



Office of the Children's Commissioner

"I think you need someone to
show you what help there is"

Parental alcohol misuse –
Uncovering and responding to
children's needs at a local level

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McDonald**

October 2014

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About the Office of the Children's Commissioner

The Office of the Children's Commissioner (OCC) is a national public sector organisation led by the Children's Commissioner for England, Dr Maggie Atkinson. We promote and protect children's rights in accordance with the United Nations Convention on the Rights of the Child and, as appropriate, other human rights legislation and conventions.

We do this by listening to what children and young people say about things that affect them and encouraging adults making decisions to take their views and interests into account.

We publish evidence, including that which we collect directly from children and young people, bringing matters that affect their rights to the attention of Parliament, the media, children and young people themselves, and society at large. We also provide advice on children's rights to policy-makers, practitioners and others.

The post of Children's Commissioner for England was established by the Children Act 2004. The Act makes us responsible for working on behalf of all children in England and in particular, those whose voices are least likely to be heard. It says we must speak for wider groups of children on the issues that are not-devolved to regional Governments. These include immigration, for the whole of the UK, and youth justice, for England and Wales.

The Children and Families Act 2014 changed the Children's Commissioner's remit and role. It provided the legal mandate for the Commissioner and those who work in support of her remit at the Office of the Children's Commissioner to promote and protect children's rights. In particular, we are expected to focus on the rights of children within the new section 8A of the Children Act 2004, or other groups of children whom we consider are at particular risk of having their rights infringed. This includes those who are in or leaving care or living away from home, and those receiving social care services. The Act also allows us to provide advice and assistance to and to represent these children.

Our vision

A society where children and young people's rights are realised, where their views shape decisions made about their lives and they respect the rights of others.

Our mission

We will promote and protect the rights of children in England. We will do this by involving children and young people in our work and ensuring their voices

are heard. We will use our statutory powers to undertake inquiries, and our position to engage, advise and influence those making decisions that affect children and young people.

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Please reference this report as follows: Manning, J., Clifton, J. and McDonald, C. (2014) *“I think you need someone to show you what help there is”*: *Parental Alcohol Misuse: Uncovering and responding to children’s needs at a local level*. London: Office of the Children’s Commissioner,

Project partners and acknowledgments

Project Partners: The Children's Society and Lifeline

The Children's Society has helped change children's stories for over a century. We expose injustice and address hard truths, tackling child poverty and neglect head-on. We fight for change based on the experiences of every child we work with and the solid evidence we gather. Through our campaigning, commitment and care, we are determined to give every child in this country the greatest possible chance in life.

Joanna Manning (Project Manager)

As National Lead Substance Misuse at The Children's Society, Joanna has established herself as a national stakeholder on the Hidden Harm Agenda with a number of published reports, specialist resources and many public speaking activities. Joanna is a member of the Advisory Council on the misuse of Drugs (ACMD) Recovery Committee, representing the voices and experiences of children in Recovery.

Lifeline: Anna Hemmings (Project Advisor)

Anna has been working in the substance misuse field for over 15 years and has specialist knowledge around working with families with complex needs. Currently, she is Head of Directorate for the south of England for Lifeline.

Carolyn McDonald (Project Researcher)

Carolyn has been working in the substance misuse field since 1994. Her extensive experience has included being Chief Executive of a central London Treatment Centre.

Jenny Clifton (Principal Policy Advisor for Safeguarding at the Office of the Children's Commissioner)

Jenny has a background in children's social work and management, and university lectureships in social work and social policy.

Our thanks are due to the following who provided so much support and guidance to the project and whose engagement made it possible.

The National Expert Group

- Emma Bond – Independent Consultant and former Lead on Hidden Harm in LB Tower Hamlets. She currently works for Action on Addiction
- Jenny Clifton – Principal Policy Adviser, Office of the Children's Commissioner
- Mandy Craig – Safeguarding Children Substance Misuse Service, Sheffield Safeguarding Children Board
- Nicola Crisp – Manager, What About Me (WAM) Nottinghamshire

- Anna Hemmings – Head of Directorate South, Lifeline
- Joanna Manning – National Lead Substance Misuse, The Children’s Society
- Carolyn McDonald – Independent Consultant
- Emma Pawson – Families Manager, NTA
- Phil Raws: Senior Researcher, The Children’s Society
- Emma Spiegler – Founding Director, COAP
- Lorna Templeton – Independent Researcher and co-author of ‘*Silent Voices*’.

The three local areas: We agreed not to identify the local areas in this final report but they know who they are and we are immensely grateful for the way in which all those involved supported and engaged with this project. In particular our thanks go to the children and young people who spoke with the study team, the parents and carers who gave time to contribute and all the individual professionals who enabled us to learn about local practice. We hope the study has been of value and that their experience will assist others to move forward with this agenda in their own areas.

Foreword by the Children's Commissioner

I am pleased to publish this rich and practical report and resource on tackling the vital issue of the effects on children when parents or carers misuse alcohol. When we published our report *Silent Voices* on this difficult issue in 2012, we said clearly that this was not a matter of, or a study about, children themselves drinking under age. It was about them being made sad, lonely, isolated and scared by adults they loved who were drinking too much, whether at a regular and dangerous level, through binge drinking, or based on drinking daily amounts beyond the safe limits. In any of the patterns we investigated with our researchers for *Silent Voices*, we found families whose children were affected by parents whose drinking habits left them unable to parent their children well. Children were, in effect, made parents to the adults in their lives, shouldering burdens beyond their years, yet unable to speak out because of the stigma they considered was attached to their lives, and the shame they thought they would bring on their families if they sought help.

After *Silent Voices*, in which we also critiqued how poorly alcohol abuse was addressed in comparison to treatment programmes for the abuse of illegal drugs, we agreed we wanted to deepen what we knew about localities' practice in England. We wanted to find ways to capture and share what is happening in localities where people wished to learn about needs and services for children and young people affected by parental alcohol misuse. This report is the result of this next phase of work.

On the basis of the commitment of those who worked in the local areas, we have been able to draw together suggestions towards gaining a better understanding of the nature and extent of needs of the children and families in local areas. In the pages that follow, you will find rich sources of sound practice in real places, making a difference in this area of work for children and young people living with parental alcohol misuse now. The work was done in a small number of areas, but is representative of varying types of places, across England. The resultant report reflects on real lives and families' and children's real stories. Much of what we recommend is based on reflections they, and experienced workers supporting them, gave us on tackling this serious social problem. The report is full of studies on what happens when services work with, as well as on behalf of, affected children and young people.

This report pulls no punches about the need to address this problem. We publish it in the belief that it is a rich resource for all of us, who are concerned with, or working to try to address, the issues it covers. I want to thank the children, young people families and localities who worked with the researchers and my Office on creating this powerful and very real contribution to a debate we as a society must go on having. Alcohol is a legal, but also a

powerful, addictive substance. Its misuse affects the adults caught up in it but the effects on their children and families are lasting, and profound. I urge that all readers learn from, and use and adapt, the suggestions for good practice found in its pages.

A handwritten signature in black ink, appearing to read 'ME Atkinson', with a long, sweeping horizontal line extending to the right.

Dr Maggie Atkinson
Children's Commissioner for England

Executive summary

Introduction

The project aimed to identify and promote good practice in response to the needs of children affected by parental alcohol misuse and their families, with key questions as to how local areas can discover the extent and need among children and young people and how services, including universal provision, can best respond. The work was informed throughout by the perspectives of children, young people and families themselves and seeks to inform the policy and practice agenda. Engagement and data collection was undertaken in three local authority areas: a seaside town, a rural county and a large town. The study employed a variety of methods to obtain relevant local data and to explore pertinent issues from multiple stakeholder perspectives.

The capture of learning and progress were key to the study, particularly in the context of the impact of recent health reforms and other changes to the policy and service landscape over the past year. To that end, local reports were prepared and shared with each area and participants informed this final report.

Key findings from the study

Prevalence

- There is a range of available sources of data at local level and collected nationally but a number of barriers to the full completion and collation of these into a comprehensive picture of local prevalence for parental alcohol misuse.
- Local bodies and strategies focus on estimating prevalence of alcohol misuse and not *parental* alcohol misuse. Estimates have relied on adult treatment data where the adult is engaged in treatment.
- There is a lack of recognition and recording of alcohol related problems as well as recognition of the need for help for children by some members of the workforce.
- The stigma and shame experienced by some parents prevents them from self-identifying as problem drinkers.
- Children may not recognise there is a problem or know that there is support available for them.
- Collaboration and liaison on information between adults' services, treatment services, children's services and wider family support services

was not structured in a way which would enable better recognition of children's needs.

