There is also little work which has considered specifically how services support children affected by parental alcohol misuse, or which has considered how parental alcohol or drug/substance misuse may differentially affect the help which children need and how they benefit.

Overall, while the studies demonstrate how children (and their families) seem to benefit in the short-term from the help they have received (see below), it is hard to generalise such findings, to conclusively attribute success to the service or intervention itself (because of a lack of control or comparison groups), or consider how different groups of children may benefit from the help which is available. An exception is the Option 2 evaluation which adopted a quasi-experimental design to include a comparison group of families who did not receive help from the service (Forrester et al., 2008). Finally, there is a need for greater economic research in this area – exceptions in the group of

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<sup>22</sup> The Comic Relief Alcohol Hidden Harm project included five different services. Two of these services (CASA and CoreKids) were also involved with separate evaluation projects, reported separately in Table D (but they have only been counted once in considering the total number of services covered by Table D).

studies included here are Families First, FDAC, Option 2 (all focused their attention in this area to the cost benefits for the care system) and Breaking the Cycle. For example, both Families First and Option 2 demonstrated the potential for their interventions to produce cost savings, particularly in relation to lower levels of involvement, and less time engaged with, the care system.

Overall, therefore, one finding from this aspect of the review is the need for more, larger scale and longitudinal, experimental research. A rare example of the type of work which is needed is a study which is underway in Germany (Broning et al., 2012). The TRAMPOLINE study is a randomised controlled trial which is comparing children aged 8-12 years who receive a nine week addiction specific group programme to another group of children who also attend a group programme but one which is not addiction specific. The trial has recruited 218 children, with data collection occurring at the start and end of the group programmes as well as six months later. This has the potential to be an important study, with learning in a number of areas, although care will be needed in the interpretation of the findings to the UK context.

Ten of the service evaluations directly included views of children, drawing on qualitative methods in most cases, with the use of questionnaires and/or drawing exercises in a few cases. While it was not always clear for some of the evaluations how many children were involved (and the final reports from the Comic Relief and CoreKids projects are not yet available), it can be estimated that over 200 children contributed to the service evaluations summarised in Table D. It should be highlighted that, for most of the services, the number of children who received help was greater than the number who participated in the evaluation.

#### *Ways of working and profile of families*

The services detailed in Table E of Appendix B work with children (and families) in a range of ways. Several of the services have a range of ways of delivering support. Examples from Table E include:

1. Individual support to children: Base Camp, CASA, Comic Relief Projects, CoreKids, Family Alcohol Service, Steps to Cope.
2. Group support for children: Base Camp, Comic Relief Projects, HHYPE Groups, Holding Families, M-PACT.
3. Whole family support (which brings at least one child and one parent together in some form): Breaking the Cycle, CASA, Families First, Family Drug and Alcohol Court (FDAC) (although the child is not present in Court), Holding Families, M-PACT, Option 2.
4. Multiple family groups: M-PACT.
5. Individual or group support to parents: Breaking the Cycle, CASA, Comic Relief Projects, CoreKids, Families First, FDAC, Holding Families, M-PACT.

The potential for group based support, and issues to consider in developing groups and working with young people (and their parents or other carers), has been highlighted by others (e.g. Broning et al., 2012; Wheeler, 2006), including for children in alternative care arrangements (Evans & Harbin, 2006). Likewise, the potential for whole family support has been discussed by others (e.g. Harbin & Murphy, 2006). A review of interventions for families affected by parental substance misuse summarised that, from a range of child welfare and drug and alcohol oriented treatment interventions, there is evidence of positive benefits (Mitchell & Burgess, 2009). Additionally, the authors concluded that, based on the evidence reviewed, there is a need for intensive family services that are based on a strong therapeutic alliance between worker and child/family, and that a range of services will most likely be needed in any area to respond to the complexity and scale of need which families will present with. Those key messages support the research reviewed here. A major gap which Mitchell & Burgess identified was the lack of services or interventions which work directly with children, although the current review suggests that there has been some improvement in this area in the last few years.

Eight of the services, including all five of the services that were part of the Comic Relief project, worked solely with alcohol. In addition to this it is noteworthy that several of the other services commented on the prevalence of alcohol misuse within the children/families that they worked with. All of the services are delivered in community settings, with the exception of the Family Drug & Alcohol Court, which is a unique initiative for the United Kingdom (based on a successful model widely used in the United States). In the FDAC model the court uses a problem solving approach; such courts both adjudicate and provide help to parents as a way of helping the child and the evaluation of the model in the United States has shown good results. A further FDAC is to operate in Gloucester and evaluations of the model in the UK have been published (Harwin, J et al 2011). The M-PACT

programme has now been piloted in a privately managed prison in Wales (and is about to be rolled out to two further privately managed prisons in England) but this work is ongoing and currently unpublished so is not included here.

The services were successful at engaging both boys and girls, and children of wide age ranges. However, there were lower levels of engagement of younger children (under the age of about 8-10 years old), although it should be noted that for some services this relates to the age of children who participated in the evaluation (and does not necessarily reflect the age of children who engaged with the service). Some of the evaluations did highlight, however, the challenges in engaging children, particularly younger children, in their research. Data on BAME status was not clear for all the evaluations but the prevailing message is that the services tended to engage, wholly or in the majority, White families. For services which also engaged adults, there was a bias towards this involving the parent(s) with the alcohol or drug problem, and for these parents to be themselves engaged with a treatment services. Moreover, there was a strong sense that there was a bias for many of the services in working with families where there was parallel involvement with child and family social care services. Overall, there were low levels of engagement of non-misusing family members – including, for example, older siblings, grandparents, aunts and uncles, and foster carers.

### *Benefits*

The evaluations of the services all detail a range of ways in which children, parents and families seem to benefit from the help they have received. This evidence is mainly qualitative and based on short-term benefits. There is not the scope within this review to consider in detail these benefits, nor to consider in detail the differences in which children and parents felt that the services helped them. Instead, Box 10 summarises the broad findings on the basis of taking an overview of the evaluations. In addition, a small number of evaluations included a drawing exercise (instead of or alongside an interview) to offer children an alternative means of expressing themselves and illustrating how the service has helped them and their families<sup>23</sup>. Examples of some of the drawings from young people, who attended three different services (two of the drawings are from children who attended M-PACT, one in the community setting, the other in a prison setting), are shown in Box 11. The drawings show the range of ways in which children can benefit, including a change in feelings, getting on better at school, improved family relationships, and an example where the child makes a link between the alcohol misuse and the changes in their family.

Overall, it seems that a number of different services/interventions are able to present encouraging findings for how children and families can be supported. It is outside the scope of this review to consider in detail the content and theoretical orientation of the models of working of these services, and this review is not investigating the extent to which this is discussed in the evaluation reports and papers. Some approaches seemed more popular – including motivational interviewing, solution focused approaches, stress coping models, ideas about working with whole families, creative ways of working with children (such as play therapy), and strengths based approaches. A useful area which would benefit from further research and learning is to gain a better understanding of the theoretical and delivery frameworks of the services as it is unclear whether a specific, named, intervention, the characteristics of an intervention/service, or a combination of the two, might be the most important (Templeton, Velleman & Russell, 2010; Kroll & Taylor, 2010). One of the evaluation reports of the London based CASA service is useful in that it focuses on the service model, considering its strengths as well as the challenges which workers face in using the model in their work with a complex group of families (Wadd et al., 2011).

There are a number of other points from these findings which it is worth drawing attention to. One characteristic which does seem to be critical is supporting children to talk about their experiences, feelings and needs. Research indicates that many children are isolated or have lived with the problems for a long time without talking to anyone/seeking help. However, some research suggests a more hopeful message than this, with almost all of the 45 young people in a European study about living with domestic violence and parental alcohol misuse saying that they had at least one person they could turn to for support (usually close family, wider family or friends) (Velleman et al., 2008). What is perhaps concerning, however, is that young people are less likely to seek help from professional sources, do not know where they could go to seek such help or engage with services

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<sup>23</sup> More information can be found in Wall & Templeton (2011) and Hamama & Ronen (2009).

much later. Issues of trust and confidentiality seem crucial to engaging with this group of children, but it is also important to highlight that professionals face significant challenges in managing the distrust, loyalty, secrecy and denial (held by both children and others in the family) to be able to gain access to children in order to listen to them, explore their experiences and needs, and put the right support in place (Taylor & Kroll, 2004).

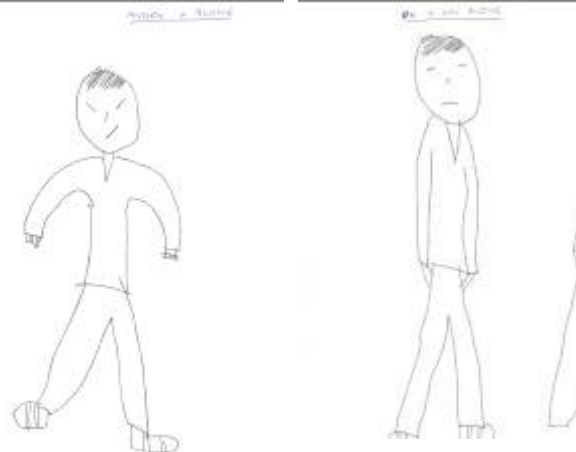
Of particular note is that many children across the studies reported improvements in family communication, largely accompanied by reductions in arguing and conflict. This supports the literature, covered elsewhere in this review, which suggests that children can often be more adversely affected by family disharmony, conflict and violence – and that such an outcome is an important one for these services. However, it was also clear from some of the studies that children did make very clear links between this and their parent's drinking (or drug use) and that the two go very much hand in hand.

### Box 10: Service benefits – for children, parents and families

- Direct involvement of children or direct service to children – focus on children and families rather than addiction – making comparisons to help received before, seeing ‘added value’ to help they received because of its child/family focus.
- Families spending time together (as part of an intervention and/or at home too) – related to improvements in family relationships, increased family cohesiveness and to changes in aspects of parenting.
- Over a third of FDAC families (39%) were reunited with their children by the final court order (21% in the comparison group). For those children who could not remain with their family, this process took on average 7 weeks less for FDAC families.
- Meeting others living with similar problems; normalisation of experiences and a sense of belonging. Reducing isolation and making friends. Being able to talk, individually or in a group, about experiences, feelings, hopes and fears.
- Children learning and understanding about addiction, how it affects them, how it affects their parents and the family. Importantly, increased awareness that they are not to blame for their parents’ alcohol or drug misuse.
- Parents becoming much more aware of what their children know about their misuse, understanding how children and families are affected, recognising how their behaviour can affect others. Parents being more able to listen to children and what they have to say about how they have been affected.
- Improvements in communication – more openness and honesty, listening to each other, reductions in arguing and conflict. Substance misuse is less of a family secret.
- Children thinking about how they cope and being able to think about alternatives, including thinking about how to keep themselves safe. Thinking about further support needs – children thinking about who they can turn to for help.
- Balancing specific (therapeutic) help for children with opportunities to have fun and engage in diversionary activities. Offering families practical help and support with other problems.
- Children being happier – changes in feelings and emotions - feeling less angry and sad, ‘coming out of their shells’, being more confident, increased self-esteem, less anxious.
- Parents learning about parenting, being able to prioritise their children’s needs and so on.
- Changes in own alcohol consumption seen for a small number of children in some studies.
- Parents reducing or ceasing alcohol or drug misuse and/or entering treatment. One project (HHYPE groups) established a relationship with the local treatment provider whereby a parent (whose child attended the groups) could be ‘fast-tracked’ to the treatment service.
- Wider benefits e.g. increased school attendance/performance, change in CPR (at risk register) status.

**Box 11: Children expressing their views of services through drawing<sup>24</sup>**

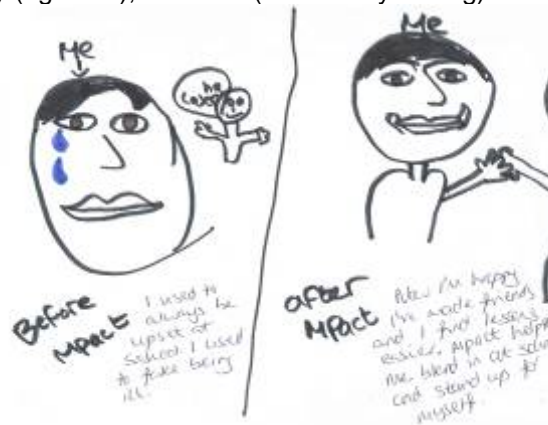
Boy (aged 14), Steps to Cope (Northern Ireland)



Girl (aged 12), M-PACT (prison setting)



Boy (aged 12), M-PACT (community setting)



Girl (age unknown), Base Camp



My parents were drinking a lot. I was upset before Base Camp came, so that's me crying and it used to draw the family apart so there is a broken heart.

