National Society for the Prevention of Cruelty to Children

Response to the National Alcohol Harm Reduction Strategy Consultation

1. INTRODUCTION

The NSPCC is the UK's leading charity specialising in child protection and the prevention of cruelty to children. We exist to end cruelty to children through a range of activities designed:

- to prevent children from suffering abuse;
- to prevent children from suffering significant harm as a result of ill-treatment;
- to help children who are at risk of such harm;
- to help children who have suffered abuse overcome the effects of such harm; and
- to work to protect children from further harm.

We have more than 180 teams and projects throughout England, Wales and Northern Ireland. Their work includes:

- family support, assessment, counselling and therapy to children and families experiencing abuse;
- specialist investigations into allegations of child abuse; and
- work within schools and other youth organisations to provide a voice for children and advocate their rights.

The aim of the NSPCC's FULL STOP Campaign is to end cruelty to children within a generation. We believe that, given the will, most child abuse can be prevented. This requires the wholehearted commitment of us all. We believe that safeguarding children is everyone's responsibility and that action to safeguard children and promote their welfare needs to be effected in all areas that touch children's lives.

We very much welcome the Government's development of a strategy for reducing the harm caused by alcohol use, and in particular its recognition of the vulnerability of children who are living with one or more parents who have an alcohol problem. As well as having significant detrimental effects on children, growing up with one or more parents who misuse alcohol also has implications for children's own future drinking habits.

Yet an analysis of health improvement programmes for 2000-2003 undertaken with four other children's charities showed that alcohol, and the impact of parental alcohol and other substance abuse on children, was accorded far less priority by health services than the use of illicit drugs.[1]

It was equally clear from the report that national prioritisation of a public health issue, such as smoking and drugs, accompanied by increased resources for tackling the issue,

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[1] *Improving Children's Health – an analysis of health improvement programmes 2000-2003* (2001). The Children's Society, NCB, Barnardo's, NCH, NSPCC. London: NSPCC.

results in real action being taken at a local level to improve the situation. The opposite is also true – if a topic is not accorded priority by the government at a national level, there is much less chance of it being tackled at local level. A National Alcohol Harm Reduction Strategy thus has important potential for leading change and focusing resources on an area that has been neglected for too long.

In our response, we contribute evidence relating to 'the implications for vulnerable groups, including children'; including key facts and figures related to these areas, the evidence that is available and key gaps in policy and practice. We have drawn in particular on the NSPCC's own practice, as well as on relevant research, to argue that the impact of parental alcohol misuse on children and their families should be regarded as a priority for the Government.

It is important to tackle this issue both in its own right, but doing so will also help to fulfil the Government's wider aims of supporting families and offering preventive and early intervention services to reduce the risks of social exclusion. It is also vital that the Government makes this issue a priority so that local authorities can be helped to fulfil their obligations under the Children Act 1989 to children in need (under Section 17), and to children at risk of significant harm (under Section 47).

2. RESPONSES TO INDIVIDUAL CONSULTATION QUESTIONS

THE PRINCIPLES THAT SHOULD UNDERPIN THE STRATEGY

Q1 Why should the Government get involved in managing the harmful effects of alcohol misuse? At what point does Government intervention become justified?

The NSPCC strongly asserts that the impact of problem parental drinking on children should be recognised and responded to by government as a key area of concern. The harm that such drinking can do to children is well documented, and has implications for children's mental and physical health, their development, their safety and relationships, their future drinking behaviours, for maintaining cohesive families, and for social exclusion. The research has recently been comprehensively summarised in a report prepared for the NSPCC, and we have included it here as a valuable up-to-date summary of what is known about the scale of parental alcohol misuse and its implications for children, their families and for society as a whole.[2]

SUMMARY OF RESEARCH EVIDENCE

i. Prevalence of the problem

A 'harmful' level of alcohol consumption is considered to be more than 50 units/week for men and more than 35 units/week for women. Statistics indicate that there are more than 2 million adults drinking at these levels in the UK. However, problems can

[2] Interim evaluation of the NSPCC/ARP Family Alcohol Service. NSPCC internal document. This service is discussed later in our submission.

arise from individuals drinking below these levels but in excess of the Government's recommended sensible drinking guidelines. Recent figures suggest that over a quarter (27 per cent) of men and 14 per cent of women drink at such levels, thus suggesting that there are several million adults whose drinking causes distress. Conservatively assuming that each problem drinker will adversely affect on average two family members, **there are at least five million family members who are negatively affected by the problem drinking of another family member.**[3,4]

The effects of problem drinking are broad and wide-ranging, reaching into every facet of human life, including physical and psychological health. This often brings employment, relationship (within and external to the family), education and financial difficulties.[5] Figures indicate that problem drinking increases the risk of familial divorce and separation and is a contributory factor to around 40 per cent of cases of domestic violence.[6]

Problem drinking also affects community life, with negative consequences arising in terms of crime, violence and public disorder. Alcohol misuse creates a huge burden on already stretched health care and other services with the annual cost of alcohol misuse to the NHS estimated to be around £3 billion[7]. Alcohol misuse and its impact on the family is not unique to the UK, its prevalence and impact having been demonstrated across Europe.[8]

ii. Implications for the Development, Welfare and Protection of Children of Problem Drinkers

