"Effective parenting is the best way to call time on Britain's binge drinking …"

FEELING THE EFFECTS

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DEMOS

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Summary

It has become a familiar refrain: binge drinking is a scourge on British society, costing billions in hospital care and criminal damage. Government, newspapers and television programmes continue to present a Britain that has become out of control with its drinking.

But behind the headlines there are indications that alcohol consumption in the UK is on the decline. According to some sources, alcohol consumption has fallen by 12 per cent since 2004, with young people in particular drinking less.[1] The number of 16–24-year-olds who said they had a drink in the past week fell from 70 per cent in 2003 to 48 per cent in 2010. An even more dramatic decrease has occurred among young children between the ages of 11 and 15 having reported drinking alcohol.[2]

From the standpoint of those concerned about minimising the harms caused by alcohol, these trends are good news that often gets lost amid hyperbolic headlines.

Of course, that doesn't mean we are all learning to drink responsibly. Many people continue to drink at hazardous levels, causing significant damage to themselves, their families and their communities. Moreover, alcohol-related harms are unevenly spread across the UK, with problems of alcohol misuse especially concentrated in the north east of England, Scotland and certain urban areas in the UK. The havoc caused to town centres on weekends as a result of heavy drinking is an obvious and troubling harm caused by alcohol. But greater damage from alcohol misuse is happening behind closed doors, in families.

Recent estimates suggest that a fifth (around 2.5 million) of all children live with a 'hazardous' drinker (someone drinks over the weekly recommended guidelines of 21 units for men and 14 units for women) and more than 90,000 babies in the UK live

with a 'hazardous' or problematic drinker (the latter being someone who has experienced physical or mental consequences as a result of drinking) as a parent.[3]

Excessive drinking hurts families in a number of ways, from family and relationship breakdown to violent and sexual abuse, as well as through quieter harms such as missed meal times or weaker social bonds for children afraid to bring friends home from school. Many of these children go on to repeat the experience and use alcohol excessively to cope with traumatic life experiences.

At the same time, previous Demos research suggests that good parenting in general may be the best and most effective approach to minimise hazardous drinking levels in society in the long term. In the Demos report *Under the Influence*, we found that evidence suggesting that 'tough love' parenting, which combines high levels of emotional warmth (particularly in the early years from 0 to 5), and strict, consistent discipline (particularly, at the ages of 15–16), reduces the likelihood of drinking excessively in adolescence and adulthood.[4]

Parental alcohol misuse and the importance of parenting

In this report we consider the impact of parental alcohol misuse on families, in particular, its impact on a parent's ability to parent and a child's likelihood of drinking excessively as a teenager and later as an adult. Many parents think their drinking has little or no impact on their families, convincing themselves that if they feed and clean their children and make sure they attend school, they have fulfilled their most important parenting duties. Parenting is not easy, and recent reports suggest that some parents – particularly among the middle classes – reach for the bottle at night to cope with the stress.[5] Yet, as our research in this report suggests, alcohol misuse is potentially hampering their ability to be the most effective, 'tough love' type of parent, which in turn increases the risk of their children developing character traits which could expose them to problematic drinking behaviour. Given the large numbers of parents drinking

above recommended limits, these findings about parenting style are particularly relevant.

Demos' research suggests that one answer to the problem of hazardous drinking is to help parents be better parents. We have therefore sought to understand the best way to support parents who are drinking problematically, and their children, to ensure that the cycle of harmful behaviour is not repeated.

Specifically, we addressed the following research questions:

- How does parental alcohol consumption, especially at harmful levels, affect parenting style?
- How does parental alcohol consumption affect children's likelihood of drinking at hazardous levels as a teenager and then later in life as an adult?
- What support is effective in helping families struggling with alcohol difficulties address their issues and be better parents?
- What makes an effective family-based intervention to prevent alcohol problems becoming inter-generational?

In order to explore these questions, we conducted quantitative research on the 1970 Birth Cohort Study (BCS) to test the impact of parental drinking on parenting styles and children's drinking behaviour. We also conducted in-depth interviews with 50 families across the UK where at least one parent was accessing alcohol support services for being a 'harmful' or problematic drinker. Where possible, we interviewed multiple members of the same family, including children.