The heart is mended because the family is together and there is less alcohol.

<sup>24</sup> Drawings taken from Templeton (2011a, b) and Templeton & Wall (2010). The drawing from the child who attended M-PACT in the prison setting is from currently unpublished research.

Another common theme from the evaluations is the potential for the interventions to target some of the protective factors and processes identified with resilience (discussed earlier in the review). Some of the examples identified in the studies considered here include: positive relationships with one or more adults (includes parents, other family members, workers or other professionals), increased self-esteem and confidence, feeling better able to make decisions (e.g. about seeking help or contact with parents), coping with negative life events, having friends to talk to about the problems, and engaging in diversionary activities. It is possible that the strengths based models used by many of the services are an important influence in this area.

Three of the studies (Families First, Option 2 and FDAC) specifically considered care outcomes for children, although the authors are quick to emphasise that this does not necessarily mean there has been an improvement in child welfare outcomes, recommending the need for further, specific (and longitudinal) research in this area. Nonetheless, Families First reported that for the majority of children the intervention had prevented their entry in to care or long-term placement outside of the family. The authors further highlight the contribution to this outcome made by the involvement of kinship carers (mainly grandparents) in these families. The Option 2 evaluation concluded that children “took longer to enter, spent less time in care and were more likely to be at home at follow-up”, although it did not reduce the likelihood of a child entering the care system (Forrester et al., 2008 p 410). However, for families who had longer-standing problems of greater severity and complexity changes were less likely to be sustained. Similarly, the evaluation of the Family Drug and Alcohol Court reported that an FDAC family was more likely to be reunited with their children by the end of the court process (39% compared with 21% for the comparison group), and that FDAC facilitated swifter processes about alternative placements when a child could not remain in the family (Harwin et al., 2011).

Many of the services have quite a broad focus and remit for the children and families that they will work with, although it is often the case that services found themselves working disproportionately with perhaps two groups of families – those where a parent or child is already known to services, and those more specifically where there is social care involvement. A strength from this work is that it has allowed for a good level of understanding about how to work with this complex, and hard to engage, group of families (e.g. Harwin et al., 2011; Forrester et al., 2008; Taylor et al., 2008). However, there remains a need for a greater understanding of how services are able to engage other groups of children and families, and of what more may be needed, particularly from mainstream services, to reach out to other group of families. Some of the services, such as Base Camp and those in the Comic Relief project, were successful in engaging harder to reach families and those not known to services. In addition, there is a need to consider how interventions can be introduced in to particular settings and with sub-groups of children. Action on Addiction’s M-PACT programme is a useful example here, with one organisation targeting families from BAME groups, and with pilot programmes having been successfully delivered into a privately managed prison in Wales<sup>25</sup>. There is a need for more such focused work.

A final area of learning is that some projects have highlighted the benefits of working with the whole family, including children and/or parents and/or family units as appropriate and according to need (e.g. Breaking the Cycle, M-PACT and the Comic Relief projects), although it should be highlighted that the children need to be at the heart of every response. Addaction has recently published a report in support of a whole family approach to responding to familial substance misuse (Kidd & Roe, 2012), although it is acknowledged that such approaches are few and far between and can raise particular challenges in a number of areas, including partnership working, training, outcome monitoring and the need for longer-term support.

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<sup>25</sup> The M-PACT research included in the review has focused on a report which pulled together findings from the independent evaluation of 13 programmes across England. A separate report is available (via the Alcohol Research UK website) on a programme delivered to a group of BAME families by one organisation in London. The prison work is ongoing, and M-PACT will be introduced in to other G4S prisons (in England) in 2012. More information on M-PACT, generally as well as the prison work, can be obtained from Lorna Templeton or by contacting the M-PACT team directly (see the Action on Addiction website).



### **Development, delivery and sustainability**

*“Notwithstanding individual preferences, in general it was a combination of having access to personal attention when it was needed, alongside group activities offering enjoyment, distraction and friendship, that most appealed” (Clay & Corlyon, 2010 p184)*

*“...given the scale of the problem, local initiatives and special projects are not enough. Effective ways of working need to be found for mainstream services” (Forrester & Harwin, 2007 p1532)*

*“All areas should ensure that specialist services outside of the family environment are available for children affected by parental alcohol misuse” (Turning Point, 2006 p30)*

It is not possible to consider all of these issues in depth so only discussion at a general level is possible. It is likely that there will be subtle nuances, and some differences, in the issues raised here according to, for example, the model of service delivery, the deliver environment and the profile of the client groups. Nevertheless, such a broad discussion is useful learning as part of this review. The list below summarises some of the overarching points which can be taken from the evaluation studies which have been considered; some key issues will then be discussed in more detail.

- Generally, there were very positive comments across the studies about workers and the help children and families received. Even when asked directly there were very few negative comments and this could be for a number of reasons. They may not have received such help before and so had nothing to compare it to in terms of thinking about what was missing or unhelpful. Others may have wanted to be positive about a service that they had found helpful, or might not have been able to articulate anything that they found unhelpful or missing about the service. Finally, it is possible that evaluation participants were more likely to find a service helpful and benefit from it.
- As has already been indicated, it is not possible to directly attribute the changes mentioned by children and families as specific to the intervention or service that they received. Yet, in many of the studies participants did make direct links between changes and the help they had received in the feedback that they gave to researchers.
- Generally, there were good levels of engagement with services and high completion rates of interventions. However, many services seemed to struggle with referrals and recruitment to their service/intervention, indicating that it takes time to embed a new service at a local level and to develop the solid partnerships required to facilitate referral pathways. While it was more the case that services worked with families who were already known to services, some projects were able to improve the engagement of ‘hard to engage’ families, while others demonstrated that they were able to support families who were previously unknown to services.
- Many of the services highlighted the benefits of bringing together multi-disciplinary teams and of agencies working in partnership, although this work took time and was not without its challenges. There were examples of good working between child & family services and alcohol/drug treatment services, or between adult and child services together. Some projects commented on the particular value of involving social workers. The role of Judge was identified as a critical component of the success of the Family Drug and Alcohol Court.
- The services used, or were informed by, a range of models of working and, in some cases, took time to develop their service or intervention model. Offering a specific service to children is vital. However, service models that are child-focused, but which also consider and involve parents and families, are common and maximise the potential for a more rounded and holistic response. Strengths based models appear to be particularly effective. It seems that a careful balance is required between structured frameworks, and the need to work flexibly and creatively.
- In many cases, participants (children and adults) wanted the help they received to continue and found time limited interventions challenging. This raises issues for workers and local set-ups as it is important to ensure that options for continued support are available locally. There is an important role here for universal services such as school or youth services. It is also important to highlight that supporting children (and families) during and after treatment, and so being able to offer support in both the medium- and the long-term, is equally as important as

help at any other time. As one author noted:

*“For many the pre-change family life was seen as preferable to the unpredictability of attempts at behaviour change and the almost inevitable relapse which change entails.....[this is like] a roller coaster of change for those young people involved” (Wheeler 2006, p37)*

- Many of the projects worked with families with multiple and complex problems. These services offered important insights into working with these families and with issues such as co-existing domestic violence/abuse. This work highlights the importance of the service model, taking into account issues such as safe practice, capacity, assessment, training and supervision (for example, CASA and the Family Alcohol Service).
- In many cases the service was new in an area and was able to demonstrate a wider local impact. However, in many cases, funding was short-term and workers and clients alike faced uncertainty about whether the service would continue.

Six broad issues will now be considered in more detail:

1. Identification, asking the questions and engagement;
2. Services working together;
3. Monitoring and outcomes;
4. Key messages for services;
5. Workforce development and
6. Involving children in the development, delivery and evaluation of services.

### **Identification, asking the questions and engagement**

*“Many parents have told me that although they were hoping that no-one would ask about their children when they entered treatment, they were most disappointed and a little suspicious when no-one did” (Robinson, 2008 p16)*

*“...children are very good at making their needs and wants known if the right climate is created for discussion to take place and provide workers take the time to listen” (Kroll, 2004 p137)*

As has been indicated elsewhere, there are a number of reasons why children, and their parents, are reluctant to seek help, and why professionals from a range of services can find this hard to identify and engage. Forrester & Harwin (2006) suggested that an over-emphasis of working with referrals from social services can make it extremely hard for services to focus on the identification of other families who also need support, and for services to understand how to respond when the case does not involve child protection issues where children are at risk (Kroll & Taylor, 2010). Coupled with a lack of services in this area, and the challenges in delivering such services, including the need for services to work together, it is easy to see why this first step in engaging children and their families is often the hardest. However, this first step is incredibly important, given the range of difficulties experienced by children affected by parental alcohol misuse, the fact that many children will not seek help for some time, and the fact that this is a group of children who come to the attention of services much later.

The challenges of engagement, and of the time needed for this process, with families affected by parental substance misuse, have been identified by several authors (Forrester & Harwin, 2011; Kroll & Taylor, 2010; Taylor et al., 2008). Both children and their families can be very fearful of disclosure and its consequences, hence time is needed to get to know the child and explore the issues at their own pace (Hill, 2011; Houmoller et al., 2011; Kroll & Taylor, 2010; Kroll, 2004). Resistance and ambivalence from parents have been identified as key issues to understand and to target in terms of engagement (Forrester & Harwin, 2011; Taylor et al., 2008). Across child and family social work Forrester et al. (2012) highlight five reasons, covering both the parents social context and the context in which social work takes place, for why parents can be resistant to engagement – namely, social structure and disadvantage, context in which child protection work is undertaken, resistance to change, parental denial or minimisation of abuse or neglect, and social workers' behaviour.

The assessment process is therefore also critical in engaging children and their families. Some of the services summarised earlier in this section have developed extended assessment and engagement processes for these reasons (e.g. CASA, Family Alcohol Service and M-PACT). Authors have also highlighted the importance of an assessment including multiple viewpoints (including, critically, the views of children) and of being able to consider the often multiple issues which need to be asked

about and taken in to account. All this requires time and skill, as well as support from managers and colleagues in partner agencies, with the need to ensure that assessment practices collectively gather all the information required, identify gaps and discrepancies, but also avoid duplication (Forrester & Harwin, 2011; Forrester, 2004). It has been recognised that an area where services work well together is within pre-birth, antenatal and maternity services and it is possible that learning from this area could be applied (Kroll & Taylor, 2010; Forrester & Harwin, 2006).

Overall, however, there is a need to consider how this group of children can be more readily identified and engaged with both mainstream and specialist services. One area where attention is needed is how to support a range of mainstream services to be better placed, in terms of, for example, knowledge, understanding, training, resources and links to other services, to engage with this group of children. Examples of mainstream services where support could be improved are primary care, education and generic youth services. For example, several studies have emphasised the increased potential role for schools to identify and support these children (Elgan & Leifman, 2011; Houmoller et al. 2011; Boon & Templeton, 2007; McInnes & Newman, 2005). Daley & Johnson (2004) describe a specialist multi-disciplinary project in Sheffield which aims to support children in schools (who are looked after or adopted), including those affected by parental substance misuse. They describe the difficulties which children may exhibit at school and of solutions which a school can introduce to support these children. Overall, the authors summarise the importance of the approach which a school needs to take, something which could also be applied to other mainstream services:

*“.....the importance of a school that is nurturing and inclusive is paramount.....teachers and staff in schools need to be knowledgeable about the underlying causes and difficulties of vulnerable children, including those with a background of parental substance misuse. However, it is also important that children’s difficulties are not over pathologised or seen as fixed and unchangeable. Teachers, parents and carers need to be realistic and optimistic that a practice and positive joint commitment can make a very real difference to children’s lives.... “.....[schools].....should not fail to appreciate the great deal that they can do, and that provisions made as part of the children’s local mainstream school are often the most effective in helping them to make progress and to feel part of the wider community. By offering routine, structure and consistency, the school can help to mitigate against disruption or disharmony in other aspects of the child’s life” (Daley & Johnson, 2004 p309 & 319)*

However, the education system will need support to improve its work in this area. For example, a survey of Swedish schools explored the potential for schools to have policy documents and to support staff training in order to better identify and support children of substance abusing parents, identifying staff training as particularly important (Elgan & Leifman, 2011). There is also a need for staff in school to have a better understanding of how parental substance misuse can affect children and how this can manifest itself in terms of their behaviour, and what this means in terms of the school’s response. For example, a child who is disruptive or aggressive may be punished or excluded, leaving the underlying cause of the problems hidden (Ofsted, 2011a). Similarly, a child who is performing well at school, but who in fact may be unhappy and concealing the truth of what is happening at home and how it is affecting them, may also remain ‘hidden’ to teachers. Finally, listening to what children have to say about what they find helpful in the school environment (for some, it is a means of escape from their home lives and somewhere where they do not necessarily want to talk about what is going on; while for others it is a general or specific source of support from teachers and/or peers in a range of ways) is crucial. The children and young people who were involved in the focus groups to discuss the emerging findings from this review (see Section 2) discussed the role of schools at some length, highlighting that the response is not a straightforward one in terms of what they expect or want, or how they would like to see schools improve their response.