The children of problem drinkers can have a particularly hard time. Estimates for the numbers of children who are currently living with an alcohol misusing parent vary from 300,000 to 2.5 million.[9] Recent statistics from the National Association for Children of Alcoholics (NACOA) suggest that there are nearly four million people in the UK who have grown up in a family where one or both parents drank to excess.[10]

These children can suffer from a wide range of difficulties and problems,[11,12] including physical, psychological, behavioural problems, a detrimental impact on their

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[3] Office for National Statistics (ONS). (2000) *Living in Britain: Results from the 1998 General Household Survey*. London: The Stationery Office.
[4] Velleman, R. & Templeton, L. (2002) *Family Interventions in Substance Misuse* in Petersen T & McBride A (2002) (Eds) Working with Substance Misusers, Routledge.
[5] Ibid.
[6] Robinson, W. & Hassell, J. (2000) Alcohol Problems and the Family: From Stigma to Solution. ARP and NSPCC.
[7] Alcohol Concern (2002) Your Very Good Health. Alcohol Concern publications.
[8] Eurocare, 1998 – full reference being sought.
[9] Cleaver, H., Unell, I. & Aldgate, J. (1997) Children's Needs – Parenting Capacity: the impact of parental mental illness, problem alcohol and drug use, and domestic violence on children's development. London; The Stationery Office.
[10] NACOA (2001-2002) *Making a difference – Annual Report*. National Association for Children of Alcoholics.
[11] Tunnard, J. (2002) research in practice: Parental problems drinking and its impact on children. Research in Practice.
[12] Brisby, T., Baker, S. & Hedderwick, T. (1997) Under the Influence: Coping with Parents who Drink too much – a Report on the Needs of Children of Problem Drinking Parents. London, Alcohol Concern.

schoolwork,[13] and developmental delay in younger children.[14] Often these children will take on responsibilities that are beyond their years (such as caring for siblings and parents and doing household chores), thus affecting their education and peer relationships. They may be too ashamed to bring friends home, or not be able to go out with friends because they have to care for a sibling or a drunk parent. The drinking can affect family holidays and celebrations such as Christmas and birthdays. Children can also experience or witness physical, verbal and sexual abuse.[15] They may also be affected by the poor parenting skills exhibited by those caring for them (many of whom often come from abusive and substance misusing homes themselves).[16] Increasingly, research provides the evidence of the impact of parental substance misuse on child welfare at both an emotional and physical level and of the effects on child-parent relationships across the life-cycle.[17]

Statistics suggest that alcohol plays a part in around a quarter of known cases of child abuse; "*children of substance misusers have high rates of removal into care*".[18] A survey by Childline in 1997 reported that they received nearly 3,500 calls in a year from children with concerns about their parents drinking.[19] A fifth to a third of calls to the NSPCC's Child Protection Helpline in a four-month period were from children who were being physically abused by their drinking parents.[20]

A key indicator of the need for a service such as the NSPCC/ARP Family Alcohol Service (discussed below) comes from child protection statistics. The vast majority of families (92%) on the Camden Child Protection Register in 1998/99 had the contributory factors of alcohol misuse and domestic violence present. Alcohol (and drugs) was the main reason for registration on the Islington Child Protection Register in nearly a third of cases for the year 1998/99.[21]

iii. Implications for social care practice

The impact of parental substance misuse on social workers (via the impact on children) is described in a recent report.[22] This study analysed 290 files that had been allocated to the long care team (and which tend to be 'heavy end' allocations); 100 of these cases (with 183 children) involved parental substance misuse. Just under a half of families were affected by alcohol misuse and another third by both alcohol & drug misuse. The authors, Forrester and Harwin, state that:

[13] Velleman, R (2002) Alcohol and Drug Problems in Parents: An Overview of the Impact on Children and Implications for Practice in Gopfert, M., Webster, J. & Seeman, M.V. (2002) (Eds) Seriously Disturbed and Mentally Ill Parents and their Children (2nd Edition), Cambridge University Press, Cambridge *(in press).*

[14] Alison, L (2000) 'What are the Risks to Children of Parental Substance Misuse?' **in** Harbin, F. & Murphy, M. (2000) (Eds) *Substance misuse and child care: How to understand, assist and intervene when drugs affect parenting*. Lyme Regis, Russell House Publishing.

[15] Op. cit. at note 11.

[16] Op. cit. at note 12.

[17] Kroll, B. & Taylor, A. (2003) Parental Substance Misuse and Child Welfare. Jessica Kingsley, London.

[18] Op. cit. at note 12.

[19] Housten, Kork & MacLeod (1997) Beyond the Limit: children who live with parental alcohol misuse. Childline.

[20] Quoted in op. cit. at note 6.

[21] Ibid.