- Local areas were developing resourceful approaches which can, and are starting to contribute to the development of a local strategy. A cross-agency and cross-professional local strategy relevant to parental alcohol misuse was essential for effective collation of information.
- It is suggested that the overall responsibility for the quantification of parental alcohol misuse might lie with Health and Wellbeing Boards as part of an overall strategy, reflected in the Joint Strategic Needs Assessment (JSNA) and the Joint Health and Wellbeing Strategy (JHWS)

Existing provision and routes to help

- The range of relevant services for affected children and their families were not well co-ordinated so that pathways to help could be made clear and explicit.
- There were missed opportunities in universal and specialist services to identify children in need of support and make appropriate referrals.
- Commissioning gaps and varied service take-up resulted when there was a lack of clear mapping of need.
- A mapping process was found to be helpful: this could helpfully involve professionals across agencies and services and incorporate an audit of targeted and specialist services which may be already supporting affected children; an audit of referral pathways; a performance monitoring exercise with services and consultation with children and young people. This is all for the purpose of ensuring that clear pathways to help for children are in place.
- Children and young people need support and guidance if they are to access help and service arrangements need to seek to address the barriers for children and families.

Best practice

- The study identified a number of 'first steps' of value to local areas: these include the mapping work above; the development of protocols; and strategies owned by partners in Health and Wellbeing Boards and Local Children's Safeguarding Boards.
- Evidence gathered during the study highlighted a number of key principles for good practice in service provision which were developed with feedback from the areas and expert group:
 - High priority to treatment for parents with children in their care

- Work with the whole family, with services for children together and separately from their family
 - Support services to have many 'front doors'
 - Agencies and services to recognise the wider impacts of the child's experience of parental alcohol misuse
 - Professionals to explain the nature and purpose of the help being provided and engage with children in this
 - Continued support to children and families through the period of behaviour change and recovery
 - Strategy, service development and evaluation to ensure service user voice, consultation and participation
 - Workforce development, professional training and continuing professional development which raises awareness and addresses the nature and impact of parental alcohol misuse on children and safeguarding needs.
- Where need had been identified and a formal process mapped, the service was in demand. Going through the basic steps of mapping, understanding, engaging and designing pathways can avoid under-utilisation and increase effectiveness of service provision.
 - Links between treatment, adults, mental health services, and children's services in the statutory and the voluntary sector will enable improved collaboration on information and service pathways.
 - The alignment of commissioning activities and the co-location of commissioning for adults and treatment services would assist in addressing the potential commissioning and service gaps.

Early intervention

Opportunities for early intervention and prevention on parental alcohol misuse include:

- Additional or enhanced screening with parents as a co-ordinated approach.
- Universal and other services to identify alcohol as a problem within a family, and to assess the adults' drinking and the child's need for support.
- Workforce development and training and awareness-raising through local cross-service forums.

- Signs and signals are more systematically identified so that support and safeguarding referrals are made for and with children and young people as needed.
- The Common Assessment Framework (CAF) is used for recording, understanding and providing support for affected children and families.

Recommendations from the Children's Commissioner

Preamble

Children living with parental alcohol misuse are children in need of support and may be children at risk of harm. It follows that there is an obligation to assess their needs under section 17 of the Children Act 1989 and that it may be necessary to consider action to protect their safety. We make the following recommendations in order that local areas take forward the suggestions made in this report, based as they are on the messages emerging from children, family members, professionals and managers in the areas who contributed their perspectives and experiences.

1. Every local authority should determine the body which holds strategic responsibility for addressing parental alcohol misuse and its impact on children and the person who leads this. The evidence from this study indicates that this body could be the Health and Wellbeing Board and that Joint Strategic Needs Assessments and Joint Health and Wellbeing Strategies are the appropriate vehicles to use.
2. To ensure an effective operational approach, the above body should draw up an integrated strategy at local level with all the agencies and departments with a role to play as partners in addressing parental alcohol misuse. These include Directors of Public Health, Directors of Adult Social Care and Children's Services, leading health and mental health service personnel, Clinical Commissioning Groups, treatment services and voluntary sector agencies.
3. All professionals who work with children should be trained to understand and address: the impact on children of parental alcohol misuse; the views of affected children; how to protect them; and how their needs are best met. We recommend that the LSCB should monitor the development of training strategies in all relevant agencies and require an annual report on implementation and progress.
4. Commissioners for children's, adults' and treatment services need jointly to agree on the nature of service provision which will address parental alcohol misuse, based on local intelligence and a shared understanding of needs and services, utilising such methods of mapping as those proposed in this report and including the involvement of children and young people. Commissioning of services should be complementary and strategically aligned.

Introduction

This study was commissioned to investigate gaps in knowledge highlighted through *Silent Voices* (Adamson and Templeton, 2012), a review into supporting children and young people affected by parental alcohol misuse. *Silent Voices* created the baseline for what is known about parental alcohol misuse, how it affects children and the services available – all with a focus on the perspectives of children and young people themselves. It presented a range of recommendations across policy, practice and research and has had wide impact. As this report was being concluded, the authors were pleased to learn that that Public Health England (PHE) are scoping a project designed to gain a better understanding of the prevalence of parental alcohol misuse and its impact on children.

The present study engaged with three local areas in order to learn about the challenges and the ways forward for improvements in meeting the needs of children and young people. One of the clear messages from this process has been how important it is that there are ‘local conversations’ about alcohol misuse. It is important to be aware that meaning and definitions of social norms and drinking cultures, and of use or misuse, will mean different things to different people. While there is guidance on recommended daily limits, there is no guaranteed safe level of drinking. Views on what constitutes harmful drinking are informed by personal experiences, reference points, knowledge and language.

Silent Voices made clear that the potentially harmful impact on children does not relate only to the amount of alcohol consumed or to one particular pattern of consumption by parents, such as dependent or high risk drinking, and that a wide group of children are affected. Therefore it is important for key people in all areas to have that initial conversation about alcohol in their area. What do we mean by alcohol misuse? What levels of use and of risk are we talking about and what is the priority? Services need to work with all stakeholders to consider a common language and definition and to make sure the right people – those with a mixture of positions and influence – are both round the table and prepared to instigate and follow through on the necessary conversations.

This report is designed to prompt such a conversation and to assist in developing and implementing a locally relevant strategy.

Purpose and aims of the study

This project aimed to identify and promote good practice in response to the needs of affected children and their families, with key questions as to how local areas can discover the extent and need among children and young people and how services, including universal provision, can best respond. It was important for the work to be informed throughout by the perspectives of

children and young people themselves and to seek to inform the policy and practice agenda, in particular the work of Health and Wellbeing Boards (HWB) and Local Children's Safeguarding Boards (LSCBs).

Fieldwork and analysis for this project was designed to meet the requirements of The Office of The Children's Commissioner's four core research objectives, which can be summarised as follows:

- **Prevalence:** How can local authorities more accurately estimate the number of children affected by parental alcohol misuse in their areas?
- **Existing provision and routes to help:** How can local authorities understand what help is currently provided, and how children and young people currently access it?
- **Best practice provision:** What was learned from the three case study areas about how children and young people might be more effectively supported?
- **Early intervention:** What would an early intervention and prevention model look like for parental alcohol misuse?

Study methods and approach

The study was not a 'traditional' piece of research in that it was structured and managed to gain an understanding of parental alcohol misuse at a local level and share the learning, rather than to solely pursue a rigorous research methodology. Ethical scrutiny and approval was undertaken through The Children's Society. Data collection was conducted in three local authority areas, from which senior managers had submitted expressions of interest (EOI) to be involved with the project, and employed a variety of methods to obtain relevant local data and to explore pertinent issues from multiple stakeholder perspectives.

In order to preserve their anonymity in this report we refer to the participating authorities as:

- **Seaside town:** A unitary authority with high levels of deprivation and economic inactivity – amongst the most deprived areas in England with around 1 in 3 children living in poverty. This area had nationally high rates of hospital stays for alcohol related harm, drug misuse and teenage pregnancy. The Health and Wellbeing Board was pursuing a focus on substance (including alcohol) misuse, early years and family, alongside safeguarding and responding to domestic abuse.
- **Rural county:** An 'upper tier' local authority council where levels of good health were generally higher and deprivation lower than the national averages (though just over 1 in 10 children grow up in poverty). The Health and Wellbeing Board had a focus on supporting family carers,

helping families facing multiple problems and reducing the harm caused by drugs and alcohol.

- **Large town:** A metropolitan borough with high levels of deprivation and unemployment. Health outcomes in this area were generally below the national average, as were the ages for male and female life expectancy. About one fifth of children live under the poverty line. The Health and Wellbeing Board here had prioritised a focus on alcohol misuse and children's health in its strategy.

Data collection and engagement

Both qualitative and quantitative data were gathered for the study in order to address the objectives. The views of a range of stakeholders were canvassed in each area, with different methods deployed with groups of participants.

Children and young people

Qualitative information was gathered from young people (aged 8–16) living in families where a parent or carer was misusing alcohol. Young people who were engaged with relevant services (in most cases a pre-existing support group) were asked to join a focus group and, where possible, were subsequently invited to individual, semi-structured interviews.

