Doncaster Parental Alcohol Misuse Service Development project

1. Introduction and context

This document brings together the learning from a collaborative action inquiry process that engaged agency partners across Doncaster working together to critically reflect on challenges in responding to rising rates of parental alcohol misuse and identify priorities for change.

Recent studies highlight the impact of parental alcohol misuse on children[1] with approximately 1 in 5 children and young people in the UK being affected. In Doncaster it is estimated there is in excess of 800 children who live in the household of an adult with alcohol dependence. Parental alcohol misuse (PAM) ranks as the most significant factor in serious case reviews. Recent data from Doncaster Children's Trust indicates that parental alcohol misuse is a factor in 58% of child protection plans. The prevalence of PAM has rocketed during the COVID-19 pandemic and is linked to domestic violence, mental health issues and the impact of wider socio-economic changes.

Section 11 of the children Act 2004 places duties on organisations, agencies and individuals to ensure their functions and any services that they contract out to others are discharged having regard to the need to safeguard and promote the welfare of children. Within Doncaster Council's local authority area, there are a range of agencies providing services and interventions for children and families experiencing parental alcohol misuse, however, in spite of the work of these services, the impact of alcohol misuse on families continues to escalate.

About this project

The Just Futures Centre for Child, Family and Communities Research at University of Huddersfield were commissioned by Doncaster Public Health, to work with Doncaster Council to explore ways of improving services and outcomes for children and families affected by alcohol misuse. Following

[1] The Children's Society (2017) Good Childhood Report
https://www.childrenssociety.org.uk/sites/default/files/the-good-childhood-report-2017_campaign-summary.pdf

initial conversations with Doncaster Council Public Health dept, it was clear that significant knowledge already existed about the extent to which children are impacted by PAM, the challenge appeared to be about how services work together to respond. The objectives of this work were therefore to engage the expertise of partner agencies in a process of participatory whole system action inquiry, working together to critically reflect on existing systems and practices and identify areas for development in responses to Parental Alcohol Misuse. Agencies involved in this work are listed at Appendix 1. This work has been given the full support of the Health and Well-being board.

Approach

The work was originally designed to involve a series of workshops undertaken in real time, with partner agencies working together to develop a deeper understanding of the complexities and challenges at play, develop a better understanding of what is needed, learn from good practice and identify actions to improve service responses. As a result of lockdown, the work was moved on line, which posed limitations on the effectiveness of the work. Two workshops were undertaken with representation from key statutory and non-statutory partners at both. Workshop one explored some of the key challenges in making a difference identifying what support and services these children and families need and how best to respond. This was followed by a service mapping exercise, which only two agencies responded to.

The second workshop involved critical assessment of existing service responses, systems and processes and identification of priorities for change to improve service responses to better meet the needs of children and families. The intention was for partner agencies to take the learning back into practice to exploit the potential for implementing change in their own services and to evaluate that as part of this work. However, this process yielded limited response. As a result, follow up interviews were conducted with 8 key partner agencies to explore opportunities and challenges for change.

This briefing report documents the learning from this whole process, conducted between February and October 2021. This report:

- documents key issues and challenges experienced by services in responding to PAM as identified by participants involved in this process
- summarises the state of the art in terms of understandings of good practice, drawing on the wisdom of professionals involved as well as a rapid review of secondary evidence
- provides recommendations of priorities for change that have been identified by participants

In keeping with the action research approach adopted, some actions have been implemented already and these are indicated in the final section. This report, including priorities for change, have been verified by partners involved in this project.

2. Key issues and challenges experienced by services in responding to parental alcohol misuse

A starting point for this work involved partner agencies reflecting on experiences in practice as they respond to parental alcohol misuse. Discussions brought to the surface issues confronted in this work on a daily basis and concerned both the nature of intervention and support for both adults and children as well as systemic issues concerned with the organisation and delivery of services.

2.1 Parental alcohol misuse is a complex issue

Parental alcohol misuse is experienced as a complex issue involving multiple facets such as parental conflict, domestic violence, poverty, debt, mental health and families under stress, which need to be responded to holistically drawing on input from multiple agencies.

