alcohol forum
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Hidden Realities

Children's Exposure to Risks from Parental Drinking in Ireland.

2020 VISION Alcohol

pobal supporting communities

the dormant accounts board

Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

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Contents

1. North West Alcohol Forum Ltd

North West Alcohol Forum Ltd (NWAF) is a non-governmental organisation established to work in partnership with all sectors inclusive of Health, Justice, Community and Education to reduce hazardous drinking and its consequences to the individual, the family and the community. NWAF was established in 2003 by the then North Western Health Board and has been involved in major landmark developments, including the report A Portrait of our Drinking, the approval as a site for action on alcohol by the Minister of Health and Children and the publication of the NWAF Alcohol Action Plan. It became a not for profit company in 2007 and has developed a community mobilisation approach with a mission of "Protecting all generations from alcohol related harms". NWAF has also taken an advocacy and lobbying role for effective national and local policy and facilitates sharing of information and research with other interested partners.

Over the last few years, NWAF has been building its role in the field of alcohol related harm and is now recognised as a national leader on community mobilisation approaches to changing alcohol culture. NWAF believes that if real leadership can be harnessed and developed, we will begin to arrest and reduce alcohol related harm in Ireland.

2. Aim of the Research Project

2.1 Background

The work of NWAF has a strong focus on the role that alcohol plays within the family and with young people and has identified a real gap in available, robust data to underpin their focus in this area. As a result NWAF was given an opportunity by the Dormant Accounts Fund, managed by Pobal, to commission an appropriate piece of research to profile and evidence the impact of alcohol on children and families. The study involves examining existing information with a 'new eye', gathering new information, hearing the reality at the coal face and collating the evidence of effective support services.

This Family and Alcohol research study was developed by NWAF Ltd in partnership with existing structures within the NW Regional Drugs Task Force (NWRDTF) area. It will seek to inform the development, enhancement and targeting of family support mechanisms and programmes for drugs and alcohol in the NW area and also nationally.

This research was issued via competitive tender and subsequently awarded to Dr Ann Hope, an Alcohol Scientist with twenty five years research experience and fifteen years of work in the applied alcohol policy area at national and international level. As the National Alcohol Policy Advisor to the Department of Health and Children (1995-2005), she acted as a catalyst for the development of many significant initiatives. She has participated in many EU research projects, is a member of several international research consortia and has worked with the World Health Organisation (WHO) on alcohol issues.

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2.2 Aim of the Research project

The overall purpose of this research study is to collate the research evidence and to help profile the extent of hazardous and harmful use of alcohol on children in Ireland, in particular in the North West Region. The research aims

- To gather data on the negative effects of parental and other adult drinking habits on children
- To gather data on the effectiveness of health and social care responses to such harm
- To make recommendations to ensure greater protection for children and to reduce children's exposure to risk from alcohol
- To make recommendations to improve the health and social services response for children and their families

The findings of this research will provide valuable new evidence on the extent of the problem, establish baseline measures against which future activities can be measured and help inform the development of appropriate support family mechanisms in the North West and Nationwide.

2.3 Conceptual base of study

The World Health Organisation (WHO), in its Global Strategy to reduce the harmful use of alcohol called for special attention to be given to reducing harm to people other than the drinker and to populations that are at particular risk, such as children (WHO 2010). The research based on alcohol's harm to others has been developing internationally in the last number of years (Room et al 2010; Casswell et al 2010; Laslett et al 2010; Greenfield et al 2009). This study has a specific focus on the risk and harm to children and families in the context of the prevailing drinking culture in Ireland and how health/social services respond.

The pyramid in Figure 1 illustrates children's exposure to the risk continuum of society's harmful drinking patterns which increases in severity as exposure comes closer to the child within the family. Hazardous drinking is widely distributed in the general population and in families with children, as shown in the lower end of the pyramid. Children's exposure to risk from parental drinking and its consequences varies, affects many children and can often be hidden (Scottish Executive, 2006). It is generally only at the severe end of the risk spectrum (top end of pyramid) where the risk and damage to children as a result of parental alcohol abuse comes to the attention of the health and social services including child welfare agencies. This study attempts to explore and estimate the extent of children's exposure to risks from other peoples drinking and in particular parental drinking through the different layers of the pyramid.

Figure: 1

The conceptual base of this study

Children's Exposure to Risk from Other People's Alcohol (CEROPA)

3. Review of Literature

The impact of alcohol on the family is extensive and contributes to the overall burden of alcohol–related harm. In the UK, it is estimated that up to one in eleven children are affected by parental alcohol problems (Prime Minister's Strategy Unit, 2004). A Scottish study, based on children's accounts of living with harmful parental drinking, reported several negative impacts, including severe emotional distress, physical abuse and violence and a general lack of care, support and protection (Wales & Gillan, 2009). An in-depth study on the range and magnitude of alcohol's harm to others in Australia showed that 12% of parents/ carers reported that one or more of their children (u18) had been physically hurt, emotionally abused or exposed to domestic violence because of others' drinking (Laslett et al 2010). The report also examined child protection information and showed that alcohol was recorded in 33% of all child abuse confirmed cases.

In Ireland, a survey on the impact of parental drinking among adults reported that of those who had parents who drank alcohol during their childhood, almost one in ten had often felt ashamed or embarrassed by their parent's drunken behaviour, or had often witnessed conflict between parents when they were drinking or felt afraid or unsafe as a result of their parents' drinking (AAI, 2009). Butler suggests that the impact of parental problem drinking on children can manifest itself in broader social and psychological disorders such as withdrawal and shyness, acting out in more aggressive ways, under-performing at school or regressing back to earlier behaviours such as bed-wetting (Butler, 2002).

The voice of Irish children was heard when the Irish Society for the Prevention of Cruelty to Children (ISPCC) reported on a survey with 9,746 children (12-18 yrs) on the effects of parental alcohol use on their lives (ISPCC 2010). The findings showed that 9% of young people said that their parental alcohol use affected them in a negative way. The negative effects included emotional impacts, abuse and violence, family relations, changes in parental behaviour and neglect. The Growing Up in Ireland longitudinal study reported on the nine-year old cohort with regard to the children's experiences of stressful life. Their mothers reported that 4% had experienced drug taking/alcoholism in their immediate family and one in seven (15%) reported that the quality of their neighbourhood environment was affected by people being drunk or taking drugs in public, which was twice as likely in the unskilled manual group than those in the professional group (Williams et al, 2009). The links between alcohol and a range of family problems such as marital separation and divorce, domestic violence, and poverty have been documented in Ireland (Hope 2008). The World Health Organisation (WHO) has emphasised the importance of protecting vulnerable groups such as children and of providing family supports that address risk and protective factors.

In 2009, following the conviction of a mother for incest, neglect and ill treatment of her six children in Ireland, an independent inquiry was established by the Health Service Executive to examine the management of the case. The presiding judge in the court case said "the children were failed by everyone around them" and was concerned that it was eight years before the children were taken into care. Subsequently in 2010 the father was convicted of sexual abuse.

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The publication of the Roscommon Child Care Inquiry Report (2010) gave rise to the urgent need for awareness and understanding nationally of the impact of parental alcohol abuse on the welfare and protection of children. The Inquiry reported that

> "There was evidence to suggest that both parents had a considerable dependence on alcohol, upon which much of the family income was spent. This preoccupation with alcohol clearly affected their parenting capacity. It was manifested by the children often being left alone when the parents were in the pub and by the older children having to fulfil adult roles such as minding and feeding younger siblings. The purchase of alcohol was also tolerated by home management staff when the mother was brought shopping. Notwithstanding this, it is noticeable that much of the attention regarding parental drinking was directed solely at the mother (although the father was also abusing alcohol). The birth of one of the children (in 1990) occurred at home following a night of binge drinking (the mother told the PHN she had drunk eleven vodkas), after which the mother did not realise she was in labour. However, she (PHN) did not subsequently raise this situation as a child protection concern with colleagues. Later, one of the parents had an additional and serious dependence on prescription drugs, but this does not seem to have been appreciated by the staff involved".
>
> ***Roscommon Child Care Inquiry Report, 2010, section 4.9***

The report noted that during the eight year period of this case that there was no "targeted training" in a range of issues including "the effects of addiction on parenting capacity". The Inquiry team suggested that the information in the report should lead to better child protection services centred on the needs of the child and recommended the need for training in "drug and alcohol dependency and in particular its effects on parenting and working directly with children".

In an extensive analysis of the welfare of children of problem drinkers In Ireland, Butler (2009) suggested that "the needs of children are not picked up as clearly or managed as effectively as would seem desirable", due to the disjointed nature of service delivery related to parental alcohol problems. He argued that the difference in focus in child welfare services (on the child) and addiction services (adult clients with alcohol problems) was a contributory factor. Butler's proposed solution was for training social workers and family support services in models of counselling and support or to implement formal protocols governing the relationship between specialist addiction services and child welfare services.

An audit of child protection research in Ireland identified a number of gaps in the knowledge base for making effective policy and implementing best practice such as little research on child neglect and vulnerable factors in child abuse, limited research on interagency and interdisciplinary work and a "shortage of evaluation studies that demonstrate the impact of interventions and what works in child protection" (Buckley et al, 2010).

The importance of parental drinking and parental supervision as an influence on youth drinking was highlighted in a recent UK study. A survey of 5,700 children aged 13 to 16 years, reported that children who see their parents drunk are twice as likely to regularly get drunk themselves (Bremner et al, 2011).

Even before the child is born, exposure of the foetus to alcohol during pregnancy increases the risk of damage to the baby. The Coombe Women's Hospital Study which examined alcohol use before and during pregnancy over a seven year period (1999 to 2005 involving 43,318 women), found that self reported alcohol use among mothers was higher (74%) before pregnancy and declined to 63% during pregnancy (Barry et al 2006). However, the decrease among the heavier drinkers (6+ units per week) was just 2%, from 9% before pregnancy to 7% during pregnancy. Given the high birth rate in Ireland, reported at 73,000 births in 2010 it suggests that at least 5,100 children each year are at increased risk of harm from maternal alcohol use, based on the Coombe figure of 7% for heavier drinkers.

4. Research Design

4.1 Methodology

This study uses what Room et al (2010) describes as a 'two frames approach' in gathering data, which means;

1. an examination of general population surveys
2. an examination of institutional/agency records, to build and expand our understanding of the harm done to children and families from others drinking and the service response to the problem in Ireland.

The research study involves analysis of existing data sets, gathering new data from the national survey and local community survey, interviews with key informants in the North West who work with children and families and examining existing family support services. The following key indicators were used to examine the effect on children by the drinking of others in the family (parents, carers or other family members), in the local community (local drinking patterns) and in the wider society (adults as role models),

1. **Proportion of adults in Ireland who engage in risky drinking patterns -** examination of national drinking survey data sets (2006, 2010).
2. **Proportion of high risk drinkers living with children** - examination of national drinking survey data sets (2006, 2010).
3. **Number of adults in the local community who engage in a risky drinking pattern** - results from NWAF Community Alcohol Survey (2011)
4. **Level of awareness of child neglect or abuse,** in local communities, as a result of someone else's drinking – Results from community alcohol survey in North West (2011)
5. **Number of children in Ireland who experienced neglect or abuse as a result of someone else's drinking** - results from the national drinking survey (2010)
6. **Proportion of those in treatment for problem alcohol use living with children** - NDTRS data (2007-2009)
7. **Proportion of children in child protection service where alcohol abuse is a contributory factor -** examination of child protection reports and data sets (2006-2009)
8. **Number of hospitalisations in the North West for child abuse (assault, neglect and maltreatment)** and the proportion involving alcohol- HIPE data (2005-2009) and child protection data.

In addition, **interviews were undertaken with key informants** who work with children and families such as family therapy services, addiction counselling services, social workers, Gardai, and other relevant groups.

Family support services were documented and considered in the context of effectiveness.

4.2 Data Sources

National Drinking Survey: The National Drinking Survey, dedicated specifically to alcohol, has been undertaken at regular intervals since 2002. It has been funded by the Department of Health and by the HSE. A similar methodology was used, that of a national representative quota sample of about 1,000 adults using face to face interviews. For the purposes of the present study, the most recent surveys (2006, 2010) were combined (N=2,011) to strengthen the analysis and used to examine risky drinking patterns and reported family related problems in the adult population and among adults who have parental/guardian responsibilities for children.

The measure to estimate **hazardous drinking** was defined as drinking at least a bottle of wine or equivalent on one drinking occasion, similar to the ECAS study (Hemstrom et al, 2002). In order to reflect the most common drinking measures in Ireland, a bottle of wine (75g) translates to 4 pints of beer (78g) or 7 single measures of spirits in Ireland (78g). The frequency response choice was; every day, 4-5 times a week, 2-3 times a week, once a week, 2-3 times a month, about once a month, one or a few times a year, never. The time frame was the past 12 months.

Family problems were measured in two ways, firstly, family problems as a result of the respondents own drinking with the question – *During the past 12 months, have you felt your drinking harmed your home-life or marriage?* The second measure, asked of all respondents,

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related to family problems' as a result of someone else's drinking – *How many times have you had family problems or relationship difficulties due to someone else's drinking?* The response choices for both questions were 1-3 times, 4 or more times, none, not applicable. The drinking context questions, two of which will be used in this analysis, were developed by GENACIS (www.genacis.org), an international research consortium on alcohol and gender issues. The first question was an indicator of **attitudes to parental responsibility around alcohol** - *How much drinking is alright as a parent spending time with small children?* Response choice was no drinking, 1 to 2 drinks, enough to feel effects but not drunk, getting drunk is sometimes alright. The second question was the frequency of **home drinking** – *how often did you have an alcoholic drink in your own home?* with the response range from every day to never in the last 12 months.

In the 2010 national drinking survey, a new section was added to measure the exposure of neglect or abuse of children because of someone else's drinking. The questions were asked of respondents who had some parental/guardian responsibility, whether the child lived with them or not. The four questions were based on the Australian harm to others survey (Laslett et al 2010), and used with kind permission from Professor Robin Room. The four questions were

- *How many times in the past 12 months have children been left in an unsupervised or unsafe situation because of someone else's drinking?*
- *How many times in the past 12 months have children been yelled at, criticised or otherwise verbally abused because of someone else's drinking?*
- *How many times in the past 12 months have children been physically hurt because of someone else's drinking?*
- *How many times in the past 12 months have children been witness to serious violence in the home because of someone else's drinking?*

Community Alcohol Survey: The NWAF Community Alcohol Survey was conducted in identified Community Mobilisation sites in County Donegal as part of the 'Time IV A Change Border Region Alcohol Project'. The aim of this project is to work with local communities to support efforts to identify, prevent and reduce alcohol related harm in their community. The Community Alcohol Survey was a tool developed to help communities examine the influences that 'assist' in creating alcohol related problems, to establish the size and shape of the problem and where to focus action for the most effective impact.