[22] Harwin, J & Forrester, D (2002) *Parental Substance Misuse and Child Welfare: A Study of Social Work with Families in which Parents Misuse Drugs or Alcohol*, First Stage Report to the Nuffield Foundation. See also an article on this research in Community Care (12-18 December 2002) 'Picking up the Pieces', pp36-37.

"the substance that caused the most harm to children – and appeared to cause the most professional difficulties – was undoubtedly alcohol".

They describe families affected by chaos, violence, relationship break-ups (often single-parent families), housing difficulties and unemployment, alongside the clear concerns that present for the children, usually categorised by neglect. Furthermore, the struggle that social workers have in working with these cases is described through the four themes that emerge from interviews:

- lack of preparation and training
- dealing with families' denial that their substance misuse is causing problems
- the threat of violence and threatening behaviour, and
- the lack of involvement of substance misuse professionals.

Given the amount of time that this work takes, and the training that staff need, studies like this have implications for social services resources. Forrester and Harwin also discuss the implications for specialist substance misuse workers, along with other professionals, such as health visitors. The legal status of alcohol and accepted and prominent role within society are seen as partial explanations for the challenges that arise when working in this area. They conclude that "this may explain why the inter-agency framework seemed to work less well in relation to alcohol abuse than to drugs".

iv Longer-term problems: into adolescence and adulthood

Many of the problems for these children continue into adolescence and adulthood. One USA longitudinal study of 146 children aged 7-18 reported that the greater the number of relatives with a drinking problem, the higher the likelihood of raised scores on measures of attention problems and delinquency.[23]

The preliminary results from a UK study[24] of several thousand adults found that over 16 per cent had experienced trauma in the home where they grew up, including having at least one problem-drinking parent. These adults were likely to continue suffering distress as a result of their childhood experiences, being more like to drink problematically, be unemployed or divorced. Thirty per cent of this group said that the problem had affected them 'very badly' as children; 10 per cent said that it continued to affect them very badly. Respondents did not describe relationships with parents as positively as children who had not grown up in these environments; they also used more negative terminology to describe some aspects of themselves.

v. Resilience

There is evidence to suggest that, despite the demonstration of the negative side of growing up with a problem-drinking parent, some children do not develop problems, either when they are young or when they reach adulthood. It seems that some children/adult children are more **resilient**. Some work has been done to explore this issue and identify factors that could 'predict' or increase the likelihood of resilience, or which could be used to promote resilience in others. Resilience factors include:

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[23] Barnow, S., Schukit, M., Smith, T.L., Preuss, U. & Danko, G. (2002) The relationships between the family density of alcoholism and externalizing symptoms among 146 children. *Alcohol & Alcoholism*, 37, 383-387.

[24] Callingham, M (1999) The ACOA Fact-Finder. *Addiction Today,* Nov/Dec.

- positive family functioning
- the presence of a stable adult figure within the family
- family cohesion and harmony
- good support external to the family (such as a teacher),
- planning or 'deliberateness' on behalf of the child to make their life less disruptive, and
- factors that are intrinsic to each child/person.[25]

The NSPCC/SRP Family Alcohol Service described on page 5 has based much of its model on this resilience work. However, resilience is a complex concept, and as Rutter[26] (1993) identified, is better seen as a relative rather than an absolute concept. This has particular implications for the assessment of children, both whose needs, and capacity to cope, will change, depending on stresses and circumstances. Challenges to children's resilience may be experienced where there is serious parental substance misuse, even more so if there is also domestic violence and/or mental health issues. Such characteristics are evident in many of the families with which the FAS is working, such that the balance between recognising vulnerability and building children's resilience becomes a key focus for the staff involved.

We discuss the implications of this research for service provision in response to Q19, below.

Q2 How far is alcohol misuse a matter of individual responsibility and when does Government have a responsibility to intervene, whether through services, legislation or persuasion?

The NSPCC is strongly of the view the Government should fully recognise the harmful effects of parental drinking on children. There is a clear need to meet the needs of these children and their families, both in terms of ensuring skilled and trained staff to recognise alcohol-related problems, and providing specialist services to alleviate alcohol-related problems and harm to children. It is not the choice of individual children to live with these risks and the damage that they can cause to them, and where families are struggling, and children's development and safety are threatened, there is a clear obligation on services to become involved.

The government itself recognised this in its strategy *Supporting Families*[27], published in 1998:

> **Wherever possible, government should offer support to all parents so that they can better support children, rather than trying to substitute for parents. … Parents raise children and that is how things should remain. More direct intervention should only occur in extreme circumstances, for example in cases of domestic violence or where the welfare of children is at stake.**

[25] Velleman, R. & Orford, J. (1999) Risk and Resilience: Adults who were the Children of Problem Drinkers. London, Harwood.
[26] Rutter, M. (1993) Resilience: some conceptual considerations. Journal of Adolescent Health 14, p626-631.
[27] *Supporting Families – a consultation document* (1998). London: The Stationery Office, p 4 , para 9.