Findings

For our quantitative analysis of the BCS, we chose an indicator of parental alcohol consumption based on their child's perception of how often or how much their parents drank: never, sometimes, often or always. Our two outcome variables were parenting styles and children's drinking levels at 16 and 34 years of age. Following our work in *Under the Influence*, we categorised four parenting quadrants or styles based on a range of questions asked of parents and their children along two axes: 'control' or

level of discipline, and 'warmth' or levels of affection. Our four parenting types are:

- *disengaged*: low discipline and low affection
- *laissez-faire*: low discipline and high affection
- *authoritarian*: high discipline and low affection
- *'tough love'*: high discipline and high love[6]

Our analysis identified two significant links between parental alcohol consumption, parenting style and children's drinking outcomes:

- *Parents who drink 'always' are significantly less likely to be 'tough love' parents:* A mother who drank 'always' was 2.6 times less likely to be a 'tough love' parent than a mother who drank 'sometimes', while a father who drank 'always' was 2 times less likely to be a 'tough love' parent than one who drank 'sometimes'. This was true after controlling for a variety of demographic factors, including gender, ethnicity, religion, employment and family income.
- *Mothers who drink 'always' are more likely to have children who drink at hazardous levels in adulthood:* 16-year-olds who perceive their mother to drink 'always' were 1.7 times more likely to drink hazardously themselves at the age of 34 than those who reported that their mother drank 'sometimes'. This was true after controlling for a variety of demographic factors. The father's drinking behaviour was not statistically influential on this outcome. At the age of 16, peer influence is a more significant determinant of a teenager's drinking behaviour than parents' drinking behaviour.

The findings above are based on the entire sample of parents from the BCS for waves 4 and 7. They are therefore representative of a broad segment of the population, including a large number of people who may be misusing alcohol but are in denial and not accessing support services.

Below, we present the findings from our qualitative interviews with 50 families across the UK where at least one

parent was receiving support services for alcohol misuse. In total, we interviewed 89 individuals, including 26 children, from a mix of 11 rural and urban locations: London, Bristol, Cambridge, Bury, Cumbria, Bridgend in Wales and Glasgow in Scotland. Because of the small sample size, we do not make any claims of representativeness for our sample. Nonetheless, our findings are instructive.

Profile of families

- A large majority of the parents we interviewed were single parents and females. It is unclear if this is a representative profile of those who receive family-based alcohol support services in the UK (from where we recruited families). Teenage pregnancy was frequently mentioned. Tales of abusive relationships, multiple or short-lived partnerships, and traumatic splits were commonplace: only one-fifth of our sample claimed to be in a stable relationship.
- Four times as many people with alcohol problems said they were raised in difficult circumstances (for example, with parents separated or bereaved, or having experienced abuse) compared with those who said they had a good upbringing. Almost half claimed to have suffered violent or sexual abuse from either a parent or family member.
- For many in our sample, drinking started at a very young age (between the ages of 11 and 13) and over half grew up with parents or grandparents with alcohol problems.
- Poor mental health and worklessness were common experiences. Many parents we spoke to suffered from a range of mental health issues, including depression, agoraphobia, panic attacks, obsessive-compulsive behaviour and bipolar conditions. Very few people in our sample were in full-time employment. For some, the lack of purpose and structure results in boredom, which can lead to drinking.

Parenting style

- Very few of the parents we interviewed classified themselves as 'tough love' parents that combine high levels of affection and discipline. They tended to describe themselves as being permissive when parenting from either apathy while drinking, or guilt. A few parents described themselves as becoming more affectionate and sentimental when they were drinking, but more reported becoming distant or disengaged.
- Some thought that drinking had no effect on their parenting abilities, as they were rarely drunk in front of their children. However, when pressed, they often admitted to their drinking having consequences that affected their children.

Children and young people

- The majority of teenagers above the age of 13 whose families took part in this research had at least tried alcohol (10 out of 14). In some cases their drinking had become problematic. However, drinking parents often said they don't feel they have the authority to forbid their children alcohol, and were more likely to adopt an approach that viewed it as OK as long as it was happening under their supervision.
- The most frequently cited consequences of alcohol misuse for children and young people in these families are becoming aggressive or developing emotional problems themselves, developing drug or alcohol problems themselves, or being reclusive. Some of the children in the families we spoke to had been taken into care or put on the at-risk register. Also common was estrangement, getting into trouble at school and with police, and neglect where children occasionally miss meals, bath-time or school. Foetal alcohol syndrome, premature birth and attention deficit hyperactivity disorder (ADHD) were also mentioned.