> "*We're presented with a multitude of issues or symptoms and its how do you unpack that to get to the root cause of the problem? Where do you even start unpacking that sometimes? And often we need to go right back to their childhood and have a look at these adverse childhood experiences. … so trauma informed practice is important and adverse childhood experiences and really getting to the route of the problems".*

Responding to parental alcohol misuse therefore involves dealing with presenting issues such as parental conflict, helping families pay the bills and bringing about family stability whilst simultaneously working with deeper underlying causes such as poverty and parents own family histories. But this takes time and requires an holistic approach. At the same time practitioners have to navigate parental resistance and denial whilst responding to statutory safeguarding responsibilities.

> *"The complexity there is that obviously we need to get to the need. So … what is the need that's underpinning the alcohol use? But what's tangled up in that is as women then start to think about their alcohol use and accept that that's a problem for them, they then become aware of the impact that's had on their child, usually shaming. So, it feels like a ball of string all tangled up and as we pull one element and we start to deal with something, something else falls out. So the mental health needs, the shame, … its hugely complex. We operate in a high challenge and high support environment … talking about really difficult things whilst trying to support women ... but see it from a very different point of view … the trauma or the underlying needs."*

2.2 Identification and engagement

Initial identification where parental alcohol misuse is an issue can be difficult as parents can often disguise the problems. Once possible alcohol misuse is detected, staff (for example in schools) can

find it difficult to engage parents, lacking the skills and confidence to open up conversations about alcohol problems with parents. These are sensitive issues. Parents often experience shame and stigma for not being a good parent and may be fearful of having their children taken away. Use of language is important, for example 'neglect' is seen as a loaded term and professional language can alienate. Not knowing how to broach the issue with parents can make practitioners risk averse and there is variability in people's willingness to engage.

> *"Its really difficult to start work that work and start that contemplation and looking at changing. Although we do have people that come in very clear that they want to stop drinking and then we have others that come in and say they want to stop drinking but very often go home and will start again and others that are very clear that they don't want to stop drinking."*

Early identification and engagement has also become more difficult as a result of cuts to resources for preventative, community-based work.

> *"We've lost, you know, family groups, we've lost all that early help provision, which makes it more difficult."*

However, there are many possibilities for opportunistic interventions, for example, when nurses visit to dress wounds or tenancy support workers visit families. With the right training these opportunities can be better exploited.

2.3 Parental resistance to support

Treatment for alcohol misuse depends on people being open to getting support, yet denial there is a problem can be common. It can be really difficult for people to accept that what they're doing has a negative impact on their family. There may be ground for statutory involvement, for example if there is a suspected child safeguarding issue, however, some families don't feel they are in need, so will resist support. So it is difficult to reach a shared understanding and commitment.

> *"We have cases at times … referrals sent in from Social Care for a family that's in need. But where we contact the family … they don't feel that they're in need. So that can be quite difficult having ... some pretty direct conversations at times as to their situation. But obviously if they don't remove themselves from that situation, the situation could be a lot worse because it could end up with children being removed. So that's difficult."*

Parents can hide the problem. Some noted how some parents engage in a balancing act, staying up late drinking then taking the kids to school and putting on a face to make everything seem fine. Practitioners are similarly in a balancing act between. Parents often fear their children will be taken away from them if they seek support. In many cases where alcohol misuse is occurring alongside a complexity of other problems, having an intervention coming in can be just another thing to deal with.

2.4 Children's needs are often marginalised

Children can often be side-lined with focus disproportionately centred on parents, on the basis that if the parent is fine the child is fine.

> *"Its rare that we see children … because we're office based rather than community-based now. So we have to rely on what parents tell us and our kind of clinical assessment skills, our observation skills, to try and be professionally curious about what parents tell us in terms of what children know or are exposed to".*

However, there is a lack of appreciation of the impact of PAM on CYP with child's behaviour seen as the problem, but at the same time may not get the support they need in dealing with the situation they are confronted with. Children often worry about leaving mum and dad at home. Service responses need to include a mandatory children plan that needs parents to agree to accept. When parents are confronted with the realisation about what their children are going through, this can have a powerful impact on parents and therefore provide a basis for dealing with underlying issues and building sustainable work with parents and the whole family.

2.5 Referrals and access to services

It can be difficult getting people to access services. But some agencies also report it being difficult to get through to services, for example by phone. If there is a delay in accessing services, the opportunity to help that family may be lost. Problems with leaving parents to self-refer or to pursue options via online resources or, as a result of information sent via email or post. Some agencies were reported to close cases if the service user didn't turn up for their first appointment. This can result in the person falling off the radar again without support.