The development of **community mobilisation** in the North West was already underway when the family and alcohol research study commenced. The Community Alcohol Survey was in the planning stage and the inclusion of a limited number of questions relevant for the Family and Alcohol research study was agreed. The questions included were somewhat similar to those used in the National Drinking Survey 2010, based on the Australian harm to others survey. In the original harm to others survey, the four questions of exposure to neglect or abuse of children were asked only of those who had parental/carer responsibility for children. However, in the North West Community Alcohol Survey, all respondents were asked the questions as the level of awareness across the community was sought. The four questions were

- How many times in the past 12 months (that you are aware of) have children been left in an unsupervised or unsafe situation because of someone else's drinking?
- How many times in the past 12 months (that you are aware of) have children been yelled at, criticised or otherwise verbally abused because of someone else's drinking?
- How many times in the past 12 months (that you are aware of) have children been physically hurt because of someone else's drinking?
- How many times in the past 12 months (that you are aware of) have children witness to serious violence in the home because of someone else's drinking?

In addition, a question on drinking status (Yes or No to consuming alcohol in the past 12 months) and a question on the frequency of hazardous drinking were included similar to the National Drinking Survey question previously outlined. In the NWAF Community Alcohol Survey each community identified, from a list of 22 options, problems seen in their community related to alcohol. Two items were used (family problems and domestic violence) for the analysis as they were relevant for this study.

Community mobilisation sites were selected following pre-development work, discussions and presentations. In each community, a Steering Committee was established made up of representatives of local community groups, organisations working in the community and residents. These Steering Committees were assisted by the NWAF Community Mobilisation Officers, 'Time IV A Change

Border Region Alcohol Project'. The Steering Committee agreed the sample size (10% of local population) and the timeframe (approx 8 weeks). Information about the survey was announced via local radio, newsletters, newspapers or parish bulletin and people in the communities were encouraged to participate with confidentiality and anonymity assured. The survey was distributed and collected through local community groups such as sports clubs, parents associations and others. The completed surveys were returned to the NWAF Community Mobilisation Officers. To ensure compatibility and ease of data input, a template and detailed coding file for all survey questions was provided by this researcher. The completed surveys were coded and entered into excel, followed by transfer to SPSS for analysis. Limitations of the NWAF Community Alcohol Survey included the self-selection of participants, the makeup of two of the communities (women only, youth predominately) and the high number of non responses on age, gender and dependent children variables.

Child protection Data:

The child protection data is published each year by the Health Service Executive (HSE) in the 'Review of Adequacy of Services for Children & Families' and can be accessed on their website (www.hse.ie). The most recent year for publication of the annual report was 2008, and in that year a detailed Child Care Minimum Dataset for each local health office was reported which provided a breakdown of the primary reason for welfare concern, child admissions to care and children in care. The list of primary reasons for welfare concern relate to family problems (7 items) and child problems (6 items) of which two relate to alcohol involvement – family member abusing drugs/alcohol and child abusing drugs/alcohol. For children in care, the four categories of abuse were included in the list of primary reasons (Appendix 1).

There are 32 local health offices (LHO) in Ireland and the North West has two LHOs, Donegal and Sligo/ Leitrim/West Cavan. The analysis of the 2008 data will present the proportion where drugs/alcohol abuse was identified as the primary reason for welfare concern or child abuse for each LHO. A comparison will be made of welfare and child abuse cases across the local health offices. In addition, the 2009 data for the North West was made available, due to the kind assistance of the North West Child Care Information Officer, which allows for a comparison between the two years (2008-2009).

Validity and reliability issues are major limitations of the child protection data set. While the four main categories of child abuse are clearly defined, other primary reasons are less well defined. Only one primary reason is identified (ticked) yet most child welfare/abuse cases involve many reasons, thus limiting the usefulness of the data and for the present study, the results would be an underestimation of alcohol involvement in child protection. As yet, no standard forms / practices across the HSE system are used to collect data on child welfare/abuse; although a new business reporting system has recently been piloted. In eight of the local health offices, the recorded primary reason identified was based on the number of families rather than on the number of children, which underestimates the figures, and no data was provided in the case of two local health offices.

RAISE data system:

RAISE is a high quality case management IT system, designed to be used by HSE Social Workers and Team Leaders as the everyday tool of the working day. The system uses web browser technology and contains all local and national standard forms needed by social workers to complete their work. However, the RAISE system is not available in all LHOs and in the Dublin region a different IT system is in place. The RAISE system provides for a detailed narrative of each child and family circumstance. The issues around child welfare and abuse are complex and varied and usually involve several reasons. However, the child protection minimum data set, published by the HSE, provides just one primary reason to be identified for each child protection case. The main purpose of working with this RAISE data set was to explore the extent of alcohol involvement alongside other key reasons in child protection. The RAISE data was provided by the Regional Child Care information Management Officer. The data was selected from the reports (detailed narrative) of the child protection cases in Donegal (2009), which extracted up to three reasons for referral and assessment. In addition, information on a number of other variables was obtained including sex, age category of child, referral source, parental employment status and report category at referral and after assessment. A request for the Sligo RAISE data set was also made; however, it was not available at time of publishing this report.

HIPE data system:

The Hospital In-patient Enquiry (HIPE) system is a computerised health information system designed to collect clinical and administrative data on discharges

from acute hospitals in Ireland. It represents patients who have been admitted to hospital and later discharged, but excludes those who visit A & E and outpatients. Acute hospitals in the North West, Letterkenny and Sligo Hospitals, provided records for child abuse–assaults (ICD-10 codes X85-Y09 (excluding Y06 & Y07 and Y87) and child abuse – neglect and maltreatment (ICD-10 codes Y06 & Y07) for the five year period 2005-2009. The child abuse records were for children under 16 years. The data was combined for the two hospitals, as some of the cases in Sligo hospital were resident in Donegal. The intention was to replicate the methodology used in the Australian study to estimate the proportion of hospitalised child abuse cases involving alcohol by using the child protection information on physical abuse with alcohol involvement. However, this specific information was not available.

NDTRS data

The National Drug Treatment Reporting System (NDTRS) is managed by the Health Research Board on behalf of the Department of Health and Children. The NDTRS is an epidemiological database on treated drug misuse (from 1990) and problem alcohol use (from 2004) in Ireland. Treatment for problem alcohol and drug use is provided by statutory and non-statutory services including residential centres, community-based addiction services, general practices and prison services but excludes alcohol related admissions to psychiatric hospitals. Service providers at treatment centres throughout Ireland collect data on each individual who attends for first treatment or returns to treatment in a calendar year. In the case of previously treated cases, there is a possibility that individuals appear more than once in the database for example, where a person received treatment at more than one centre or at the same centre more than once per year. For the purpose of this study, the HRB kindly provided information for the North West region on all treated cases reporting problem substance use, treated cases reporting alcohol as a problem substance (main or additional) and treated cases reporting alcohol as their only problem substance. Treated cases will be examined by living arrangements (living with whom) to establish the proportion of problem alcohol users who live with children in their household in the North West. NDTRS data is considered a reliable dataset with a national standardized form and clear objectives and routine collection across the country. The coverage on alcohol data varies across the country, although continues to improve with high coverage in the North West.

Focus Groups

Focus groups were conducted (one in Donegal, one in Sligo) with frontline staff that work in family support services and included social workers, youth workers, addiction counsellors, and community support services (NGOs). The purpose of the focus groups was to gain insight into the role of alcohol related problems in family support services.

Some of the questions posed were:

- *What alcohol related problems do you see in your work?*
- *What are the consequences for children of parental alcohol drinking?*
- *How severe does the alcohol problem have to be before it is raised as a concern by family support workers?*
- *What are the skills that help you intervene?*
- *What are the most effective support services?*

In addition, a discussion on alcohol terminology took place.

4.3 Framework for analysis

The framework for analysis is guided by the recent research work on the range and magnitude of alcohol's harm to others undertaken by colleagues at the AER Centre for Alcohol Policy Research in Melbourne, Australia (Laslett et al 2010). To ensure quality control, a number of external researchers were consulted regarding the research and included Dr Shane Butler, School of Social Work and Social Policy, Trinity College, Dublin; Professor Robin Room and Ms Anne-Marie Laslette, AER Centre for Alcohol Policy Research, Melbourne, Australia Dr. Norman Giesbrecht, Centre for Addiction and Mental Health, Toronto, Canada.

5. Results

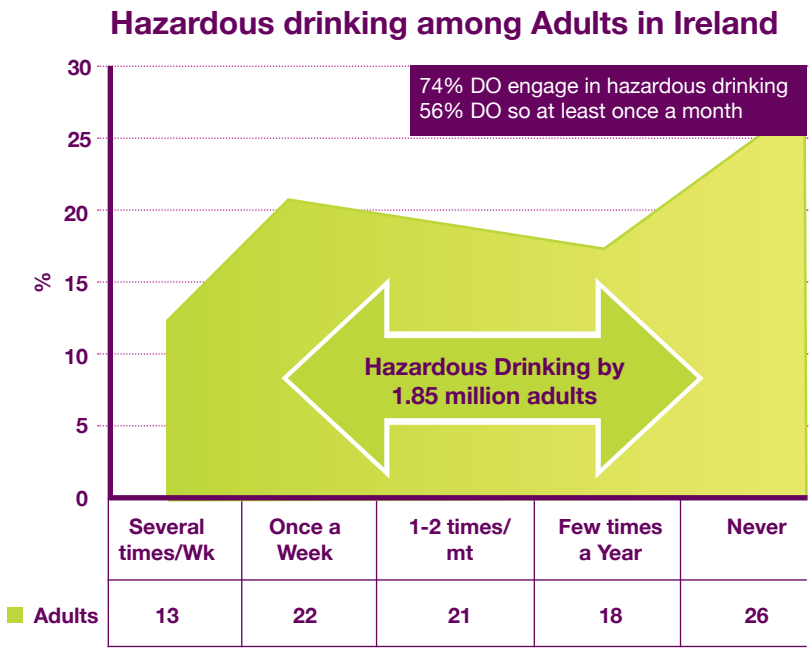
5.1 Adults as role models – Risky drinking patterns in Ireland

This section explores the level of risk which children are exposed to from adults drinking in society and within families. A number of measures were used to examine risky drinking patterns, alcohol harms and attitudes to parental responsibilities around alcohol. The National Drinking Surveys of 2006 and 2010 were combined and used for this analysis, giving a total sample of 2,011 adults aged 18 years and over.

Overall, abstainers represented 22% of the adult population in Ireland, while 78% reported consuming alcohol in the past 12 months. The frequency of hazardous drinking in the adult population showed that the vast majority of drinkers (74%) reported at least one episode of hazardous drinking in the past 12 months, defined as drinking at least a bottle of wine or equivalent (4 pints of beer or 7 single measures of spirits) on a drinking occasion. This translates to 1.85 million adults (18+ yrs) in Ireland engaging in hazardous drinking, based on the Census 2006 figures. Over half (56%) of adult drinkers (1.37 million) engaged in regular hazardous drinking, at least once a month (Figure 2).

Figure: 2

Proportion of Adults engaged in Hazardous Drinking (75+grams/occ)



Source: National Drinking Surveys, 2006 and 2010 combined.

The prevalence of family problems as a result of someone else's drinking was reported by 14% of respondents. This translates to approximately 449,000 adults/families negatively affected by others' drinking. Attitude to parental responsibility around alcohol use was measured by how much drinking was considered appropriate when a parent spends time with small children. The majority (78%) of adults reported no drinking was appropriate in such circumstances and 20% said 1-2 drinks were alright and just 2% felt it was alright to feel the effects or that getting drunk sometimes was alright. When asked if help was available in their local area for children and individuals who experience problems as a result of someone else's drinking, over half (53%) responded that they did not know and just one-quarter (27%) agreed that help was available for those who experienced problems as a result of others drinking. Among drinkers, the proportion of adults who reported regularly drinking at home (at least once a month) was 45%. Just 6.5% of drinkers reported their home life was harmed due to their own drinking.

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Table: 1

Risk to children from other peoples' drinking and service support by socio-demographic variables

	Family problems as a result of someone else's drinking	Attitude to Parental Responsibility with small children (agree no drinking is appropriate)	Help available for children and individuals with problems as a result of someone else's drinking as local level (Agree)
	%	%	%
OVERALL TOTAL	13.9	77.7	26.8
GENDER			
Male	11.3	74.8	24.0
Female	16.5*	80.6*	29.6**
AGE GROUP			
18-24 yrs	17.6	74.6	29.7
25-34 yrs	16.8	75.3	25.6
35-49 yrs	13.9	76.9	27.6
50-64 yrs	13.0	79.7	26.8
65+yrs	7.1*	82.8	24.6
MARITAL STATUS			
Married	12.1	78.9	25.4
Single	16.0**	76.2	28.3
SOCIAL CLASS			
ABC1 (upper)	13.6	78.2	25.5
C2(middle)	9.1	78.7	28.1
DE (lower)	19.3*	75.8	27.1
REGION †			
Dublin	12.5	79.6	11.5
Rest of Leinster	15.2	83.7	32.4
Munster	14.1	79.9	25.0
Connaught/Ulster	11.1	72.2**	33.3*
DRINKING STATUS			
Abstainer	12.6	86.5	27.9
Drinker	14.3	75.3*	26.5
HAZARDOUS DRINKING			
At least once a month	14.9	71.4	23.2
Less often	13.4	80.2*	30.3*

**significant difference (p<.01; **p<.05); † region based on 2010 survey as variable not available in 2006*
Source: National Drinking Surveys, 2006 and 2010 combined.

There were significant differences in socio-demographic variables in several of the risk measures (Table 1).

Family problems as a result of someone else's drinking were more often reported by women (16%) than men (11%). Younger adults had the highest rate of reported family problems which decreased as age increased, with the lowest rate (7%) in the 65 plus age group. Reported family problems from others drinking was more common among single than married people (16% vs. 12%) and a greater number of people from lower social class (19%) reported family problems than other social class groups. While overall, the level of awareness of **available help** for those with problems as a result of someone else's drinking was low, women (30%) were more likely to be aware of available help than men (24%) in their local area. One in three people from the regions of Connaught/ Ulster and Rest of Leinster were aware of available help services. However, only 11% of people in Dublin were aware of local services. Those who engaged in regular hazardous drinking were less likely to be aware of available help in their local health area. Attitudes to **parental responsibility** about parental drinking when spending time with small children showed that women (81%) were more likely than men (75%) to agree that no drinking is the most appropriate behaviour. The figure for those living in the Rest of Leinster was 84%. Those living in the Connaught /Ulster region had the lowest level of support (72%) for no drinking when parents are spending time with small children.