The young people who took part in a focus group were encouraged to comment on a fictional case study and to discuss how their own experiences of services compared. Those who went on to be interviewed were asked in more detail about personal experiences of parental alcohol misuse and the impact it had had on them and their family.

Alcohol misusing parents

It was felt to be important to explore the perspectives of both parents in treatment for alcohol misuse and of non-using parents/carers or another family member – including kinship carers. Children and young people do not exist in isolation and are part of families who are often key in the child's access to support.

In the adult focus groups, mirroring the approach for young people, a case study was discussed and debated to explore experiences of support and, where these took place, the interviews focussed on individual accounts.

Professionals

Service commissioners, strategic managers and practitioners with a key role and interest in parental alcohol misuse within each area were asked to engage with the study through membership of a local expert group. This was managed differently in each area, but the work either 'piggy-backed' on a pre-existing strategic or operational forum, or a new group was established specifically for the study. Typically, local expert groups involved managerial and online professionals from a range of universal, targeted and specialist settings, including agencies beyond the structures of the local authority itself.

The local expert groups met three times during the period of fieldwork for the study to coordinate the local phases of fieldwork, and brokered access to existing services and service users for the purposes of research. In addition a meeting was convened with the lead commissioner for substance/alcohol misuse in each local authority, and a specific exercise was conducted with a range of practitioners and managers in each area to map 'routes to support' for young people living in families where a parent or carer was misusing alcohol. This was done by mapping potential pathways based on a fictional case study. In each area there were also many conversations with individual staff and the sharing of information via email, both of which served as additional less formal means of data gathering.

Tables in Appendix 1 detail the numbers of young people, parents and professionals who took part in each exercise in each area.

Rapid Evidence Assessment

A Rapid Evidence Assessment (REA) (quick overview of existing research and information on a constrained topic and a synthesis of the evidence uncovered)¹ was also conducted, combining a national and local focus. The REA explored:

- the level of parental alcohol misuse in each participating area (prevalence, effects and local need) through scrutiny of published data. A 'minimum data set' was designed for this purpose asking each area to bring together relevant data from a variety of sources. (Appendix 2: Minimum dataset Table).
- other detailed local data and information to compare and contrast with the overview in the *Silent Voices* research.

National Expert Group

Information and data gathering for the project was augmented by the recruitment and coordination of a National Expert Group, whose function was to bring particular knowledge and experience to the study, to advise on the work as it developed, to share examples of good practice, to discuss emerging findings and to contribute to dissemination activities. The group met three times during the course of the study and provided very helpful comments on the final report.

¹ For a fuller explanation of REA methodology see <http://www.civilservice.gov.uk/networks/gsr/resources-and-guidance/rapid-evidence-assessment/what-is>

1. Understanding prevalence

The overview which was obtained across the areas was that local data sources – whether this was adult treatment services data, children’s services data, or Joint Strategic Needs Assessments (JSNAs) – are all helpful but had a variety of flaws. They did not provide the ‘jigsaw pieces’ to combine into a comprehensive picture of local prevalence for parental alcohol misuse, thereby undermining the prospects of adequately responding to children affected.

While concrete answers to the research questions remain elusive, the report adds value to the excellent elucidation of the issues in *Silent Voices* by exploring what parental alcohol misuse and related services look like in reality in three local authorities.

The study found that there was much work in progress in local areas on estimating prevalence of alcohol misuse but not of *parental* alcohol misuse. There was priority work on alcohol misuse in place as part of the local strategy for HWBs in all areas, but the JSNAs and Joint Health and Wellbeing Strategies (JHWSs) varied in respect of having a main focus on health, welfare or crime and adult or young people’s own usage. These findings were echoed in a recent report published by Alcohol Concern (2014). In fact, in only one area was the strategy specific to alcohol use in the context of parenting and even then it required a further focus on how to discover and address the impact on children.

There were also variations in bringing together information and cross matching data on other factors affecting children and families such as domestic abuse and young carers. Data on young carers and particularly on those caring for adults with alcohol misuse problems was not evident. The experience of gathering local expert groups for this project may have some relevance for the kind of cross-professional participation and communication needed to develop a focus on parental alcohol misuse locally. Some groups worked more successfully than others and it is suggested that they worked best when linked to a clear area strategy relevant to parental alcohol misuse. Alcohol screening existed in some degree within all the areas but it needed to be more linked up between separate services, applied within universal services and used as a basis for strategic planning. Variations between study areas as to what is collated with reference to alcohol misuse, as distinct from drug misuse, as well as the use of the available data suggest it is likely that this will be the case more widely.

Resourceful local approaches

The study found many examples of resourceful and innovative practice in

understanding prevalence which could be built upon to incorporate a more developed focus on parental alcohol misuse and the impact on children, including:

- locality specific research and analysis of alcohol related harm and risk
- detailed analysis of Common Assessment Framework (CAF) data
- use of domestic abuse data to estimate impact on children from both
- screening
- bringing together professionals as routine
- safeguarding protocol linked to child protection procedures for cross area use for those working with parents and carers with drug and alcohol problems
- surveys
- stakeholder events
- appointment of specific support workers linking adult treatment and children's services with the role of providing training for both, planning and contributing to service development.

Key findings: Barriers and challenges

- Nationally collected adult treatment data (NATMS/NDTMS) captures some data about parents in treatment – but the picture is incomplete. Adults may not disclose that they have children or that they are in contact with any children.
- Local authorities have not routinely collected data around parental alcohol misuse, particularly in children's services. Estimates have relied on adult treatment data and therefore are limited to households where the adult is engaging with treatment services. A point made clear in the research behind *Silent Voices*.
- A range of services collect data which is not necessarily collated by local authorities. One of the three exemplar local authorities selected to participate in the research stated in their EOI that:

The data we have is drawn from multiple sources and multiple agencies; therefore it is neither consistent in the way it is recorded nor in how accessible it is to any single agency. The challenge we face is firstly to gather the data successfully in one location and secondly to be able to understand the relatively accuracy, meaning and value of the individual and collected outputs (Large Town).

The potential for more helpful data collation following revised guidance from the Department for Education (DfE) concerning the assessment of children in need is welcomed (DfE, 2013).

There are barriers to generating reliable local estimates of the number of children affected by parental alcohol misuse, and to what degree, which

include general and local issues:

- Underreporting of alcohol intake: 40% of alcohol bought is unaccounted for when analyses are made of how much the nation drinks (Boniface, 2013).
- A lack of recognition and recording of alcohol related problems by some social workers and other staff in children's services. This may be due to insufficient training and/or badly-designed assessment tools and is in the context of the potential for the problems to be hidden, denied or understated by parents and for these issues to be considered secondary to other concerns. This was picked up in *Silent Voices* and linked to inadequate pre- and post-qualification training. An AdFam research study also found that '*practitioners had different opinions and experiences of training, but there was consistently a hearty appetite for it*' (AdFam, 2013).
- The lack of liaison and co-ordination of adult, children's and treatment services in respect of children's needs arising from parental alcohol misuse.
- Low levels of direct inter agency referrals between treatment services and children and family services staff and a possible preference for encouraging self-referral for treatment and support, which may mask the numbers of children in alcohol misuse affected households.
- The stigma and shame facing some parents who do not self-identify as problem drinkers, which is supported by societal norms, with the consequence that parental alcohol misuse is often a hidden issue and its scale or range is not represented in treatment figures.² One mother interviewed for this study, who was a binge drinker, studiously avoided alcohol treatment services:

...because they're for alcoholics...I do have a problem but not a massive one. To be an alcoholic you have to drink every day. I don't drink every day so I'm not an alcoholic...Services are full of people that are really bad, shaking and stuff, that is not me. The place gave me the creeps.

- Early introduction to and normalisation of alcohol misuse for children are barriers as they do not recognise there is a problem or even know that there is support available for them. *Silent Voices* pointed to the wide acceptance of alcohol use, and children saw this as a major obstacle to recognition of their needs.
- Carers, including kinship carers do not seek help or know help is available to them due to stigma and shame.

² For further details see: www.drinkaware.co.uk/understand-your-drinking/is-your-drinking-a-problem/binge-drinking

- Some front line staff are not well prepared, whether through lack of confidence or competence, to have the conversation about alcohol with parents or with children.

At a local level, it was found that there were other barriers and challenges: some potentially relevant data on domestic abuse or the Common Assessment Framework (CAF), which was not always gathered, would have added value on understanding on prevalence. There was wide variation between areas, which was in part a feature of the extent of the existing focus on data collection and was linked to strategic approaches. It was suggested that data collected for the Troubled Families programme would be helpful if it matched or correlated against other data captured. It was a feature of the study that no one person had access to all the information, which may not mean that figures were not obtainable, just that the full array of data was not analysed in order to understand prevalence.

All of the above general and local issues make it hard for local areas to consider what kind of services and interventions ought to be commissioned. An understanding of the issues affecting children goes beyond counting and requires that there is an understanding of impact.