A final issue to consider in terms of identification is that of screening to improve identification of children, particularly in universal services. An English study involving 66 in-patients (mainly male, primarily with alcohol problems) reported that low numbers of children had problems (identified through use of the Strengths & Difficulties Questionnaire), including substance misuse or mental health problems (Redelinguys & Dar, 2008). While it is acknowledged that there are limitations to the study, nevertheless this work makes a useful contribution in adding to the complexity of understanding the extent to which children may be affected by parental substance misuse, and the capacity for resilience which many of them display. An Australian study reported rather different findings through its use of the SDQ by drug and alcohol workers with the families of 48 children (Gruenert et al., 2008). Findings showed that children seemed to have significantly greater problems

in four of the five behaviour domains measured by the SDQ than a general community sample (emotional symptoms, conduct problems, hyperactivity and peer problems, but not pro-social behaviour) – although 24% of children were classed as ‘of concern’ because they scored in the abnormal range for behaviours. Authors comment on the potential for the use of such a tool by workers with parents in drug/alcohol treatment settings – early intervention – although would need to be supported by worker training, good engagement with parents, and access to support for children who are identified as having problems. Elgan & Leifman (2011) – recommend the use of a questionnaire such as CAST (Children of Alcoholics Screening Test) to screen children in the school setting.

### **Services working together**

*“The challenge is for all services across adult-based alcohol services and children’s services.....to provide a coordinated approach to meeting the needs of the whole family. There needs to be a shared vision that is translated into shared standards and measures for improvement, to align how adult services and children services support children and families, and these must be jointly assessed on their performance”* (Turning Point, 2006 p30)

Several of the services discussed above demonstrate the potential for successfully developing multi-agency and multi-disciplinary partnerships. Nevertheless, it is still widely recognised that this continues to be an area where further understanding and support is needed. A survey of services for children of drug misusing parents reported that few referrals came from adult drug treatment services (Clay & Corylon, 2010) while Forrester & Harwin (2006) reported the low number of referrals to social care which came from primary health care professionals and workers in drug and alcohol treatment services. A national English survey of social workers and social care practitioners also highlighted the reality of making referrals to specialist substance misuse services and working jointly with practitioners from substance misuse services (Galvani et al., 2011).

Overall, there is much to be done to encourage partnership working between a range of services, and to extend partnership working approaches to include universal services. Some of the issues to be consider as part of the developments which are needed include, for example:

- Supporting adult and child services to work together when each is focused on the needs of individuals within the family. For example, adult alcohol treatment services find it hard to consider the needs of children while, conversely, children’s services find it hard to consider the specific needs associated with parents’ alcohol misuse.
- Clarifying and understanding the differences between services in terms of ‘thresholds for intervention’, interpretation of confidentiality guidance, and information sharing. There is also a need to understand how to use these processes as vehicles for engagement and joined up working rather than seeing them as barriers to effective working.
- Encouraging services to understand that it is everyone’s responsibility to support children (and their families) where there are issues such as parental alcohol/substance misuse, and supporting them to understand the more specific roles which each area of service delivery might have in the overall response which is needed.
- Continuing to encourage services to work together when multiple problems are present to ensure that the range of needs are met by the collaborating partners involved with the child or family.

A number of things have been identified as contributing to effective joint working practices. This includes multi-agency initiatives such as joint commissioning and planning, training, forums to bring practitioners together, jointly developed tools and policies (such as referral pathways and assessment tools), crossover posts and the lead professional role (e.g. Kroll & Taylor, 2010; Sawyer, 2009; Nagle & Watson, 2008; Statham, 2004). It should be highlighted that there a number of excellent examples of partnership working within existing services (Table D). For example, the team of workers who delivered the HHYPE Groups and the team which supports the work of FDAC, came from a range of other local services, while the teams of M-PACT facilitators in each area where that programme operates are usually the result of local partnerships. Furthermore, many of the services brought together highly skilled and multi-disciplinary teams (such as the Comic Relief projects), which bring

valuable opportunities for partnership working with the disciplines/services which practitioners represent.

Another example of a joint working initiative is in Islington, where two specialist posts, a childcare social worker and a health visitor, were employed and placed within adult treatment services (Nagle & Watson, 2008). The aims of the initiative were to support improved communication and working between adult and children's services in order to ensure that more children came to the attention of services and that workers in the treatment services were supported in their work with the families. The combined posts meant that support could be provide ante-natally as well as to the under five's and to children of school age and a number of jointly developed tools supported the work and led to what the authors concluded was a shift across the Borough towards 'Thinking Family':

*"...They are also beginning to view children and young people as more than 'risk' factors, as illustrated by an increase in referrals for family support rather than child protection"* (Nagle & Watson, 2008 p452)

Another example is in Brighton (Welsh et al., 2008). Parents of Children at Risk (POCAR) is an interagency intervention, supported by a multi-agency steering group, which brings together an existing service for female drug users and their families with the local statutory treatment service and the Crime Reduction Initiative. This project highlights the challenges with such a partnership, and the commitment and perseverance which is needed, yet also recognises the potential of such work:

*"A further success has been improved working relationships between Children's Services and Adult Drug Treatment Services; close communication between these services has enhanced understanding of each others' roles and the impact of drug use in the family. There has been a great commitment from all the partner agencies to ensure the programme is a success; however, the levels of communication required are intense and this has a significant impact on the resources of providers....."* (Welsh et al., 2008 p460)

### **Monitoring and Outcomes**

The dual issues of monitoring and recording information about children who use services, and of measuring outcomes associated with service usage, remain substantial challenges. There are a number of reasons why this is such a difficult area and one where little progress has been made, including IT issues associated with recording such information, different recording practices between services working with the same families, and resistance from professionals to taking on this additional aspect to their work. Furthermore, the lack of outcome measures to support the evaluation of interventions in this area has been highlighted (Woolfall & Sumnall, 2010). The work of both Addaction (e.g. through its Breaking the Cycle service, see Kidd & Roe, 2012) and CoreKids (Westminster Drugs Project) to develop outcome tools to support their work therefore has the potential to make a useful contribution to the field. However, this work is focused towards adult clients/family members, and an area requiring attention is to measure, from the perspective of children themselves, how they feel a service or intervention is helping them and facilitating change for them and their family.

It is possible that greater direction from a national level might help drive forward the changes which are needed in this area and the support which services will need, although the reality of this with the introduction of increasingly localised agendas remains unclear. A few years ago Alcohol Concern called for a Public Service agreement in this area and for specific targets to be introduced, for example to reduce number of children in care (Shenker, 2008). However, it should be noted that such a target would not reflect that, for some children, being placed in care is potentially a better outcome than remaining in the family situation.

The Institute for Research and Innovation in Social Services (IRISS) in Scotland has published guidance to support services which work with parental substance misuse to develop an outcomes focused approach (IRISS, 2011) It should be noted that the guidance is oriented towards adult services but a companion guidance document focuses on the generic issue of outcomes for children and young people<sup>26</sup>. The guidance for parental substance misuse uses the outcomes framework

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<sup>26</sup> See <http://www.iriss.org.uk/project/leading-outcomes> for details.

recommended by the Aberlour Trust, which lists five core intervention and risk areas; namely, risk reduction, resilience, parenting, dependency, and life skills – each area has a number of components to it. One of the suggested tools listed in the guidance is the Outcomes Star, which is a method for facilitating and measuring change when working with vulnerable groups of people. There are a number of Stars, to support work with particular issues or groups of people, which may have relevance to encouraging a more outcomes focused approach when working with children and families affected by parental alcohol/substance misuse<sup>27</sup>.

### ***Key messages for services***

From the research which has been reviewed it is possible to suggest a list of issues which need to be considered when developing and delivering, individually or in partnership, services to support children and families affected by parental alcohol/substance misuse (Box 12). The overall approach which is needed could be based on the following principles:

1. Predominantly child centred;
2. Takes a multi-agency holistic approach to minimise fragmentation and compartmentalisation of services;
3. Offers both intensive and targeted support, to individuals and whole families, within a framework of universal provision;
4. Guided by joint commissioning and planning, which is supported by evaluation and outcome monitoring;
5. Models an holistic family oriented approach, guided by an appropriate consideration of risk as well as the incorporation of strengths and goals focused work;
6. Operates within safe practice frameworks;
7. Offers a range of options for children and families in terms of help/interventions, and which is not necessarily time-limited, and considers where support in the longer-term is needed.
8. Draws on evaluation by children and young people themselves.

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<sup>27</sup> See <http://www.outcomesstar.org.uk/> for more details.

## Box 12: A menu for services to consider<sup>28</sup>

- Listening to children and including them and their views in the planning, development, delivery, review and evaluation of services.
- Understanding the difficulties which both children and families have in coming forward for help and engaging with services, and being able (as appropriate, and with partner agencies as relevant) to develop a response which considers the needs of children, parents and the whole family.
- Screening and assessment processes, and appropriate procedures/pathways to engage children (and families) with services – particular focus on early identification/intervention and on making the process increasingly child oriented.
- Flexible services which have a range of options, can cater to individual need and offer support for as long as they are needed. Change does not happen quickly, time is needed.
- Support is equally important when the misusing parent is in treatment or has completed treatment, making support in the longer-term important.
- Flexibility in service delivery - after school support and support during holidays, outreach services, home-based support and services which can respond to need according to, for example, rural location of the needs of families in different communities.
- Developing substance misuse services which are more family focused. Fast-track to treatment and rehabilitation for parents.
- Having services which support children and families to engage with local communities and mainstream services. Potential for peer support services.
- Being creative in the types of services which are available to children. Including, for example, including diversionary (fun) activities and the opportunity developing trusted and safe relationships with key adults e.g. mentoring support, creative ways of working, group support, anonymous support (such as a helpline), drop-in centres, out of hours support, individual and family counselling.
- Support for parents and children away from social care environments.
- Ensuring children and families can easily find out what services are available and how they can be accessed.
- Importance of basic training for workers (and advanced training where appropriate), and the importance of supervision to support the work.
- Resources to support the work – for children, families and professionals.
- Understanding that children may have a range of needs; this may include 'talking therapies', information, practical support, targeted support for key issues (e.g. MH, bullying, school work, offending, own alcohol/drug use), or support as a young carer.
- Increased involvement of and support to children when parents are in residential treatment and rehabilitation services.
- Supporting children in certain environments (e.g. foster or residential care) to have improved access to services like ChildLine.
- Coherent policies between agencies on specific issues (e.g. kinship care).
- Consider specific needs of groups of children (e.g. from BAME groups, those affected by FASD, those in care) and also of specific groups of parents/carers (e.g. kinship carers, foster/adoptive carers). Increased support to younger children.

<sup>28</sup> Cleaver et al., 2011; Turning Point, 2011; Clay & Corlyon, 2010; Mariathanan & Hutchinson, 2010; Boon & Templeton, 2007; Turning Point, 2006; McInnes & Newman, 2005; Gorin, 2004; Kroll, 2004.

### **Workforce development and supporting practice**

In order to support the issues which have been discussed above, there are a number of matters which need to be addressed to ensure the workforce, both specialist and mainstream, is both prepared for such work and supported to do the work efficiently and safely. There are a number of guidance documents and other resources, for children, parents and workers, to support work in this area. Some examples are given in Table I in Appendix B.

A key issue to consider is training. Inevitably, this issue has focused on social workers. In light of findings from two national surveys in this area, one with student social workers (N=121: Galvani & Hughes, 2008), and one with social workers and social care practitioners (N=646: Galvani et al., 2011), which reported that high numbers of participants had received no or minimal substance misusing training and did not, as a result, feel adequately prepared for such work, it is clear that this is an area where attention is urgently needed (see also Forrester & Harwin, 2011). However, alongside work which is needed in this area, it is equally important that other professionals in specialist and universal services receive training in both understanding and working with parental alcohol/substance misuse (e.g. Elgan & Leifman, 2011). More specifically, many professionals would benefit from focused training on alcohol. For example, Forrester & Harwin's research reported that social worker attitudes towards alcohol can influence their practice. Social workers can have different thresholds for intervention with parental alcohol misuse compared with parental drug misuse, which can affect their response and decisions and, ultimately on care plan arrangements. As another author highlighted such ".....differences that may be partly attributable to professional attitudes and levels of awareness rather than parental capacity per se" (Hart, 2004 p259).