Table: 2

Risk to children from other peoples' drinking and service support by socio-demographic variables (Base is Drinkers Only)

	Regular hazardous drinking (at least once a month)	Regular drinking at home (at least once a month)	Harm to home life from own drinking
	%	%	%
OVERALL TOTAL	55.6	45.5	6.5
GENDER			
Male	68.0	46.3	8.8
Female	42.4*	44.8	4.0*
AGE GROUP			
18-24 yrs	72.9	35.8	6.7
25-34 yrs	59.9	46.6	6.9
35-49 yrs	54.8	50.3	8.3
50-64 yrs	49.2	47.2	4.3
65+yrs	31.2*	41.4*	4.1
MARITAL STATUS			
Married	50.2	50.0	5.9
Single	61.2*	40.5*	7.2
SOCIAL CLASS			
ABC1 (upper)	53.2	50.9	5.6
C2(middle)	56.7	43.8	5.7
DE (lower)	57.3	39.6*	8.5
REGION			
Dublin	73.3	45.4	11.2
Rest of Leinster	49.0	40.3	4.0
Munster	56.9	46.0	6.5
Connaught/Ulster	60.0*	58.6*	3.1*
HAZARDOUS DRINKING			
At least once a month		47.2	8.9
Less often		43.3	3.4*

** significant difference (p<.01; ** p<.05); Source: National Drinking Surveys, 2006 and 2010 combined.*

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Among drinkers, a greater number of men in comparison to women engaged in **regular hazardous drinking** and the proportion of hazardous drinkers decreased as age increased (Table 2). Almost three out of every four (73%) young adults (18-24 age group) engaged in regular hazardous drinking. Those who were single (61%) were more likely to be hazardous drinkers in comparison to married persons (50%). In terms of regional spread, the highest rate of regular hazardous drinking was in the Dublin region (73%) and lowest in Rest of Leinster (49%). In Connaught/Ulster, six out of ten adult drinkers were involved in regular hazardous drinking. **Reported harm to home life** as a result of own drinking was more common among men than women (9% vs. 4%) and among those who live in Dublin (11%). Harm to home life was more likely to be reported by those engaged in regular hazardous drinking in comparison to less frequent drinkers (9% vs. 3%). **Drinking at home** on a regular basis was reported more often among those aged over 25 years. Home drinking was more common among married people (50%), among those in higher social class (51%) and highest in the Connaught/ Ulster region (59%). Among **females of child bearing age (18-49 yrs), 47% of women engaged in regular hazardous drinking.**

Section 5.1 Key results:

Adult's risky drinking patterns in Ireland

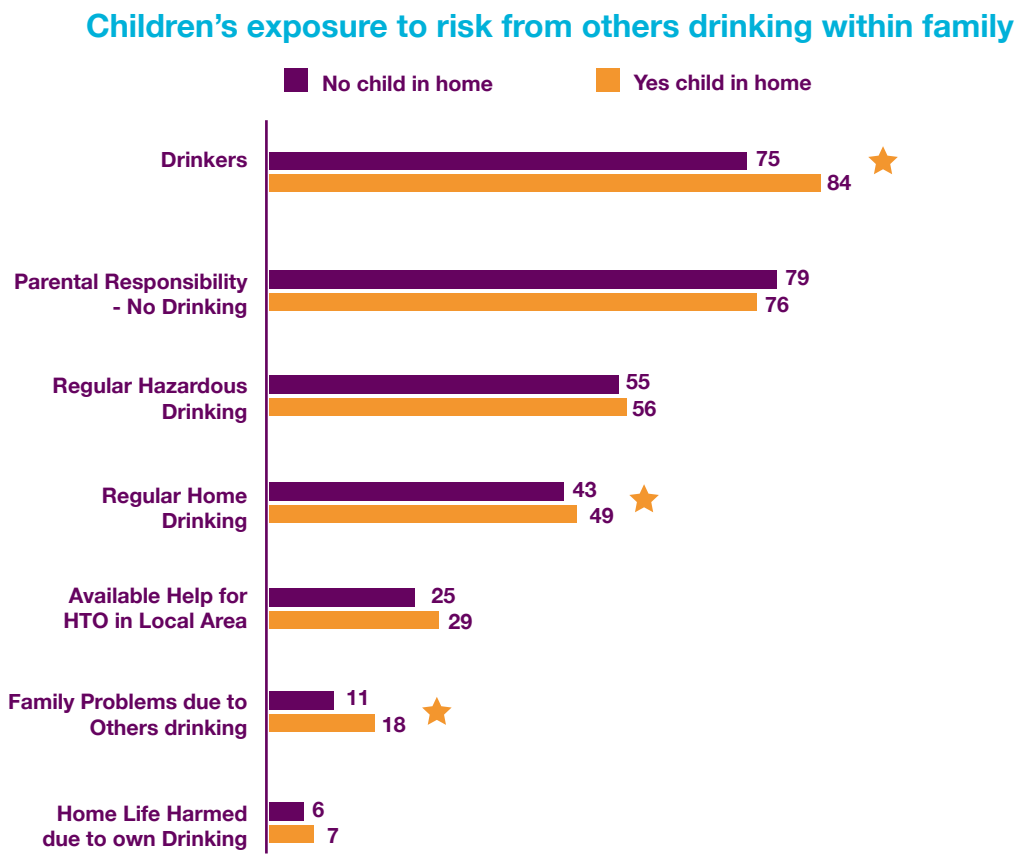
- Over half (56%) of adult drinkers engaged in **regular hazardous drinking** (4 pints or more -78 grams/ occ), at least once a month.
- Regular hazardous drinking was reported more often by men, those who were single, those under 65 years of age and those living in Dublin.
- Almost half (46%) reported regular **drinking at home** (at least once a month).
- Drinking at home was reported more often by those over 25 years, those who were married, those from upper social class and those living in Connaught/ Ulster region.
- One in seven (14%) adults reported **family problems**, as a result of someone else's drinking.
- Family problems due to others drinking were reported more often by women, those under 35 years and those from lower social class.
- Just over one in four adults (27%) were aware that **help was available** in their local area for children and individuals who experienced problems due to someone else's drinking.

5.2 Children's exposure to risk from others drinking within families

Children living in the home where risky drinking patterns are present increases the risk of exposure to alcohol related harm. To explore this issue, the same measures as above (from the National Drinking Surveys) were used to compare adults with children living in their home versus adults with no children living in their home. In the national drinking survey sample (n= 2,011), 38% of adults had children (u18) living in their home with family size ranging from one child to six children in the home. **Regular hazardous drinking was reported by over half of (56%) adults who had children living in their household.** Using the most conservative estimate of family units, this suggests that 194,000 families with children under 15 years live in households where adults engage in regular hazardous drinking. With an average of 1.4 children per family unit this translates to **271,000 children exposed to risk from parental hazardous drinking,** based on Census 2006 figures (CSO 2007). The estimated figure for children of all ages living in families with parental hazardous drinking is over half a million (587,000). A comparison of households with and without children showed that adults who had children living in their home were more likely to drink at home on a regular basis (49% vs. 43%), were more likely to report family problems as a result of someone else's drinking (18% vs. 11%) and were more likely to be drinkers (84% vs. 75%) (Figure 3).

Figure 3:

Children's exposure to risk from hazardous drinking adults living in family home



significant difference (p<.01)

Source: National Drinking Surveys, 2006 and 2010 combined.

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A second dataset, the National Drug Treatment Reporting System (NDTRS), managed by the Health Research Board, was used to examine the number of treated cases for problem alcohol use in the North West with children living in their household. For the purpose of this study, the Health Research Board kindly provided data for the North West region on all treated cases reporting problem substance use, treated cases reporting alcohol as a problem substance (main or additional), treated cases reporting alcohol as their only problem substance and information on their living conditions (Living with whom) for the period 2007 to 2009. A total of 3,234 cases residing in the North West area entered treatment for problem substance use over the three year period, 2007 to 2009. Of those, **2,980 cases (92%) reported alcohol as a problem substance and one in four (25%) of those presenting with problem alcohol use were living in households with children.** The number of treated cases reporting alcohol as their only problem substance was 2,417 for the three year period, representing 75% of all treated problem substance use cases and of those 29% were living in households with children.

Table: 3

Treated cases reporting alcohol as their only problem substance, 2007-2009

Living with whom	2007		2008		2009		Three year	
	n	%	n	%	n	%	total	%
Alone	195	(26.8)	250	(29.8)	272	(32.0)	717	(29.7)
Parents/Family	179	(24.6)	199	(23.7)	172	(20.2)	550	(22.8)
Friends	11	(1.5)	22	(2.6)	23	(2.7)	56	(2.32)
Partner (alone)	91	(12.5)	118	(14.1)	99	(11.6)	308	(12.7)
With partner and child(ren)	**183**	**(25.1)**	**170**	**(20.3)**	**191**	**(22.4)**	**544**	**(22.5)**
Alone with children	**45**	**(6.2)**	**46**	**(5.5)**	**63**	**(7.4)**	**154**	**(6.4)**
Other/Not known	24	(3.3)	33	(3.9)	31	(3.6)	88	(3.6)
TOTAL	**728**		**838**		**851**		**2417**	

Source: National Drug Treatment Reporting System obtained from the Health Research Board

The treated cases reporting alcohol as their only problem substance by living arrangement for the three year period are presented in Table 3. Overall, there was an increase (17%) in the number of treated cases reporting alcohol as their only problem substance, from 728 cases in 2007 to 851 cases in 2009. Those living alone had the highest number of treated cases for problem alcohol use in each of the years. The number of treated cases reporting alcohol as their only problem substance living in a family (with partners and children) varied between 2007 and 2009 and was highest in 2009 (191 reported cases), while those living alone with children was similar in 2007 and 2008 and increased in 2009 to 63 reported cases. The proportion of persons (treated cases) reporting alcohol as their only problem substance living with children (with partners and children and living alone with children) was similar in 2007 (31%) and 2009 (30%) and somewhat lower in 2008 (26%).

Section 5.2: Key results:

Children's exposure to risk from others drinking within the family

- Over half (56%) of adults engaged in **regular hazardous drinking had children living in their household.**
- **Drinking at home** was reported more often (49% vs. 43%) by adults who had children living in their home, as recorded in the National Drinking Surveys
- **Family problems** as a result of someone else's drinking was reported more often (18% vs. 11%) by adults who had children living in their home

- As recorded in the **National Drug Treatment Reporting System**, a total of 3,234 cases residing in the North West area entered treatment for problem substance use over the three year period, 2007-2009.
- Of those, 92% reported **alcohol as a problem substance**
- One in four (25%) of those presenting with problem alcohol use were living in households with children

5.3 Community awareness of risk to children

As part of the NWAF Community Mobilisation development, six communities in County Donegal participated in a community alcohol survey. The community alcohol survey included four items to measure exposure of children to neglect and abuse, with the focus on the level of awareness across the community participants. The four items used were similar to the Australian harm to others survey (Laslett et al 2010), child left in an unsafe situation, child verbally abused, child physically hurt, child witness to violence in the home. Two of the community groups surveyed were not what could be described as a cross section of a community. One of the groups was exclusively women by design (Community Five) and the second community (Community Four) had a majority of young people, which reflected ongoing active youth participation in alcohol related projects. Therefore, the results are provided for each community and not combined together. The details of the characteristics of the community groups are presented in Table 4. Most of the groups had a mix of gender (excluding Community Five), age (excluding Community Four), and dependent children, although the item non-response rate was high. The proportion of drinkers ranged from 62% in Community Four to 88% in Community Six. Based on those who reported drinking in the past 12 months, regular hazardous drinking, defined as drinking 4 pints or more (78+ grams/occ) at least once a month (4 pints is equivalent to 1 bottle of wine or 7 single Irish measures of spirits), ranged from 50% to 78% across Communities. In the predominately youth group (Community Four), almost two-thirds reported regular hazardous drinking.

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Table: 4

Characteristics of community groups who participated in Community Survey

Community	One	Two	Three	Four	Five	Six
N=	101	87	94	106	61	105
	%	%	%	%	%	%
GENDER						
Male	37.6	19.5	35.1	46.2		28.6
female	53.5	59.8	64.9	42.5	100.0	67.6
Non response	8.9	20.7		11.3		3.8
AGE						
Under 40 yrs	39.6	29.9	27.7	79.2	19.7	34.3
40+ yrs	37.6	31.0	43.6	3.8	52.5	41.9
Non response	22.8	39.1	28.7	17.0	27.9	23.8
MEAN AGE	42 yrs	41 yrs	46 yrs	18 yrs	46 yrs	46 yrs
Dependent children						
Yes	39.6	41.4	22.3	8.5	37.7	42.9
No	43.6	37.9	43.6	70.8	49.2	50.5
Non response	16.8	20.7	34.0	20.8	13.1	6.7
DRINKER						
Yes	84.2	81.5	72.8	62.2	75.4	88.5
No	15.8	18.5	27.2	37.8	24.6	11.5
HAZARDOUS DRINKING						
At least once a month	77.6	57.6	61.2	63.3	50.0	61.9
Less often	22.4	42.4	38.8	36.7	50.0	38.1

Source: NWAF Community Alcohol Survey in County Donegal, 2010-2011

The level of awareness of risk to children because of someone else's drinking varied greatly across communities, from 12% to 57%. However, the rank order of the four risks was similar across all the communities (Table 5). Awareness of children being yelled at, criticised or otherwise verbally abused ranked first in five of the six communities and awareness of children left in an unsupervised or unsafe situation because of someone else's drinking was the second highest ranked risk. However, the predominantly youth group reported awareness of children being physically hurt ahead of children left in unsafe situation. There were no significant differences across gender, age, those with dependent children or drinking patterns on the four risk items.

As part of the NWAF Community Alcohol Survey, participants were asked to identify problems in their community that related to alcohol misuse from a list of 22 options. In five of the six communities surveyed, family problems was ranked in the top ten ahead of domestic violence. In the predominately youth group, alcohol related family problems were ranked 5th which might suggest that young people are exposed to risk due to someone else's drinking in the family.