How best to estimate prevalence

Using the national data

Estimates based on national formulae are widely used but they do present problems and limitations. The kinds of figures identified in, for example, *Hidden Harm* (Advisory Council on the Misuse of Drugs, 2003), the *Alcohol Harm Reduction Strategy* (Cabinet Office, 2004) or *New Estimates of the number of children living with substance misusing parents* (Manning et al, 2009) do not take into account regional and local variations in drinking culture. National datasets are best used alongside local reliable and meaningful data whether this is from assessments, interventions or services. This will assist with gaining a better understanding of prevalence and there is scope for improvement in both.

Ensuring the best use is made of the parental alcohol misuse indicator in the 'factors identified at end of assessment' section of Children's Services assessments

The DfE has released guidance to local authorities updating the requirements for data collection in children's services (DfE, 2013). This occurred after the main study period and includes updates to the 'factors identified at end of assessment' that will, from 2014, include identification of parental alcohol misuse. The statutory requirement to collect data on parental alcohol misuse should go a long way towards addressing some of the problems in collating local prevalence data described above.

However, in order to support accurate recording, and to make the most of the new data in a local authority context, it is suggested that further steps are taken:

- There is a need for robust alcohol awareness training programmes to enable, equip and empower social workers and other professionals to have necessary conversations about alcohol with parents and other adults in households.
- In order to ensure the data collected is both highly visible and useful to local authorities, it is suggested that a measure of parental alcohol misuse – informed by children’s services returns – be included in Public Health England’s Local Alcohol Profiles for England (LAPE)³ and also ensure that information is included in Diagnostic Outcomes Monitoring Executive Summary (DOMES)⁴ reports to allow local authorities to contextualise the scale of the problem in their local areas.

Using Alcohol Screening Tools: Early identification of alcohol misuse

Alcohol screening tools were developed as a simple method of screening excessive drinking and to assist in brief assessment. They aim to provide a framework for intervention to help risky drinkers reduce or cease alcohol consumption and thereby avoid the harmful consequences of their drinking. Importantly, screening has the scope to be an early identification tool which then leads to support and assistance. The Seaside Town reported that all data from screening is used, collected into the JSNA, incorporated into the Alcohol Needs Assessment and used to direct the local strategy. The strategy in turn directs the policy and planning, alongside published evidence from other locations. However, those in this study area recognised that this was not currently useful for the prevalence of parental alcohol misuse, as it was not able to describe the impact or outcomes from screening, nor did it inform strategic planning or local provision around parenting and children affected.

Therefore, screening tools need to be developed that:

- focus beyond the person undertaking the test
- focus on impact as well as units and consumption
- can be easily undertaken in universal services
- ask different questions at differing points of engagement
- enable correlation of findings from screening tools
- have a single repository for the screening tool responses.

A member of the National Expert Group was keen to share experience around a best practice methodology for screening. We detail this here in order to indicate the potential of this approach as a contributor to improved measurement of the prevalence of parental alcohol misuse.

³ For further details see <http://www.lape.org.uk/>

⁴ For further details see <http://www.nta.nhs.uk/uploads/diagnosticandoutcomesmonitoringexecutivesummary-domes.pdf>

Sheffield Alcohol Screening Tool

In recognition of the low number of referrals from services working with children and families into adult drug and alcohol services, both locally and nationally, Sheffield Health & Social Care NHS FT (SHSC), providers of adult Substance Misuse Services in Sheffield, developed a web-based screening tool to enable workers from all children, adult and family services to quickly screen for problematic alcohol use, using a validated tool. The tool also provides clients with personalised brief advice and can be used to refer clients, with their consent, to the alcohol service immediately.

The development of the Sheffield Alcohol Screening Tool has helped promote:

- a consistent approach to alcohol misuse by all services in Sheffield
- early identification of a parent misusing alcohol, and therefore better and earlier identification of children who live with alcohol misuse so support can be offered
- appropriate assessment and intervention

The screening tool has helped improve the ability of front line staff in universal services to identify parents who are misusing alcohol at the stage when the evidence base for successful early brief intervention is strongest. This approach is at the core of the Sheffield Hidden Harm Strategy 2013 –16 and has been endorsed by both Sheffield Safeguarding Children Board (SSCB) and Sheffield Drug and Alcohol Coordination Team (DACT).

Collection and assembly of locally available data

It is suggested that a step-change is needed in the extent to which local authorities work to piece together data sources in order to produce a more complete picture of the prevalence of parental alcohol misuse at a local level. The onus needs to fall on both adult treatment services and children's services to provide the necessary data. The following model may be applied in local authority contexts.

Overall responsibility

- Due to the many agencies involved in identifying and supporting a family with parental alcohol misuse problems, the findings from this study indicate that overall responsibility for the quantification of the issue could lie with Health and Wellbeing Boards.

- It would follow that the Health and Wellbeing Board would be responsible for determining who leads on the commissioning of the necessary collation and analysis of datasets.
- These datasets will derive from a variety of sources, and each should be reasonably expected to cooperate with the LSCB under existing data and intelligence sharing protocols.
- HWBs bring together all major partners to agree local priorities through the development of the JSNA and JHWS. The existence of a protocol between drug and alcohol partnerships and children and families services⁵ should be cross referenced in these key local documents and implemented across the range of settings (Public Health England have recently published a JSNA Support Pack of relevance to the local authority's commissioning remit).⁶
- The LSCB has a strong role to play in supporting information sharing between and within organisations and addressing any barriers to information sharing, as well as delivering, monitoring and evaluating training, including multi-agency training to safeguard and promote the welfare of children and families. Such training should include the impact of parental alcohol misuse and the potential risks to children.

Adult treatment and recovery services

- Services to have a renewed focus on the importance of determining the presence or absence of children in the households of all adults undergoing assessment, at reviews and as part of recovery plans.
- Services to record information concerning parenting support offered and follow up and support offered to children and other family members affected by the adults' use.
- Services offering Tier 2 interventions to capture data on parents and ensure this is reported back to commissioners to form part of data and intelligence gathering.
- Commissioners of adult treatment and recovery services should be proactive in sharing NDTMS/NATMS data and DOMES reports, and bringing figures relating to parental alcohol misuse to the attention of LSCBs and Local Health and Wellbeing Boards.

⁵See: <http://www.nta.nhs.uk/uploads/safeguardingprotocol2013.pdf>

⁶Further details at: [Good practice prompts for planning comprehensive interventions in 2015-16](http://www.nta.nhs.uk/healthcare-JSNA.aspx) and <http://www.nta.nhs.uk/healthcare-JSNA.aspx>

Children's services, including but not limited to children's social care

- Children's Services to focus on effective and consistent recording of alcohol misuse data (relating to all children and adults in the household) as required by the DfE social work returns guidelines.
- Children's Services to also adopt a consistent language and vocabulary for use in narrative case notes so that the extent and nature of misuse is clearly communicated to any other professionals working with a family and/or reading case files.
- Collection of data about potential parental alcohol misuse issues at assessment stage in other services working with children: such as Young Carers Services, Child and Adolescent Mental Health Services (CAMHS), Youth Offending Teams (YOTs), those using Common Assessment Frameworks (CAF) and Team around the Child (TAC) assessments. It is suggested that a set of definitions is adopted which is consistent with that in DfE social work return guidance, complemented by appropriate support and training for the staff concerned.

Other services

In line with OFSTED's *What about the children?* report, (2013) it is suggested that there be routine identification and recording of parental alcohol misuse in a broader range of services through the use of robust and holistic assessment and screening tools. This will include adult mental health services, Troubled Family Projects and broader adults' and children's services. The role of GPs; primary care practitioners (health visitors, school nurses for example); and antenatal and maternity services in identifying needs arising from parental alcohol misuse should also be included.

2. How local areas can map the current landscape of service provision for children and families

The three local authorities involved in this study were selected, at least in part, because they all had some support available to children and family members affected by alcohol misuse. During data collection, the study team engaged with young people, parents, carers and practitioners. With each audience, routes taken to access this support were explored through case studies, real examples and process maps, depending on the audience concerned.

The existing landscape

The services provided varied along the following lines:

- **Focus:** Focus on children, or whole family, or both
- **Engagement:** Engagement with family members together, or separately: including whether it was the using or non-using parent/carer who was involved
- **Time:** Time-limited intervention or rolling participation
- **Participation:** In one to one environment, or group therapy
- **Outcome:** Focus on fun activities and distraction, or focus on solution and family support.

The landscape of services and referral pathways dealing with parental alcohol misuse, both within and across councils, was varied, patchy and ad hoc. Services were more and less integrated into referral pathways, and whilst services existed in all of the areas looked at, they were dealing with different kinds of problems and with different age groups and levels of need.

While all of the three local authorities involved in the research did offer some form of help to some children and young people, and were able to identify some possible pathways to help, there was clear consensus that the level and amount of help was insufficient and the routes to accessing it far from perfect. *'We've cracked it in terms of young people and their own drinking'*, reflected one practitioner, *'but we're nowhere near when it comes to young people affected by their parents' drinking'*. *'We talk about alcohol in terms of the number of units people drink, but not in terms of its impacts on the family and what we can do to support the family'*, stated another.