In addition, local authorities have a clear duty to provide services for children in need under Section 17 of the Children Act 1989. A child is defined as being 'in need' if: "he is unlikely to achieve or maintain, or to have the opportunity of achieving or maintaining, a reasonable standard of health or development without the provision for him of services by a local authority" or "his health or development is likely to be significantly impaired, or further impaired, without the provision for him of such services; or he is disabled". Under Section 47 of the Act, local authorities must take action to protect a child who is at risk of "significant harm". In practice, cases involving alcohol more often come to the attention of Social Services under Section 47 concerns. However, there are thousands of children whose parents' drinking puts them in the 'in need' category of concern. Ideally, family support services should be available at this point.

The importance of prevention and early intervention in work with children and families has been increasingly emphasised by the Government. Examples include the preventive elements of the Children's Fund[28], and the new local preventive strategies that will be developed in every upper tier and unitary local authority from April 2003 for preventative services for children and young people aged 0-19.[29]

One of Forrester and Harwin's findings[30] was that the more serious the child welfare concern, the greater was the likelihood that parental substance misuse was a factor in the case: 40 per cent of children on the child protection register and 62 per cent of those subject to care proceedings involved substance misuse (a finding also reported by others[31]).

Forrester and Harwin contrasted the very slow response to alcohol-related problems with the 'rapid response' by social services and health to parental drug misuse. They argue that "systems to detect and hopefully [to] prevent harm to children worked poorly in relation to alcohol misuse". There were very low levels of identification of the problem before birth, and no referrals at all from health visitors, who are in fact well-placed to identify problems at an early stage. However, though the subject is not an easy one to raise, and training is required to help professionals in this sensitive area; further, the lack of service provision is also very likely to undermine professional efforts to tackle the problem.

It is thus not surprising that Forrester and Harwin found that cases were rarely referred to social services until the child had been harmed. Of the 13 children who ended up in hospital nine involved alcohol misuse, and the authors also found that the most behaviourally disturbed children all had parents who misused alcohol. Such late referral of cases vastly increases the likelihood of care proceedings being taken, and the authors point out that care proceedings do not only have a "profound impact on children and their families", they are also very costly and make great demands of social workers. They are thus best avoided if at all possible. These findings are of key

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[28] http://www.cypu.gov.uk/corporate/index.cfm
[29] Ibid.
[30] 'Picking up the pieces', in *Community Care* 12-18 December 2002, pp 36-37; available at: www.communitycare.co.uk.
[31] Op. cit. at note 7.

relevance to the Government's national strategy to reduce alcohol-related harm, as well as to its stated aim of supporting parents to enable children to be raised in their own family and to work preventively.

The NSPCC suggests that the lack of awareness, training and appropriate services are all likely to be significant factors in this low level of professional recognition and response, and the authors themselves identify the need for improved inter-agency working and training to improve the likelihood of better early identification. They also highlight the need to target services more effectively at women, as 83 per cent of the families they studied were affected by maternal substance misuse.

Raising awareness

We further suggest that the government has an important role to play in more generally raising public and parental awareness of the impact of parental drinking on children, in the same way as the government has shifted attitudes to drink-driving. More general awareness of this kind has the potential to create a social climate in which professionals' awareness will also be raised, and any concerns about parental drinking more expected and acceptable.

Q5 What principles should underpin a national alcohol harm reduction strategy?

The NSPCC suggests that a fundamental principle should be that the welfare and interests of children should be a paramount consideration for all work undertaken in this area.

HEALTH: PREVENTION, TREATMENT AND THE IMPACT ON THE NHS

Q14 How do you define harmful drinking? What factors do you take into account in deciding whether heavy drinking has become problematic drinking?

A key factor in determining whether an individual's drinking is harmful should be an assessment of its effect on the functioning of the individual's children and family, as well as the impact on the drinker themselves. Adult services need to think holistically about how adult behaviours affect those around them, for whose care they may be responsible. It is essential that a child in need/child in need of protection perspective should be a fundamental component of assessing adult drinkers – there is a need to Think Adult, Think Child.

While not all adults are parents, assessment tools should be developed to take this aspect of people's lives into consideration, and adult and children's services should work together to ensure an effective response to both the adult and the child. A family-focused, holistic treatment approach, such as that outlined below, should be available in every local authority to treat parents whose drinking is adversely affecting their children.

Q15 How clear is the evidence both for the health costs and the health benefits of alcohol? Are there key pieces of research of which we should be aware? Where are the gaps in the evidence?

We have outlined above the extensive impact of parental alcohol misuse on children's health, development and functioning. It is important that the social care costs of parental alcohol misuse are also recognised by government. In our response to Q2 (above), we have highlighted the high financial cost of taking out care proceedings to protect a child, as well as the great amount of social work and other professional time this demands. There is extensive evidence that children who are taken into care do far less well on a range of health and educational measures than other children; they are also more likely to become teenage parents, and to offend. All of the latter have great financial and social cost implications for the government. Developing and investing in holistic alcohol services that can build on families' strengths, develop children's resilience, and above all help families to stay together, would be a worthwhile investment and save money for the government in the longer term, as well as improving parents' and children's lives.