Table: 5

Awareness of risk to children because of someone else's drinking in the past 12 months

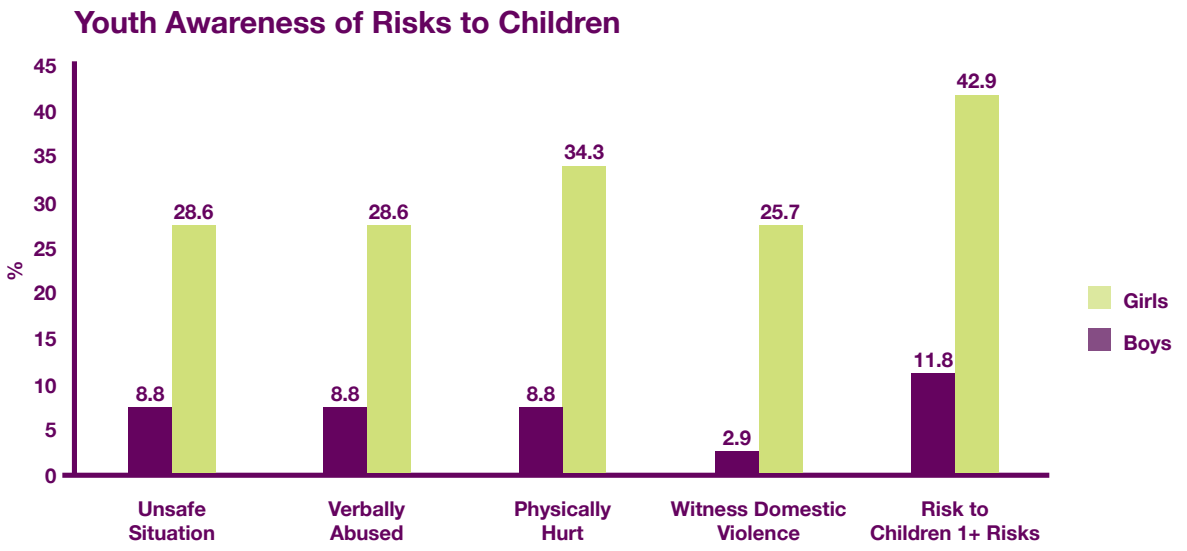
Community	One	Two	Three	Four	Five	Six
Risk to children 1+ risks	45.5%	57.5%	11.7%	27.4%	24.6%	21.0%
	Rank	Rank	Rank	Rank	Rank	Rank
1. Children left in an unsupervised or unsafe situation	2nd	2nd	1st	3rd	1st	2nd
2. Children been yelled at, criticised or otherwise verbally abused	1st	1st	2nd	1st	1st	1st
3. Children been physically hurt	4th	4th	2nd	2nd	4th	4th
4. Children witness to serious violence in the home	3rd	3rd	2nd	4th	3rd	3rd
Identified alcohol related community problems						
Family problems	11th	9th	8th	5th	9th	7th
Domestic violence	9th	12th	8th	14th	11th	12th

Source: NWAF Community Alcohol Survey in Country Donegal, 2010-2011

Given that the majority of participants in the one of the communities were young people, a separate analysis of those under 18 years of age (n=72) was undertaken. The level of awareness of risk to children as a result of someone else's drinking showed significant differences between boys and girls. Girls were much more likely than boys to report awareness of children being physically hurt, verbally abused, left in an unsafe situation and witness to domestic violence (Figure 4). It is not possible to know if the reported awareness of risk was experienced by them, siblings or by other children they knew.

Figure 4:

Youth Awareness of risks to children among youth (under 18 yrs) in Community Four



Source: NWAF Community Alcohol Survey in County Donegal, 2010-2011

Section 5.3: Key results:

Community awareness of risk to children

- Awareness of children being verbally abused as a result of someone else's drinking ranked first in five of the six communities participating in the NWAF Community alcohol survey.
- Awareness of children left in an unsupervised or unsafe situation was the second highest ranked risk.
- In a youth group (u18) awareness of risk to children because of someone else's drinking was reported more often by girls than boys

5.4 Children's experience of neglect and abuse

In the National Drinking Survey of 2010, a new section was added to measure the exposure of neglect or abuse of children because of someone else's drinking. The questions were asked of respondents who had parental/ guardian responsibility, whether the child lived with them or not. The four questions were based on the Australian harm to others survey (Laslett et al 2010) and used with their kind permission, which allowed for cross- country comparison.

Overall, one in ten adults reported that children for whom they have parental responsibility experienced at least one or more of the harms - verbal abuse, physical abuse, witness to violence in the home or left in unsafe situations, as a result of someone else's drinking. The highest reported single harm experience by children was verbal abuse (9%). Children left in an unsupervised or unsafe situation was reported by 5.4% of adults. Almost one in twenty (4.8%) reported that children were witness to alcohol-related domestic violence and 2.8% reported alcohol-related physical abuse of children.

Table: 6

Harms experienced by children reported by adult respondents with parental responsibilities (Base: 680 respondents with children living in or out of the household)

	Children left in an unsupervised or unsafe situation	Children been yelled at, criticised or otherwise verbally abused	Children been physi-cally abused	Children witness to serious violence in the home	Risk to children 1+ harms
	%	%	%	%	%
OVERALL TOTAL	5.4	9.2	2.8	4.8	10.1
GENDER					
Male	4.6	8.4	2.7	3.6	9.0
Female	6.1	10.1	2.9	6.0	11.1
AGE GROUP					
18-34 yrs	5.1	10.1	1.9	4.7	11.9
35-49 yrs	4.7	8.7	3.7	3.3	8.1
50+ yrs	6.3	8.7	2.9	6.6	10.0
MARITAL STATUS					
Married	5.6	8.6	2.5	4.4	9.1
Single	5.0	9.9	3.1	5.3	11.2
EDUCATION					
Primary	6.0	11.9	3.0	7.7	10.8
Secondary	5.4	10.1	3.3	5.0	10.6
Third level	5.2	6.5	1.9	3.7	8.6
SOCIAL CLASS					
ABC1 (upper)	5.1	8.4	1.5	2.9	9.7
C2(middle)	3.8	7.0	2.8	2.8	6.7
DE (lower)	7.4	13.0	4.6	9.8*	14.6*
REGION					
Dublin	7.8	10.0	4.9	5.9	10.7
Rest of Leinster	2.4	6.5	0.6	4.7	8.5
Munster	3.5	10.9	1.7	4.1	9.9
Connaught/Ulster	7.7**	9.4	3.4	4.3	11.5
COMMUNITY					
Urban	6.4	10.0	3.2	5.0	10.7
Rural	3.6	7.9	2.0	3.6	8.9
CHILDREN LIVING IN HOME					
Yes	5.4	8.7	3.4	4.5	9.8
No	5.2	9.8	2.1	5.3	10.4
DRINKING STATUS					
Abstainer	3.6	8.1	2.9	5.1	8.1
Drinker	5.8	9.5	2.7	4.8	10.6
HAZARDOUS DRINKING					
At least once a month	7.9	14.4	4.2	6.5	15.1
Less often	4.3	7.3*	2.2	4.2	8.2*

*Significance *p<.01; ** p<.05. Source: National Drinking Survey 2010.*

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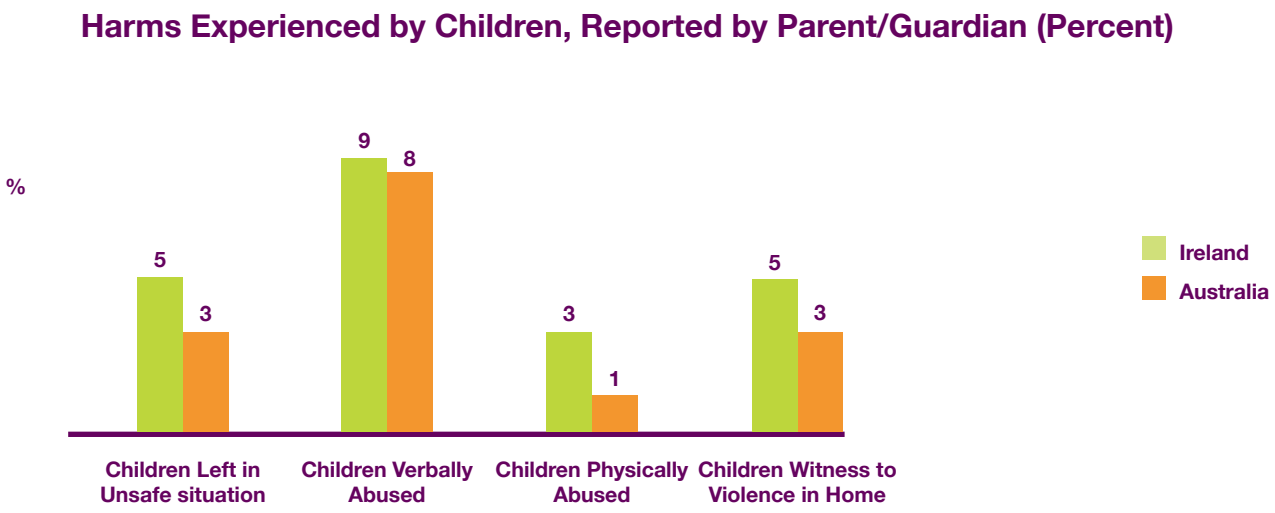
An examination by socio-demographics showed there were significant differences in social class and drinking pattern, in reporting at least one or more of the harms (Table 6). Adults who engaged in regular hazardous drinking were more likely to report that children experienced one or more harms as a result of someone else's drinking in comparison to less frequent hazardous drinkers (15% vs. 8%), with child verbal abuse as the key harm for hazardous drinking. This may suggest that not only the acknowledged 'other heavy drinker' results in harm to the child, but that the parent reporting regular hazardous drinking may also contribute to the child's exposure to risk. A greater number of adults from lower social class (15%) reported at least one or more harms to children in comparison to middle social class (7%) or upper social class (10%), with witness to domestic violence as the significant differentiating factor. Children left in unsafe situations were more common in Dublin and Connaught/Ulster (8%) than in the other regions.

A comparison between Ireland and Australia showed, that a greater number of Irish adults with parental responsibility reported that children experienced harms due to someone else's drinking (Figure 5). Ireland had a marginally higher proportion of adults reporting in each of the four harms – verbal abuse, child left in unsafe situation, child witness to violence in the home and physical abuse. However, the rank order of the four harms was similar in the two countries.

Figure 5:

Comparison between Ireland and Australia on harm experienced by children as a result of someone else's drinking, reported by parent/guardian



Source: National Drinking Survey 2010 & Australian Survey

Section 5.4 Key results:

Children's experience of neglect and abuse

- One in ten adults reported that children for whom they have parental responsibility experienced at least one or more of the harms - verbal abuse, physical abuse, witness to violence in the home or left in unsafe situations, as a result of someone else's drinking.
- At least one or more harms experienced by children were reported more often by parents who engaged in regular hazardous drinking and by those from lower social class.

5.5 Child Abuse and the involvement of alcohol

Three data sources were used to explore the involvement of alcohol in child welfare and abuse; the Child protection data set for Ireland published in the Review of Adequacy of Services for Children and Families, the RAISE data set for Donegal and the Hospital in-patient data (HIPE) for child abuse and neglect in the two Acute Hospitals in the North West (Donegal and Sligo). To set the context for the involvement of alcohol in child protection, a short summary of the reporting and assessment of child welfare and child abuse cases for Ireland is provided.

5.5.1 National Child Protection Data Results

An examination of national data reported by the Health Service Executive for the 3 year period 2006 to 2008, the year for the last available published data at a national level, showed an overall increase in the number of reports received by the Social Work Departments regarding child protection issues, from 21,040 reports in 2006 to 24,668 reports in 2008. The increase has been shown in all of the five categories - welfare, neglect, physical abuse, sexual abuse and emotional abuse (defined in Glossary of Terms). The increase in the number of reports received by the Social work departments may reflect a greater awareness and willingness of agencies and the public to submit reports. By far the highest single category is for welfare issues (Table 7).

Table: 7

Number of reports received by Social Work Departments by category, Ireland

Primary type of Concern	2006	2007	2008
Welfare	11,579	12,715	12,932
Physical abuse	1891	2152	2399
Sexual abuse	2150	2306	2379
Emotional	1814	1981	2192
Neglect	3606	4114	4766
Total	**21,040**	**23,268**	**24,668**

Source: Annual Review of Adequacy of Services for Children and Families, HSE

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The reports received were accessed by social workers and a proportion sent forward for an initial assessment, at least half of the reports underwent an initial assessment. The child abuse categories tended to have a higher proportion of reports that received initial assessment (Table 8).

Table: 8

Number of initial assessment by category, Ireland

Primary type of Report	2006 n	2006 (% of reports)	2007 n	2007 (% of reports)	2008 n	2008 (% of reports)
Welfare	6221	(53.7)	7690	(60.5)	7518	(58.1)
Physical abuse	1291	(68.2)	1529	(71.0)	1704	(71.0)
Sexual abuse	1495	(69.5)	1715	(74.4)	1657	(69.6)
Emotional	1100	(60.6)	1233	(62.2)	1270	(57.9)
Neglect	2413	(66.9)	1907	(46.3)	3215	(67.4)
Total	**12,520**	**(59.5)**	**15,074**	**(64.8)**	**15,364**	**(62.3)**

Source: Annual Review of Adequacy of Services for Children and Families, HSE

In the North West, the local health offices (LHO) are divided into two areas, Donegal and Sligo/Leitrim/West Cavan. A four year period (2006-2009) is covered, due to the kind assistance of the North West Child Care Information Officer who made the 2009 data available. The child population is significantly different in the two LHO areas, in that Donegal has a child population of 40,288 and Sligo/Leitrim/West Cavan has a child population of 22,036, based on Census 2006. This is important to keep in mind when examining the raw numbers. The number of reports received by the Social work department in Donegal was highest in 2007 (1,148 reports), showed a decline in 2008 and increased again in 2009 (Table 9). As in the national data, the single highest category of reports was for welfare concerns. There was variation across the four years in the number of reports received in the different abuse categories in Donegal. The number of reports for sexual abuse was highest in 2006 and declined over the four year period. Reports for physical abuse was low in 2008 but substantially increased the following year in 2009.