Key points include:

- There was a range of services: from family support (not always with direct support to children), to services which are for children but not specific to parental alcohol misuse, such as those for young carers.

- Children accessing these services had also had very different experiences of alcohol in their families, ranging from those for whom parental alcohol misuse was an identified risk, to those whose parents had actually lost their lives due to drinking. This diversity of provision reflects the broad nature of services involved with children affected by parental alcohol misuse as identified in *Silent Voices* and is not unusual.
- The children and young people had found their way to these services through a number of different routes and pathways, but primarily through referrals from schools and school-based services and interventions, which had picked up on the secondary consequences of parental alcohol misuse in the home for example, poor attendance or poor behaviour – *‘At school you get support when your behaviour becomes a problem, then they come to you because of that’* (16 year old girl).
- Other key referrers were Children’s Social Care, either for those assessed as children in need or subject to child protection processes and adult treatment services, where a child had been identified in the household.
- Young people spoke about how they found managing their emotions difficult and this was often a way in which schools picked up on these problems. *‘The anger goes round and round in my head, I get dizzy and hot I can’t cope I just burst. I have anger issues’* (13 year old girl).
- Children only referred themselves in the area that had a long established service which was well integrated into local provision.
- Most notably, none of the children who were spoken to in the study had approached anyone for help, *‘Even though I had a problem I wouldn’t have done anything about it. I am embarrassed if I’m honest’* (16 year old male).
- Moreover, when asked about help in our focus groups, children and young people assumed that the only help available was for the alcohol misusing parent, not for themselves.
- Children and parents or carers were very aware of the impact that parental alcohol misuse had upon them but that they only came to notice and help only came when the misusing parent hit crisis either as a result of poor physical health or when there were child protection concerns, *‘When I had passed out the kids used to come down and kick me to check if I was alive’* (44 year old woman); *‘You can’t get help with the family stuff until you get treatment yourself but it can take years for you to think you have a problem’* (46 year old woman).

Identifying Gaps in referral pathways

A process mapping exercise⁷ was undertaken with a range of professionals and, most helpfully, with a mix of front line practitioners and strategic managers. This is considered a useful exercise to discover a child's route to help and support and aims to uncover:

- what services are on offer
- what practitioners/managers know about the services
- how they believed the processes to work
- what the practitioners/managers experience was of working within these processes.

Those in all three areas identified a number of points at which key referrals were not being consistently made, or at which key actions were not being taken. In practice, they felt, this meant that many children who may be suffering from the ill-effects of parental alcohol misuse might not be identified, let alone given access to the kinds of services there to support them.

Universal services

Schools

Schools often had different ways of dealing with pupil support needs and family issues: a state of affairs that was deemed likely to become more entrenched due to the diversification of education. In one of the areas, for example, efforts to engage local schools in the alcohol agenda had been made, but it was felt that this was impossible due to de-centralisation and the sheer volume of schools to be worked with. As one practitioner put it, '*schools are like their own little planets*', making it very hard to design and monitor seamless pathways to help. Another practitioner questioned, '*Do schools have family support workers? I don't know any more*'. Either way, the lack of knowledge regarding how schools could or would identify a problem is evidenced. This is compounded by the fact that the young people themselves have mixed views on the role of school in supporting them as was highlighted by the young people we spoke with:

Don't see why teachers should be involved with family things. It's like they are becoming your mum and dad (12 year old boy).

At Assemblies show different things that can happen in a family and where to get help, use a story to make people think what is going on behind closed doors. Then tell them where you can get help (14 year old girl).

⁷For further details, see:

http://www.institute.nhs.uk/quality_and_service_improvement_tools/quality_and_service_improvement_tools/process_mapping_-_a_conventional_model.html

Health services

Practitioners stated that partners in health services were not consistently making safeguarding referrals relating to children living in households where a parent or adult is misusing alcohol. Examples of missed opportunities to identify where a child may be in need of support services included:

- Ambulance services – which, it was recognised, are working in pressured circumstances and do not always make safeguarding referrals when they attend a patient who has become ill through drinking at home, ‘*There’s a big burden on ambulance services to make the decisions*’ stated one practitioner.
- GPs – whose limited time with patients and whose focus on clinical outcomes means that the needs of the children in the household of presenting adults are not consistently discussed or identified.
- Hospitals – where offers of alcohol treatment services are routinely made when a patient is admitted, but often to people who may lack the resources to follow up on those offers, or who may discharge themselves before services are taken up, preventing the identification of children who may also be affected. Many of the parents who were spoken to in the study had themselves been admitted to hospital several times due to alcohol misuse but in none of these cases had parental admissions led to subsequent provision of support for the children. Further, one practitioner felt that ‘*the alcohol liaison service offered by the hospitals is not consistent*’. Other practitioners in this same focus group felt that they didn’t know what hospitals were supposed to do in their local area when it came to parental alcohol admissions – in terms of whether the child would be identified for support or not.

Clarity of referral routes

This is not to say that referrals to parental alcohol misuse services did not come from schools, GPs and hospitals as indeed some of the services received referrals from these sources, but rather that the pathways were often not clearly delineated, and that there was scope for children’s cases, even potentially serious cases, to ‘fall through the net’. As with the need for strong partnership in delivering good data to understand the local prevalence of parental alcohol misuse, best practice in referral is also likely to require a consistent approach across universal services to case identification and referral pathways.

Specialist services

Children’s services

As discussed in the section above, there was a feeling amongst practitioners that the children’s services workforce might be under-equipped to tackle signs of alcohol misuse in the home. This is not necessarily about workers not having the right skills, but perhaps about the ways in which the identification

of parental alcohol misuse might conflict with their desire to work *with*, rather than *against*, families. This may be compounded by the fact that they might not be knowledgeable about the kinds of services that exist to help children in families where parental alcohol misuse is an issue:

Services need to be more proactive when you are in a situation that you can't even see, open a dialogue, and include the kids in this (44 year old mother and drinker).

Adult treatment services

In one local authority there had been an attempt to establish a referral pathway from adult treatment services to a service offering help and support for children – however practitioners from within the specialist support service highlighted the fact that despite ‘*hundreds*’ of known parents being in treatment at any one time, only four referrals had been actually made over a period of six months. This suggests that practitioners in adult treatment services are not reporting against the four relevant items in NDTMS which includes:

Harm reduction information to parents. All parents in treatment should receive harm reduction information in relation to their parenting. This should involve a strengths-based discussion as well as written information around a number of risky lifestyle areas, such as the impact of substance misuse on children and the family, protective factors for children, storage of medication, safe storage and disposal of needles, and what to expect from drug and alcohol treatment services working in collaboration with children services (PHE, 2013).

Equally, it could be that the treatment service staff believe that they are providing adequate information and support to enable the parent to provide support to their own children. Again, this means that the children may not be receiving support in their own right but would only be evidenced through a case file audit.

I only got help through the Health Visitor noticing that something was not right. I would not have asked for help (35 year old woman).

I felt like I was stuck in a corner trying to find out where to get help (49 year old man).

Suggested next steps

Understanding prevalence is only the first step in addressing the harm caused by parental alcohol misuse. The next step is to understand what support is currently available to children suffering the effects of parental alcohol misuse, and the current pathways to those services, before improvements and enhancements can be made at the local level to support services for those already suffering and services that are concerned with early intervention and to prevent future harm.

Based on the experience of working with the three local authorities to map children's access to support services, it is suggested that councils take the following actions.

1. An audit of targeted and specialist (tier 2 and 3) services working with children

Either commissioned or conducted in-house, this audit could establish which services locally could potentially already be supporting children and young people in addressing the harm caused by parental alcohol misuse. The audit could include those services that may already be providing support informally as and when need is disclosed (such as youth services, targeted youth work, school-based counselling, young carers services, social work, 'troubled families' teams, school-based SEN, breakfast and after school clubs) as well as specific and specialist parental alcohol misuse services. The outcome of this audit could, for example, be stored in the form of an online directory or similar resource, as the Rural County in this study had done. This can become an easy point of reference for different practitioners and professionals.

2. An audit of referral pathways

Once services have been identified, an exercise can be undertaken to establish how practitioners understand referrals and referral pathways to operate both between services, and from universal provision into these services. One method for doing this, as used in this study, would be to organise professional and practitioner focus groups from within local services, and present them with case studies.

The groups can then map the ideal processes of identification of the case and the subsequent referral pathways. This kind of exercise should also raise questions about current practices, and allow service directors, commissioners and planners to map the precise points where practitioners are unclear of current procedures. The main learning from this approach in the study was that it is imperative to ensure that there is good representation from across the service provision and from both practitioners and management in order to achieve this.