Q17 What, in your experience, are the most appropriate means of prevention of alcohol dependence and alcohol misuse? What forms of training are most appropriate for professionals in health and social care, as well as other fields, who play a role in prevention?

Prevention and Training

We have made suggestions above about the government having an important role to play in raising awareness about the impact of parental drinking on children (see page 9).

There is a need to distinguish between primary prevention, that is preventing harm occurring, and secondary prevention which aims to minimise further harm. Where alcohol and harm to children is concerned, there is a great deal of work to be done in the area of early intervention and secondary prevention. In the long term, however, such work with the children of problem-drinking parents may reduce the likelihood of the children themselves developing problems with alcohol when they are adults, as there is evidence that the latter is linked to the former (see above).

There is a need for professionals who work with children and for professionals who work with adults to develop their awareness of the impact of parental alcohol misuse on children, and how they can recognise and respond to this. As with other child protection issues, health professionals, such as GPs and health visitors, who provide universal services to families, are ideally placed to identify families where parental drinking may be problematic and take action to prevent further harm. Currently, many lack the skills to identify such families (problem drinkers can be very adept at hiding their habit), and even if they do identify a problem, there are virtually no services to which they can refer them for help. This undermines the effectiveness of their practice, and creates a cycle of neglect of and non-response to the issue, as these barriers to engagement with the issue mutually reinforce a lack of action.

More work should be done with pregnant mothers ante-natally to determine whether their alcohol consumption is like to harm her baby, either in the womb or after it is born.

There is also a need for much better inter-agency working and mutually supportive professional practice. It is crucial that treatment for adult drinkers should take account of the whole life of the drinker, and not only their individual drinking habit. There is a need for child protection training and protocols for adult alcohol workers, and assessment and treatment should take account of the drinker's family circumstances, and in particular whether they have a parental responsibility for any children. Social workers and others working in child protection also need to understand more about the impact of problem drinking, and develop a greater understanding of how they can respond effectively to this.

Q19 Do current treatments for alcohol dependence and hazardous drinking work? Are they sufficiently tailored to meet differing individual needs? Are there forms of treatment we should be aware of? Is there a need for guidance for the commissioners of local treatment services? How should individuals best access treatment services?

Family-focused treatment services

Despite the substantial evidence of harm, service provision for families in which there is problem parental drinking is lacking. Traditionally, services have focused on the needs of the drinkers and families have been seen as an adjunct to their treatment. Research from both adult and child-centred services[32] underlines the difficult balancing act required when developing an alliance with the parent, whilst retaining a child-centred focus. Thus, services for family members or family units in their own right, are scarce. A national mapping exercise of services for families and children[33] found that only fourteen such services existed, yet their importance is clear:

> **problem drinkers are more likely to maintain their goals when families are directly involved in treatment and this also minimises the trauma that children experience…All services contacted felt that there was a local and national need for family services…and that the need is demonstrated by the numbers of people actually accessing the services that do exist.[34]**

A local needs assessment of the services required for these families was undertaken in Camden & Islington for the same study, and the main conclusion from this was that:

> **there are a significant number of families experiencing problems around alcohol, and … these problems are difficult to treat within the system of services that are currently available. It was also clear that agencies [which] come into contact with these families often struggle to meet their**

[32] Op. cit. at note 15.
[33] Op. cit. at note 6.
[34] Ibid.

complex needs and would welcome a one-site day centre resource that addresses alcohol problems in a family focused way.

There is thus a clear need to develop treatment services which meet the needs of the whole family, as this approach is more likely to succeed in supporting children and other non-drinkers in the household, and in sustaining a change in drinking patterns. It is important to appreciate that treatment that includes consideration of the whole family is also more successful for the drinker. For example, a parent returning to a family after detoxification is more likely to maintain abstinence or controlled drinking if it has been possible to think about the whole system and change some of the factors in the situation – family relationships, stress in parenting - that may have contributed to alcohol misuse in the first place.

Yet, with a few notable exceptions, adult alcohol services tend to address only the needs of the problem drinker, and not the needs of their children and non-drinking partners. This failure to consider the wider effects of the problem means that these children's needs are being neglected by the public services, as well as by the problem-drinking parent.

The issue of joint alcohol and drugs services

Currently, there is much more funding for substance misuse programmes that treat both drug and alcohol dependence. However, the research presented in our submission establishes that there are a substantial number of families who experience problems linked with parental alcohol misuse, where illegal drugs are not a factor. In inner-city areas with high concentrations of children in need, there is a good argument for providing distinct alcohol and drug dependence services, as there are large numbers of children affected by their parents' alcohol misuse. In more rural areas, there may be better arguments for creating joint services, because of difficulties with transport and access. However, local authorities and primary care trusts should be given the resources and the flexibility to develop separate services where they feel they are justified, and should not be constrained by dedicated funding streams. This is of particular concern, as the very much faster response to illegal drug use, and political prioritisation of this issue, means currently that families' needs for services that can respond to alcohol dependence are being neglected, and we strongly advise that this should not continue.