Experience of alcohol support services

- Very few people in our sample self referred to support services. Often health care specialists or alcohol support services became involved only after incidents involving police, social services or schools, health concerns or pregnancy. The most commonly cited route into help was through a GP, followed by social services.
- Many parents said it is difficult to access appropriate support when they are struggling, and the system only kicks in when things are desperate (for example, when coming into contact with police or social services after they had been drinking). Some spoke of finding the courage to address their problems, only to find there is a long waiting list to get help. Other problems include transport costs to meetings (particularly in rural areas), discomfort in group meetings, lack of childcare, and lack of follow-up care.
- The most common support for children came in the form of mentors or specialist help at school. The children stated that they appreciate having someone to talk to and meeting children who share their experiences. However, some said there is a stigma attached to receiving services, so some children reject it. Many children said they were unaware that external help is available for them.
- Family-based intervention can bring families closer together by improving communication and making parents aware of the impact they are having on their children. Understanding this is enough for some parents to try and change their behaviour.

Policy recommendations

Helping parents address their alcohol misuse is a critical element to family-based support, both in reducing harms now and breaking the cycle of abuse. In this way, we can help parents be better parents, which our research suggests could be one of the most effective ways of minimising the number of people who are 'hazardous' or problematic drinkers – now and in the future.

While our aim is to help all parents be better parents (i.e. 'tough love' parents) we do not advocate doing so in an overly

patronising way. It is difficult enough being a parent, even when the stresses of daily life are relatively light. Often we need simply to make sure parents realise that parenting style and consumption of alcohol have an impact on their children's drinking behaviour; for some parents this will involve more frequent but light-touch intervention, such as encouraging children to speak about their feelings or confronting parents with the impact of their behaviour and levels of alcohol consumption. Occasionally more intensive 'whole family' based support will be required, including parenting classes and workshops.

Our policy recommendations are aimed at a wide range of stakeholders. National government has a role to play in setting the right tone, priorities and levels of funding. New local public health boards and local authorities will be responsible for allocating local area public health budgets, including information campaigns in local GP surgeries as well as commissioning more intensive family intervention projects. There is also clearly a significant role for the alcohol industry, which has a motivation to target those misusing alcohol in order to minimise the harms caused by alcohol. We also speak directly to all parents who read this report in the hopes that our research will help them understand the impact of their behaviour and modify it if necessary.

Recommendations for all families

Target information campaigns at parents

The Government, health service, charities and the alcohol industry should all ensure that parents are aware of the impact that their drinking can have on their ability to be effective, 'tough love' parents. Parents should also be aware of the evidence suggesting that 'tough love' parenting is a potentially powerful protection against their children drinking hazardously when they are adults.

There are a number of valuable websites and resources for people to learn about the harmful effects of excessive drinking, including those provided by NHS Choices, Alcohol Concern, and the website Netmums. However, the majority of adverts and

information awareness campaigns focus on units consumed and the harms to the drinkers themselves rather than providing advice to those responsible for children. With the exception of the charity Drinkaware, very few appear to offer direct advice to parents, not only about their children's alcohol consumption, but also about the impact of their own drinking and parenting style.

The alcohol industry should commit to devising awareness campaigns aimed specifically at parents in areas with high levels of parental alcohol misuse. This could take place in the context of the Government's Public Health Responsibility Deal, which aims to get businesses to make commitments for improving public health.

Schools, parent–teacher associations and employers may all play a role in getting information to parents about the impact of parenting style and alcohol consumption on their children. Advertising companies that have worked on behaviour change campaigns – including the Drinkaware campaign – should be brought in as stakeholders and consultants, alongside the Government's Behaviour Change Unit.

Alcohol companies should also commit to targeting parents as part of their focus on consumer communications in conjunction with the EU Alcohol and Health Forum.

While the messages would be both varied and targeted, parents need clear and consistent advice about how to approach alcohol when their child is a teenager. Our research and other previous research suggests that consistent and strict discipline, combined with limiting the availability of alcohol to teenagers, is the best approach to ensure that children do not drink alcohol at 'hazardous' levels. Information campaigns for parents should take a clear and unequivocal line on this point.

Identification and brief advice

The use of identification and brief advice (IBA) interventions, for example at hospitals and GP surgeries, could help to get parents thinking about their alcohol consumption levels and modify their behaviour. As noted in *The Government's Alcohol Strategy*, IBA is a quick and simple intervention for those who drink above the guidelines but are not accessing alcohol support

services. IBA should also include specific guidance to those who are parents or have childcare responsibilities. Health and wellbeing boards in local areas with high levels of parental alcohol misuse should especially prioritise the use of IBA with parents.