An important development therefore in terms of workforce development is the Family Training Programme (Alcohol Concern/Wendy Robinson Consultancy), which has been running for about three years (currently funded by the Department for Education). The aim of the programme, through a range of courses and supporting resources, is to develop direct practice skills for a range of practitioners, covering engaging families, building resilience in children, developing protective parenting and collaborative approaches to risk and child protection for a range of professionals from universal and specialist services<sup>29</sup>.

Some academics in this field have considered the potential adaptation for younger populations of interventions which have been developed for adult family members. Two such examples will be considered here; Motivational Interviewing (Forrester et al., 2012, 2006; Forrester & Harwin, 2011)<sup>30</sup>, and the 5-Step Method (Templeton, 2010; Harwin, 2010).

Forrester and colleagues explore the potential for motivational interviewing (MI) to support social workers to manage resistance in their own work and to minimise other reasons for parental resistance which they come across in their work (Forrester et al., 2012, 2006; Forrester & Harwin, 2011). Forrester et al. (2012) explain that one of their reasons for introducing motivational interviewing in to social work practice is that it has a strong evidence base for working with alcohol problems. Their research (Forrester et al., 2006) illustrated that the majority of social workers have confrontational communication styles and have low levels of listening skills, but that, with two days training in MI, a group of social workers (in child and family teams in London) were displaying greater empathy and reduced confrontation in their work (including with parental alcohol misuse), which they felt did lead to improvements in relationships with their clients, as well as being more confident and less stressed. However, Forrester et al. are cautious about the wider implications of their findings, indicating that, for example, two days training is not sufficient to raise social workers skills in MI to the required level or for the techniques to be employed routinely in their practice. An interesting final point noted by Forrester et al. (2012) is that some research has highlighted that MI seems to be particularly effective with clients from BAME groups.

Another example, discussed by Templeton (2010) and Harwin (2010), is the potential for the 5-Step Method, a brief intervention for adult family members affected by a relative's alcohol or drug misuse (Copello et al., 2010a, b) to be applied with young people. Such an intervention has recently been

<sup>29</sup> See <http://www.alcoholconcern.org.uk/consultancy-and-training/consultancy-training/family-training> for more information.

<sup>30</sup> Forrester and colleagues have published other papers on this subject, and have also completed research for Alcohol Research UK (see their website for more details), with three references selected for inclusion in this review.



piloted in Northern Ireland with young people aged 12-18 years affected by parental substance misuse and/or parental mental health problems (Templeton, 2011). While the results from this initial pilot, which involved 21 practitioners and 23 young people, are encouraging, suggesting that the model can be successfully adapted, further work is needed. Harwin (2010) discusses the potential for such a brief intervention to fill a gap in terms of support needed when “problems are serious but perhaps not critical” (Templeton, 2010) and where the complexities of the involvement of children and family services are absent. Harwin also discusses the potential for such an intervention within ‘generic’ family services such as SureStart, Children’s Centres, youth services or the education sector, although she also highlights the need for appropriate training and supportive frameworks to ensure safe practice. While Harwin is more cautious about introducing the 5-Step Method within ‘social services’ she recognises its potential, and the useful contribution it could make to social workers who have little or no training in this area.

### **Involving children in the development, delivery and evaluation of services**

There is a key role for children in the development, design and evaluation of services. The participation of children in all elements of service delivery is something enshrined within the UN Convention on the Rights of the Child (UNCRC) – see section one of this report for more detail. It is also considered within the youth sector as a key indicator of effective service delivery.

Numerous approaches, tools and techniques exist for gaining children’s participation in service design and evaluation. One framework for enabling, and measuring, this process is provided by the ‘Hear by Right’ model recommended by organisations such as the National Youth Agency and Participation Works. Based on McKinsey’s Seven-S Model of Organisation Change<sup>31</sup> ‘Hear by Right’ is a tool which enables organisations to evidence what participation already takes place, where there are gaps and how to develop an action plan for improvement. More recently the Local Government Association has also commissioned publication of guides to support local authorities in commissioning services for children and young people, including supporting children’s participation in the commissioning process (see Table I).

#### **Key Messages**

1. There is no clear picture of the number and range of services available to children (and families) affected by parental alcohol misuse.
2. The number of services, and evaluations of some of these, is growing. There is evidence of a range of ways in which children parents and families seem to benefit from services and interventions. However, there is a need for research to consider the potential longer-term benefits of such support, to include comparison with control groups, and to assess cost-effectiveness.
3. It is unclear whether the potential benefits of services are driven by a particular model or intervention, or if it is the characteristics of the support, and the relationships between children/families and workers which guide change.
4. Interventions which operate with strengths based frameworks appear to be beneficial in engaging families and facilitating change. Some research has indicated the potential for the transferability of interventions developed for adults to younger populations (for example, Motivational Interviewing and the 5-Step Method).
5. Some services have demonstrated success in working with both hard to engage families and families who were previously unknown to services. However, families already known to a range of public services tend to dominate caseloads and a greater focus is needed to reach those children and families who are not already known to services.

<sup>31</sup> Shared values; Strategies; Structures; Systems; Staff; Skills and knowledge; Style of leadership. From: R.H. Waterman, T.J. Peters, and J.R. Phillips, "Structure is not organisation", McKinsey Quarterly in-house journal, McKinsey & Co., New York, 1980

6. Services need to be flexible in a range of ways – for example, not be time-limited, work in a range of (creative) ways, be prepared to offer support in the longer term, offer a range of things to children and families, and consider how to support children and families separately as well as working with family units.
7. The links between universal/specialist services, adult/children & family services and alcohol/drug treatment services are crucial. There are a number of benefits to partnership working, and some examples where this has been successful are linked to joint commissioning and planning, training, forums to bring practitioners together, jointly developed tools and policies and the lead professional role.
8. Workforce development is a critical issue, with particular emphasis needed on training social workers, schools and universal services (such as primary care, education and generic youth services).
9. Easy routes to accessing services, such as free and confidential helplines, are an important part of the support which this group of children need.
10. It can be very hard for children to talk about parental alcohol misuse; however, children have told us some of what they need in order to get help. Children want a patient, empathetic and sensitive approach, based on trust, in which someone who is helpful, caring and encouraging recognises their circumstances and takes the time to get to know them.
11. Services for children experiencing parental alcohol misuse need to extend beyond childhood and support young adults, many of whom need additional support with issues after parent(s) are receiving treatment and after they have left the family home.

## Research Question 5: What is the current policy context for children and families where there is parental alcohol misuse and how might it be improved?

*“Hidden Harm should not be solely equated with child protection” (Hill, 2011 p6)*

*“Children affected by parental alcohol problems do not receive the attention they deserve. We do not know how many children are involved, the full extent of the impact on their lives, and how their needs might best be met. Despite a proliferation of services and initiatives developed for them across Europe, there remain many and significant shortcomings in the policies and services designed to promote their well-being” (Harwin et al., p71)*

There are several areas of policy which can be associated with parental alcohol misuse. This section of the report does not aim to give a comprehensive view of this area. Rather, it aims to give an overview of the key policy drivers which have considered this issue, how this has moved the issue forward and where gaps remain.

Overall, over the last 10 to 15 years there have been improvements in policy, across the United Kingdom, in terms of recognising and attempting to respond to children affected by parental substance misuse (Velleman, 2010), although the extent to which alcohol has been considered varies. Policy in England in this area has been largely driven by two overlapping areas of policy – drugs policy, and the children and families agenda. The major catalyst for policy change came in 2003 with the publication of the Advisory Council on the Misuse of Drugs report Hidden Harm: Responding to the needs of children of problem drug users (ACMD, 2003) and a subsequent progress report (ACMD, 2007) which noted that, for England, the Government had accepted 42 of the 48 recommendations made in the original report. Coupled with a growing focus from successive Governments on families over the same period (Every Child Matters, Think Family, Respect, and Troubled Families) there has been substantial progress in recognising and supporting children affected by parental substance misuse. However, there are major limitations to the progress which has been made. Overall, it is likely that the lack of a clear picture about prevalence in this area is preventing the issue of parental alcohol misuse getting the policy attention that is required.

The Government’s Alcohol Strategy<sup>32</sup> was published in March 2012. Disappointingly there is very little focus specifically around parental alcohol misuse and the impact upon families. In comparison the National Drug Strategy<sup>33</sup> is much stronger around the impact of parental use and families. This perhaps reflects the broader issue, outlined above, that the response to alcohol related harm has been weaker, in comparison, to that of illegal drug misuse.

With regards to drugs and alcohol policy, there has been a greater focus placed on children who are at risk, particularly those known to child care services or who are the target of the Government’s family agenda, which has meant that there has been less progress made in identifying and supporting the larger numbers of children defined as ‘in need’ and who are often not known to, or engaged with, services. The Government’s ‘troubled families’ approach, which aims to targets 120,000 families, does not include parental substance or alcohol misuse as one of its seven defining criteria. Rather, “drugs and alcohol misuse’ is a discretionary measure which may be applied at the local level when seeking to identify families”. Further, as highlighted by Adfam and DrugScope in a discussion of the troubled families agenda:

*“it’s also worth noting that when drugs and alcohol do appear, it’s as a manifestation of high costs for local authorities, rather than as something troubling to families in their own right.” (Adfam/DrugScope, 1st May 2012 p7)*

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<sup>32</sup> The Government’s Alcohol Strategy, March 2012, © Crown Copyright. ISBN: 9780101833622. Available at: <http://www.homeoffice.gov.uk/publications/alcohol-drugs/alcohol/alcohol-strategy?view=Binary> (last accessed July 2012).

<sup>33</sup> DRUG STRATEGY 2010 Reducing Demand, Restricting Supply, Building Recovery : Supporting People to Live a Drug Free Life. Available at: <http://www.homeoffice.gov.uk/publications/alcohol-drugs/drugs/drug-strategy/drug-strategy-2010?view=Binary> (last accessed July 2012).

In terms of moving the issue of parental alcohol misuse more to the forefront of key policy agendas, it is important that initiatives such as 'Troubled Families' consider the role which substance/alcohol misuse plays within the families which it aims to support. However, it is also imperative that the issue of parental alcohol misuse is considered much more broadly than the current focus on families who are 'troubled' and/or at risk. Patterns of alcohol consumption are extremely varied, and parental alcohol consumption at all levels, not just dependent drinking, has the potential to affect children, meaning that the policy response needs to take a similarly broad approach. Overall, despite its greater prevalence, far less attention has been given to parental alcohol misuse, an issue that has often been subsumed within the wider drugs agenda. The Hidden Harm progress report (ACMD, 2007) recommended that the needs of children affected by parental alcohol misuse be given greater attention (Hill, 2007). However, there remains a greater focus on parental substance/drugs misuse without also explicitly mentioning or considering alcohol (Turning Point, 2011 & 2066; Delargy et al., 2010; Mariathasan & Hutchinson, 2010). Alcohol seems to be a more 'hidden' problem than drug misuse, with parents and other family members reluctant to come forward for help, which contributes to the increased risks faced by children. A suggestion from this review is that all children (almost by default, at least initially) living with parental alcohol misuse should be seen as 'children in need', with far greater emphasis given by research, practice and policy towards this significantly large, and overburdened, group of children.

A further issue to highlight, based on research in Scotland (Wilson et al., 2008), is that policy in the area of parental substance misuse has been too narrow in its focus in a number of areas:

*“policy constructions of parental substance use have focused on young children rather than young people.....policy construction should take a broader, longer-term perspective.....the piecemeal nature of current policy approaches to parental substance use and youth transitions highlights the situation of some, while obscuring that of others – particularly those who.....lack parental support”* (Wilson et al., 2008 p283 & 286).

Another limitation, given the common co-existence of alcohol with other problems such as domestic violence or mental health problems, is that opportunities have been missed for different areas of policy to work together to consider the best integrated response to children (and families) where there is parental alcohol (or drug) misuse. As a result of this there has also been an overall lack of policy and practice direction, at both national and local levels, in terms of encouraging services to work together to support these children and their families. There are some examples of joint working protocols which have been developed, but much more work in this area is needed.

It was highlighted by the Expert Group convened for this review that there is an opportunity, on the back of this review, to get the issue of parental alcohol misuse on to local agendas, particularly with regards to elections for police and crime commissioners and local mayors. The Expert Group felt that debates around drugs and alcohol misuse at the local level often revolve around the night-time economy and this report may present a platform for which this debate can be refocused on the impact to families and children. While there may be many examples of local policies and guidance with regards to parental alcohol misuse none were identified through the searching of literature for this review or through requests made via the Local Government Association Knowledge Hub(s). A more extensive review process than that achieved through a Rapid Evidence Assessment, or activity specifically focused on addressing this gap, may be required to elicit current examples of policy at the local level.

The policy focus for this review is on England. However, there have been some important developments elsewhere in the United Kingdom, and areas of learning which could be applied to the English situation. Some examples are listed briefly below.