> "If that family don't agree, you're on a hiding to nothing and so, you know, for me, a lot of these issues, they're all workforce development issues … whatever pressures people are under, its just 'I'm a social worker, I'm closing this case, but such and such is still happening, so I'll refer it to that service that deals with that … but actually that family are not aware of that referral, don't want that referral … then you also don't have a social worker …because they've shut them".

Many parents are struggling to cope and are unlikely to be motivated to pursue support and treatment options. Similarly, agencies such as ASPIRE rely on self-referrals, but if people do not self-refer they can fall away without support. It was also felt that having drug and alcohol services situated together could be a barrier to clients attending.

Reliance on self-referral with some agencies means that problems in families may not get addressed. Where people are referred by agencies as a service requirement e.g. probation or tenancy support,

connecting problem drinkers with treatment and support is more likely. However, parents are often reported as not self-referring even if it is a condition of their tenancy or probation.

Some agencies are not getting referrals from key services such as Domestic Violence team, Police, Adult services, Children Services and Mental Health. Some public services questioned whether it was their role to refer. Others report an issue with getting referrals but with insufficient information about the case.

> *"Its not just the information sharing agreements that are important, it's the practitioners adhering to them and that's where the sticking point is because if you ask … whether we have a mutual information sharing agreement in place, the practitioners don't know one way or the other. They just want to make a referral and they want to do it as quickly as possible with as little work as possible and so you get referrals that are virtually blank and so you have no choice but to ring that family … and sometimes they won't have asked consent, so you'll be ringing parents and they have no idea why you're ringing and say 'I don't want to stop using … don't phone me again'.*

Some agencies are of the perception that services are unable to see people who are under the influence. This apparently is not the case as treatment agencies work with all people at whatever their situation.

2.6 Not knowing what services are available

This is an issue for both parents and practitioners. Whilst treatment agencies such as ASPIRE are generally well known, this is not the only form of support for families. Some professionals are not aware of who to refer to and what the process is for this.

> *"The main thing that has come out for me today is the fact that there is this plethora of expertise and a lot of service is available and whether … its about threshold or whether it's just that we don't know enough about it to be able to make appropriate referrals and things like that. … there's so much information and there's so much service available for people, but its just how do we know about it and how do we join that up appropriately."*

It is not sufficient to just provide information or send a letter in the hope the person concerned will phone up go on-line as some people struggle to get out of bed and get dressed, so searching the internet is unlikely. Similarly, a failure to get through to services on the phone can mean people lose interest. When agencies fail to make contact with a new service user, there are reports that the case is dropped because they "wouldn't engage" and the person is lost from the system. Children also need to know what to do and where to go if they have concerns about their parent drinking.

2.7 Limited capacity and resources: Trying to do more for less

There is an unprecedented demand on services, yet many services report year-on-year budget reductions that limit the scope of the work.

> *"Services have gotten more and more squeezed about who they can work with and under what circumstances and … thresholds get higher and higher … because, you know, resources get more and more limited. So services end up almost working at firefighting level, but at a crisis intervention level, when I suppose what we're thinking about is taking it right back to universal mainstream preventative work which becomes more difficult as your resources get squished."*

As a result, it can be difficult accessing specialist services. This can involve long delays, yet people need support now not in 8 month's time. In particular, it was widely reported that many services were doing little more than fire-fighting, leaving the capacity to provide the important therapeutic intervention and take on referrals limited. From a service perspective, a conflict often exists between meeting the high demand on services/practitioners and **having time for deeper work with parents** and support them through the cycle of change.

> *"Its about having time to build up trust and slowly encourage them to open up, to strip themselves of their barriers … and speak with honesty, which is really difficult to achieve … it can be very emotive … But that's when you … know that you're on the route to supporting people to make positive change, once they break through that. But it's a slow process."*

People may receive treatment services, but then relapse and come back into treatment again. This is common in drug and alcohol treatment services and part of the cycle of change, but time and flexibility is needed to work with this. Pressure of case-loads and chasing KPIs also reduces time for services to pause and reflect on their practice and look at the bigger picture.