Emphasise and invest in early identification

Research suggests that the first three years of a child's life are the most important for their emotional and social development.[7] Demos research found that if parents showed affection and warmth to their children in early years those children were less likely to grow up to drink at 'hazardous' levels as teenagers and adults.

Every effort should be made to ensure that parents who may have a drinking problem are identified and provided with the right guidance and support while their children are as young as possible. Training is needed for midwives and GPs to recognise parents who may be misusing alcohol and to advise them or refer them to services if needed. Schools, social workers and other professionals also have a role in identifying children in need, for which they too require training.

Recommendations for family-based interventions

We make the following recommendations for family-based interventions aimed at parents who are 'harmful' drinkers.

Good family-based support includes, at minimum, three elements:

- consistent and trusting personal relationships between the key worker and the family
- tailored, personalised support based on the specific situation of the family
- ongoing support, even if this is light touch

Give children a voice

Giving children a voice can help parents to recognise the impact of their behaviour and convince them of the need to seek help, as

well as better understand the impact and needs of children. All alcohol support initiatives aimed at parents should also emphasise parent–child engagement sessions so that the child's voice can be heard.

Focus on parenting

Given the evidence of the importance of parenting to children's outcomes, providers of family-based alcohol support programmes should strongly prioritise and require the majority of service users to receive advice on parenting techniques. Communications around such programmes to parents and families should always include sufficient recognition of the stresses and difficulties of parenting, and the fact that all parents can improve their parenting abilities.

Support parents through an individually tailored service

Our research suggests that different services tend not to be integrated in a way that produces the best outcomes for these parents in helping them to control their drinking. Many families spoke about not being able to access support for mental health issues or worklessness until they first stopped using alcohol. This was despite the fact that mental health and worklessness were, if not drivers of alcohol misuse, significant obstacles to addressing their problem with alcohol. Tackling mental health problems first and foremost, or at least simultaneously as tackling alcohol misuse, must be a priority for policy change. Employment agencies could also be engaged, for example to help alcohol misusers deemed to be capable make their first steps back into work, even if they are not completely abstinent. There is also a need for greater alignment between children and adult services.

Coordinate with those working on the 'troubled families' agenda

The Government's 'troubled families' agenda is based on the idea of providing comprehensive, whole family support to the families with multiple problems that cost the state large amounts of money. While alcohol and drug misuse are 'third tier' criteria for identifying 'troubled families', it is likely that alcohol misuse is a factor in most of these families, alongside a range of other

problems. In this respect, the profile of 'troubled families' is similar to the 50 families whom we interviewed for our research. Thus, the interventions provided as part of the 'troubled families' agenda should take into account the lessons discussed in this report. However, not all families with parents who are harmful drinkers will be classified as 'troubled families', and it is vital that family-based interventions remain available for these families as well. Those responsible for delivering the 'troubled families' agenda must work closely with local health and wellbeing boards, as well as charities already delivering family intervention projects to ensure efforts are properly joined up and coordinated.

Introduction

According to Prime Minister David Cameron, it has become 'acceptable [in the last decade] for people to get drunk in public in ways that wreck lives, spread fear and increase crime'. As a result, binge drinking has become a 'scandal' that costs the NHS £2.7 billion a year.[8] Newspapers like the *Daily Mail* and television programmes like *Booze Britain* and *Booze Britain 2: Binge Nation* have perpetuated the idea that a binge drinking 'epidemic' is currently gripping the UK.

Behind the headlines, statistics suggest a more complicated picture. According to data compiled by the NHS, levels of alcohol consumption overall in the UK have been falling. In 2010, 68 per cent of men and 54 per cent of women reported drinking in the week before the survey, compared with 75 per cent of men and 59 per cent of women in 1998.[9] The same downward trend is observable among young children between the ages of 11 and 15. According to the NHS, 13 per cent of secondary school pupils reported drinking alcohol in the week previously compared with 18 per cent in 2009 and 26 per cent in 2001. Moreover, according to the Alcohol Education Trust, there was a decline in binge drinking among 16–24-year-olds between 2001 and 2006: young men reported a 9 per cent drop in those 'binging' while young women reported a 5 per cent drop.[10]