DEMONSTRATION PROJECT: FAMILY ALCOHOL SERVICE RUN BY NSPCC AND ARP (ALCOHOL RECOVERY PROJECT) IN THE LONDON BOROUGHS OF CAMDEN AND ISLINGTON

The Family Alcohol Service (hereafter abbreviated to FAS) offers an innovative response to the serious issues of alcohol misuse and its impact on families and children. The service is in its first, pilot, year, and is being evaluated by a team from Bath University led by Professor Richard Velleman. The Interim Evaluation Report has just been completed, and we present some of its findings below.[35]

[35] Op. cit. at note 2.

The aims of the Family Alcohol Service (FAS)

The multi-disciplinary team aims to alleviate concern and anxiety in family situations and prevent harm to children. It builds on the work of an earlier, smaller, project run by the NSPCC in Camden that worked solely with the children of problem drinkers, both directly and via training and consultation with other professionals.

The aim of the service is to prevent family breakdown through early intervention and by bridging the gap between adult treatment and childcare services. We achieve this by:

- Providing a Parents and Family Programme, which aims to encourage and support drinking and non-drinking parents/carers to increase their understanding of how problem drinking can affect family life, child development and play and learning
- Direct services to children, such as individual therapy and support groups, through which we work towards stimulating a child's personal growth, self-esteem and capacity to cope, helping them to recover from past difficulties and move forward.
- Collaboration with professionals on their work with families affected by alcohol problems through training, consultation, advice and information.

The Model

The service is based on a model of systemic working. It is solution-focused, and works flexibly with families' strengths and values. Family Alcohol Service staff aim to assess therapeutic need and then develop a care plan to meet that need. Staff work systemically with all members of the family who attend, ensuring a central focus is kept on the children and the impact on them.

The pilot FAS aims to provide a new, systemic, holistic service to children and all other family members affected by problem drinking, including the drinkers themselves. The mission statement of the FAS is to:

- Address alcohol problems in a family-focused way so as to alleviate suffering to families and prevent harm to children;
- Prevent family breakdown through family-focused early intervention;
- Bridge the gap between adult alcohol treatment and childcare services; and
- Raise awareness of the issues relating to alcohol and family life.

The model is also firmly rooted in other policy developments over the last few years, including two major Department of Health documents, the *Framework for the Assessment of Children in Need and their Families*[36] and *Working Together to Safeguard Children*.[37] The *Framework for Assessment* visualises assessment as a process that incorporates three keys areas – developmental needs, parenting capacity, and wider familial & environmental factors, and these are all key areas within the FAS practice model.

[36] Department of Health (2001) Framework for the Assessment of Children in Need and their Families, Consultation Draft, http://www.doh.gov.uk/scg/frameassess.htm.

[37] Department of Health (1999) Working Together to Safeguard Children: A guide to inter-agency working to safeguard and promote the welfare of children. London, The Stationery Office.

The services key referral and assessment criteria are to work with:

Families with dependent child/children, where there are specific difficulties in parenting and childcare as a direct result of alcohol problems

This includes parents who:

- have children who are considered at risk, or on the Child Protection Register or looked after by the local authority;
- are addressing alcohol problems and currently receiving a service;
- are aware that alcohol is a problem but who are not sure what help they need to make changes;
- have recently completed an alcohol treatment programme and who need support with child care issues;
- are partners/relatives of problem drinkers who need support for themselves;

and children who:

- are growing up in a problem drinking family environment, and as a result of this have support needs of their own;
- are considered at risk, on the Child Protection Register or looked after by the local authority.

<u>Profile of service users</u>

(the following findings are based on information available for 35 families)

<u>The children</u>

- The families contain 63 children aged 16 years and under (details of children older than this are not always given). At least half of these children are aged 10 years and under.
- The children are fairly evenly split between boys and girls. In eight of the families there are three or more children aged 17 years and under.
- In four of the families there is a child with a disability.
- Given the high number of referrals from Social Services, many children are, have been or may be placed on the Child Protection Register (CPR), usually under the category of neglect.
- Care proceedings are currently underway with at least two families.
- Examination of the referral and assessment information demonstrates a pattern consistent with previous research. The families have often been and still are highly chaotic, with a multiplicity of problems. Many of the children have been without consistent love and care from one or both parents for a considerable time. Many children are living with other family members or in care. Many children have experienced stressful childhoods, and have missed out on educational and social opportunities due to non-attendance at school and fulfilling caring responsibilities towards siblings and parents. In some cases children have been seen out on the streets alone (in one case, begging), or accompanied by a drunk parent. One parent was reported in the case notes as having said about her children that they were:

> **"embarrassed" The worker recorded the mother saying that the [the children] were constantly looking for drink and battling with her so that she would not continue drinking and at times [they] would throw alcohol away".**

<u>Profiles of engaged families</u>
Many of these families are experiencing a multiplicity of problems, including violence, mental health problems, difficulties with housing or employment, and relationship difficulties. In some cases the problem drinker or non-problem drinker comes from a background of alcohol misuse and violence. The families have also endured a high level of separation and trauma. Precision is hard as information is not available for all families, but in many cases the parents are separated and the distant parent has little or no contact with the children. In cases where there are many children, these are often fathered by more than one man. The children (and the parents) have been disrupted by the change and loss of parental figures.