> *"You see an issue and put an intervention in, but you're still working away like a swan behind the scenes trying to do all the other things, rather than taking perhaps more of a helicopter view and trying to get upstream of the issues."*

2.8 Silo working

> *"We … focus more on the adults because they're the ones under our care, we do consider people around them, but have very little impact on the people around them, … so its very singular. We look at that one person and that one person, … so for us, I just feel we are quite tunnel visioned on that one person … so you don't get a feel for how that family dynamic works, … you don't get a feel for anything."*

In spite of many services making regular referrals to other agencies, there is a feeling that across the board not all professionals know what services exist in order to make the necessary referrals to enable people to access the right services at the right time. A number of participants felt that **multi-**

agency working is difficult in practice with services tending to be just focused on meeting their own KPIs. This is despite a widespread acknowledgement of the importance of multi-agency working. Some perspectives suggest that partnership processes have been undermined as services have been restructured.

One of the problems with multi-agency working is that there is often a delay in securing 'supplementary' services from other agencies due to waiting lists, in which time the person concerned has fallen out of the system. This is also a common pattern when service users are asked to self-refer. For example, if as part of treatment there are mental health issues that need working with, a referral can be made but the service user may not follow up. Similarly, as alcohol misuse is often part of a complex set of issues it can be difficult to disentangle and distil the issues into parts that align to service remits. In some cases there can also be an impasse arising out of agencies saying they won't work with a particular issue such as mental health, until the alcohol misuse is brought under control. Yet this can be difficult without stabilising their mental health.

Existing services do good work but there is clearly a need for better joint-working to use resources/services more effectively. As one worker stated:

> "*We probably already have all of the services that we need to have, they just don't necessarily talk to each other in the way that they need to talk to each other, if at all."*

Many participants in this process argues for the need for an holistic family approach to combat the relative isolation of children and adult services.

2.9 Alcohol misuse is a symptom of wider socio-structural factors

Many of the services provided for alcohol misuse are with health and care agencies. PAM is symptomatic of underlying socio-economic and cultural issues, yet there are limited measures to address the social context of alcohol misuse. Unemployment and housing are big issues. Socio-cultural norms around drinking alcohol exist wherein having fun means drinking alcohol and can be difficult to break. Drivers of alcohol misuse are further exacerbated by financial problems due to cuts to universal credit and rising prices. There is a need to work with families in a different way to find out what the triggers and stressors are and for social interventions that target the roots of alcohol misuse.

3. Good practice in responding to Parental Alcohol Misuse

In spite of challenges services experience, there is a clear sense for many partners of what constitutes good practice in responding to parental alcohol misuse that concurs with evidence

elsewhere[2]. Secondary review of evidence and learning from the two PAM service improvement workshops have identified the following elements of good practice that can frame service development.

- **Knowledge about what services exist** for parents and professionals providing practical support and information and clear pathways to appropriate services that enable timely referrals with clear protocols for referrals; whole system pathway (with multiple entry points & clear referral pathways).

- **Early identification to prevent escalation** by supporting the development of confident families (secure base, self-esteem, self-efficacy, positive parenting behaviours and stable family relationships); appointment of early intervention coordinators, early response to parental conflict and domestic violence, focus on pregnant mothers and young parents

- **Work force development -** Upskilling frontline staff (e.g. schools, nurses, safeguarding leads as well as police, fire service etc) to raise awareness about parental alcohol misuse and the impact on children (e.g. through Adverse Childhood Experiences training), development of appropriate skills to identify signs of alcohol misuse, and develop confidence to initiate conversations for example through use of Signs of Safety; as well as knowledge of local service systems and processes for referral. Incorporating parental alcohol misuse into children's services operations and recruitment of key staff.

- **Community outreach to enable early intervention and prevention** and improve family access to services (incl. hidden harm workers and CAMHs outreach); one stop shops providing information and access to services; public education and awareness raising campaigns; and place-based whole family support in high-risk areas through locality hubs (family hubs) to reduce stigma.