Table: 9

Number of reports received and Number of initial assessment by Social Work Department by category, Donegal

Primary type of Report	2006 Donegal Reports	2006 Initial Ass	2007 Donegal Reports	2007 Initial Ass	2008 Donegal Reports	2008 Initial Ass	2009 Donegal Reports	2009 Initial Ass
Welfare	486	260	689	372	551	26	631	349
Physical abuse	46	28	87	64	26	6	112	60
Sexual abuse	134	86	129	81	92	6	72	54
Emotional ab.	75	44	125	75	79	4	68	22
Neglect	129	81	118	80	122	5	92	18
Total	**870**	**499**	**1,148**	**672**	**920**	**47**	**975**	**503**

Source: Annual Review of Adequacy of Services for Children and Families. 2009 information was obtained from Child Care information Officer in NW, HSE

Table: 10

Number of reports received and Number of initial assessment by Social Work Department by category for Sligo/Leitrim/West Cavan

Primary type of Report	2006 Sligo Reports	Initial Ass	2007 Sligo Reports	Initial Ass	2008 Sligo Reports	Initial Ass	2009 Sligo Reports	Initial Ass
Welfare	544	488	703	672	701	49	667	209
Physical abuse	15	15	1	1	46	18	57	28
Sexual abuse	6	6	26	26	22	4	84	34
Emotional ab.	11	11	10	10	30	8	29	7
Neglect	5	5	5	5	16	9	60	28
Total	**581**	**525**	**745**	**714**	**815**	**88**	**897**	**306**

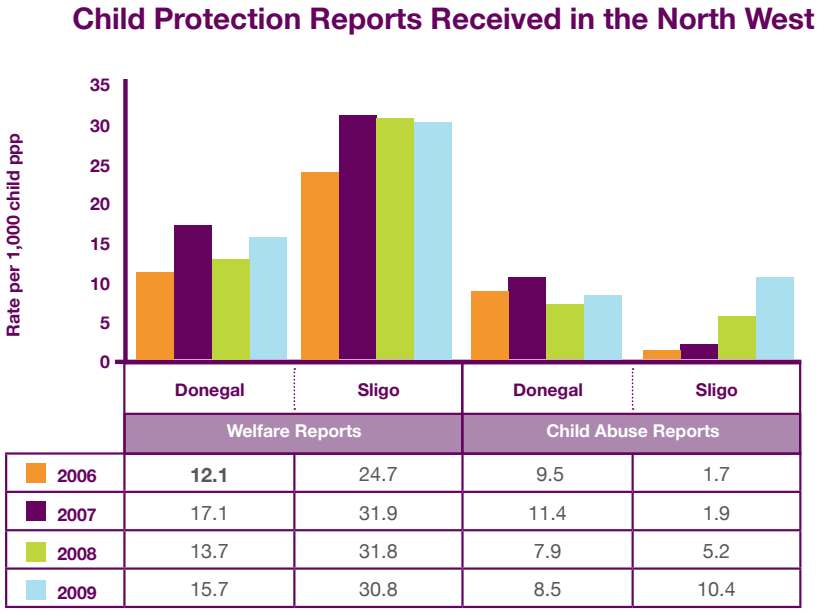
Source: Annual Review of Adequacy of Services for Children and Families. 2009 information was obtained from Child Care information Officer in NW, HSE

The number of reports received in Sligo/Leitrim/West Cavan showed an increase over the four year period, from 581 in 2006 to 897 reports in 2009 (Table 10). There was a marked increase in the number of reports received for sexual abuse and neglect between 2008 and 2009. Reports on physical abuse and emotional abuse increased from 2007 onwards.

A comparison between Donegal and Sligo, based on the child population figures (rate per 1,000 child population), showed that Sligo had a higher rate of Welfare reports received by the Social Work Department over the four year period (Figure 6). Donegal had a higher number of child abuse reports received per head of child population in comparison to Sligo, up to 2008. However, in the latter two years (2008-2009) there was a significant increase in the rate of child abuse reports received by the Sligo LHO.

Figure: 6

Welfare and Child Abuse Reports received, per head of child population for Donegal and Sligo



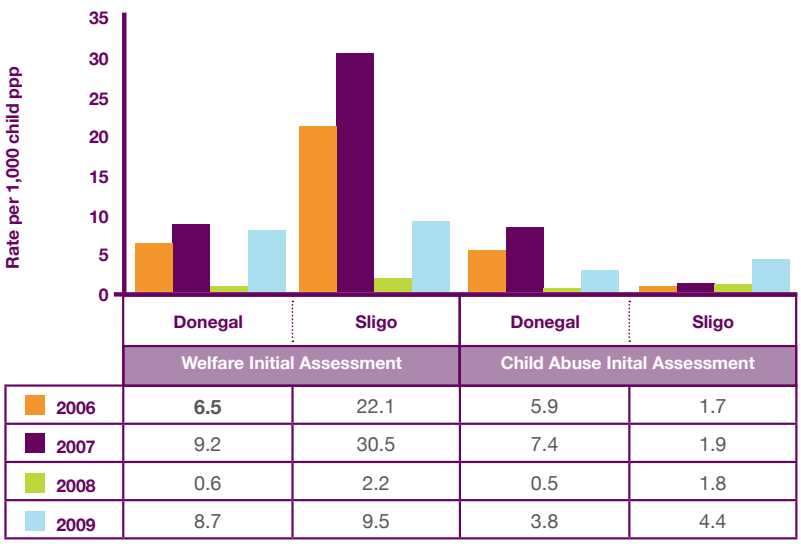
Source: Annual Review of Adequacy of Services for Children and Families. 2009 information was obtained from Child Care information Officer in NW, HSE

A comparison in the number of reports that went to initial assessment showed that Sligo had a higher number of welfare initial assessments per head of child population in the earlier period (2006-2007) and Donegal had a higher number of child abuse initial assessments (Figure 7). In both Donegal and Sligo (LHO), the level of initial assessments was exceptionally low in 2008, due to the change-over to both a new means of reporting and operational changes implemented to reflect the new business processes. The significant increase in the number of child abuse initial assessments per head of child population for Sligo in 2009 may partly reflect the changed recording system.

In 2009, under the new reporting system, the rate of child welfare reports received was higher in Sligo than Donegal (30.3 vs. 15.7 per 1,000 child population) while the rate of initial assessment were similar (Figure 7). The rate of child abuse reports received per head of child population was marginally higher in Sligo than Donegal (10.4 and 8.5 per 1,000 child population) as was the child abuse initial assessment rate.

Figure: 7

Welfare and Child Abuse Initial assessment, per head of child population, in Donegal & Sligo



	Welfare Initial Assessment		Child Abuse Inital Assessment	
	Donegal	Sligo	Donegal	Sligo
2006	6.5	22.1	5.9	1.7
2007	9.2	30.5	7.4	1.9
2008	0.6	2.2	0.5	1.8
2009	8.7	9.5	3.8	4.4

Source: Annual Review of Adequacy of Services for Children and Families. 2009 information was obtained from Child Care information Officer in NW, HSE

In the National Child Care minimum data set of 2008, only the principal reason was reported for child welfare concerns, admission to care and total number of children in care. Among the list of possible reasons for Child protection (See Appendix 1), two involved alcohol - *family member abusing drugs/alcohol and child abusing drugs/alcohol.* This study looked at the proportion (percent) of drugs/alcohol involvement as the primary reason for child welfare concern and child abuse, keeping in mind that only one primary reason was published for each case. For **child welfare concerns**, the national average of the proportion involving a family member abusing drugs/alcohol, as the primary reason, was 15%. Child abusing drugs/alcohol as the primary reason was just 2.8%.

Fourteen of the thirty two local health office areas were above the average (Table 11). Counties along the Western seaboard (HSE West) had six of the eight LHOs above the average, with **Donegal the highest, with 24% of child welfare concerns attributable to family member abusing drugs/ alcohol as the primary reason**. In Sligo/Leitrim /West Cavan, the proportion attributable to drugs/alcohol abuse of family member was 16%. While the proportion of children abusing drugs/alcohol as the primary reason for welfare concern was low, several of the counties near the Western Seaboard from Donegal down to Kerry were higher than the national average (2.8%). In Donegal 5.4% of welfare concerns was recorded as child abusing drugs/alcohol as the primary reason. The national

average for families abusing drugs/alcohol in child welfare issues is most likely an underestimate as several of the LHOs recorded the number of families with children rather than the number of children.

For **admissions to care**, and for the total number of **children in care** in 2008, the overall average of the proportion (percent) of alcohol involvement due to family member abusing drugs/alcohol was 15% and 15.5% respectively (Appendix 2a, 2b). Many parts of Dublin were over the national average, as were several of the counties on the Western Seaboard for family member abusing drugs/alcohol as the primary reason for child abuse. In county Donegal, **almost one in five (19%) cases of children being admitted to care was primarily due to family member abusing drugs/alcohol.** In Sligo/ Leitrim /West Cavan, just over one in ten (11%) cases was identified as a family member abusing drugs/alcohol as the principal reason. For children in care, the proportion attributable to family abuse of drugs/alcohol was 14% in Donegal and 4% in Sligo. As in welfare, the proportion of children abusing drugs/alcohol as a primary reason for being in care was very low. In the large urban areas such as Dublin and Cork, it is possible that drugs rather than alcohol could be the primary drug of abuse or possibly poly-drug abuse. It is also possible that differences in the results could be partly attributable to variation in the social worker classification recording system.

Table: 11

Primary reason for Welfare Concern – involvement of drugs/alcohol

Local Health Office	Family member abusing drugs/ alcohol proportion (%)	Child abusing drugs/ alcohol proportion (%)
HSE WEST		
Donegal	24.3	5.4
Sligo/Leitrim/West Cavan	15.8	0.0
Mayo	13.8	4.6
Roscommon	22.0	9.8
Galway	13.3	1.9
Limerick	18.9	0.5
Clare	17.6	0.0
Tipperary NR	21.0	1.1
HSE SOUTH		
Carlow/Kilkenny	4.6	2.3
Kerry	14.5	3.6
North Cork	30.0	0.0
North Lee	16.1	0.0
South Lee	0.0	0.0
Tipperary SR	5.8	4.5
Waterford	0.0	0.0
West Cork	20.0	0.0
Wexford	8.0	1.7
HSE DUBLIN NORTH EAST		
Cavan/Monaghan	23.3	0.0
*Dublin North	10.6	0.0

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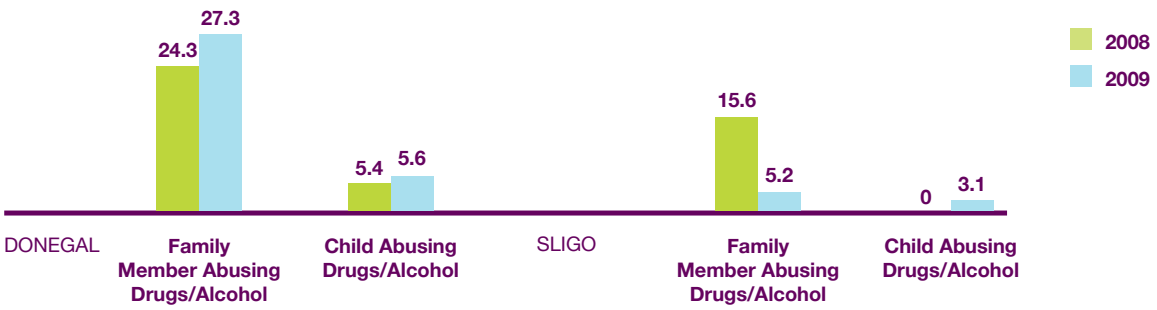
Local Health Office	Family member abusing drugs/ alcohol proportion (%)	Child abusing drugs/ alcohol proportion (%)
*Dublin North Central	15.0	0.0
*Dublin North West	15.2	0.0
Louth	No data	
Meath	13.3	0.0
HSE DUBLIN MID LEINSTER		
*Dublin South	21.3	0.0
*Dublin South city	14.8	0.0
*Dublin South East	3.8	0.0
*Dublin South West	13.5	0.0
Dublin West	No data	
*Kildare/West Wicklow	0.0	0.0
Laois/Offaly	17.7	3.4
Longford/Westmeath	25.6	4.7
Wicklow	10.4	1.3
TOTAL *	**14.7**	**2.0**
TOTAL (exclude Dublin*)	**16.1**	**2.8**

**Dublin, Kildare/West Wicklow only recorded the number of families not children therefore these figures are likely to be an underestimation. Source: Review of Adequacy of Services for Children and Families, 2008.*

While only one reason was identified for child welfare and child abuse cases, the involvement of family members abusing drugs/alcohol was an important factor. The results presented are most probably an underestimation of the true extent of the involvement of alcohol in such cases.

A comparison between 2008 and 2009 of **child welfare concerns** attributed to drug/alcohol abuse in the North West showed that in Donegal the proportion of family member abusing drugs/alcohol as the primary reason increased from 24% in 2008 to 27% in 2009, however, there was no change in the proportion of children abuse drugs/alcohol (Figure 8). In Sligo, the proportion family member abusing drugs/alcohol decreased between 2008 and 2009 from 16% to 5% and there was an increase in the proportion of welfare concern involving child abusing drugs/alcohol from none in 2008 to 3% in 2009. It is difficult to say if the recorded changes (increase/decrease) represented a 'real' change or was due to changes in the reporting system.

Figure 8:
Comparison of Child Welfare concern in North West- involvement of alcohol/drugs,



5.5.2 RAISE data

RAISE is a high quality case management IT system designed to be used by Social Workers and Team Leaders as the everyday tool of their working day. The 2009 RAISE data set, provided by the NW Child Care Information Officer, was information based on the Child protection Notification system for County Donegal involving 63 children from 29 families. The cases were made up of 49% male and 51% female children, with nearly half (49%) in the 0-5 age group with the next highest (27%) in the 6-12 age group. The top four sources of referral were social work (29%), school (19%) health (17%) and the Garda (14%). The purpose of the analysis was to explore the extent of alcohol involvement along with other key reasons for child abuse issues, given that several reasons usually contribute to the complex issue.

Alcohol abuse was mentioned in one of every three cases (36%) as a reason for child protection concerns. Child out of control due to behavioural problems (27%) was the second ranked reason, followed by parent unable to cope, physical abuse, child with health problems, poor parenting skills, domestic violence and mental health problems. Alcohol abuse also interacted with several other problems issues. The main findings were

Parental alcohol abuse interacted with several other issues (rank order)

- Child out of control due to behavioural problems
- Domestic violence
- Mental health problems
- Parent unable to cope

Parental alcohol abuse featured in three of the report categories at the initial referral of child (rank order)

- Child Welfare (the vast majority)
- Physical abuse
- Emotional abuse

Report category after assessment showed a changed rank order

- Child Welfare & Emotional Abuse (ranked 1st)
- Neglect
- Physical Abuse

Parental alcohol abuse was

- More likely where there were male children
- More likely in the 0-5 age group
- More likely among parents who were employed
- More likely to be referred by school, Gardai, health professional
- Less likely to be referred by social worker

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5.5.3 Hospitalisations for child abuse in the North West

The Hospital in-patient data system (HIPE) was used to examine the number of presentations to hospital for child abuse and neglect cases in the North West. The two acute hospitals in the NW, Letterkenny and Sligo, provided the HIPE data, meeting the criteria of ICD-10 codes for child abuse- assaults, neglect and maltreatment for children 0-15 years for the five year period 2005 to 2009. The results presented in Table 12 showed there were a total of 101 cases of child abuse assaults and 6 cases of child abuse – neglect and maltreatment in the five year period, with an average of 20 cases for assaults per year and 1.2 cases of neglect. Child assaults were about 3 times more common among boys than girls.

Table: 12

No of hospital discharges (HIPE) by year and child abuse diagnosis, 2005-2009, North West

Child Abuse	2005	2006	2007	2008	2009	Total	5 yr average
Child abuse- assault	33	27	19	16	6	101	20.2
Child abuse – neglect & maltreatment	0	1	3	2	0	6	1.2
Total	**33**	**28**	**22**	**18**	**6**	**107**	**21.4**

Source: HIPE data for Letterkenny and Sligo Acute Hospitals

However, the most striking feature was the decline over time in the number of child assault cases with the sharpest decline between 2008 and 2009. A possible explanation for the drop in child assaults presentation in hospitals in 2009 could be the sharp increase in the number of reports of physical abuse in Donegal from 26 reports in 2008 to 112 reports in 2009, perhaps as more proactive intervention by social workers avoided the need for hospital admissions.