- In at least four families at least one parent is from a minority ethnic background.
- The vast majority of the cases engaging with the FAS have alcohol problems alone, not jointly with illicit drug problems. Some also have problems with prescribed drug use.
- Of the families that have engaged, problematic illegal substance use is known to be a factor in only four families.

<u>The drinkers</u>
In over 20 cases (information is not available for some families), it is the mother who is the problem drinker, though in a few cases both parents are believed to have problems. Many of these mothers also have mental health problems.

<u>What features of the service do families value?</u>
Family members have told us that they welcome the therapeutic approach of the service, and the way it identifies and builds upon a family's own values and strengths to achieve their treatment goals. This is often in contrast to their previous experiences of alcohol services, which for many were more judgmental and less supportive.

The families engaging with the service also appreciated the flexible approach adopted by FAS staff (a key element of the FAS model). The provision of taxis for clients, the willingness of staff to work out of hours, the provision of home visits, have all worked to make families feel valued and have had a strong impact on their engagement. These features are recommended as good practice by Harwin and Forrester's work.

Home visits have included a visit to a mother with a new-born baby, a visit to another mother having a home detoxification, help for a mother to get the home ready for her children to return, and taking a client to a lock-up garage to get things for the home.

Parents have said of the service:

> **"[it's] comfortable, safe, non-judgmental, really helpful … until I started here I was really beating myself up … getting the balance right … [FAS**

worker] is easy to talk to…encouraging … it's a great release, I don't feel judged … always come away feeling positive".

"they seem to have everything covered … it's safe and welcoming … they're great people, it's a great service … I'm very glad it's here … I've only got praise for the place".

Early Outcomes for Engaged Family Members

Child-related outcomes: A reduction in Child Protection Register (CPR) status has been seen in some families. In at least two cases, there have been significant improvements in this area: in one family, all children are now off the CPR and it is hoped that care proceedings will be resolved by a supervision order rather than a care order. In another family, the status has similarly been reduced to a supervision order.

More generally, relationships between parents and children have improved in some cases, and a number of families report that their family life is more stable. Given the time that it may take for many of these families to reach a point where a change in CPR status or a care proceeding outcome can be achieved, it is important to look at the kinds of things that need to happen for such outcomes to be possible. This means focusing on parenting skills and the improving relationships that can be seen between parents and their children. Again, this is a key idea within the FAS Model. One mother reported that she has learnt a great deal about herself as a parent:

> **"[I now have] more understanding of the qualities I have as a mother … this place focuses solely on me as a parent, my parenting skills … positive changes to do with my kids is to do with here".**

The children who have engaged have reported that they have welcomed the opportunity to come to a service where they can receive help alongside their parents. It has been apparent that Play Therapy has given them space to express how they are feeling, what is of concern to them, and how family life and family relationships work.

It also appears from data obtained from other family members and from staff that, even in cases where children have not engaged with the service, there has been a measurable positive impact on them, which could be attributable to the FAS.

Drinking-related outcomes: In some cases the alcohol consumption of the problem drinking parent has decreased. In other cases, problem drinking family members who were abstinent when first attending the service have remained so:

> **"I don't even want a drink … I feel calm and collected and I've got my life back on track" (Parent).**

In summary, the work of the Family Alcohol Service to date has shown that:

- It is possible to develop a practice model to work in a holistic way with families and children
- A multi-disciplinary team can be built to put this model into practice

- Families can be engaged using this model, and
- Families have started to change while working with this model, and better outcomes are being achieved for children, their parents and for other services who are working with the families.

THE IMPLICATIONS FOR VULNERABLE GROUPS

Q36 Which children and young people do you see as being most vulnerable to the consequences of alcohol misuse?

Children who live with one or more parents who drink are especially vulnerable to the consequences of alcohol misuse. As the evidence outlined above shows, these are often families where problems can be very entrenched, and there may be multiple difficulties within the family. The experience of our FAS is that the cases that are hardest to work with are families where there is also domestic violence.

However, children who live in isolated or single-parent families are the children who are most vulnerable to parental alcohol misuse. Those in single-parent families do not have a non-drinking parent to protect them, and isolated families do not have a supportive network and caring adults outside the family that can mitigate the effects of alcohol misuse; the lack of such friendships and trusted adult relationships heightens difficulties for the child. These most vulnerable children therefore do not have the protective factors that encourage resilience in children, and are isolated - not integrated into the community, or an extended family, where other adults could have an influence on them.

Further, if parents do not engage with services it can mean that the child is prevented from gaining access to services in his or her own right. Disabled children in such families may not have their own needs met because of their parents' chaotic lifestyle.

Q39 How can services provided by the state and others to vulnerable groups with complex problems be joined-up most effectively? Are there examples of joined-up delivery it would be helpful for us to be aware of? What gets in the way of joining-up services?