- **Use of Asset based approaches -** supporting development of family self-advocacy, family champions model (Family recovery champion workers) peer support, Importance of being empowering, non-judgmental and solution- rather than deficit-focused including use of appropriate language. Interventions should be strengths-based, restorative and long term

- **Ensuring timely access to specialist therapeutic interventions** and support including whole family work and use of trauma-informed approaches to get to the root of problems. Specialist support: Recovery from alcohol dependency, MH support, family therapy (through

[2] From a rapid review of literature and learning from National Evaluation of children of alcohol dependent parents innovation fund.

family hubs), complex case workers (and case management approach), 'Holding families' support for parents in prison pre and post release

- **Making time to build relationships of trust** to enable deeper therapeutic work with parents and time to work through cycle of change

- **Strong partnerships/joint-working –** consistent and coherent whole system approach, e.g. through Multi-agency safeguarding hubs (MASH), use of multi-agency change groups, multi-agency 'virtual teams' to improve identification and support to families

- **Whole family approaches –** to understand and respond flexibly to the complexity of family situation, improving family relationships, developing parenting skills and building family resilience, CRAFT (community reinforcement approach and family training) to support families, four-tired model (general to complex needs) including parenting education programme, evidence-based family strengthening prevention interventions, family case worker support (e.g. Option 2 in Wales), Moving Parents and Children Together.

- **Recognition of the specific needs of children** e.g. improving emotional mental health & wellbeing, placing children at the centre (TAC), use of ACE and respite for children and young people, tiered model of support: general needs – complex needs

- **Reducing stigma** – through public communications campaigns using appropriate language

Agencies may already be adopting some of these good practices to different degrees. In other cases, these are acknowledged as ideals, which may be difficult to realise in practice depending on the remit of individual services and available resources. This summary of good practice does however corroborate the priorities for change that have been identified through this work.

4. Identifying priorities for change

Following critical reflection on issues and challenges and the development of a shared appreciation of good practice in responding to parental alcohol misuse, implications for improving services and support were considered and priorities for change were identified for developing provision. These were then further refined through follow up conversations with key services.

Specific recommendations for developing Doncaster's response to parental alcohol misuse are as follows:

Recommendation 1: Making parental alcohol misuse a strategic priority

Despite statutory and specialist services that exist, increasing levels of prevalence of parental alcohol misuse continue. There is a strong view that parental alcohol misuse needs elevating to a higher level of strategic importance across Doncaster. Capacity of services is a major issue that has been highlighted. Given that parental alcohol misuse extends across policy domains and encroaches on the remits of multiple public sector agencies, the need for **a parental alcohol misuse reduction strategy is imperative with a clear delivery plan and resources identified to implement it**. This is likely to come from a combination of joint commissioning, linking with wider initiatives (for example New Doncaster Neglect Strategy, and Safer Stronger Doncaster partnership), external funding and coordinated service provision to make better use of existing services. This would need to include increased capacity for specialist services and new roles such as community outreach workers and a parental alcohol misuse multi-agency coordinator.

One of the reasons often given why services don't make changes and put measures in place that are needed is because of resources. However, cost benefit analysis undertaken by Doncaster council[3] indicates that it is more costly not to make changes as the following case study cost benefit analysis examples highlight.

Cost benefit analyses

Case study 1: Total costs for drug, alcohol and Hepatitis C treatment were £34,100, while the wider gross social benefits in the first year after intervention were £384,760 (£350,660 after costs). Wider social benefits include those associated with Local Authority Social Care, Education, Housing and Treatment, as well as wider benefits from NHS, CJS and indirect and intangible benefits. The benefit-cost ratio shows that the value of the benefits is 11 times the value of the costs spent. Social benefits associated only with Local Authority (Social Care, Education, Housing and Treatment) total £244,100 (£210,000 after costs) for the first year after intervention, 7 times more than the costs spent.

Case study 2: Total costs for drug and alcohol treatment were £2,400, while the wider gross social benefits in the first year after intervention were £150,710 (£148,310 after costs). Wider social benefits include those associated with Local Authority Social Care, Education, Housing and Treatment, as well as wider benefits from NHS, CJS and indirect and intangible benefits. The benefit-cost ratio shows that the value of the benefits is 63 times the value of the costs spent. Social benefits associated only with Local Authority (Social Care, Education, Housing and Treatment) total £94,500 (£92,100 after costs) for the first year after intervention, 39 times more than the costs spent.

NB: It is important to note that these estimations are likely lower than the actual benefits achieved in this case due to the availability of information available for this case - for example, it is not known whether there was exclusion from school, truancy or counselling for any of the older children so these treatments have not been recorded.

[3] Jessie Pearson (Policy and Insight Manager, September 2021)

Recommendation 2: Building multi-agency capacity for an holistic family service

Multi-agency working is widely accepted as good practice and is acknowledged as being central for responding to parental alcohol misuse. Consideration should be given to rethinking provision as a multi-agency framework that enables joint commissioning and coordination of services to meet strategic goals of reducing the impact of parental alcohol misuse.