Whether the involvement of alcohol played a role in child assault cases is not specified in the HIPE data. However, in order to estimate alcohol involvement in child assault hospital cases the intention was to replicate the methodology used in the Australian study using the proportion of physical harm cases from the child protection data which had alcohol involvement. However, in Ireland that figure is not reported in the child protection cases. Therefore, an estimate was not possible.

Section 5.5 Key results:

Child Abuse and the involvement of alcohol

- In Donegal and Sligo the total number of reports received by the social work departments regarding child protection increased between 2006 and 2009.
- In 2009, under the new reporting system, the rate of child welfare reports received by the LHO was higher in Sligo than Donegal (30.3. vs. 15.7 per 1,000 child population).
- The rate of child abuse reports received by LHO was marginally higher in Sligo than Donegal (10.4 vs. 8.5 per 1,000 child population).

- One in seven (15%) child welfare concerns involved a family member abusing drugs/alcohol as the primary reason, based on HSE national child protection data.
- Almost one in four (24%) cases of child welfare concerns in Donegal was attributable to drugs/alcohol abuse of family member, for Sligo/Leitrim/West Cavan the figure was 16%.
- Almost one in five (19%) children being admitted to care in Donegal was primarily due to family member abusing drugs/alcohol care, the national figure was 15%

- Alcohol abuse was mentioned in one of every three child protection cases when examined with other key reasons, based on the RAISE data for Donegal.

6. Views of frontline staff working with family support services

Focus groups were conducted (one in Donegal, one in Sligo) with frontline staff that work in family support services and included social workers, youth workers, addiction counsellors, and community support services (NGOs). The purpose of the focus groups was to gain insight into the role of alcohol related problems in family support services. Some of the questions posed were:

- What alcohol related problems do you see in your work?
- What are the consequences for children of parental alcohol drinking?
- How severe does the alcohol problem have to be before it is raised as a concern by family support workers?
- What are the skills that help you intervene?
- What are the most effective support services?

In addition, a discussion on alcohol terminology took place. The main themes that emerged are outlined below.

6.1 Binge Drinking - the drinking norm in Ireland

All of the participants in the focus groups agreed that so much of Ireland's culture and celebrations are centred around alcohol, including christening, communions, festivals and sport with the added new dimension of increased home drinking. Binge drinking is now seen as the drinking norm with the view 'its just a few pints' and is a feature of every weekend, common across age and social class. This was seen as different from other European countries (excluding UK). College students were mentioned as being a group displaying 'horrible' excesses of drinking and some wondered if all their money was spent on drink instead of food. Staff felt that in Ireland, getting drunk was seen as acceptable, normal and very cheap to achieve, given current promotions/discounts in the off-licence sector. Alcohol advertising was perceived as extensively linked to sporting activities around rugby and football matches, where drinking large quantities of alcohol was common.

6.2 Youth doing what they see

The exposure of children to alcohol was said to start at an early age where many parents bring their small children to the pub with them. Celebration with alcohol was seen as a learned experience for teenagers, given the pervasiveness of the drinking culture in Ireland. Emotional care of self was said to be changing, with sexual health a chronic problem (with amnesia and blackouts). Girls are exhibiting more 'bravado' or reckless behaviour similar to boys as a result of drinking large quantities of alcohol. Some staff felt that there was little focus on risks and consequences of drinking among the youth.

6.3 Parental responsibility for youth drinking

There was a concern that parents can be unsure as to what is appropriate and mixed messages are sometimes given by parents, mainly because there are mixed views between parents. Some parents buy alcohol for their children or have them drink at home, while others try to delay alcohol use in their children for as long as possible. Some staff suggested that when parents have drink taken, it was easier for teenagers to push the boundaries than when their parents were sober, therefore the result is no consistency in parenting. Supervised discos/ concerts/ exam celebrations were seen as parents abdicating responsibility for the care of their children, with several examples of how teenagers access large quantities of cheap alcohol around such events. It was felt that there is a great fear of 'parents being parents'. Frontline staff believe that greater support is needed for parents (parents to parents) and curtailing cheap alcohol is a necessity.

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6.4 Parental alcohol problems

Denial

Frontline staff believe that conditioning in Ireland has resulted in binge drinking being seen as normal drinking and therefore not a problem. There is a denial among parents that binge drinking is a problem among adults or themselves.

Exposure to risk

There is also the view that binge drinking is seen as exempting parents from responsibility and that the child is not factored into the drinking situation. A night out with both parents binge drinking does not factor in the possibility that their child may become sick and need care, with the question – can they cope adequately? Some frontline staff reported that weekend binge drinking by parents meant parents were not available to their children and saw this as a form of emotional abuse.

> *"Sunday does not exist with the family, parents not involved with children on a Sunday, not cooking for them or bringing them to their activity – general attitude is that this is normal life."*

Relationship issues

Parental alcohol abuse can harm the ability of the parents to form positive relationships with their children with different responses when drinking and sober (Jekyll and Hyde).

As told by one staff member:-

> *"Children loved him when he was drinking because he was comfortable with being affectionate yet when sober or hung over they didn't want to know them."*

The reverse can also occur with parents, as a staff member explained

> *"Child sees dad taking one bottle from the fridge, knows what it's going to be like in 4 hours – sometimes it can be 20 bottles later – angry and aggressive."*

Poor coping

Alcohol abuse can trigger problems such as fights, lack of money for family, unemployment, domestic abuse, unstable mental health, accidents and health problems. The reverse can also occur where such problems may result in parents using alcohol as a crutch to cope with such issues, compounding the problems into a downward spiral. Parental secret drinking can continue for years before it comes to light as a problematic issue that has to be confronted.

Family members

Some staff mentioned problem drinking among older siblings in the family which influences younger siblings drinking and can negatively affect young children in the family.

6.5 Parental drinking - consequences for children

Survival instinct

Several staff suggested that many children have great resiliency and good coping skills and some just learn to bear it. However, the issue of the problem drinking parent can become ingrained in the family and result in denial that a problem exists and/or that the problem is alcohol. The opposite was also reported, where children were asking services – why is no one helping – especially when both parents are drinking.

Hidden secrets

Staff agree that children can be very effective is keeping the parental drinking problem a closed secret. However, their social life can be negatively affected where children are slow to make friends and afraid to invite friends to their house.

> *"Kids don't want people to find out that a parent had a drink problem. It's a taboo to talk about it - Big secret issue."*

Care role reversal

Because of parental alcohol problems, some children become the carer where many households task are left to them – getting to school, cooking, cleaning, shopping for food etc. The burden of caring can impact on the child's school performance which includes being late for school, behind in homework, isolated, bullying or even dropping out of school.

"Hidden work that children do-laundry, making lunch, shopping, knowing exactly income –how much will be spent on alcohol, how much the partner will give the parent. Knows every intimate detail when they can brings friends, almost like a hyper vigilance that's where burnout comes, managing it all."

Visible abuse

Staff agreed that some types of child abuse are more visible such as physical abuse, when children present to the emergency room /GP with unexplained/suspicious injuries which can be investigated or where visible signs of malnourishment, weight loss can be visible signs of neglect. However, emotional abuse is more difficult to pin down and can be hidden for years. Some staff reported that, in their experience, alcohol was commonly linked with domestic violence.

Fear of separation

Some staff suggested that children have a fear of being separated from parents and can see the social worker as a threat. However, as pointed out, the social worker tries to keep the family together, balancing the protective factors, like the one stable adult in household, and the risks to the child from the abusing parent/adult.

"Children don't want to leave parents, doesn't matter how bad it is. Mention of social workers instils fear and shut down. Family was fragmented before, but sticks together when social worker arrives. Children cover up all the time."

Inter-generational

Several of the frontline staff have seen evidence of generational abuse, where the adult child of the problem drinker does not know what normal is and may need to learn 'normal' parental coping skills when parents themselves or for some, they may repeat the cycle and use alcohol as a crutch for coping with life problems, while denying it as a problem with themselves.

6.6 Intervention – when?

Crisis point

For most of the frontline staff, an intervention with clients regarding alcohol problems generally only occurs when the problems have accumulated to a crisis point, where the parent or child 'hits the wall'. It can also occur when depression, anxiety, mental health issues arise, reported as common in children/students who are exposed to parental drinking problems. In some cases, the alcohol problem only arises when the parent themselves have identified it as a problem.

"Only problem when the person themselves have identified it as a problem and they are going for treatment – the damaged relationship, the binge drinking, the child neglect goes unidentified and unaccounted for in Ireland."

Asking the hard questions

Some staff felt it was not their brief to ask about parental drinking, others said they would report their concerns if they suspected alcohol as a problem and others would refer to addiction services. For some, there must be clear evidence of child abuse/neglect first before alcohol abuse is raised as an issue.

'Alcohol abuse is not enough to report, need something else – physical abuse, emotional abuse, neglect – there is a danger that it (Alcohol problem) will not be reported."

In a community based family service, an open door policy can allow family members to drop in to discuss problems before a crisis occurs. However, confronting the issue that the parent is hurting their child is difficult, which needs time and skill to acknowledge.

Interagency Work

While referrals between professional services have improved, it was felt that greater interagency work was needed, as it was not as effective as it could be. The identification of needs (ION) model where families are asked what their needs are in terms of supportive services is seen as a way forward. Early intervention on alcohol problems was also mentioned as being important, as currently interventions tended to be at the end of the problem continuum – alcohol dependency.

"Working with families and children where alcohol abuse is an issue but not necessarily child protection status (more early intervention) but still a lot of harm and damage is being done emotionally."

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6.7 Ways of working with families

There was full agreement among staff on the importance of working with families in a respectful and humane way. Most importantly was the starting point - families are doing their best in the circumstance they find themselves, so look at what people are doing right, not just what is going wrong and promote an expectation that they can expect more from life. Active listening, being open to what parents are saying, non-judgemental, building rapport with children and family, respect, taking fear away from the individual, value and respect clients, build rapport with family, avoid stigma, show kindness - were all mentioned as important to working effectively with families.

6.8 The meaning of Binge Drinking

Some of the staff knew of the scientific definition of binge drinking as 6+ drinks. However, many said that in Ireland, binge drinking was more likely to be seen as 9-10 drinks, 'a real binge'. For some, there was a reluctance to put a number on what they considered binge drinking. A night out with a few sociable drinks was not seen as a binge, even if the number of drinks exceeded the definition. A more descriptive method to define binge drinking was used by some staff- drinking for reasons other than pleasure, the physical and psychological negative consequences of drinking, prolonged drinking over the weekend. In many cases, the descriptive terms used were an interchange between binge drinking and drunkenness 'someone who is completely hammered'. Alcohol abuse was seen mainly as using alcohol to cope with problems or affecting normal function while alcohol dependency was seen as an addiction – needing a drink before the person could function.

While the frontline staff talked about the binge drinking conditioning in Ireland seen as normal, their descriptions also suggested that they themselves were also conditioned by this same view when it came to raising the issue of parental alcohol problems as a contributing factor in child abuse and neglect.

Section 6 Key results:

Views of frontline staff working with family support services

- Family support service staff described the damaging drinking culture in Ireland which in their view sets the tone for the community and influences how harmful drinking is addressed.
- Staff intervention with families around alcohol problems tended to occur when the problems had accumulated and a crisis point was reached.
- Staff examples of the burden that children bear from parental alcohol abuse included care role reversal and keeping the problem secret at great cost to the children in their social life and schooling.
- There was full agreement among staff on the importance of working with families in a respective and humane way.

7. Family Support Services

The HSE is required under legislation (Child Care Act 1991, Child Care Act 2001) to provide family support services to promote the welfare of children who may be at risk of abuse or neglect or whose needs are not adequately met. In the future, the HSE agenda is for a more integrated delivery of children and family services with a whole-system approach. The strategic direction of the HSE Children and Families Services will have a greater focus on community based prevention and early intervention services within a Primary Care context, as outlined by the Task Force for Children and Families Social Services (HSE 2010). The reframing of service delivery is to be a 'needs led' model that responds along the family support continuum within a preventive framework and intervention.

In addition to the services provided by the HSE, Service Level agreements with the HSE are in place with many agencies that provide a range of universal to targeted family support services. The services provided are based on level of needs and categorised using the Hardiker classification:

Level 1
(all children and families),
Level 2
(children and families needing extra support)
Level 3
(children and families needing intensive assistance)
Level 4
(children and families in crisis need urgent intervention).

The services include child development and education intervention, community development, youth work, home-based parent and family support programmes, parent education programme and therapeutic work. There are also a wide range of other HSE programmes promoting the well-being of children and families under the umbrella of health promotion, in mental health services and addiction counselling services.

One of the tasks for this study was to examine how effective were the family support services in Donegal and Sligo. The criteria used for effectiveness were based on measured outcomes and its impact on families, in other words what difference did the family service make to the well-being of the family and in particular to the welfare of children? A wide range of family support services are available in the North West. For example, in Donegal 25 Service Level agreements and a further twelve family support programmes such as area partnership or community groups and family resource centres are in place. The figures for Sligo/Leitrim/West Cavan, shows 20 Service Level agreements and a further 7 family support programmes. However, few have been evaluated for effectiveness in terms of outcome measures.

All of the programmes monitor their services in terms of general information and whether key targets for service uptake was achieved and some undertake process/ implementation evaluation, such as delivery of the service, client satisfaction. While several programmes are respected and thought to be effective, very few of the family services are independently evaluated, have a focus on outcome measures and show effectiveness for the families participating in the family services and which are published. Raphoe Springboard has been formally reviewed and Lifestart is subject to a longitudinal evaluation currently taking place. Two family support service programmes which met the above criteria, and that this researcher was able to access (published report) were - the Strengthening Families Programme in Donegal and the Springboard Resource House Project in Sligo which are summarised below.

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7.1 Strengthening Families Programme - Donegal

The Strengthening Families Programme (SFP) is an evidence-based family skills training and parenting programme in the prevention and reduction of substance abuse and juvenile delinquency in youth and improves the parenting skills of parents of high risk adolescents. The programme was developed by Dr Kumpfer at the University of Utah and delivered with training, support and advice from the team in the LutraGroup. The effectiveness of SFP as an alcohol and drug prevention programme has been documented (Foxcroft et al 2003, 2008) as has its effectiveness in reducing mental health problems in a 10 year follow-up (Spoth et al 2006).