- In Scotland the issue of parental substance misuse and the impact on children is a priority issue within national drug and alcohol policy, although much of this focus is towards children at risk. In 2012, there has been an important development in terms of implementing policy at a local level across Scotland. Seven core outcomes have been agreed, outcomes against which all Alcohol and Drug Partnerships (there are 30 of them) will be expected to deliver against. Outcome 4 is focused on children and families and states that, “CAPSM: Children and family members of people misusing alcohol and drugs are safe, well supported and have improved life-chances: this will include reducing the risks and impact of drug and alcohol

misuse on users' children and other family members; supporting the social, educational and economic potential of children and other family members; and helping family members support the recovery of their parents, children and significant others" (Copello & Templeton, 2012).

- In Wales children and families affected by substance misuse has also been prioritised in the national substance misuse strategy. Another important initiative in Wales is the roll-out of Integrated Family Support Teams). Like the English 'Troubled Families' model, the aim is to support vulnerable complex families with complex problems. However, unlike the English model, the Welsh approach is concentrating its efforts towards families where parental substance misuse is an identified issue.
- In Northern Ireland the issue of parental substance misuse has been prioritised through both the national New Strategic Direction for Drugs and Alcohol (Phases 1 and 2) and the national Hidden Harm action plan. This has been accompanied by a series of targets and outcomes for responding to this issue, along with a statement of the importance of addressing the issue as a children and young people's one.

It seems that there are a number of issues which are important in terms of the development of policy in this area. Based on a review across Europe, a summary of key factors which contributed to the provision of services for Children Affected by Parental Alcohol Problems (ChAPAPs) is reproduced in Box 13 (Harwin et al., 2010 p66).

**Box 13: Main criteria for optimal provision (children affected by parental alcohol misuse)**

- An awareness of the issues facing ChAPAPs, and the services necessary to meet their needs, on the part of the government, local services, voluntary organisations and the public at large;
- A consistent political commitment and motivation to view ChAPAPs as a priority and provide necessary services within the broader context of provision for children and families;
- Effective and coherent alcohol policies that, among other things, restrict availability of alcohol;
- Systematic national recording on the prevalence of ChAPAPs and on the prevalence and recognition of foetal alcohol syndrome disorder;
- Cooperation and collaboration between different services, promoted by effective networks and other coordinating links, as well as partnership working between central and local government;
- Evidence-based services and provision informed by sufficient and appropriate research as well as examples of good practice demonstrated by international colleagues;
- High quality training for all professionals working with ChAPAPs in either a direct or an indirect role;
- Adequate funding to resource services and initiatives beyond the short-term;
- Services to identify ChAPAPs at an early stage and particularly before parents are provided with treatment; and
- An open-minded approach to new service developments that does not reflect a resistance to change.

## Key messages

1. Over the last 10 to 15 years there have been improvements in policy in terms of recognising and attempting to respond to children affected by parental substance misuse in the UK. Despite this, there remain major limitations to the progress made.
2. Addressing the lack of prevalence data in this area may serve to give greater policy recognition to the issue of parental alcohol misuse.
3. The current family-focused agenda does not address parental alcohol misuse at a strategic level. There is a lack of alcohol specific focus. Similarly, there is less recognition, and response, to alcohol misuse, compared to drugs misuse. The need for a campaign similar to Hidden Harm for alcohol has been championed before – by agencies including Turning Point, The Children’s Society and Alcohol concern – and may be beneficial.
4. The emphasis within policy on children at risk, and on the most vulnerable or ‘troubled’ families is welcomed. However, the number of children who can be affected by parental alcohol misuse is likely to be a far greater group and policy must achieve a finer balance to also consider the needs of all children who can be affected by parental alcohol misuse, many of whom will be ‘in need’.
5. Harms associated with parental alcohol misuse are not necessarily correlated with the level of alcohol consumption. Policy must ensure that it does not take a narrow focus on parents who are dependent drinkers, but that it considers how to best support all children who may be affected by a range of patterns of parental alcohol consumption, including dependent drinking but also, for example, binge or harmful drinking.
6. Parental alcohol misuse often co-exists with a range of other problems. For example, children may be more adversely affected by family disharmony, conflict and violence but children make very clear links between this and parental drinking. Greater integration of different areas of policy, to consider the issue of parental alcohol misuse and the development of a more consistent response across policy, is needed.
7. Policy has focused largely on young children, however, for many growing up with parental alcohol misuse problems may continue into their young adult life. Policy development needs to take a broad enough scope to encompass this.
8. In an ever changing climate it is unclear which Government department should take the lead with this issue, how Government departments should work together to develop the best response, or which areas of policy should be targeted in order to give the issue of parental alcohol misuse greater policy attention.

## **Research Question 6: What are the gaps in our knowledge about children affected by parental alcohol misuse, and of services for these children?**

While there are a number of strengths to the work which has been conducted in the area of parental alcohol/substance, this review has inevitably highlighted a number of gaps in understanding this group of children, their families and the help which they need. In relation to the consultation exercise involving children and young people, and the five main questions which this review set out to investigate, the following gaps have been highlighted.

### ***Experiences of children***

- The size of the problem, the number of children who are affected by/living with parental alcohol misuse, remains unclear. There are also no England/UK data on how many children are affected by FASD (foetal alcohol spectrum disorder).
- A lack of work which has considered the specific ways in which parental alcohol misuse can affect children, and in understanding wider cultural and societal influences (such as family influences in developing knowledge, expectations and intentions about alcohol, and the way in which alcohol is portrayed in a range of media including advertising) and how they impact upon how children are affected by parental alcohol misuse.
- A need for a greater understanding of the role of gender with regards to:
  - How maternal and/or paternal alcohol misuse, and its impact in terms of mothering and fathering, affects boys and girls;
  - The low numbers of boys seeking support – between 71% and 80% of children and young people contacting helplines are female.
- A lack of research which has explored how a range of different groups of children are affected by parental alcohol misuse – including young carers, children from a range of BAME groups, children of prisoners, children who are bereaved, the young homeless, and children who are cared for by others.
- A lack of understanding of how older young people/young adults remain affected by parental alcohol misuse in childhood, and of how they reflect upon and process their experiences as they get older.
- Work in this area has generally not considered the level of consumption of alcohol (for example, harmful, hazardous, dependent, binge-drinking) and how this relates to the experience of children and the levels of harm they face. The consultation exercise with young people, and some of the research in this area, has suggested that the ‘disease model’ of alcoholism can be a useful framework to aid children’s understanding about their parents’ alcohol misuse; yet we do not really understand how children may view or find helpful different theoretical approaches to understanding alcohol use and misuse.
- Many families ‘recover’ from an alcohol problem without accessing services, yet we do not understand how these families experience this journey of natural recovery and what this might mean for children, how they experience this, how are they are affected and whether they would still benefit from support and intervention.

### ***Wider issues***

- A lack of research which has considered how children are affected by the dual experience of living with parental alcohol misuse and domestic violence and abuse, and of how children understand the relationship between alcohol misuse and violence.
- We know far more about children ‘at risk’ who come to the attention of a range of services; we need to build a similar level of understanding about children at lower levels of risk who are nonetheless ‘in need’. Alongside this, there is a need to understand why children affected by parental alcohol misuse tend to remain hidden from services and how this may be influenced by the attitudes and responses of a range of professional groups.

### ***Protective factors, coping and resilience***

- There is a need for more longitudinal research to understand how protective factors and processes may operate and change over time, and how this may influence a child's coping and capacity for resilience.
- The consultation with young adults suggested that 'coping' is not a term which the participants related to as children; as young people and young adults they were more able to reflect on how they had coped. Yet, they were clear that the association between coping and resilience/survival was not a straightforward one and was not necessarily well understood by professionals.

### ***Meeting the needs of children***

- There is no clear picture of the number of services which are available to support children and families affected by parental alcohol misuse.
- There is a lack of evaluative research to understand how services and interventions can benefit children and families. There is a need for experimental/quasi-experimental research and longitudinal research to consider the longer-term benefits associated with help, as well more quantitative and economic based research. Finally, there is a need to increase the participation of young people in such research and evaluation (including peer-led work).
- Further work in this area could usefully consider what it is about a service or intervention which facilitates change – is it the model and theoretical underpinnings of a particular approach, is it the characteristics of the services and workers, or is it some combination of the two?
- There is a gap in understanding how best to improve the response of a range of universal services, such as primary care, schools and youth services. The consultation with young people highlighted the important role that schools have to play in this regard, although the issues raised by the young people suggested that a number of things need to be considered when supporting schools to do more in this area.
- There is a need for an enhanced programme of training, specifically on alcohol, for a range of professionals from universal services (such as schools) and specialist services (such as social workers and alcohol treatment), to raise their knowledge and understanding about parental alcohol misuse and its impact on children.

### ***Policy context***

- There is a lack of specific focus on parental alcohol misuse in policy development, including the Government's Alcohol Strategy (2012). This is despite important developments in this area elsewhere in the UK.
- Policy should be developed with a broad remit that considers how best to support all children affected by different patterns of parental alcohol misuse, not just dependent drinkers. It should also seek to encompass adults still dealing with issues resulting from parental alcohol misuse experienced at another point in their life.



## Conclusions

Summary information of what has emerged from this review is threaded through the report in the direct quotes from children and young people, in summary boxes and tables of information and in the key messages highlighted at the end of each section (and repeated as an executive summary at the start of the report). Our intention is that this allows the reader to use the review both as a complete document and also to dip in and out of specific findings for the different research questions which structure our report: experiences, wider issues; protective factors; services; policy context and gaps.

Our conclusions for this section of the review are not intended to encompass all the summary information included in the report but to highlight the main conclusions which will inform the way forward. Some conclusions will offer new insight and suggestions whilst others will have been aired before. The latter are more numerous and will come as no surprise to many readers. We make no apology for that. Rather, we use such a statement, which was discussed at length and endorsed by the Expert Group, to highlight that our understanding of children affected by parental alcohol misuse remains an issue which is largely ignored, or which is subsumed by wider agendas which prioritise illegal drugs. The young people who we spoke to, particularly the older ones, held quite strong opinions that society's attitude towards alcohol, its portrayal in a range of media (including advertising), and the attitudes of many professionals are preventing the needs of many children being met. More importantly, as a result of this it seems that many children are remaining invisible and silent about their experiences.

What this review adds, therefore, is a focus on parental alcohol misuse and on the extent to which children have been heard and included in work in this area. As a result, in conclusion this review is able to make the following statements.

1. Parental alcohol misuse is a sizeable problem, far greater than parental drug misuse, and one which permeates far in to individual and family life. Alcohol's role in everyday life seems to be a barrier to identifying these children, to facilitating their engagement with services, and to offering them the support and intervention which they need.
2. Parental alcohol misuse impacts upon children in a very wide range of ways, yet is a problem which children and families can remain silent about for many years and which as a result means that children access or reach the attention of services much later and often in relation to other issues.
3. Not enough is known about the impact of parental alcohol misuse amongst specific groups of young people, including Black Asian and Minority Ethnic (BAME) groups, young carers, those growing up with foster carers, grandparents or other kin carers or in residential homes and those also affected by bereavement, prison or homelessness.
4. There is a clear distinction by gender with girls far more likely to seek support (for example, to call a helpline, use a website, tell a teacher/other adult, or access a local service) than boys. This is evident across other issues which children call ChildLine about but, with specific regards to parental alcohol misuse, it is not fully understood why boys do not seek help/support? This may result in boys and young men coming to the attention of services through, for example, offending behaviour and then resisting engagement with services focused on that presenting behaviour rather than the underlying causes/issues. Ideally an earlier intervention focused on the parental alcohol misuse (and other issues) affecting young boys needs to be achieved and more work needs to be done to facilitate engagement with boys.
5. We do not understand in detail how the level, frequency and severity of alcohol consumption and its consequences affect children, nor how natural recovery processes in some families may influence the experiences and needs of children. However, the evidence suggests that it is not just children of dependent drinkers who experience negative repercussions of parental alcohol misuse. A broader consideration might be beneficial and might help services to reach beyond those people already known to them through presenting with other issues.