> *"It makes me think about how you could set services up differently and have more joint working and integrated working between children and adult services and family working is something that's much talked about in (Doncaster) Council, as is post-Covid mental health from an all-age perspective".*

This would enable efficient mobilisation of existing resources and more seamless provision of an holistic service and help prevent service users falling out of the system in the process of referrals. A multi-agency framework needs to involve:

- Rethinking commissioning and delivery of services using an **holistic child and family approach**, rather than a collection of disaggregated services, to provide a more joined-up approach, in particular bringing together child and adult services.
- **A spectrum of support** from early help and parental/family support (including dealing with the impacts of social determinants) through to treatment and therapeutic interventions coordinated with a multi-agency framework
- Development of a **multi-agency protocol** to systematize joint working, including common assessment framework, information sharing agreement and key worker roles, and understanding the **role of different services.**
- Enforcing **accountability of services** including a critical assessment of the way in which the responsibilities and remits of agencies are being exercised.
- Implementing multi-agency working in practice by providing **resources for joint visits**
- Employment of a **multi-agency coordinator** to oversee commissioning, delivery and impact. This is imperative given the complex, multi-faceted nature of parental alcohol misuse. There would be value in locating this role in Public Health.
- **Regular multi-agency liaison meetings** to monitor and 'oil the wheels' of inter-agency collaboration.
- Parental alcohol misuse **champions** in each service for advice and guidance on referral procedures.
- **Cross service strategic management group** to ensure the right services with a parental alcohol misuse remit are round the table to enable buy-in, joint working and strategic linking with wider cross council initiatives such as the Neglect sub-group.

- Adoption of a **locality-based approach** to enhance possibilities for more effective multi-agency working (see 4.8)

Recommendation 3: Whole family approach

Adoption of a **whole family model** in responses to parental alcohol misuse that is consistent across all partner agencies that responds to the complexity of issues at play in an integrated and coordinated way and that places children at the centre. Examples already exist of whole family approaches such as Families Moving on Together (FMOT).

Key to whole family approaches is the adoption of an **asset-based and solution-focused approach** that seeks to empower family members. Accordingly, this needs to involve changing the paradigm in service provision away from perceived social and medical deficits in families. Hence, rather than seeing children's behaviours as the problem, instead seek to support them to deal with the difficult situation they are experiencing, for example, using adverse childhood experience and trauma informed approaches. Similarly, understanding the difficulties a parent is going through and following up, rather than closing the case, when they fail to turn up for their first appointment.

Holistic child and family services would need to involve a **tiered model of support** involving universal to specialist target provision for complex needs and should encompass education, awareness raising and prevention, early help, treatment and family support to sustain change after treatment. These are further elaborated below.

Across these services there needs to be a recognition that recovery from alcohol misuse is a long journey and is often a symptom of a complexity of underlying issues which take time to deal with. **Sufficient time needs to be provided for practitioners to work flexibly in response to different individuals and to allow for the cycle of change to unfold**. This needs to also involve having time to build trust and establish rapport as a foundation for therapeutic work and, in turn, provision of continued support. At the same time given the challenges of alcohol reduction, more emphasis needs to be placed on ensuring effective child and family support is in place to ensure children as well as parents can manage.

Recommendation 4: Child-centred and specific support for children

Having children central to everything changes the dynamic of service responses with services guided by children's needs and wellbeing rather than adult focused services which may at best take account of children's needs. Adoption of a team around the child approach is one way of realising a child-centre service in practice. Within an overall constellation of holistic child and family services, there is a need for greater recognition of the specific needs of children which are often different from parents. Where parents are referred for treatment, needs assessment of children is also important. Whilst many agencies are aware of safeguarding responsibilities, more attention is needed to

children's needs beyond safeguarding concerns. This needs to involve supporting children's voices in child protection procedures as well as ongoing daily support for children and families. These include:

- Being aware of the mental health impacts on children of adverse childhood experiences such as parental alcohol misuse
- Ensuring specific therapeutic support is available for all children rather than just those deemed most at risk and meeting the high thresholds
- Children knowing who to go to if they have concerns
- Access to support by a trusted adult and help to manage the impacts of parental alcohol misuse
- Respite care for children when needed and not limited solely to those with a child protection plan

Schools are key to identifying need, providing support and enabling referral and access to specialist services when needed. Whilst safeguarding processes are generally well advanced in schools, there is value in reviewing arrangements for more proactive family support as outlined above.