The implementation of the Strengthening Families programme in Donegal, which began in late 2009, has been developed by North West Alcohol Forum with funding from the NW Regional Drug Taskforce and HSE West. It is a 14-week skills training programme that involves the whole family in three classes (parents, teens and the combined family) run on the same night, once a week. Evaluation of the programme is undertaken by the LutraGroup. In Donegal, evaluation (pre-post test design) has shown that overall 16 out of the 18 outcomes measures showed positive results. Six of the eight youth outcomes improved including concentration, social skills and lower aggression and depression. There was no change in hyperactivity and criminal behaviour among youth. Family measures on communication, organisation, strength and resilience, conflict and cohesion all improved significantly, as did parents parenting skills. An independent evaluation of the delivery of the programme in Donegal found two additional issues which enhanced the programme, an interagency approach and a basic cost benefit analysis (Holywell Report, 2010). An interagency approach was achieved by local agencies working creatively (in kind contributions) and collaboratively (joint planning and training) to improve the lives of local people thereby gaining 'partnership capital'. The programme was lead by a dedicated Co-ordinator appointed to manage the delivery of the project. The cost benefit analysis showed that due to the effectiveness of the programme, a reduction in the necessity of providing extensive support to the families occurred and therefore cost savings were achieved. To date, four Strengthening Family programmes have been delivered which involved 36 families and 109 individuals. The levels of success have been such that the International Fund for Ireland has decided to fund the extension and development of the project in the North West.

7.2 Springboard Resource House Project - Sligo

The Resource House Project in Sligo, established in 1996 as a community resource centre in consultation with local residents, became part of the national Springboard 'family support initiative' in 1998. The project aims to support and empower families to achieve their full potential, recognising that all families undergo stress at some stage. It works closely with the community to meet identified needs and with other relevant agencies. A comprehensive evaluation of the work of the Resource House project was undertaken by the Child and Family Research Centre, NUI Galway (Forkan, 2008). An important component of the evaluation was to assess possible life outcomes for the Service users who engage with the Resource House project.

Three measures, social support, self-esteem and perceived competence and acceptance, were used to assess the impact of the project on the life outcomes of children and young people. The results showed that there were high scores in social support and self esteem among the children who participated and their continued use was recommended to provide valuable sign-posts to the family support community of what works.

A wide range of family support services are available in the NW. However, very few of these services have been evaluated (outcome measures) to show effectiveness. The above mentioned projects illustrate that key outcomes can be measured and should be an essential part of family support services across the HSE in the new integrated delivery model of children and family services. The development of key outcome indicators would greatly enhance the ability to evaluate the effectiveness and cost effectiveness of family support services.

8. Summary and Conclusions

The purpose of this study was to profile the exposure of children to risk as a result of hazardous drinking among adults in Irish society, and in particular in the North West and to examine the health/social service responses to family alcohol problems. It involved gathering new information, analysing existing data with a 'new eye' and looking at relevant family services. This study shows that the vast majority of drinkers in Ireland engage in hazardous drinking and over half do so on a regular basis. This suggests **that 1.85 million adults in Ireland engage in hazardous drinking and that about 1.37 million adults do so regularly.** These findings are similar to other Irish research (Morgan et al 2009) and those from EU surveys which included Ireland (TNS 2007, 2010). The implications of these findings pose a major challenge for policy makers and highlight the need for action across government in Ireland (Hope & Butler 2010). While adolescents, college students and young adults are 'seen' as the hazardous drinkers in Irish society, this evidence also shows that at least half of those under 65 years are regular hazardous drinkers, with a higher proportion in the young adult age group.

Therefore, because of the spread of hazardous drinking across adult society, it is not surprising that children's exposure to risk from other peoples' alcohol is significant. Adults in society are important role models for children and the learning of behaviour by observation has been well documented (Critchlow 1986). Children tend to mirror what adults do in their surroundings and alcohol is no exception, where children drink and also drink to get drunk in Ireland (Long & Mongan 2010). A recent survey among children (13-16 yrs) in the UK reported that children who see their parents drunk are twice as likely to regularly get drunk themselves (Bremner et al, 2011).

Children living in homes where risky drinking patterns are present have an increased risk of exposure to alcohol related harm. In this study, **regular hazardous drinking was reported by over half of Irish adults who had children living in their household**. At a most conservative estimate, this suggests that 194,000 families with children under 15 years live in households where regular hazardous drinking occurs. This translates to at least **271,000 children (u15) exposed to risk from parental hazardous drinking and up to 587,000 children of all ages** on a regular basis. Adults with children living in their home reported they were more likely to drink at home on a regular basis and were more likely to report family problems as a result of someone else's drinking, in comparison to families with no children living in the house. A recent survey in Ireland among children (12-18 yrs) reported that 9% of children felt their parents' alcohol use affected them in a negative way (ISPCC 2011). The consequences of hazardous drinking in Ireland are many and have been well documented (Mongan et al 2009, 2007; Hope 2008). Alcohol-related harm extends to a wide range of people around the drinker, including children.

At a local level, awareness of risk to children because of someone else's drinking was evident in communities in Donegal, as part of the NWAF Community Mobilisation development. The top two risks were similar in almost all of the communities, awareness of children being yelled at, criticised or otherwise verbally abused and awareness of children left in an unsupervised or unsafe situation. However, it is important to distinguish between the level of awareness of risk and actually knowing that the risk occurred. The recent national drinking survey addressed this issue. The national results showed that **one in ten adults reported that children, for whom they had parental responsibility, experienced at least one or more harms** – verbal abuse, physical abuse, witness to violence in the home or left in unsafe situations, as a result of someone else's drinking, which was similar to data from an Australian study (Laslett et al 2010). Adults who were regular hazardous drinkers were more likely to report that children experienced verbal abuse due to others drinking. Adults from lower social class were more likely to report that children witnessed domestic violence.

The value of using both general population surveys and agency/institutional records, which Room et al (2010) describe as the 'two frames approach', is that this allows the spectrum of children's exposure to risk from other people's alcohol (CEROPA) to be studied in a more comprehensive and integrated way. It can also highlight possible gaps in the knowledge base and in the adequacy of the service responses to meet the needs of children and their families. The examination of the survey data clearly shows that hazardous drinking patterns are widely distributed in the general population, represented in the lower half of the CEROPA pyramid (Figure 9). However, only the severe end of the spectrum (top of the pyramid)

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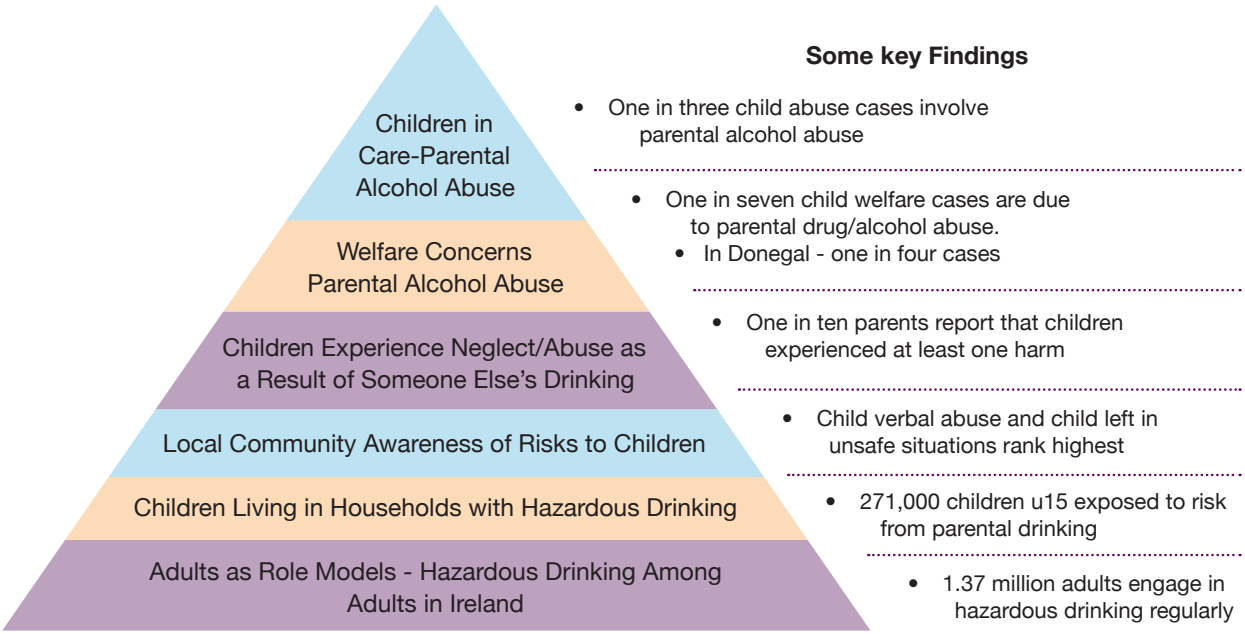
tends to come to the attention of public agencies, including child welfare services. But the severe cases develop out of the larger pool of families with less notable risky behaviours and problems. So, while it is important to provide services for children of the more severe and urgent cases, there is also a need for attention to reducing the pool out of which the severe cases come with a range of effective alcohol policy measures such as regulating price, availability, marketing and early intervention.

Figure: 9

Children exposure to risk from parental drinking

Children's Exposure to Risk from Other People's Alcohol (CEROPA)



At the severe end of the risk continuum (top of the pyramid), risks and harm to children from parental drinking can be traumatic and life changing. The HSE national child protection information showed that, on average, one in seven child welfare and child abuse cases involved drugs/alcohol abuse by family members as the primary reason of concern. However, many counties along the Western seaboard (HSE West) were above the national average for welfare cases involving family drugs/alcohol abuse, with Donegal the highest at one in four child welfare cases. For children in care, many parts of Dublin were above the national average, as were several of the HSE West counties for families abusing drugs/alcohol as the principal reason. In the larger urban areas such as Dublin and Cork, it is possible that drugs rather than alcohol could be the primary drug of abuse or possibly poly-drug abuse.

Given that several reasons usually contribute to the complex issue of child abuse, the RAISE data (narrative info) for Donegal was used to explore the interaction of alcohol involvement along with other key reasons for child abuse. This analysis shows that parental alcohol abuse (excluding drugs) was mentioned in one of every three cases, as a reason for child abuse concerns, which is double that in the child protection reports when only one primary reason in given, and similar to the findings in Australia (Laslett et al 2010). Parental alcohol abuse also interacted with several other problems such as child out of control due to behavioural problems, domestic violence, mental health problems and parent unable to cope. Parental alcohol abuse was more likely among parents who were employed which may allow the alcohol problem go unnoticed. These findings highlight the involvement of alcohol in child care and the extent of parental alcohol abuse as a contributing factor to child welfare and child abuse.

There are major limitations to the Irish child protection data in terms of how the information is collected and what data is reported. The ways in which social workers report the primary problem underlining particular family circumstances lack reliability, as no countrywide standardized or common assessment framework is in place and no common IT system is in place for recording the information, although a new business reporting system has recently been piloted. The way in which the data is currently reported limits its usefulness, such as presenting only one primary reason for child/ welfare abuse cases, and in the case of alcohol/drug involvement this underestimates the extent of the problem. A comparison of the child protection and **RAISE data showed that alcohol involvement was double that of the child protection reports when more than one reason was examined.** Given the significant impact of harm to children from others drinking, as presented in this report, it seems reasonable that information systems should be designed and used so as to facilitate and highlight this fact. One can only conclude that the child protection information system on key risks such as alcohol currently available does not provide meaningful information. A more effective national standardized system needs to be in place to provide quality information that will help inform effective policy decision making. The inconsistencies in risk assessment and other practices in the delivery of children and family services have been highlighted in a Strategic Review of service delivery (PA Consulting Group, 2009).

Profile of the North West

The profile of children's exposure to risk from other peoples' alcohol for the North West brings together the different threads in this study. The evidence suggests that hazardous drinking is common in the North West region (Connaught/Ulster), where **six out of ten adult drinkers reported regular hazardous drinking.** This was the second highest region after Dublin. This level of hazardous drinking was confirmed by the local community survey results in Donegal, although caution is warranted in detailed comparisons, as the community samples were not a representative quota sample. In one community sample, which were predominately youth (u18), the proportion of regular hazardous drinkers was similar to the adult regional result, suggesting that adult drinking behaviour in the North West is mirrored in youth drinking behaviour. **Regular drinking at home was more common in the North West region** (Connaught/Ulster) than in other regions. Problem alcohol use dominates the NDTRS reported treated cases for substance problem use in the North West, with nine out of every ten cases reporting alcohol as the problem substance.

Attitudes to parental responsibility about alcohol showed that the North West region (Connaught/Ulster) had the lowest level of support for 'no drinking when parents spend time with small children'. Family problems were ranked in the top ten issues related to alcohol abuse in five of the six communities in Donegal. In the predominantly youth group, family problems were ranked fifth, which might suggest that young people are exposed to risk due to someone else's drinking in the family or perhaps in families that they know. Alcohol related youth projects have been active in this community, which may influence the higher awareness of alcohol issues. Girls were three times more likely than boys to have an awareness of risks to children. In the North West region (Connaught/ Ulster) and in Dublin, **it was more common for adults with parental responsibility to report that children experienced risk by being left in unsafe situations,** than in other regions. This finding was also corroborated in the Donegal local communities, where awareness of children left in unsafe situations was ranked in the top two risks for children. One in three people from the NW region were aware of available help in the local area for children and individuals who experience problems as a result of someone else's drinking, although higher than in other regions, this would need to be increased. The number of treated cases for problem alcohol use in the NW, as recorded by the NDTRS, showed that one in four cases were living with children, which highlights the importance of direct available supports for children in such circumstances.

Child protection information for Donegal and Sligo/ Leitrim/West Cavan areas showed the total number of reports received by the social work departments increased between 2006 and 2009. In 2009, under the new reporting system, the rate of child welfare reports per head of child population received by Sligo was higher in comparison to Donegal. In relation to child abuse reports received, the rate was also marginally higher in Sligo than in Donegal. The lack of attention to at least half of the child welfare reports may suggest that the child welfare concerns are not as urgent and/or that the threshold level for entry into the child protection system is high. However, the lack of attention to child welfare concerns, while understandable given the priority of their brief, may result in re-entry into the system as a more serious problem later. Therefore, early intervention for the less 'urgent/serious'

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child welfare cases would be a more effective and cost effective strategy, in a system stretched to capacity. The involvement of **family drug/alcohol abuse as a primary reason for child welfare concerns was particularly high in Donegal (almost one in every four cases)** and increased between 2008 and 2009. These findings suggest that there is a need and an opportunity to provide family members with early intervention to reduce children's risk and exposure to parental alcohol abuse in Donegal. At a national level, **children abusing drugs/alcohol** as a primary reason for child welfare concern was very low, however, **Donegal had the second highest level (one in twenty children)**, where the child abusing drugs/ alcohol was the primary reason for the welfare concern, highlighting a need to prevent and reduce youth drinking.