Despite this evidence suggesting downward trends, levels of alcohol misuse are unevenly distributed throughout the UK. Statistics of alcohol-related harm and consumption levels suggest that alcohol misuse is especially common in the North of England and Scotland: 50 per cent of northern drinkers regularly 'binge', compared with approximately 33 per cent of southern drinkers.[11] Nearly all local authorities (98 per cent) that have significantly higher proportions of adults drinking above their recommended units are located in the North.[12] According to

the Royal Geographic Society, men in the most deprived areas of Scotland are 'up to seven times more likely to die an alcohol-related death than the average'.[13]

Violence from alcohol is also positively correlated to how far north the location is, but the result is skewed by urbanisation. For example, Wiltshire, which does not have any major metropolitan areas, reported 373 instances of violent crime fuelled by alcohol in 2003 and 2004 while the West Midlands, which contains Birmingham, reported 4,140 alcohol-related crimes in the same period.[14] Moreover, according to the NHS, 'there are more people admitted to hospital in the north east with alcohol-related problems than any other part of the country'.[15]

There also remain concerns about the number of young people in the UK consuming alcohol, which is relatively high compared with other European countries. According to the European School Survey Project on Alcohol and other Drugs, British teenagers are among the most likely in Europe to report drinking heavily; approximately 52 per cent of boys and 55 per cent of girls admitted to binge drinking within 30 days of the survey being undertaken.[16] Only the Isle of Man and Denmark have a greater proportion of teenage girls who binge drink regularly, and although there are more European nations whose boys drink to excess, the UK is still within the top third.[17]

While *The Government's Alcohol Strategy* has focused on public disorder and crime in town and city centres caused by drunken revellers, it is arguable that the greatest public harm caused by alcohol occurs behind closed doors.

Parental alcohol misuse

A number of recent reports have highlighted the scale of parental alcohol misuse in the UK. According to the latest figures, more than 2.5 million children, including 90,000 babies, in the UK are living with a parent who is drinking alcohol 'hazardously' by exceeding the Government's recommended weekly unit consumption levels.[18] Moreover, according to figures in *The Government's Alcohol Strategy*, 33 per cent of adults in alcohol treatment (approximately 31,000 individuals) are parents with

childcare responsibilities, while a further 20 per cent are parents whose child lives elsewhere.[19]

From domestic abuse to lack of parenting, young people and children can suffer significant harm as a result of a parent's drinking problem. Figures from the National Society for the Prevention of Cruelty to Children (NSPCC) show that children who have a parent abusing alcohol are over three times more likely to report physical abuse than children who do not have such a parent.[20] Even for the many children of alcoholics who do not suffer direct physical or sexual abuse, the effects of growing up with an alcoholic parent can be deep-seated and long lasting. Children can suffer from a number of difficult emotions due to parental alcohol abuse, including feelings of guilt, anxiety, confusion, anger and depression, as well as an inability to form close relationships.[21]

Children of alcohol abusers may also be more likely to become alcoholics themselves because of the stress and trauma they may suffer growing up in a chaotic household. While there are studies that suggest there is a genetic predisposition towards alcoholism, researchers see environmental factors as extremely influential. One Danish study, one of the few to take a longitudinal approach, has confirmed that parental alcoholism plays a definitive role in an offspring's chances of developing a drinking problem.[22] It discovered that a child is more than twice as likely to develop an alcohol problem if parents have a pre-existing problem themselves, and that exposure to parental alcoholism is a significant risk factor for alcoholism developing in the child.[23]

What is the Government doing to tackle alcohol misuse?

Earlier this year, the Coalition Government released its Alcohol Strategy, which included a range of measures to reduce binge drinking and alcohol-related harms.[24] The centrepiece of the Government's approach is the introduction of a minimum unit price for alcohol following the lead of the Scottish Government. The Alcohol Minimum Pricing Bill was passed in the Scottish

Parliament in May 2012; it introduced a minimum unit price for alcohol of 50p, which will substantially increase the cost of alcohol currently charged at less than 50p per unit, such as Tesco Strong Dry Cider.[25]

Proponents of a minimum unit price, such as Sir Ian Gilmore, the former President of the Royal College of Physicians, point to evidence that higher pricing will reduce overall alcohol consumption as well as alcohol-related harms such as hospitalisations as a result of alcohol misuse.[26] Critics of the bill argue that it penalises all drinkers – including those who drink responsibly – and has less of an impact on problematic drinkers.[27] Critics also attest that the minimum unit price would infringe free trade rules and would amount to a market distortion. The Scottish Whisky Association and other drinks industry organisations and companies have filed formal complaints to the European Commission.[28]