6. Parental alcohol misuse is closely correlated with a wide range of issues, which can further influence how children may be affected. It is a problem which seems particularly correlated with violence, abuse and conflict.
7. There is increased recognition that many children are less affected by their experiences than might be expected, yet we do not fully understand the relationship between risk and protective factors, coping and resilience, or how these factors and processes operate and change over time, now how they are understood by children as they grow up.
8. There is a clear and important distinction to be made between 'coping' and 'resilience'. Coping or perhaps more accurately 'getting by' in the short term does not necessarily equate to resilience in the long term. There is evidence of children reporting 'hiding' or escaping from their day-to-day lives, anger, aggression, truancy and violence as different ways of 'coping'. It may also be the case that discursive narratives around children 'coping' with parental alcohol misuse leads to inaction or inertia on the part of universal services and in policy. This is not acceptable and the scale of the problem – highlighted in this report and elsewhere – emphasises the need for action on parental alcohol misuse.
9. Far greater attention has been placed on children who are at risk, and who are usually known to child and family social care services, and who are often seen as coming from particularly vulnerable, complex and chaotic families. This means that there are vast numbers of children who remain hidden and whose needs are unmet. There is a risk that the current policy and practice response will continue to prioritise the needs of certain groups of children and their families at the exclusion of a far larger group who are not known to services and who might be described as 'surviving in silence'. Policy responses solely predicated around the 'problem/troubled families' could exacerbate this problem. A broader policy response is required.
10. The services which are available seem to demonstrate encouraging evidence, albeit mainly in the short-term, that a range of interventions and services can help and support children and families, leading to positive change in a range of individual and familial domains. Yet, often services are small and time-limited with a corresponding deficit of robust and longitudinal evaluative research in this area. Although it has been highlighted before it warrants reiterating that services need to be able to demonstrate what works through robust impact measurement and this should be incorporated into commissioning processes.
11. The review talked to over 20 children, young people and young adults about the emerging findings and key messages. The views of the participants both endorsed many of the emerging themes from the review as well as facilitating a greater understanding of issues important to children and young people.

The main conclusions described above inform the next steps which emerge from this review. It is not within the remit of this review to make specific recommendations for organisations or individuals. Our intention here is to highlight what we believe are the most important areas to progress with regards to research, policy and practice.

### **Research**

A number of gaps in current research have emerged from this rapid evidence assessment of children and young people's experiences of parental alcohol misuse in England (these are described in detail in the preceding section). Calls for more research, particularly for more quantitative, outcome-based research and for research incorporating an element of economic basis are common place in social science and in this regard such 'next steps' as 'more research' will come as no surprise but are worth reiterating.

The starting point for championing a refocusing of resources towards parental alcohol misuse – as opposed to drugs misuse – is the sheer scale of the problem and, inherent in that, the potential for positively impacting on the lives of children and young people. While the scale and persistence of issues relating to parental alcohol misuse remains unclear or based on 'best estimates' the championing of the cause is somewhat hampered.

A better understanding of scale and impact of parental alcohol misuse should be pursued, particularly for those groups of children less heard by policy makers in this area – including BAME groups, the bereaved, children providing care, children leaving care and children of prisoners. It would be particularly helpful to see longitudinal studies in this area, robust evaluations which include an assessment of the social value created by services (e.g. Social Return on Investment) and children and young person-led research projects.

### **Policy**

Despite improvements over the last decade or more this review and the input of the expert steering group suggest that the current policy response to parental alcohol misuse in England, at both national and local levels, is weak and this is an area where considerable opportunity for progress exists. The stand-out policy issue is the extent to which parental alcohol misuse is seen as less of a priority than parental drug misuse. Previous calls for an alcohol focused ‘Hidden Harm’ report have gone unheeded but the case for such a campaign remains.

Service providers at the local level have the opportunity within the current Coalition Government policy directive around localism to incorporate parental alcohol misuse within emerging agendas, such as tackling child poverty and working with troubled families. New structures for local service delivery – including health and well-being boards and publically elected police and crime commissioners<sup>34</sup> – could provide the opportunity to re-position alcohol misuse around the needs of children and families, rather than the night-time economy and anti-social behaviour.

There is clearly a link between parental alcohol misuse and domestic abuse/violence. While, again, this is not a new finding, it warrants reiterating. Policies joined-up at national and local level would support joint, multi-agency practice in service delivery. Practical activities such as joint information sharing and training events between practitioners and joint-commissioning of services might increase referrals and help reach those ‘hidden’ from services.

More specifics on ‘what works’ in England from the perspective of children and young people with regards to reducing the negative impact of parental alcohol misuse is needed. Commissioning frameworks should ensure that service incorporate realistically-funded evaluation, with the active participation of children and young people.

### **Practice**

What this review has highlighted is that there are some excellent services which are successfully engaging with and supporting children and young people affected by parental alcohol misuse. While much of this review has focused on gaps, and the research and other work which is needed to further the response to this group of children, there is also an opportunity for the range of good practice which is out there to be better disseminated in order to draw attention to the successful ways in which many services are supporting children and families.

The main point to emerge with regards to practice is around the need for more understanding, more cooperation and better support for practitioners with specific regard to parental alcohol misuse. Workforce development lies at the heart of bring about a positive change in the direct response from practitioners in children- and adult-focused specialist services and in universal services.

A key issue from a practice perspective is parental alcohol misuse being recognised as an important issue in its own right at an early stage. This would mean more children ‘in need’ coming to the attention of services earlier and children suffering less harm as a result. A key aspect of this is to ensure that focus is not solely given to young children of dependent drinkers but also to teenagers and to young adults and in families with patterns of drinking result in short and long term harm to children.

What also emerged strongly from the review were issues around ‘coping’ and resilience and the difference between the two. Where children appear superficially to be coping or ‘getting by’ this must not be considered a justification for inactivity or prioritising other issues as this may mask underlying problems.

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<sup>34</sup> The first elections of police and crime commissioners (PCCs) will take place on 15 November 2012.

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## Appendix A - Final search strategy

### Children and Young People<sup>35</sup> Affected by Parental Alcohol Misuse: a research and policy review of needs and services

#### Research questions, definitions and search strategy – February 2012 (revised following comments from Expert Group – and agreed with Jenny Clifton from OCC on 23/02/2012)

##### Overview of project

(based on OCC tender specification and CRC's proposal for the review)

- a. Focus on parental alcohol misuse. However, it is acknowledged that wider parental substance/drug misuse literature will be consulted and included in the review.
- b. The age range of children which the review will consider is 4/5-18 years. Hence the lower age limit is the age at which children start school, while the older age limit matches that of the definition of child as stated by the UN Convention on the Rights of the Child.
  - a. It is beyond the scope of this review to actively search for and review work relating to pregnancy and the periods around birth and immediately beyond. Similarly, it is beyond the scope of the review to actively search for work involving young people (young adults) aged 18 and above. However,
- c. Work which considers children and young people's own perspectives will be prioritised.
  - a. There will be consideration of issues relating to parents and the wider family in so far as they are identified within the review, which has its primary focus on children.
- d. Included documents will consider the extent to which populations of children (e.g. looked after, BME, disabled) are considered and the extent to which overlapping issues (e.g. domestic abuse, mental health, exclusion, poverty, homelessness) are considered.
- e. Search parameters are UK literature within the last 10 years (so 2001-early 2012) and work in the English language.
- f. Focus is England. Academic research from across the UK will be considered. Documents related to policy, practice guidance and services will be included, but primarily from England.
- g. Towards the end of the project, draft findings from the review will be discussed with populations of young people who have lived/are living with parental alcohol/substance misuse – we are already engaged in discussions with individuals who will assist us with this part of the project.

##### Overview of Methodology

Primarily, the study will undertake a rapid evidence assessment (REA), the key stages of which are:

Stage of REA	Time	Anticipated input from Expert Group (EG)
Clarification of research questions and agreement of definitions	Early February	'Virtual' input on draft document focused on research questions, definitions and search strategy
Search and selection process	February	Assistance with accessing documents
Quality assessment (using template and agreed criteria)	March	'Virtual' input to agree quality assessment checklist Face-to-face meeting to discuss 'dataset', assessment of documents and preliminary themes emerging from the review
Synthesis of the findings	April	'Virtual' consultation on final project outputs Assistance with dissemination

<sup>35</sup> The term 'children' is used throughout the review for brevity, to include children and young people aged 4-18 years.

## Research Questions

The context of these research questions is to focus on England to review what is known about the needs and experiences of children & young people affected by parental alcohol misuse (PAM).

1. What is known about the experiences of children and families where there is PAM and to what extent is this informed by the views of children and young people themselves?
2. What is known about protective factors and processes in this population and how they can minimise risk/negative outcomes?
3. What is known about services, and their delivery, and the impact/benefit of such services for children (and families) where there is PAM and to what extent is this informed by the views of children and young people themselves?
  - a. Delivery is likely to include a range of issues – including assessment, training, partnership working, outcomes and monitoring. Will also consider opportunities and barriers around accessing services.
  - b. We do not intend to go directly to services and frontline staff – but we will be examining the extent to which a range of issues (including identified gaps) which relate to practice are considered in the literature that we review.
4. What is the current policy context for children and families where there is PAM and how might it be improved?
5. What are the key wider issues associated with PAM (e.g. unemployment, domestic abuse, mental health) and how do they relate to risk/protective factors for children and families?
6. Thinking about questions 1 to 5 above, what are the gaps in our knowledge about children affected by PAM, and services for these children?

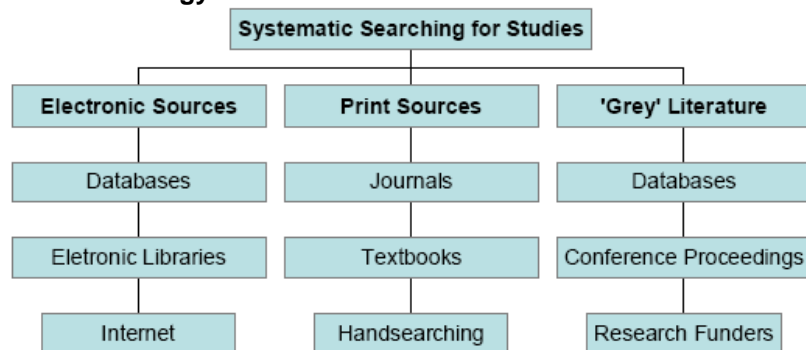
## Key search terms

The key search terms that we will use (separately and by combining terms) are:

1. Children and young people (used separately or together)
2. Parental alcohol use/misuse/abuse/alcoholism/problem drinking/binge-drinking
3. Parental substance use/misuse/abuse/addiction
4. Parental drug use/misuse/abuse/addiction/problem drug use
5. Families (combined with other terms in list)
6. Child protection/safeguarding (combined with other terms in list)

The approach to searching will vary according to the resource. As a rule, however, academic databases (and some other sources) will be searched using combinations of the search terms listed above. Other sources (such as organisation websites) can be scanned (e.g. resources sections or publications pages) for relevant documents – utilising some of the search terms if necessary (or scanning the website to see how they organise and define their work and searching that way).

## Search Strategy



(Davies 2003)

Taken from Government Social Researchers (GSR) Toolkit available at

<http://www.civilservice.gov.uk/networks/gsr/resources-and-guidance/rapid-evidence-assessment>

The table below summarises the key resources that we plan to search/draw upon in undertaking the search for the review (informed by the diagram above).

We wish to identify documents in the following areas:

- Academic research (books, chapters and papers)
- Policy documents and guidance (at both a national and a local level)
- Practice guidance
- Resources for children (and families) e.g. supporting service delivery
- 'Grey' literature – reviews, reports, theses, conference reports
- Documents related to service delivery – such as research and evaluation studies and reports (published & unpublished)

We will not actively search for work using other forms of media (such as websites, social media or TV documentaries/films for example). However, we expect such items to come up as the review progresses – i.e. mentioned as good practice within a policy document or included within a research study or named as a resource to support practice. We will of course monitor this and discuss within the review. We can also discuss forms of media and use of websites, social media as a theme later in the review – and their potential etc. in researching and developing services in this area. This may be one area we consider developing when involving children later in the project.

We do not intend to go directly to treatment organisations to explore the research or other documents (e.g. practice guidance or resources) which they may have undertaken/published. Some of this work will be identified anyway through the agreed search strategy. Some of the work (e.g. suggested by the Expert Group) is already known to the research team.

We anticipate that much of the identified literature will be known to the Research Team and/or the Expert Group. Nevertheless, we wish to undertake a structured search, using the resources and knowledge of ourselves and the Expert Group, to confirm the documents we are finding as well as identifying work that we are not aware of.