Hospitalisations for child abuse in the North West showed that **child assaults were more common than child neglect and maltreatment**. However, the most striking feature was the **decline over time in the number of child assault cases**, with the sharpest decline between 2008 and 2009. A possible explanation could be the sharp increase in the number of reports of physical abuse in Donegal in 2009, thus providing a more proactive intervention by social workers and family support services and avoiding the need for hospital admissions. The involvement of alcohol in child assault hospital cases was not possible to estimate, as the necessary information (alcohol involvement in child physical abuse cases) was not reported in the child protection reports.

Discussions with frontline staff working with family support services in the North West explored the role of alcohol related problems in family support services. A sense of 'swimming against the tide' was reflected in many of the comments, as the staff described the damaging drinking culture in Ireland and in the North West which sets the tone for the community, including family support staff, on how harmful drinking is addressed. Given that 'getting drunk' was seen as normal and acceptable in the broader society, **staff intervention around alcohol tended to be at crisis point**, a more reactive than proactive response. Concerns were raised about youth drinking and its consequences, but staff recognised that youth were 'doing what they see around them' and that there was a great fear of 'parents being parents'. **The exposure of children to risk from parental alcohol problems was amplified by examples of the burden children bear such as care role reversal, keeping the problem secret at great cost to the child in their social life and schooling**. Staff also recognised that some children have great survival instincts, with resiliency and coping skills. For staff working with families in crisis, the starting point is that families are doing their best in the circumstances and the focus is a balance between encouraging what people are doing well, as well as tackling the problem issues. While the frontline staff talked of the binge drinking conditioning in Ireland, their descriptions of binge drinking also suggested that they themselves were largely conditioned by this same view when it came to raising the issue of parental alcohol problems with intervention mainly happening at the crisis end of alcohol abuse and dependency.

Butler (2009) has argued that the needs of children of problem drinkers could be more effectively managed. The findings in this project suggest that the responses of family support services to parental alcohol abuse do show a number of factors in play, including a priority/ pressure to deal with child abuse issues, the split focus between the child (through social work services) and the parent with alcohol problems (addiction services), the lack of engagement regarding alcohol problems among social workers and family support workers where the tendency is to refer immediately to addiction counsellors, and the delay in raising alcohol as an issue with families. This delay may be partly influenced by the 'normalised' binge drinking culture, resulting in a reactive crisis management approach and occurring at the most severe end of the harm continuum.

What is needed is an integrated service using the Four Tier Model (NTA 2006), where targeted screening and brief interventions are delivered by a wide range of generic health and social workers, thus broadening the treatment base and ensuring what Heather et al (2006) describes as *"detecting problem drinkers before they become help-seekers"*. Applying this rationale to family support services would suggest that generic workers (like family support workers and social workers) should be helped to see direct involvement with alcohol/drug issues as a legitimate function for themselves and one which they have a basic adequacy to manage without always thinking of referral to specialist addiction services. The Strengthening Families Programme is a good example of family support which can be delivered by generic workers and which has proven to be effective. This approach would allow the specialist alcohol treatment services to manage the more complex cases.

A wide range of family support services are available in the NW. However, very few of these services have been evaluated (outcome measures) to show effectiveness. The key question needs to be "*what difference does the family support services make to the family and in particular to the welfare of children?"* The development of key outcome indicators would greatly enhance the ability to evaluate the effectiveness and cost effectiveness of family support services. Buckley et al (2010) has identified the lack of evaluation studies of what works in child protection as an important knowledge gap for implementing best practice.

Conclusions

The evidence of widespread hazardous drinking in Irish society among the population is clear, undeniable and reconfirmed again in this study, as in other previous research in the past decade. This is not a 'youth only' problem but is endemic across the adult population. The protection of children will require major attitudinal and behavioural changes in Irish adults, if we are to honour our commitment to the WHO European Charter on Alcohol that *"all children have the right to grow up in an environment protected from the negative consequences of alcohol consumption"*. The findings show that children in Ireland and in the North West are exposed to significant risks from others drinking.

While there are active networks and a range of family support services available in the North West, a greater focus is needed for all service providers working together for families and the protection of children. The framework for an integrated service needs to be proactive, broad and inclusive of all health and social workers. Clear targets are necessary to reduce the exposure of children to risk from alcohol by reducing parental and other adults hazardous drinking. Effective family support services are needed that actively address family alcohol problems through prevention and early intervention, as well as the more specialised treatment services as part of an integrated strategy to tackle family alcohol problems, which impact on the welfare of children.

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9. Emerging Priority areas

The priority areas outline a broad range of strategic requirements and related operational actions that emanate from the evidence in this report. These requirements will necessitate action at national, regional and local level if there is to be progress in preventing and protecting children and future generations from alcohol related harm

1. **Collective responsibility** – Common hazardous drinking patterns among adults in Ireland is at the core of the problems identified and must fundamentally change to prevent and protect children from alcohol related harm in Irish society. There is no one Department, Agency or Strategy that has responsibility for making this happen. The development of collective responsibility requires;
   - **Leadership** – Strong leadership and real commitment at national, regional and local level is needed to consolidate individual and group responsibilities to effect the change that is vital to protect children from alcohol harm.
   - **Cross party agreement** – The harms identified in this report are apolitical. Whether in Government or opposition, political will must be committed to ensure that public policy decision making is 'child proofed' and gives priority to protecting children from alcohol harm against competing interests across government
   - **Community Empowerment** – Community attitudes and understanding are central to a process of cultural change. Communities need to be supported by Government to develop a process of bottom up mobilisation that implements evidence based local actions and policies to reduce the exposure of children to alcohol.
   - **Assertive approaches** – A proactive approach across all service providers, education, justice, youth, social and health services and the many NGO's that work with children, is needed where alcohol should be clearly seen as a 'high risk' issue in preventing and protecting children from alcohol related harm.
2. **Information & Communication** – This report expands upon the level of robust information that exists and has been developed over the last 20 years, both nationally and internationally. To effect real change with this data we need to;
   - **Apply the evidence** – The most effective alcohol policy measures to protect children have been well rehearsed - regulate pricing to avoid cheap alcohol, reduce density of the off-licence sector and reduce children's exposure to alcohol marketing – these policies need to be effectively implemented.
   - **Information access and availability** - A reliable national information system is needed in all aspects of child welfare that provides meaningful information on key risk factors such as alcohol to help inform the development of effective policy.
   - **Quality Assurance** – Effective interventions will always be required to ensure support for children and families. In choosing these interventions strong consideration must be given to how these interventions are evidence based, quality assured and evaluated so that a greater level of success can be assured
3. **Enhance the Rights of the Child** – This report provides evidence on the physical, intellectual, emotional, environmental and economic impacts on children from alcohol use in Ireland. The Rights of the Child are a key policy issue for Ireland and work must be progressed to strengthen those rights.

Operational Priorities

Information

- To undertake a review of HIPE data to improve access and availability to pertinent alcohol data for child protection and welfare.
- To further examine the incidence and prevalence of parental alcohol abuse across relevant social and health agencies.
- To identify within all child and family assessments conducted by the HSE or funded agencies the prevalence of the child as a carer for parental alcohol abuse.

Training

- To work in conjunction with the HSE National Addiction training programme (NATP) to develop modular training on early identification and intervention on alcohol and drug abuse for all health care staff who's work brings them into contact with children and parents and to ensure more effective HSE interdisciplinary case management.
- To provide training for social workers and family support services in models of intervention, counselling and support.
- To provide training in identification of problems earlier for community and primary care teams.
- To provide training on the effects of substance abuse and addiction on parenting capacity

Prevention

- To raise awareness among parents of their important role and influence in protecting children and reducing children's exposure to risk from parental alcohol use and abuse.
- To promote awareness awareness among Irish adults about the harms of youth drinking.

Intervention

- For government to introduce minimum pricing, as a matter of urgency, to reduce underage drinking and to reduce drinking large volumes of alcohol and/or episodes of heavy drinking.
- For government to introduce regulation to reduce children's exposure to alcohol marketing that appeals to youth.
- To develop protocols to enable better communication and working relationships between addiction and child welfare services
- To review the Northern Ireland Hidden Harms Strategy as a basis for the development of a national strategy for children living with parental alcohol and drug abuse.
- To promote greater awareness of available child friendly supports for children living with family alcohol problems.
- To develop anti natal alcohol screening protocols and brief interventions packages for pregnancy at primary care and in hospitals
- To further develop the community mobilisation on alcohol tool kit model through the National Substance misuse strategy 2009-2016 and the Regional and Local Drug Task Force structures.
- To identify and support those parenting alone with alcohol and drug problems.
- To provide early intervention with family members for the less urgent/serious child welfare cases to reduce children exposure to parental alcohol abuse
- To ensure that all children of parents treated for alcohol and drug problems have access to appropriate advice, information and family support.

Evaluation

- To develop key outcome indicators to evaluate the effectiveness and cost effectiveness of family support services and other relevant programmes based on enhanced family and child wellbeing.

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Appendix 1

Health Service Executive - Child Protection System

Review of Adequacy of Services for Children & Families 2008
Child care minimum dataset

Primary Reason for Child Welfare concern following Initial assessment
(one is selected)

Child Problems

- Child with emotional/behavioural problems
- Child abusing drugs/alcohol
- Child involved in crime
- Child pregnancy
- Physical Illness/disability in child
- Mental health problems/intellectual disability in child
- Other, please specify

Family Problems

- Parent unable to cope
- Family member abusing drugs/alcohol
- Family member involved in crime
- Domestic violence
- Physical illness/disability in other family member
- Mental health problem/intellectual disability in other family member
- Family difficulty re housing /finance
- Parent separation /absence /other disharmony in home
- Other, please specify

Principle reason for Admission to care or for Children in care
(one is selected)

- Abuse
- Emotional abuse of child
- Neglect of child
- Physical abuse of child
- Sexual Abuse of Child

Child problems

- Above list

Family Problems

- Above list

Appendix 2a

Primary reason for Admission to Care – involvement of drugs/alcohol

Local Health Office	Family member abusing drugs/ alcohol proportion (%)	Child abusing drugs/ alcohol proportion (%)
HSE West		
Donegal	19.0	0.0
Sligo/Leitrim/West Cavan	11.1	0.0
Mayo	31.7	0.0
Roscommon	19.6	0.0
Galway	6.4	5.8
Limerick	15.5	0.0
Clare	9.6	1.9
Tipperary NR	22.7	0.0
HSE South		
Carlow/Kilkenny	8.2	2.0
Kerry	11.8	0.0
North Cork	10.3	2.6
North Lee	11.3	0.0
South Lee	24.7	1.1
Tipperary SR	24.1	0.0
Waterford	3.3	3.3
West Cork	5.4	0.0
Wexford	17.8	0.0
HSE Dublin North east		
Cavan/Monaghan	7.4	0.0
Dublin North	12.0	0.0
Dublin North Central	29.2	0.8
Dublin North West	15.8	0.0
Louth	0.0	0.0
Meath	9.1	0.0
HSE Dublin Mid Leinster		
Dublin South	35.3	0.0
Dublin South city	11.4	0.0
Dublin South East	25.0	0.0
Dublin South West	17.9	0.0
Dublin West	2.7	0.0
Kildare/West Wicklow	20.0	0.0
Laois/Offaly	22.2	0.0
Longford/Westmeath	0.0	0.0
Wicklow	25.0	0.0
TOTAL	15.0	0.8

Source: Review of Adequacy of Services for Children and Families, 2008

Appendix 2b

Primary reason for Children in Care – involvement of drugs/alcohol

Local Health Office	Family member abusing drugs/ alcohol proportion (%)	Child abusing drugs/ alcohol proportion (%)
HSE West		
Donegal	13.7	1.6
Sligo/Leitrim/West Cavan	3.9	0.0
Mayo	9.9	0.9
Roscommon	20.7	0.0
Galway	25.9	0.0
Limerick	16.9	0.0
Clare	27.0	0.8
Tipperary NR	19.8	0.0
HSE South		
Carlow/Kilkenny	12.2	1.4
Kerry	16.2	0.0
North Cork	3.8	1.3
North Lee	6.6	0.3
South Lee	9.5	0.0
Tipperary SR	14.9	0.0
Waterford	8.0	0.0
West Cork	26.2	0.0
Wexford	11.7	0.0
HSE Dublin North east		
Cavan/Monaghan	4.6	0.0
Dublin North	10.2	0.0
Dublin North Central	12.6	0.3
Dublin North West	25.6	0.5
Louth	2.2	0.0
Meath	8.4	0.0
HSE Dublin Mid Leinster		
Dublin South	26.2	0.0
Dublin South city	24.1	0.0
Dublin South East	36.3	0.0
Dublin South West	30.1	0.0
Dublin West	3.7	0.0
Kildare/West Wicklow	11.0	0.0
Laois/Offaly	21.3	0.0
Longford/Westmeath	11.2	0.0
Wicklow	29.1	0.0
TOTAL	15.5	0.2

Source: Review of Adequacy of Services for Children and Families, 2008

Glossary of Terms

Child Abuse: (defined in the Children First: National Guidelines for the Protection and Welfare of Children (2010). Office of the Minister for Children and Youth Affairs.

Neglect: Neglect is defined in terms of omission, where the child suffers significant harm or impairment of development by being deprived of food, clothing, warmth, hygiene, intellectual stimulation, supervision and safety, attachment to and affection from adults, and or medical care.

Emotional abuse: Emotional abuse is normally to be found in the relationship between a parent/carer and a child rather than in a specific event or pattern of events. It occurs when a child's need for affection, approval, consistency and security are not met. Unless others forms of abuse are present, it is rarely manifested in terms of physical signs or symptoms.

Physical abuse: Physical abuse is any form of non-accidental injury or injury that results from wilful or neglectful failure to protect a child.

Sexual abuse: Sexual abuse occurs when a child is used by another person for his or her gratification or sexual arousal, or for that of others.

Hazardous use: A pattern of substance use that increases the risk of harmful consequences for the user. Some would limit the consequences to physical and mental health (as in harmful use); some would also include social consequences. In contrast to harmful use, hazardous use refers to patters of use that are of public health significance despite the absence of any current disorder in the individual user. The term is used currently by WHO but is not a diagnostic term in ICD-I0. http://www.who.int/substance_abuse/terminology/who_lexicon/en, *accessed July 2011*

Harmful drinking: A pattern of psychoactive substance use that is causing damage to health. The damage may be physical (e.g. hepatitis following injection of drugs) or mental (e.g. depressive episodes secondary to heavy alcohol intake). Harmful use commonly, but not invariably, has adverse social consequences; social consequences in themselves, however, are not sufficient to justify a diagnosis of harmful use.
http://www.who.int/substance_abuse/terminology/who_lexicon/en, *accessed July 2011*

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