The Alcohol Strategy proposes strengthening the powers of local authorities to close down premises consistently found to be selling alcohol to underage drinkers in England and Wales. It suggests there should be consultations on banning below-cost selling and multi-buy promotions alongside an expectation on universities to educate their students. A pilot scheme of 'enforced sobriety' is to be launched using community sentence orders, though further mechanisms are unclear.[29]

The Strategy is also notable for its emphasis on a localised approach.[30] Newly created health and wellbeing boards in local authority areas will be responsible for allocating public health budgets, which will include a ring-fenced amount for tackling drugs and alcohol misuse. The health and wellbeing boards, as well as local authorities, will be responsible for allocating their budgets according to local area needs, including commissioning family intervention projects for tackling complex or entrenched problems in families.

According to Donald Henderson, the head of the Scottish Public Health Division, Scotland has taken a public health approach to alcohol-related difficulties, rather than the criminal justice approach of England and Wales. This is partly explained by the severity of the problem in Scotland, which has been

estimated to cost £3.56 billion every year, or £900 for every adult living in Scotland.[31]

The Scottish Government has taken a particular and explicit interest in parental alcohol misuse and supporting children, especially in the early years. One of the seven outcomes that alcohol and drug partnerships are judged on includes ensuring that:

children and family members of people misusing alcohol and drugs are safe, well supported and have improved life chances: this will include reducing the risks and impact of drug and alcohol misuse on users' children and other family members; supporting the social, educational and economic potential of children and other family members; and helping family members support the recovery of their parents, children and significant others.[32]

In England and Wales, family-based interventions have also featured more prominently among alcohol support services. The National Treatment Agency for Substance Abuse, the NHS's special authority on drug treatment, pledged in 2008/09 that 'all services will be focused on considering family issues by 2011'.[33] According to the Alcohol Strategy, Family Intervention Projects (FIPs) have led to a 34 per cent reduction in drug and alcohol problems, 58 per cent reduction in anti-social behaviour and 50 per cent reduction in their children's truancy.[34]

In 2011, Prime Minister David Cameron announced his Government's 'troubled families' initiative, which pledged to target the estimated 120,000 families in the UK whose members suffered from multiple problems and cost the state most in welfare, health and criminal costs. Much of the local family-focused work that is or would be targeted at parents with alcohol or drugs misuse may be subsumed within the Government's 'troubled families' agenda. However, by its very nature any 'troubled families' intervention will be targeted on a wide range of issues and not just alcohol. Crime and anti-social behaviour, child truancy and unemployment are identified as the three main characteristics of 'troubled families'. There is also a fourth 'high costs to the state' criterion that is designed to give local

authorities flexibility in identifying families with other needs, and can include drug and alcohol misuse.

The importance of parenting and 'character skills'

One significant aspect of family-based interventions is a focus on parenting.

There are a number of charities that provide interventions designed to support parents whose children use or are at risk of using alcohol or drugs. Most of these are commissioned by local authorities to deliver services in their area. For example, Action on Addiction runs M-PACT (Moving Parents and Children Together), a structured intervention to help children and families suffering consequences of substance misuse.[35] Addaction runs a similar programme called Breaking the Cycle, 'which takes into account the needs of the whole family'.[36]

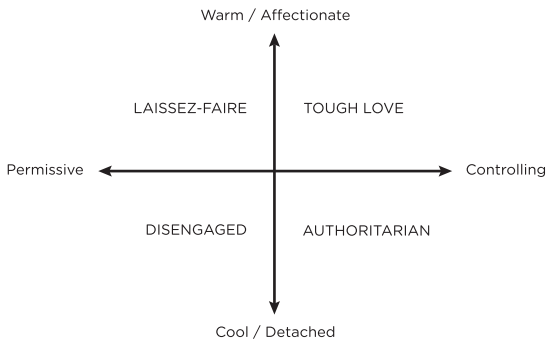
This emphasis on parenting for families with alcohol problems is essential. However, previous Demos research suggests that parenting in general across the whole of the population can have a large impact on whether children become hazardous drinkers, both as teenagers and later in life as adults.

In recent years, research has demonstrated the importance of character skills – such as the ability to delay gratification, practise moderation, and have a sense of responsibility and general respect for others – for achieving better life outcomes, including the moderate and responsible consumption of alcohol. The development of character skills depends on many factors, but parenting style has the greatest impact.