3. Data collection exercise and partnership working

Having conducted an audit of existing services and pathways, local authorities could undertake a numerical audit of referral data to establish the extent to which different services and pathways are being used. This exercise is likely to highlight many of the problems and gaps in the data identified in the previous section, but will also serve to highlight where there is partnership working, alongside over or under provision of services. A suggestion was made that evidence of partnership working constitute indicators for performance monitoring.

4. Consultation with children and young people

Asking children and young people in existing services how they came into

contact with that service provides information on how any referral system works in reality. One clear advantage of talking with children and young people is that it will allow local authorities to understand coping mechanisms and support structures that may exist outside of formal service provision, giving an idea of capacities within communities to deal with parental alcohol misuse problems, and crucially where those capacities might be strained, or inappropriate. Focus groups and one-to-one in-depth interviews, moderated by a third party rather than by the provider of that service, are advised as a means of consultation. However, asking young people how they accessed this help is not straightforward. Conducting research with children and young people that can be usefully fed into an exercise in referral and service mapping will need to be strongly facilitated such that their feedback can be collected naturally and in their own words, but also relayed in terms which will influence the processes accordingly. The following list provides examples as to why there may be a potential mismatch between children and young people's responses, and the world of local authority service planning:

- None of the children spoken with in the course of this study had, at any point, 'asked' for help, at least not in the sense of seeking professional intervention in their families or their own wellbeing. This links very strongly to findings from OCC's *Recognition and Telling* report which states, '*It is important for professionals to notice signs and symptoms of children's and young people's distress at any age and not to rely unduly upon the child or young person to talk about their abuse. A significant risk of reliance on verbal telling is that a child's silence or denial means that abuse is not pursued*' (Cossar et al, 2013).
- Children and young people may not understand 'services', even where they have been in contact with them. Whilst the young people in the study mentioned 'groups' they had been to and 'people' they had seen they were often unaware that they represented 'services'. In fact, children and young people may not even consider that it might be a council's job to help them if their parents drink too much. '*When you're going through that though you think you're the only person going through that, so don't want to speak to anyone*' (16 year old girl).
- Children and young people may not recollect pathways and referrals as clearly as practitioners might expect them to and might find it hard to distinguish between the various adults and people involved, such as teachers, counsellors, social workers, youth workers.
- Children and young people may feel removed from the process they had been through, due to the normalisation of alcohol misuse, '*I realised when I went into care that this didn't have to be the way*' (16 year old girl); '*I looked after my sisters, I thought it was normal*' (16 year old girl).
- In all of the cases encountered through the study, the children and young people had arrived at services with the help or guidance of an adult, who

had navigated 'the pathway' on their behalf. *'I think you need someone to show you what help there is'* (14 year old girl).

- Many children and young people had found ways to respond to their situation. These survival mechanisms show a level of resourcefulness but cannot be seen as solutions to the situation, or necessarily as evidence of resilience, as was pointed out in *Silent Voices*: *'My dad came and got me away from the house when my mum was drinking, you have to try and get away'* (12 year old boy) ; *'I play games all the time on my X-Box that calms me down'* (10 year old boy).

3. Towards best practice in supporting children affected by parental alcohol misuse

Findings

The study found a number of best practice examples in the three areas as indicated below.

- A strategy led by Health and Wellbeing Board, informed by the JSNA and inclusive of information concerning parental alcohol misuse which enables identification and planning concerning impact on children.
- The development of data collation from wider sources.
- Support for children not dependent on the alcohol misusing parent being in treatment.
- Clear and robust referral pathways in place from adult treatment into young carers services, which has resulted in two posts being funded by the council to support young carers in families affected by substance misuse.
- Using feedback from users of services.
- Children and parents able to explore the impact of the parental drinking together.
- Group work available to children and parents/carers.
- Specialist posts working within the Substance Misuse Service and alongside the Children's Centre's Parenting and Family Support Team to support families requiring early intervention and those who are 'hard to reach'.
- Hidden Harm Champion network.
- Co-ordination of services in contact with children and families affected including a regular cross- service forum for those working with children.
- Service Commissioning Teams commission a range of pilot one and two year innovative projects across the county in order to support the alcohol recovery system and provide the opportunity to evidence good practice which can be utilised to inform future commissioning decisions.

Integrated and cross-theme commissioning

With these first steps toward best practice in mind, it might be worth making the distinction between ‘best services’ and ‘best commissioning’. Whilst it is important to understand what a ‘best service’ might look like, it is clearly first necessary to consider ‘best commissioning’: this will strategically seek to deploy services that will meet well-understood local need.

While all of the authorities worked with had core, commissioned and some externally provided services for children affected by parental alcohol misuse, these services dealt with different stages within a child’s journey, and in different ways. Some for example, were interventions specifically designed to address issues within homes and families to do with alcohol, others were more diversionary, seeking to remove children from those contexts and give them respite and relief.

Some dealt with older young people, others with younger children. Ideally a matrix of planned and integrated provision would cover all cases that could potentially arise within a local area: from young children to older children; whole families and child/young people oriented; from early intervention to treatments and therapies; from structured interventions designed to tackle problems head on; to diversionary projects designed to give respite. In reality however, given budgetary constraints and local need, the provision of services commissioned to target areas of most concern locally is the next best option.

It is worth noting in this context that the data collection highlighted both services that were underused and those that were over-subscribed in one of the study areas. In one of the areas that had introduced an automatic referral process from adult treatment services, there were waiting lists for affected children. In other areas, referrals had not been forthcoming, and there was spare capacity within commissioned services. The point is clear: where need had been identified and a formal process mapped, the service was in demand, but where services had been commissioned without first going through the basic steps of mapping, understanding, engaging and designing pathways, the service was under-utilised, and was perhaps not being as effective as it should be. This point stands regardless of the specific structure and format of the services being provided.

Barriers and catalysts to implementing a best practice model

It would be all too easy to lay out a series of recommendations, and ignore the practical considerations around implementation, while failing to recognise the difficulties that might arise in trying to move towards best practice. Based on the study, it is clear that there may be a number of problems in implementing the kinds of suggestions which have been made so far:

- It is not always easy to raise the awareness and profile of one particular issue in a local authority – especially when alcohol is one of many ‘competing’ risks and sources of harm in the lives of families locally;

together with , for example, drugs, domestic violence, acute poverty. One local authority involved in the study had struggled to attract practitioners to an awareness-raising event, and faced many difficulties maintaining interest and engagement from schools following the deployment of specific toolkits and awareness-raising initiatives.

- Many services and needs are competing for the same dwindling financial resources in budgets; with services being rationalised and integrated, rather than new ones created.

On the other hand, the study also revealed that amongst practitioners and within local authorities there was a great appetite for learning and improvement. This can and should be leveraged to catalyse change, and build towards best practice.

First steps: Questions emerging from the work

The first two steps in the list below echo suggestions made in later sections of this report. Having been through this process with councils contacted as part of this study, however, it is recognised that they are likely to uncover as many questions as answers. With this in mind this report attempts to pre-empt, and give forewarning of, the kinds of issues that are likely to emerge, and the kinds of questions that will need to be answered in order to plan and commission services more effectively:

- Do you have a robust and complete picture of the extent of parental alcohol misuse within your local area?
- Undertake a mapping exercise of local parental alcohol misuse services for children, and the pathways and routes into them.
- Establish a robust set of local parental alcohol misuse protocols. These could be agreed by LSCBs and local HWBs. Public Health England published guidance on what such protocols should aim to achieve and what they should contain (Public Health England, 2013) but in the light of this study, such protocols will need to address the following:
 - Who exactly should be making referrals when a parent is identified as misusing alcohol: GPs? Social workers? Adult treatment workers? School nurses? The answer is likely to be all of these agencies and more, but at present, responsibilities are perhaps not articulated clearly and often deferred to someone else.
 - Whether identification and referral relating to parental alcohol misuse is an overarching responsibility for the entire children's services inter-agency workforce, as it already is for signs of drug abuse, domestic violence or neglect, for example.
 - Where referrals could be sent, at the various levels of need or risk, and for the different ages of children and young people: social care/ multi-agency safeguarding hubs? School TAF coordinators? Directly to

- o specially designated support services?
- o The thresholds for various levels of 'assessment of need' and management of thresholds.
- o The need for a common language and understanding around alcohol misuse across different services and agencies.
- o Local procedures for consent and authorisation. Could children have a right to access help without the consent of their parents, for example, applying Fraser Guidelines⁸ to assess the young person's competency to access services in their own right?

The need to undertake these first steps could be clearer. In the absence of a clear understanding of local prevalence, and a clear map of local services and referral pathways, the effectiveness of different kinds of services is, to a certain extent, moot, since the 'best' way of delivering services will depend on local need. At the very least this will be determined by:

- the best estimate of numbers of children and young people affected locally based upon a new approach
- the other local problems that might be faced by children and young people affected by parental alcohol misuse and, conversely, the levels and kinds of protective factors that children and young people in the area may have
- the scope of the work done by existing services with children affected by parental alcohol misuse: in particular, young carers and school-based support
- the socio-cultural and demographic characteristics of children and young people in the local area, and the sections of this population, that are most likely to be identified as being affected by parental alcohol misuse
- for many of the adults engaged by the study, the intergenerational impact of alcohol misuse was a common thread. Statistics show that children of alcoholics are twice as likely to have alcohol problems themselves. The parents in the focus groups did not disprove this; however, it is an area requiring further attention and research.