Source	Purpose	Comments
Academic databases (online) Available through De Montfort University Library (Leicester) or the University of Bath	Access published (peer-reviewed) academic literature Some will also identify 'grey' literature	Project Cork PsychInfo and PscychExtra Scopus Cochrane Collaboration & CRD (York) CER UK Plus Social Care Online Research Register for Social Care Social Policy and Practice Education Evidence Portal British Education Index (BEI) Education Resources Information Centre (ERIC)
Other online resources – such as organisations & funders	Access reports, policy documents, practice guidance, service evaluations and other 'grey' literature	Adfam Alcohol Concern Alcohol Research UK Institute of Alcohol Studies Drugscope Joseph Rowntree Foundation STARS National Initiative NACOA COAP Al-ateen National Treatment Agency SCIE NICE Index to Theses
Textbooks/chapters	Access published academic literature	Personal knowledge: research team, expert group Identified through other parts of search process

Various online sources - organisational	Access key literature related to overlapping issues with PAM (e.g. domestic abuse, prisoners, grandparents/kinship care, mental health, social care)	Stella Project BASW Grandparents Plus Action for Prisoners Families Ormiston Children & Families Trust Children's organisations – ChildLine, NSPCC (Inform), Barnardo's, NYA, NCH, NCB, Children's Society, Mentor UK
Various online sources and contact with colleagues in Scotland, Wales and Northern Ireland	Access key literature specific to UK (non-England) – focus on policy, guidance and 'grey' literature such as reports and service evaluations	Alcohol Focus Scotland Scottish Families Affected by Drugs (SFAD) Scottish Child Care & Protection Network Scottish Network of Alcohol Practitioners for the Young Alcohol Concern Welsh Office
'Ad hoc'	Access range of published and unpublished literature	Snowballing identified references 'News alert' services e.g. DS Daily, NSPCC CASPAR Journal alerts (academic services) New Directions in the Study of Alcohol Group Journal

## Appendix B – Research Tables

Table C: Research which has included the views of children – England

Study & location	Sample of Children	Details
<b>Alcohol only</b>		
Ohslon (2011)  UK		Evaluation of NACOA helpline
Velleman & Reuber (2007) Also Velleman et al. (2008) & Templeton et al. (2009)  England and Europe	8 young people aged 12-18 (7 female) who were living with domestic violence and parental alcohol problems NB: Final quantitative dataset included 5 of these 8 young people	Part of a larger European study which involved 45 young people (and a comparison sample of 13 from Germany) who completed questionnaires and/or were interviewed. Data from Germany, England, Malta, Poland and Spain
Turning Point (2006)  England	Not stated	Focus groups and interviews with children, parents and service providers (Turning Point services)
Sekhon (2000) in Orford (2012)  England	7 Sikh daughters of problem drinking fathers	Interviews as part of PhD Thesis which also involved 24 Sikh wives and 10 male problem drinkers
Velleman & Orford (1999)  England	164 young adults (aged 16-35) who had grown up with a parent with an alcohol problem Also a comparison sample of 80 young adults who had not grown up with a parent with an alcohol problem	The sample were interviewed twice at length, with interviews roughly 12 months apart. Included collection of some quantitative data.
ChildLine (1997)  UK	3,255 callers to ChildLine (April 1995 - March 1996)	Evaluation of callers to ChildLine – focus on those whose records showed they talked about PAM
Brisby et al. (1997)  UK	3 children (2 girls, one boy, aged 9-15 years)	Part of wider report which included lit review and collecting views of services – also informed by ChildLine data (ChildLine, 1997)
<b>Alcohol as part of parental substance misuse</b>		
Houmoller et al. (2011) – final report Bernays et al. (2011) – report for young people  England	50 young people (30 girls and 20 boys) aged 10-18 years. At least half of the sample affected by PAM. 16 YP were followed up – between 1 and 3 times up to 12 months from the first interview	Family Life Project – a longitudinal qualitative study which also included interviews with 11 significant others, 29 substance misusing parents (unrelated to the main sample of YP) and 17 service providers
Fraser, McIntyre & Manby (2009)  England	8 young people (aged 4-14 years, 4 boys and 4 girls, all White British); 7 affected by PAM	Part of a larger study to explore the impact of PSM in the Midlands, also involved 25 parents (18 families)
Mayer (2004)  England	Not stated.	Book chapter discusses experiences of children from BME groups, informed by those who have engaged with the STARS Project – indicates that about 25% of 160 who engaged with the project between 2002-2004 were from BME groups.



<b>Study &amp; location</b>	<b>Sample of Children</b>	<b>Details</b>
Forrester & Harwin (2004)	N=26 children aged 7 and above. PSM had been a major factor for 16 of the children and an issue for another 5.	Study talked to children about their experiences of care in the two years since the care order.
Louise (2004)	Case study	One young adult writing about her experiences of parental substance misuse and of being adopted
Kroll (2004) N/A	Not stated	Review of 7 studies (5 UK, 4 of which considered alcohol only) which have considered the experiences of children
Gorin (2004) N/A	Not stated	Comprehensive literature review, which focused on work which had considered the views of children, and which also considered domestic violence and parental health problems
<b>Drugs only</b>		
Clay & Corlyon (2010)	14 young people aged 9-17 years who had accessed services for children with drug misusing parents	Part of a wider survey of services for children of drug misusing parents – also involved a DAT survey and 10 service managers
Kroll B & Taylor A (2010)	42 C&YP aged 4-20 years, accessed through children and young people services (i.e. social services). Authors acknowledge that alcohol misuse was one of a number of other co-existing issues for many of the families.	Part of a wider study which also involved interviews with 40 drug misusing parents and 60 health and social care professionals

Table C includes work from the UK which has included England. The table does not include evaluation research (i.e. work which has focused on considering the views of children as part of service/intervention evaluations) – this is covered separately later in the review.

Table D: Research which has included the views of children – elsewhere

Study & location	Sample of Children	Details
Alcohol only		
Holmila et al. (2011) Finland	70 respondents aged 12-18years, mostly girls (17% boys)	Qualitative data collected through web-based questionnaire
Alcohol Focus Scotland (2011)	500 respondents to survey aged 11-18 years, slightly more female respondents	2 page summary only available - little information provided
Hill (2011) Scotland	30 children and young people aged from nine to 20 years old participated in individual, pair or small group interviews or a group work programme	PhD Thesis based on qualitative study using participatory approaches to research with children. Author also produced a video where she discusses the findings of her research.
ISPC (2011) Ireland	9,746 anonymous, self-report questionnaires completed by children from 70 Secondary schools, 8 primary schools and 6 Youthreaches. Respondents were aged 12-18 years and 53% were female, 47% male.	Broad quantitative study based on largely closed-questions (one open-ended) covering young people's own alcohol use/attitudes and their experience of parent/guardians alcohol use. Large
ENCARE (2010) Germany	74 adolescents in the affected group (60% female, age range 11-19, mean age 15.5years) and 109 adolescents in the control group (51% girls, age range 11-19years, mean age 15.07years). Sample from Germany, Austria, Norway and Cyprus.	A prospective cohort field study based on a 'clinical sample' of parents who had a diagnosis for alcohol & had been in inpatient or outpatient treatment because of it. Children had lived with at least one alcoholic parent in the same household for at least six months of the last two years. Study involved a postal questionnaire with adolescents and telephone interviews with alcoholic and non-alcoholic parents.
Wales et al. (2009) Scotland	Qualitative research based on analysis of ChildLine caller database (230 call records from April 2008-March2009 screened for Scotland location, plus comparative call records from 1999-2009); 78 enhanced case notes; 4 focus groups with 19 volunteers and 1 staff focus group with 9 counselling supervisors.	Quantitative analysis of calls to ChildLine, plus qualitative analysis of extra detail provided in sample case notes & focus groups. Useful summary of recommendations for services.
Christoffersen & Sothill (2003) Denmark	Multivariate logistic regression analysis using database containing 155,000 children born between 1966 and 1973.	Children and parents were followed for a 15-year period between 1979 and 1993.
Casas-Gil & Navarro-Guzman (2002) Spain	226 children; 108 from parents who misuse alcohol	Analysis of direct outcome variables measuring academic performance of school-children from Cadiz, Spain. All participants – affected and control group – drawn from same schools. Study identified 5 variables on which performance of children of alcoholic parents was poorer (intelligence; repeating a grade; low academic performance;

Study & location	Sample of Children	Details
		skipping school days; dropping out of school).
Hill, Laybourn & Brown (1996) Scotland	20 children (full age range unclear) living with parental alcohol problems, and 7 young adults who were interviewed retrospectively about their experiences	A number of parents and professionals were also interviewed
<b>Alcohol as part of parental substance misuse</b>		
Ronel & Cahana-Levy (2011) Israel	19 adolescents	A qualitative phenomenological study of high-risk adolescents experiencing PSM. Focus on perceptions of self and parents as subjective risk or protective factors
Moore, McArthur & Noble-Carr (2011) Australia	15 young people aged between 11 and 17 years (10 aged between 14 and 17 years), 8 female: 7 male. 8 had a mother and 5 had a father who had an alcohol or other drug issue. For 2 participants both parents used and 2 had siblings who used.	Qualitative study, based around participatory research methods/interviews, with young carers of a parent/s with alcohol or other drug issues.
Olszewski, Burkhart & Bo (2011) UK/Europe	Not stated/known	Secondary presentations of quotes from children collected from other studies (including UK).
Wilson et al. (2008) Scotland	A sub-sample of 7 participants were drawn from Bancroft et al., 2004). A 'case-study-type' approach using selected excerpts from interviews.	Focus on the policy constructions diverting attention towards care leavers and NEET young people and away from other young people lacking parental or service support. Also looks at policy construction around PSM.
Moe, Johnson & Wade (2007) USA	50 children of substance users were interviewed – no further details given.	Randomly selected from a larger survey involving 149 young people aged 7-13 years. Roughly half girls and half boys – two thirds White and 28% Hispanic/Hispanic mixed race.
Thomas et al. (2005) Wales	21 young carers – 8 boys and 13 girls – aged between 9 and 18 years – average age was 14. Largely recruited through young carer projects.	Broad study into the experiences of young carers, including at least 3 young carers who were caring for an alcoholic or mentally ill parent.
Bancroft et al. (2004) Scotland	38 young people aged 15-27 years (most – 23 – aged 16-19 years) with parents with an alcohol/drug problem. 20 female: 18 male. None were members of a Black, Asian or Minority Group.	Qualitative interviews supported by a 'life-grid' and open-ended topic guide, transcribed and coded for analysis.
Corbett, 2004 (Scotland)	Not stated.	Chapter presents things that children have said when they have accessed services run by Aberlour Child Care Trust.
Barnard & Barlow (2002) Scotland	36 young people – aged 11 to 17 years – 23 were resident with drug dependent parent.	Two-year qualitative study - main focus is on drug dependence.

This table summarises work which has been completed in the UK (not England) or elsewhere

Table E: Services for children & families affected by parental alcohol misuse

Service	Reference(s)	Summary of service	Involvement of C&YP in evaluation
England – alcohol only			
Family Alcohol Service	Velleman et al. (2003) Taylor et al. (2008) Waller & Templeton (2003)	Multi-disciplinary solution focused support to families. Two stage model, focusing on assessment and then intervention, which involves individual and family work. Contact with 74 families in first 12 months, 17 families had sustained engagement (work with children in 11 of those families). In those 17 families: 11 cases mother the drinker: almost equal numbers of boys & girls; half of children aged 10 and under; high level of social services involvement	13 YP interviewed. In addition the evaluation involved interviews with 16 other family members, FAS staff and referrers, access to case notes quantitative data (though not from children).
Base Camp *	Wall & Templeton (2010a, b) – final report & published paper on one aspect of the work	Evaluation of pilot projects in 3 areas of England, aiming to support C&YP affected by PAM (where parents are or are not accessing treatment). Offers group and individual support.	Approx. 26 YP contributed to the evaluation through interviews and/or completing a drawing exercise. Questionnaire data (SDQ) also collected but not available for final report; interviews also with 7 parents and Base Camp workers.
Comic Relief Alcohol Hidden Harm Project	Final report is not yet available but preliminary findings have been shared with the research team to inform this review <sup>36</sup> .	Evaluation of projects in 5 areas of England which have developed new services to support children affected by PAM. The 5 projects supported over 350 children over the course of the 3 year evaluation period.	Interviews/focus groups involving 37 C&YP, draw & write exercise completed by over 30 children, and outcome questionnaires completed by about 60 C&YP (unclear of extent of overlap between datasets and so of how many individual C&YP participated in the evaluation)
England – wider parental substance misuse			
Family Drug & Alcohol Court (FDAC)	Harwin et al. (2011)	Specialist family court (supported by two district judges), supported by a multi-disciplinary team, operating within care proceedings. Focus is on PSM, considering outcomes for children within their families. Evaluation included 6 month follow-up.	77 children (55 families) who entered FDAC over the pilot period (18 months, 3 London Boroughs). Comparison sample involved 49 children (31 families). Although no direct data collect from children their cases were reviewed and there were interviews with 37 parents and various staff involved with FDAC.

<sup>36</sup> Please contact Peter Argall at Comic Relief (P.Argall@comicroelief.com) for more information.