In the early 1990s the American clinical and developmental psychologist Diana Baumrind looked into which parenting styles had the best outcomes for children.[37] She found that 'tough love or authoritative' parenting was the most likely parenting style to produce in children a secure identity, higher self-esteem, greater autonomy, higher school achievement and higher levels of social responsibility and pro-social behaviour.

Echoing Baumrind's research, the Demos report *Building Character* found that 'tough love' parenting (figure 1) was most likely to produce 'character capabilities' such as the ability to

Figure 1 **The two axes of parenting style**



apply oneself to a task and regulate one's emotions. Moreover, the effect of parenting style was more significant for children's outcomes than socio-economic background.[38]

Under the Influence: parenting style and children's alcohol consumption

In the Demos report *Under the Influence* – the precursor report to this one – we explored the impact of parenting styles on children's drinking behaviour at the age of 16 and later in life at the age of 34.[39] By analysing two longitudinal datasets – the Birth Cohort Study (BCS) and the Avon Longitudinal Study of Parents and Children – we found evidence suggesting that high levels of parent–child affection between the ages of 0 and 5 years old, and strict discipline at the age of 16, may reduce the likelihood that a child will drink excessively in adolescence and adulthood.

We also found evidence suggesting that 'disengaged' parenting has a detrimental impact on an offspring's drinking behaviour: our analysis showed that 'disengaged' parenting at age 10 makes a child twice as likely to drink excessively at age 34, while 'disengaged' parenting at age 16 makes a child eight times

more likely to drink excessively at the age of 16, and over twice as likely to drink excessively at 34.[40]

This report

In this report we focus on the impact of parental alcohol consumption on both parenting styles and children's alcohol consumption levels. Our research suggests that helping parents who are abusing alcohol be better parents is an effective way of improving outcomes for all family members. This, we argue, can be done by improving understanding about the effects of alcohol on parenting and helping drinking parents face the reality of how their behaviour affects their children. In particular, we looked at the impact of parental alcohol consumption on parents' ability to be 'tough love' parents. Then we questioned how to improve support for parents with a hazardous relationship to alcohol so they can be better parents, thus helping break the cycle of unhealthy behaviour for the next generation.

In order to explore these questions we have conducted further quantitative research on the BCS in order to test the impact of parental drinking on parenting styles and children's drinking behaviour. We also conducted in-depth interviews with 50 families across the UK where at least one parent was a 'harmful' or problematic drinker. Where possible, we interviewed multiple members of the same family, including their children.

Defining problematic alcohol consumption

Arriving at a definition of alcohol abuse can be difficult and controversial. The Department of Health publishes recommended daily limits for adult alcohol consumption: 3–4 units a day for men and 2–3 units a day for women.[41] Yet, the concept of abuse is relative and some can drink more units than others without the same ill-effects on themselves and those around them.

The Government classifies three 'types' of problem drinking:[42]

- 'hazardous drinking', which constitutes a person going over the recommended weekly allowance (21 units for men or 14 for women)
- 'harmful drinking', which constitutes drinking above weekly limits as well as experiencing health problems that are directly related to alcohol
- 'dependent drinking', which is more difficult to measure in units of consumption.

'Binge drinking', which is a form of hazardous drinking, is when someone drinks over twice the daily-suggested limit (8 units for men or 6 for women) in one session.[43]

For this report, our aim was to recruit families where one of the parents was a 'harmful' drinker: that is, where their drinking led to harmful consequences in terms of physical and mental health for themselves or for other members of the family. We therefore recruited parents who were accessing family-based alcohol support services, which we used as a proxy indicator for 'harmful' drinking. Oftentimes, referral to these programmes had occurred not as a result of the opinion or urging of a family member, but rather through the recommendation of a GP, school or social services in response to an incident involving parents' drinking.

For the quantitative analysis of the BCS, determining who in the sample were 'harmful' or problematic drinkers was more difficult because of the available indicators. Underlining the relationship between parents and children, we decided to use an indicator based on a child's perception of how often their parents drank, with answer choices being 'never', 'sometimes', 'often' and 'always'. While a child reporting their parents drinking 'always' does not necessarily imply 'harmful' drinking, it is reasonable to assume that all 'harmful' drinking parents in the BCS sample would be most likely to appear in the 'always' category.