Recommendation 5: Early help

There is widespread concern that early help services that once existed have been cut leaving a gap in services. Early engagement to provide **support for families in difficulties and work to improve family relationships to prevent problems escalating to conference is seen as critically important.** Whilst it can be difficult recognising where alcohol misuse may be occurring, ensuring practitioners are sufficiently trained in detecting potential problems and are confident about how to open-up conversations where alcohol misuse is suspected, is key. Appointment of an early intervention coordinator was highlighted as important, in particular, if adopting a locality-based approach (see 4.8). Community outreach also provides an important resource by getting to know communities and being better positioned to detect incidents and changes in family dynamics. Early recognition in turn enables intervention, support and referrals to be put in place quicker including intensive whole family support for example Families Moving on Together (FMOT).

Recommendation 6: Education and prevention

Education and training for children in schools about alcohol misuse, how to identify signs of parental drinking and outlining where they can go for support is important for supporting children. Other avenues for education and prevention work might include youth councils and other youth groups. There is also potential for young people themselves to take on roles as peer educators and with younger children.

This also provides an opportunity for early signs to emerge, connections to be established and early help provided. Family hubs attached to schools can also provide contexts for community workshops about alcohol misuse which in turn can provide an opportunity for potential contact and help with families in need as well as bringing conversations about drinking into the open which can help reduce stigma and shame.

Public education campaigns and community workshops highlighting the problem of parental alcohol misuse and raising awareness of options for help and support are important as part of prevention and early intervention initiatives. Engaging high profile Doncaster people/celebrities to share experiences of alcohol misuse and recovery have been suggested as a possible approach to alcohol misuse campaigns.

Recommendation 7: Referrals and accessing the right support

A key issue concerns parents, children and workers **knowing what support is available and how to access it.** There appears to be gaps in referrals between key agencies, for example from Social Care. As a result of this work a Directory of Services has been produced via the DMBC Your Doncaster webpage. This should be followed up to identify the extent to which this is being used by agencies and parents. In addition, it is

Referral procedures should be reviewed for all agencies and a **referral protocol** developed to mandate agencies to ensure all required information is shared, and to follow up with service users when they don't turn up for appointments or self-refer. This would prevent people falling through the gaps in the system. In turn, often with substance misuse, people don't want to be referred and don't want to give up their alcohol. In such cases, procedure need to be put in place to monitor the family from a safeguarding point of view and make available support for the child and family as appropriate to prevent problems escalating.

As part of a multi-agency approach, make effective use of a **key worker** role to provide a single point of contact, to make the connection with the person or family concerned to build trust, provide information, talk through options, provide support in accessing the right services (including encouraging parents to attend services and self-refer), and provide continued support.

A review of referral procedures needs to include an assessment process to ensure services, and in turn referrals, are appropriate, respond to service user's needs and goals rather than being guided by what services provide and can enable timely access to services needed. Suggestions were made about making better use of **survivor and peer support networks** as is happening in domestic violence work. For some service users, knowing that there is support from people who have been through their experience can make a real difference in terms of engaging and sustaining change.

Recommendation 8: Locality-based work

Some of the difficulties with realising multi-agency working in practice could be mediated by the adoption of locality-based working **prioritising areas most in need**. A locality-based approach would enable professionals to connect better and build relationships with specific communities and would mean that families and communities would define the services needed rather than being service-led. By being locality-based, multi-agency working is more easily realisable reducing the likelihood of people being lost in referrals between services. **Being place-based enables workers to become more attuned to family and community needs** and changing fortunes and events in families. By working in this more holistic way, there are also, in turn, more opportunities to recognise and respond to the wider social issues that underlie parental alcohol misuse such as welfare support, housing and employment and implement new ways of working including providing community activities (such as creative activities and family diversionary activities) during which conversations about parental roles and family life can happen. There are precedents for place-based working of this kind[4] including multi-agency work in Mexborough. These approaches are also already implicit in the work of some partner agencies such as St Ledger homes.