We have made reference to some of the factors relating to joined-up services above. Key issues that need to be addressed include:

- better training and awareness for health and social care professionals of the impact of parental alcohol misuse on children, and how to recognise and respond to it in a non-judgemental manner;

- the need for joint adult and children's services protocols so that both children's needs and adults' needs in this area can be effectively identified and addressed.

- overall, professionals do not feel confident to deal with families with alcohol problems, and they need training to realise that they may already have transferable skills that would be effective in this area of social care. Professionals also need to be encouraged to link in more to appropriate resources, and work together rather than trying to hand over the whole case.

Another problem, however, is the lack of services that work in this area. Illegal drugs have had a far higher political, and thus also practice, priority. Resources need to be directed towards alleviating the problems of families where parents' drinking is harming their children.

In the evaluation of the FAS it was clear from discussions that some referrers are delighted that the FAS is now functioning. Some were quick to tell us that it fills a gap in service provision and that it meets families' needs in ways that other services do not:

"[We] feel much better. [We are] continuing our own work [but] this gave her more, more than we could give her … a huge gap [has] been filled … [there is a] greater awareness of the focus on the whole family".

Another referrer noted that the engagement of a family with the FAS led to a change in her own role (mainly to her having less contact with the family):

"[I was] relieved because there are so many family issues".

Q40 How realistically can these vulnerable groups be dealt with by mainstream services and how far do they need services which are tailored to individuals groups and indeed to individuals on a case-by-case basis? What is your experience?

As indicated above, there is a clear role for mainstream primary health care and social work services to work with this vulnerable group, both in terms of primary and secondary prevention. However, they need the training, skills and resources to undertake this work effectively. It needs to be made a clear priority to ensure that professionals are equipped in this way.

It is also important that primary care and social work professionals should have training and develop services to address the needs of those affected by parental drinking, and not just to focus on the drinker.

OTHER ISSUES AND CHALLENGES

Working with black and minority ethnic families

It can be especially challenging to work with families where at least one family member is from a minority ethnic background. Cultural and religious issues can add a further layer of complication when treating alcohol misuse; for example, there ay be feelings of stigma and shame; families may be isolated, and there may be a lack of

services able to meet people's different language needs. These issues should be considered as important areas to address both in service commissioning and in professional training.

For example, there is an increased stigma attached to alcohol misuse in Moslem culture, where drinking is not tolerated. Our Family Alcohol Service is currently working with one such family and finding that workers are engaging more with the non-drinking partner and the children, as another problem could be the father losing face by talking about his situation to women, who are also white (our service is looking at how it can itself cater better for such needs, for example by recruiting a male worker).

This is a challenging but enriching areas where the way forward is to find out about the individual background and culture of each family directly from them and work with that experience.

Families with complex issues
Challenges have arisen in our FAS in families where there are other issues, such as domestic violence, or mental health issues. These issues are part of ongoing team discussions, and will lead to changes and developments to the practice model as well as to the identification of training needs. Some of the children are very young and others have disabilities that have raised further challenges for the team. One disabled child who has complex communication needs cannot be seen individually at FAS as the team does not have the specialist skills to work with her, but she will be involved in family sessions. Family support is part of the care plan with the mother, to help her cope with her child's disability and its influence on how the child and the family respond to the father's problem drinking.

Parents' communication with their children about treatment
Problem-drinking parents, particularly when they are in denial about their drinking, as those sent by Social Services Departments often are, cannot think that they might be adversely affecting their children. They will naturally be on the defensive, and need to be helped to think about this issue through reiterating what the referring agency are saying they are concerned about, and helping them to explain to their children about the service, and helping them to encourage their children to attend themselves. The service has developed a children's booklet and a game that can help parents explain to their children about the FAS, and help them think through how they will talk to their children about the FAS and about coming in for sessions.

CONCLUSIONS

For too long, debates about children, young people and alcohol have focused on their own consumption of alcohol, and have failed to acknowledge and recognise the substantial impact and harm that parental alcohol misuse has on children. The NSPCC strongly believes that the National Alcohol Harm Reduction Strategy should address this harm as an urgent priority. There is a clear role for government to take the lead on this issue, and to ensure that such damaging environments for children are responded to effectively by health and social care

professionals working with both adults and children. This will involve creating greater awareness of the issues we have highlighted above, and their implications for children and their families. It will also require improved training, and responsive family alcohol services that will use a systemic model of working with children and non-drinking partners of drinking parents, in order to effect a long-term sustainable change in drinking patterns.

There is a role for many government departments and agencies to take action in these areas, including the Department of Health, the Children and Young People's Unit and the National Treatment Agency (NTA). We suggest that there is scope to extend the priorities of the NTA to include a programme of work specifically on the impact of parental alcohol misuse on children and young people. There are clear links with social exclusion, as indicated in the research outlined above, and potential for harm that will extend into the next generation – both in terms of harmful levels of drinking, and in terms of impaired and reduced parenting capacity. The fact that alcohol is legal may make it a greater challenge to take action to combat the harm it can cause, but it is not a reason to continue to neglect this harm, and the children that are affected by it.