Service	Reference(s)	Summary of service	Involvement of C&YP in evaluation
M-PACT * (Moving Parents and Children Together)	Templeton (2012, 2011) <sup>37</sup>	Structured programme which runs for 8 weeks & brings several families together at a time. Involves group work as well as separate time for children and adults. From 13 programmes – 64 families: 82 children (43 girls, 39 boys, age 6-18 years): 75 adults (46 female, mainly misusing parent). Alcohol primary or additional substance of misuse in over half of families. In 44 families, all participants White British.	37 YP (from 13 programmes) – 34 individual interviews & a group session with 4 YP. 12 YP also completed a drawing exercise. Qualitative data also collected from 36 parents (mainly the misuser) and many of the group facilitators. Questionnaire data also collected from YP and parents.
HHYPE Groups	Templeton (2010)	Group programmes for young people living with PSM – one group for 8-11 years and the other for 11-14 years. 7 girls; 8 boys – majority affected by PAM (maternal in many cases)	7 YP (from 15 who attended the groups) were interviewed. In addition, art work from group sessions was made available. Interviews also with group workers
CASA Family Service (NB: CASA also part of Comic Relief Hidden Harm Project)	Galvani et al. (2011) – focuses on service evaluation  Wadd et al. (2011) – focuses on looking at the service model	Uses model called 'Child Focused Family Intervention for Substance Misuse' which offers whole family support & support to children. Works through 4 stages – engagement, assessment, intervention & disengagement. Overall sample from which evaluation sample drawn unclear.	2 YP were interviewed. Data also collected from 13 adults (11 female) and from 9 workers from partner agencies.
Families First	Woolfall, Sumnall & McVeigh (2008)	Multi-component, intensive support service which provides advice, social work intervention and parenting support for adults and families on substance use related issues. Informed from Option 2 model. 8 families, including 18 children aged up to 13 years.	None (due to young age of many children). Interviews with 15 staff, 5 stakeholders and 11 parents. Questionnaire data also collected from parents.
CoreKids (NB: one part of CoreKids was also part of the Comic Relief Hidden Harm Project)	Final report not yet available but one member of the research team (LT) has been involved with this work <sup>38</sup> .	Offers a range of individual (children and parents) and family based support in locations within London and across Hertfordshire	Work has focused on developing and testing quantitative outcome measures for completion by parents and by children. Final numbers involved not yet available.

<sup>37</sup> There are numerous reports published from various individual evaluations of M-PACT programmes. The document which has been included here is a report which pulled together data from the evaluation of 13 programmes and an article which is forthcoming in Child & Family Social Work.

<sup>38</sup> Please contact Carolyn McDonald at Westminster Drugs Project (cmcdonald2@wdp-drugs.org.uk), or Lorna Templeton, for more information.

Service	Reference(s)	Summary of service	Involvement of C&YP in evaluation
Holding Families	Murphy et al. (2007)	Partnership project to offer whole family support engaging several families at a time. Evaluation of first two programmes – number of participants unclear	Data (using mixed method questionnaires) collected from 10 children (details of children unclear). Data also collected from 8 adults and workers.
Breaking the Cycle (BtC) *	Novak & Templeton (2009)	Evaluation of pilots in 4 areas of England, offering a family intervention (focused on the child) where there is PSM (one site was alcohol only).	7 YP were interviewed. Qualitative data also from interviews with adult family members (26), BtC Coordinators, managers, referrers and other key stakeholders. Quantitative data also from a monitoring tool which collected data from 68 families (unclear how much data from children).
<b>Elsewhere in the United Kingdom – parental substance misuse</b>			
Option 2 (Wales) <sup>39</sup>	Forrester et al. (2008) Emlyn-Jones & Hamer (2004)	Intensive family preservation service which works with a family at crisis point, when a child is at risk of being taken into care. Involved 279 children (Option 2 sample) and 89 children (comparison sample) – alcohol a feature for 171 (61%) children in the main sample.	7 YP (8 families, aged 9-15) interviewed. Part of larger quasi-experimental study; interviews also with 11 parents.
Steps to Cope (Northern Ireland)	Templeton L (2011)	Pilot evaluation to test the adaptation of an intervention for adult family members (the 5-Step Method) for young people living with PAM or parental mental health problems. Involved 21 practitioners and 23 YP. YP – 15 female, 22 White, age 12-17 years. 13 YP living with PSM (in 12 cases it was alcohol, mainly mothers)	Data available about all 23 YP. 7 YP (details not given) contributed directly to the evaluation – through interviews, a drawing exercise or by sharing work they had done during the intervention.

\* In addition to the evaluation reports which have discussed these three projects (Base Camp, M-PACT and Breaking the Cycle) separately a paper by Templeton, Novak & Wall (2011) considered interview data from 23 young people (aged 10-17, 11 female, 2/3s affected by parental alcohol misuse) who had attended the three services. Note also that some of these young people (from Base Camp) also provided drawings which were discussed separately in Wall & Templeton, 2010).

<sup>39</sup> The Option 2 Model has been rolled out elsewhere (particularly in England) but covered here is published work on the evaluation of the original model in Wales.

Table F: Parental alcohol/substance misuse in childcare social work

Study	What is known about PAM/PSM
<p>Forrester &amp; Harwin (2007, 2006, 2004) London</p>	<p>290 files going for long-term allocation – 100 cases (involving 186 children) involved PSM. 41 families (82 children) affected by PAM; in a further 27 families (39 children) there were both alcohol &amp; drug problems. Violence more likely in the families where there was alcohol misuse. PDM cases were more likely to involved children under 12 months old; PAM was more common in cases for children aged 2-13 years. PSM families – high proportion of lone-parent families, often mothers who were also the main carer. Presence of alcohol misuse more likely to lead to placements on the Child Protection Register whereas drug misuse was more likely to be associated with care proceedings. PAM – strongest correlate of placement breakdown.</p> <p>A 2 year follow-up of the 100 families reported that under 50% of the children were still with their main carer (ongoing concerns remained for many of them). Approximately half of children were still living with 'serious' PSM. Living with PAM was a factor associated with increased likelihood of removal. Poorer welfare outcomes were more likely for children who lived with PAM (and who remained at home; DV and being a boy were also associated with poorer outcomes).</p>
<p>Fraser et al. (2009) Midlands</p>	<p>Audit in 2002 – PSM featured in 75% of families involved in care proceedings and (for one month) in 30% of initial child protection case conferences.</p>
<p>Cleaver et al. (2007) England, various locations</p>	<p>357 cases from six English local authorities (three regions). PSM the reason for referral in 52% of cases (DV in 60% of cases; both were issues in 20% of referrals). Nearly half of cases involved children under 5, but this was not more common in PSM cases. Nearly 90% of the children were 'White'. From assessment data – a third of children were living with PAM (third with PDM, half with DV, quarter with PSM and DV). PAM more likely to be associated with DV. Overall – high numbers of families where children were highly vulnerable, had unmet needs, and were exposed to multiple other (familial and environmental) risks. Study also explores outcomes of initial assessments, strategy discussions, S47 enquiries, core assessments, care plans and child protection conferences.</p>
<p>Forrester (2004) London</p>	<p>Follow-up of an earlier file study of 400 consecutive referrals to social services – referrals that were closed rather than allocated – study considers re-referrals and their association with significant harm. Study discusses 18 re-referrals (involving 11 families, 14 children) – reporting that one of the four variables associated with increased likelihood of a re-referral was parental alcohol misuse in the closed referral.</p>
<p>Hayden (2004) Portsmouth (6 childcare social work teams)</p>	<p>74% of responding social workers held cases where PSM was an issue (22% of all cases); equated to 92 families (which included nearly 200 children; further data available for 85 families). Over 75% of cases involved PAM, on its own or in combination with other substances. PSM identified as major concern in over half of families – alcohol featured more than illegal drugs in these cases.</p>
<p>Bell &amp; Sim (2004) Glasgow – survey of social workers in fostering and adoption team</p>	<p>807 children supported in family placement by the team – parental drug misuse a factor for 395 of them (48%) – unclear how much alcohol featured in these families.</p>

Table I: Resources to support practice

<b>For children</b>	<b>For parents and other adult family members/carers</b>	<b>For professionals</b>
<p>ChildLine</p> <p>COAP – Children of Addicted Parents and People</p> <p>Nacoa helpline and website</p> <p>'What About Me?' Nottingham and Nottinghamshire</p> <p>Northern Ireland Taking the Lid Off materials</p>	<p>OCC and Children's Society Leaflet – You are not on your own<sup>40</sup></p> <p>Adfam resources e.g. Journeys series of publications</p>	<p>Option 2 Preventing Breakdown manual (Hamer)</p> <p>'Rory' and 'Oh Lila' resource packs (Alcohol Focus Scotland - <a href="http://www.alcohol-focus-scotland.org.uk/oh-lila">http://www.alcohol-focus-scotland.org.uk/oh-lila</a>)</p> <p>Bath MHRDU Toolkit</p> <p>Northern Ireland Taking the Lid Off materials</p> <p>Adfam resources e.g. Journeys series of publications</p> <p>Adfam (with AVA Stella Project &amp; Comic Relief) - Thinking it Through - DVD &amp; resource pack for those working with YP aged 12-16 affected by substance use &amp; DV</p> <p>STARS National Initiative - includes DVD 'Ask About Me' and details of practice tools for practitioners</p> <p>BASW pocket-guide for social workers (alcohol &amp; drugs)</p> <p>NSPCC. Seeing and Hearing the Child - CD for pros working with children affected by PSM. Also Children's Voices DVD - children talking about their experiences</p> <p>DCSF (2010)</p> <p>NTA (2010)</p> <p>DCSF, NTA &amp; DH (2009)</p> <p>Embrace (Alcohol Concern) materials for alcohol services working with C&amp;F (and alcohol users) where there is also domestic abuse)</p> <p>Stella Project Toolkit - working with alcohol and DV - includes a section on working with children</p> <p>The Hear by Right framework for young people's participation:</p> <p>The National Youth Agency's ten toolkits for commissioning services for children and young people:  <a href="http://www.nya.org.uk/routes-to-success/commissioning-toolkits-for-local-authorities">http://www.nya.org.uk/routes-to-success/commissioning-toolkits-for-local-authorities</a></p>

<sup>40</sup> <http://www.starsnationalinitiative.org.uk/pdfs/Stars%20Resource%20booklet%20final.pdf>



## Appendix C – Focus group plan (WAM)



**Date:** Mon 23<sup>rd</sup> April 2012, refreshments from 4:30pm with 5:30pm start.  
**Duration:** 90min focus group  
**Venue:** What About Me? (Mansfield, Nottinghamshire)  
**Objective:** To discuss emerging findings from our OCC review of parental alcohol misuse with children and young people who have experienced it and are receiving support from WAM.  
 1. Do our findings ring true with children and young people?  
 2. What are the most important next steps?

Session	Start	Duration	Activity
Arrivals & refreshments	16:30	60min	Children and young people arrive at WAM and have some food and drink with the researchers and their key workers.
Session starts – intro's & explanations	17:30	5min	Intros & explanations, reminder of consent; confidentiality; right to withdrawal; support after the session; what will happen with info. "The Children's Commissioner wishes to hear children's views on the needs and problems they have and also ideas about what should be done so that we can pass these on to government and other people."
Messages from children	17:35	15min	<ol style="list-style-type: none"> <li>1. Use a voting exercise to get children &amp; young people to move around the room – agree &amp; disagree – based on messages from young children (Family Life Project).</li> <li>2. What is missing from the list? Any to add?</li> <li>3. Do you think adults listen properly to what children say? Which adults do and which don't?</li> </ol>
Coping & resilience	17:50	20min	Ask each participant to draw around their hand. At the end of each finger, write the name of a person/s or organisation which has helped you or given you support. Write a few words down the fingers about what they have done/do to help/support you. Put a sticky-star next to the one that helps you most of all.  What has helped you to cope? If someone your age had similar problems to you and asked what to do, what would you suggest? Brainstorm and flip-chart responses. Are there any people/organisation you would say they definitely shouldn't speak to? Why do you say that?
Children's routes/barriers to accessing help/info	18:10	25min	What stopped you getting help earlier or what do you think stops other people from getting help? Brainstorm and flip-chart responses. Rank all the options giving each participant three votes (three sticky-stars to place next to the most important option. If time, "What other services would you like? How could services help children and young people sooner/quicker?"
A positive thing from their experiences	18:35	10min	A positive topic to (almost) finish on. Participants were asked if there was anything positive that they could think of that they had learned or that had come out of some of the difficult experiences they had grown up with/were growing up with at home? This was a group discussion with notes taken.
Naming the work	18:45	10min	A fun exercise to finish – cut up some of the key words, use drawings etc – and, working in pairs, get children to come up with suggestions for title of the report. Vote on the best title across both focus groups & give a small prize for winner.
Close session	18:55	5mins	Quick recap of the session/debrief, check if OK & offer support.



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