Learning and feedback from the project

The project had particular regard to enabling learning both within each local area and across the areas. Therefore, following the data gathering and after some preliminary analysis, a feedback session was held in each of the three sites. This presented an opportunity for participants to attend who were not members of the local expert group, to hear about the study and add any further information. Alongside the draft overview report, each area has received a local report that captures data and information against the four study objectives and is relevant to their area. It is hoped that this will be a

⁸ See: http://www.nspcc.org.uk/Inform/research/briefings/gillick_wda101615.html

marker of learning and progress on parental alcohol misuse. Whilst seeking feedback on both the draft local and overview reports it was felt to be important to capture progress made in the local areas during and since the study commenced. Illustrations of these, provided by study areas, are recorded below.

Illustration 1

As a result of the project and the request for CAF data, the CAF team have changed the mechanism on the spreadsheets to record Drug or Alcohol Misuse as a separate heading, both for the parent as a user and/or the child/young person. This is an important move forward, recognising the need to be able to extrapolate from the data. In addition, with the move to E-CAF, drug and alcohol misuse fields will be built into the system so that reports can be run, thus providing a better understanding of need. There has been a targeted training programme, which has prompted consideration as to whether it is the CAF that is the right threshold for the families that workers are supporting, or whether they are utilising other assessment tools.

Illustration 2

The process of data mapping was very helpful for framing the issue in a way that could be discussed in an increasingly informed context and has then allowed different conversations to take place. The key events have included development of a Parental Substance Misuse Action Plan 2014 –18, the co-location of Parental Substance misuse family workers with tier 2/3 'stronger families' teams and other milestones. There has been evolutionary change and the biggest change was not a single event but the wider growth in change potential. A joint training event was held around parental substance misuse, with social workers and drug/alcohol treatment workers; from that event 22 professionals signed up to revise the joint protocol in relation to substance misuse. This capacity for change would not have been in place without the study. It has therefore contributed to change in the following ways:

- The co-location of parental substance misuse family support staff within tier 2/3 'stronger families' teams. Initial feedback suggest that this has worked well and resulted in increased referrals and up-skilled the wider workforce. The sustainability of these arrangements are currently being explored.
- Commissioners and staff from within social care, audited some case files against the local protocol and identified gaps in practice, which resulted in the joint training event mentioned above. This is seen as the start of driving improved understanding and joint working between services.
- Public Health, the DAAT and Children's Services have come together as a result of the project to launch a pilot of the Sheffield Alcohol Screening Tool.

Illustration 3

The recommendations in the report have been built into the re-commissioned drug and alcohol treatment services in a variety of ways.

- A dedicated family worker post whose remit is to support and train keyworkers to make sure that they are family focused within their daily practice when working with clients.
- Drug and alcohol workers are commissioned within the Families In Need initiative adopting a Think Family approach and delivering both prevention and treatment options to the whole family.
- Keyworkers within the drug and alcohol treatment services contracts are required to carry out family assessments.
- The CCG have commissioned a substance misuse midwife to reduce the impact of alcohol use during pregnancy.

Suggested approaches to good practice

In terms of differentiating between the effectiveness of services that provide support to children and young people affected by parental alcohol misuse, it is fair to say that good evaluation data is lacking, as was reported in *Silent Voices*. That said, the evidence gathered from this study, in terms of what is currently being done to support children and young people affected by their parental alcohol misuse, suggests certain key principles in terms of service provision. These are summarised in the table below and are based on the discussions with children and with family members.

Principle	Rationale
Accord high priority to (or 'fast track') treatment services to all parents with children at home	<p>Above all else, children and young people said the most important thing for them was to tackle their parent's drinking. When presented with the case study in the focus groups, they said consistently that this was the most important thing that needed to happen in the family.</p> <p>Children enjoyed diversionary activities, fun days out and group work but this did not diminish their sense of urgency around helping parents overcome their alcohol problems.</p>

<p>Work with the whole family: Tackle the parent's drinking and address the child or young person's needs both individually and together as a family</p>	<p>A three-strand approach to tackling parental alcohol misuse benefits from being able to give time and space to children and adults individually, allowing each to discuss freely the impacts of drinking on them, and the personal resources they might draw on to cope with it; whilst also addressing immediate issues of family functioning.</p>
<p>Support services to have many 'front doors', so that any professional can connect a child or young person with them.</p>	<p>A necessary corollary to this point is to make professionals, children and families fully aware of all the support services that may exist.</p>
<p>Services to acknowledge the wider impacts of the child or young person's experience – e.g. on school attendance and attainment, mental and social wellbeing, own risky behaviours – and engage appropriately with other professionals and agencies involved in their life.</p>	<p>Young people described the difficulty in disclosing the difficulties they were facing and the barriers posed by the need to talk to many adults separately in different contexts.</p>
<p>Professionals to explain the nature and purpose of the help being provided – so that children and young people can contribute to setting goals over an appropriate time-period</p>	<p>Children and young people were not always able to articulate the benefits of their involvement in services, so were not always able to comment confidently on their usefulness or their progress.</p>
<p>Services to continue to provide support to the whole family throughout the period of 'detox' and 'behaviour change'. This will help to maintain relationships, and help enable parents to adapt to the new sets of demands they must face</p>	<p>The changes that take place in families once drinking misuse has been addressed can be challenging. Both parents and young people described the sense of struggle as roles were changed and redefined, alongside the immediate challenges brought by 'detox' and finding new routines.</p>
<p>Support services to provide a long-term commitment to service users,</p>	<p>Short-term interventions may fail to take into account the wider needs</p>

<p>with differing levels and packages of support required for recovery⁹</p>	<p>and problems that a family may be facing. They may also fail to recognise that the needs of parents, children and families change over time, especially during a period of changing behaviour and routines. The ad-hoc nature of funding for alcohol misuse services may be partly to blame for the fact that services cannot provide the long-term commitment that is needed both by families, and by local authorities-in terms of being able truly to measure the success of alcohol misuse services.</p>
<p>Embed service user voice, consultation and participation.</p>	<p>In order to ensure that services are designed and delivered according to need, it is essential that service users are asked what they need and want; what worked and where are the gaps.</p> <p>This should include exploring peer and community led provision.</p>
<p>The evaluation of services with success criteria established at or before the point of commissioning – in a manner consistent with the core principles of outcome-based commissioning</p>	<p>Measurable outcomes for children, parents and families – both short and long term – of a range of indicators such as wellbeing, health, relationships and resilience.</p> <p>Targets in terms of reach: numbers of referrals and successful completions as a proportion of estimated prevalence</p> <p>Evaluation by children, parents and families themselves.</p>
<p>Workforce development, professional training and continuing professional development</p>	<p>The wider workforce need information and understanding about the nature of parental alcohol misuse, the potential impact upon and needs of children and the services available to them.</p>

⁹For further details, see: <https://www.gov.uk/government/policies/reducing-drugs-misuse-and-dependence>

During the drafting of this report, a toolkit was published which looks at *Developing, Assessing and Mapping Alcohol Hidden Harm Services for Children and Families*.¹⁰

¹⁰ This tool kit can be accessed at: <http://www.alcoholhiddenharmtoolkit.org.uk/getting-started>

4. An early intervention approach to addressing children's needs

The study aimed to explore what might be the ingredients of an early intervention and prevention model for parental alcohol misuse. From a parental perspective, prevention would mean that population-level efforts to reduce alcohol consumption and reduce problem drinking are emphasised for adults. Early intervention could lead to existing drinking parents being identified earlier. This is likely to involve additional or enhanced screening with parents at key points – in pregnancy or during their parenthood. The Sheffield Health and Social Care NHS Foundation Trust continues to promote the use of the alcohol screening tool across all universal service providers, and has identified additional opportunities where it could be used with parents and carers. City-wide use of the Sheffield Alcohol Screening Tool has already resulted in:

- a significant increase in referrals into the adult alcohol service from children's services
- better and earlier identification of children who live with alcohol misuse so appropriate support can be offered to them
- more accurate prediction and better understanding of alcohol misuse within the client group accessing different services
- 59% of those parents screened to date by children's social care identified as reaching the score threshold and therefore requiring further assessment
- a sharp increase in the number of adults engaging with treatment services in Sheffield.

An alternative perspective to consider is that of the children and young people wanting their parent(s) to stop drinking. Interventions could be centred on the adult drinker earlier so as to prevent the harm caused by parental alcohol misuse.