Community-based family hubs and the provision of drop-in facilities can make information, advise and pathways to support more accessible and normalised through integration into the fabric of neighbourhoods. This can also help mitigate feelings of shame and stigma that can prevent parents seeking help and instead provide a sense of anonymity for those service users that feel stigmatised by attending the building that the local community know as a drug and alcohol service. Location of hubs adjacent to schools, in a similar way to parental support advisors or family link workers, is a way of making services easily accessible whilst in turn enabling the colocation of workers from multiple agencies.

Recommendation 9: Workforce development and training

To enable more effective responses to parental alcohol misuse, various priorities for workforce development and training have been identified. These include:

- Raising awareness about the impact of alcohol misuse on children and families
- Developing skills and confidence for practitioners to be able to have awkward conversations with parents and children around alcohol and impact on family
- Ensuring all professionals are aware of services available as well as referral procedures and the responsibilities of agencies in following up to ensure parents and children make connection to services.
- Training in hidden harms and signs of safety (where not already provided), adverse childhood experiences and trauma-informed approaches

[4] See for example Healthy Neighbourhoods Public Health initiative in Bristol

- Awareness of, and training in, Multisystemic Therapy for Child abuse and neglect (MST-CAN) and Families Moving on Together (FMOT) approaches
- Review of the content and availability of Mental Health services in terms of fit to service user's needs

Workforce development is one of the ABCD actions which could provide the mandate and perhaps the resources to provide training in a coordinated and mandatory way. There is also scope to engage and utilise people with lived experience in training.

Recommendation 10: Ongoing monitoring, service evaluation and improvement

One of the difficulties with this type of work is being able to assess when outcomes have been successful. Decrease in drinking and restored stability in the family can be seen as a success even though further parental alcohol misuse cannot be guaranteed. All the same, there is an apparent absence of monitoring evidence that provides data about the impact of services. This is undoubtedly difficult and should not detract from direct work with families however, this would provide a clearer indication of which services are working with families and the impact of that work. **Developing monitoring and evaluation procedures would therefore be instrumental in providing an evidence base concerning the use of services and to inform further service development and commissioning decisions**. Periodic monitoring reviews could be undertaken in network meetings - as part of the multi-agency management group mentioned above – to continually review and learn from practice across the system.

There was recognition that identifying criteria for monitoring success is difficult as successes depend on each case and can be culturally variable. One suggestion was to reduce the numbers of children on child protection plans yet, putting in support that makes a difference before situations escalate is also a success. Given suggestions of areas of incompatibility of service systems and the lived realities of families, there is value in undertaking an **evaluation of service users experience to understand the extent to which services provided are meeting the needs of parents and children.** Service user evaluation processes could then be integrated into the work of services including ongoing reviews and on leaving services. Other areas for further research include finding out more about the causes of alcohol misuse in Doncaster and talking to former service users to find out what worked and what was a barrier.

Next steps

This practice-based action inquiry process has engaged service providers in critically reflecting on the challenges and opportunities in responding to parental alcohol misuse and using that learning to identify priorities for change to better meet the needs of children and families. Considerable expertise exists, but there is an urgent need to act on these findings and bring about changes to Doncaster's offer to families experiencing parental alcohol misuse.

> *"There is nothing new in 'working together, early help etc. .. the conundrum is how to get that happening in practice. New developments may be written in Strategy documents, but what is important is how you get the messages and new ways of working adopted in practice."*

It is imperative that service directors and commissioners get behind this work and give time to engage in dialogue to evolve a way forward.

These priorities and actions will be taken forward as strategic developments driven by the Parental Alcohol Misuse Working Group involving DCST working with Doncaster Public Health and will be presented to the Health and Wellbeing Board and Doncaster Safeguarding partnership to support further dialogue and action.

Appendix 1: Agencies involved in this work

Doncaster Public Health; Project 3; ASPIRE; Alcohol and Drug Service; RDaSH; DCST (Social work, Carers, Parent and Family Support Service); Early years; Domestic abuse Hub and the Domestic Abuse Navigation service; DMBC Adult services including DSAB; St Leger Homes; Doncaster Royal Infirmary (including DBTH); Probation service; Project 6; HMP Moorland and Hatfield; Public Health England; NHS (School nursing); Police; South Yorkshire fire and rescue; Riverside; Adult mental health services including IAPT; Complex lives; Bentley Primary school; Warmworth school

This report was produced by Barry Percy-Smith, Just Futures Centre for Child, Youth and Family Research, University of Huddersfield. 2021