The immediate challenge here is that, as has been seen in this study, there are a number of barriers for children and young people accessing help, and they may well not ask for this. Children and young people explained that they did not think of their parent's drinking as a 'problem they can get help for': it is something they struggled with in isolation, and with the assumption that no other child undergoes the same hardship. They did not, therefore, go looking for help. The only help they could conceive of was help for the drinking parent, not help for themselves.

The onus is, therefore, firmly upon universal and other services to identify alcohol as a problem within a family, and to assess the adults' drinking and the child's need for support. This may require additional skills, understanding and screening tools for use by a far wider range of professionals – tools and

skills which may be used also to identify other factors beyond just alcohol; for example drugs, domestic violence, and poor nutrition. It will require workforce development and, improvements in the content of professional training and post-qualification professional development, so that these sufficiently address the nature and impact on children of parental alcohol misuse.

The Common Assessment Framework proved in one area to be a well embedded multi-agency early intervention assessment and planning tool, which is used to provide coordinated and prompt support to vulnerable children, young people and their families.

True early intervention means that signs and signals are more systematically identified so that referrals are made by teachers, teaching assistants, GPs, school nurses, youth workers and others. In this study, one illustration was provided by the Seaside Town, where the approach is a cross disciplinary, new early support framework. The framework is managed and steered by a multi-agency sub group within the Children and Young People's Trust. The aim of the group is to provide a strategic steer and ensure a holistic approach to early intervention and support for families in the area in order to prevent escalation into statutory provision. In providing this strategic overview, the group takes account of and aligns government initiatives and funding streams to ensure integration with the overall vision of support for families, to deliver services in a more effective and efficient way.

While aspirations for early intervention and prevention are both correct and laudable, the findings of this study, however, make it clear that the provision for children already suffering the harm of parental alcohol misuse is ad hoc, with unclear routes for help and support. The suggestion from this study is that pathways should be clarified and services developed for those children already in need in addition to investing in resources for an early intervention approach.

5. Conclusion: Suggested ways forward

This study has explored parental alcohol misuse and how it is uncovered and responded to at a local level by talking directly to those children and adults affected and to those charged with providing services to meet their needs. The findings reflect the different stages of development in the local areas at a period in time and demonstrate the learning and progress that local authorities have made on the agenda. This was also a period in which a number of changes were taking place and new developments, for example in health service structures, were in early stages. Illustrations provided and analyses of local practice developed through this study point to the potential for moving forward with this agenda. The difficulties of accurately estimating the numbers of children affected by parental substance misuse in each area should not prevent those responsible for strategic and operational management from addressing the needs of children and families affected.

Some specific suggestions from the study partners are made here in respect of the four study objectives.

Understanding prevalence

- Overall responsibility for the quantification of parental alcohol misuse, including commissioning of the necessary collation and analysis of datasets could, it is suggested, lie with HWBs.
- HWBs need to ensure that the local impact of parental alcohol misuse upon children and families, including those children who are young carers, is addressed with a local, robust, response reflected in JSNAs and JHWSs, in order to meet duties under the Children and Families Act 2014 and the Care Act 2014.
- Data collected on the 'Troubled Families' programme and from other indicators of stress factors for families, such as domestic abuse, would be usefully matched or correlated with data captured on parental alcohol misuse.
- National datasets are best used alongside local reliable and meaningful data whether this is from assessments, interventions or services and from adults, (support, mental health and treatment) and children's sources.
- Use of the model of dataset developed for this project is proposed as a way of gathering a minimum data set.

Routes to help

- Ensure robust and clear referral pathways into support for children and families affected are in place.
- Seek to remove and address the barriers and issues of stigma that exist for children and families when seeking help and support.
- Undertake a mapping process involving professionals across agencies and services and incorporate an audit of targeted and specialist services which may be already supporting affected children; an audit of referral pathways; a performance monitoring exercise with services and consultation with children and young people. This is all to the purpose of ensuring that clear pathways to help for children are in place.
- Children and young people need support and guidance if they are to access help and service arrangements need to seek to address the barriers for children and families.

Best practice

- Use the principles from this report to guide multi-disciplinary strategic planning.
- Consider the value placed by children and parents/carers on group work and the opportunity to meet others in similar situations to themselves.
- Use feedback from children and parents/carers in the design and delivery of services.
- The alignment of commissioning activities and the co-location of commissioning for adults and treatment services would assist in addressing the potential commissioning and service gaps.
- Develop protocols and strategies owned by partners in Health and Wellbeing Boards and Local Children's Safeguarding Boards.
- Consider how to adopt a 'whole family approach' for any young carers in families affected by parental alcohol misuse, following the Care Act 2014 and the Children and Families Act 2014.

Early intervention

- Consider additional or enhanced alcohol screening with parents as a co-ordinated approach.
- Universal and other services to identify alcohol as a problem within a family, and to assess the adults' drinking and the child's need for support.

- Workforce development, training and awareness raising through local cross-service forums.
- Ensure signs and signals are more systematically identified so that support and safeguarding referrals are made for and with children and young people as needed.
- Ensure that The Common Assessment Framework (CAF) is used for recording, understanding and providing support for affected children and families.

Recommendations from the Children's Commissioner

Preamble

Children living with parental alcohol misuse are children in need of support and may be children at risk of harm. It follows that there is an obligation to assess their needs under section 17 of the Children Act 1989 and that it may be necessary to consider action to protect their safety. We make the following recommendations in order that local areas take forward the suggestions made in this report, based as they are on the messages emerging from children, family members, professionals and managers in the areas who contributed their perspectives and experiences.

1. Every local authority should determine the body which holds strategic responsibility for addressing parental alcohol misuse and its impact on children and the person who leads this. The evidence from this study indicates that this body could be the Health and Wellbeing Board and that Joint Strategic Needs Assessments and Joint Health and Wellbeing Strategies are the appropriate vehicles to use.
2. To ensure an effective operational approach, the above body should draw up an integrated strategy at local level with all the agencies and departments with a role to play as partners in addressing parental alcohol misuse. These include Directors of Public Health, Directors of Adult Social Care and Children's Services, leading health and mental health service personnel, Clinical Commissioning Groups, treatment services and voluntary sector agencies.
3. All professionals who work with children should be trained to understand and address: the impact on children of parental alcohol misuse; the views of affected children; how to protect them; and how their needs are best met. We recommend that the LSCB should monitor the development of training strategies in all relevant agencies and require an annual report on implementation and progress.
4. Commissioners for children's, adults' and treatment services need jointly to agree on the nature of service provision which will address parental alcohol misuse, based on local intelligence and a shared understanding of needs and services, utilising such methods of mapping as those proposed in this report

and including the involvement of children and young people. Commissioning of services should be complementary and strategically aligned.

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Appendix 1: Table of Participants across all three sites

Group contact	Number of meetings	Total Number of Participants
Local Expert Groups	9	Membership of between 6 and 17
CYP Focus Groups	5	15
Alcohol Using Parents Focus Groups	5	27
Kinship Carers Focus Groups	3	6
Practitioners Process Mapping Sessions	3	22
1 to 1 Interviews	3	3
Feedback Sessions	3	46
Meeting with services to discuss focus groups	8	8+

Appendix 2: Minimum dataset table

Source of data	Essential	Desirable	Comments	
NDTMS Data Full Year with all sections	X			
NDTMS Data Parental Breakdown info with compliance levels	X			
NATMS Data Full Year with all sections Same year as NDTMS	X			
NATMS Data Parental Breakdown info with compliance levels	X			
Domestic Violence Data Collection (MARAC)	X			
No. of Looked After Children and separated into DfE categories children looked after (CLA) and the form captures the reasons for being CLA and the 8 categories are: <ol style="list-style-type: none"> 1. Abuse or neglect (aka significant harm) 2. Child's disability 3. Parental illness or disability (incl addiction) 4. Family in acute stress (e.g. parenting capacity is diminished) 5. Family dysfunction (e.g. parenting capacity is chronically inadequate) 6. Socially unacceptable behaviour (this is of the child) 7. Low Income 8. Absent parenting 	X	Alcohol as factor		
No. of Children subject to Child Protection Plan and the categories of abuse for becoming subject to plan: Neglect Physical Abuse	X		Alcohol as factor	

Sexual Abuse			
No. of Children referred as child in need and under what category at initial assessment – see 8 categories listed above.	X	Alcohol as factor	
No. of Children/Families with a CAF	X	Alcohol as factor	
YOT ASSET data: Section 2 of this form (family and personal relationships) *Evidence of family members or carers with whom the young person has been in contact over the last six months being involved in heavy alcohol misuse?	X		
Hospital Admissions linked to Alcohol Adults	X		
Hospital Admissions linked to Alcohol CYP	X		
What Alcohol Screening Tools are used	X		
Where is Alcohol Screening done	X		
Adult and Young Carer data <ul style="list-style-type: none"> • Total numbers seen • Main reason for caring • Who caring for 	X	Alcohol as factor	
What other data sources are used to inform strategic decision making around alcohol prevention and treatment	X		

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