1 Findings: Birth Cohort Study – parents who drink 'always'

As mentioned above, we wanted to build on the quantitative analysis presented in *Under the Influence*[44] by considering the impact of parental drinking behaviour on parenting style and offspring's drinking habits at ages 16 and 34. For reasons discussed in the technical appendix, we limited our analysis to the 1970 Birth Cohort Study (BCS) and excluded the Avon Longitudinal Study of Parents and Children, which was used in *Under the Influence*.

In our analysis of the BCS we were interested in two specific questions:

- How does parental alcohol consumption, especially at harmful levels, affect parenting style?
- How does parental alcohol consumption affect children's likelihood of drinking at hazardous levels as a teenager and then later in life as an adult?

It is worth noting that this type of quantitative analysis is inevitably limited by the availability of data and precise measures, so definitions will always be imperfect and contestable. For this analysis, we used the measure of drinking behaviour for the offspring employed in *Under the Influence*, which is a simple weekly-based unit definition of whether someone drinks over the Department of Health's recommended weekly allowance of 21 units per week for a man and 14 units per week for a woman. We also used the same collection of indicators to categorise parents in one of four parenting types according to the attachment and discipline axes (see figure 1 in the previous chapter, as well the technical appendix).

We added a further measure of parental drinking to test its impact. The indicator we used is from the survey of children

undertaken as part of the BCS (wave 3) and is based on those children's perceptions of how much their mother and father drink, with the possible answers being: 'never', 'sometimes', 'often' or 'always'. While there are questions about how the child's perception matches the reality of parental drinking behaviour, we would argue that this is a useful and appropriate measure since we are considering the impact of parental drinking on children first and foremost.

Parenting style and parents drinking behaviour

In *Under the Influence* we discovered evidence suggesting that 'tough love' parenting is the most effective parenting style to ensure that children do not binge drink at age 16 and later in life at 34.[45] To test this, we ran a regression that controlled for a range of additional characteristics that could have an impact on the results – such as gender, ethnicity, parents' drinking habits, employment in social class – thereby isolating the effect of parenting style. In this report we wanted to understand what impact parental drinking behaviour has on whether parents are likely to adopt a 'tough love' approach.

We found that the odds of parents having the 'tough love' parenting style when their children are aged 16 decreases by 26 per cent for every increase in how much the father drinks when a child is age 16 ($p = .037$) and 38 per cent for every category increase in how much the mother drinks when a child is 16 ($p = .003$) when controlling for a variety of demographic factors, including the teenager's sex, ethnicity and religion, the parents' ethnicities and employment, and the family income. Put differently, the odds of being 'tough love' parents exponentially decreases by 26 per cent for fathers, and 38 per cent for mothers, every time a child's perception of his or her parents' drinking behaviour changes from 'never' to 'sometimes', 'sometimes' to 'often', and 'often' to 'always' (table 1).

The only stronger predictor of whether parents exhibit the 'tough love' parenting style is the gender of the teenager. If the child is female the odds of parents having a 'tough love'

Table 1 **The relationship between parents' drinking behaviours and parenting types**

Parenting type	Fathers Frequency perceived to drink			
	Never (%)	Sometimes (%)	Often (%)	Always (%)
'Tough love'	8.8	51.3	29.5	10.3
Authoritarian	9.2	40.7	30.4	19.9
Laissez-faire	4.8	34.2	38.0	22.9
Disengaged	3.3	34.9	34.7	26.9
Parenting type	Mothers Frequency perceived to drink			
	Never (%)	Sometimes (%)	Often (%)	Always (%)
'Tough love'	22.0	54.8	19.2	3.9
Authoritarian	20.6	50.9	20.1	8.3
Laissez-faire	6.2	51.3	32.9	9.5
Disengaged	9.5	49.7	28.9	11.8

parenting style are 1.73 times greater than if the child is male, when controlling for all other factors. This is a 73 per cent increase in likelihood for females to have 'tough love' parents than males in the exact same circumstances.

While the odds of parents being either 'authoritarian' or 'disengaged' could not be predicted reliably, there was a connection between the mother's drinking behaviour and her likelihood of adopting a 'laissez-faire' parenting style. The odds of mothers adopting this style increase by 1.47 times for each category increase in how much the mother drinks when the child is age 16, when controlling for all other factors. This indicates that the likelihood of mothers having a 'laissez-faire' parenting style exponentially increases by 47 per cent every time their drinking behaviour goes from 'never' to 'sometimes', with the same jump between the drinking behaviours 'sometimes' and 'often', and 'often' and 'always'. Thus there is a 4.66 times

increase in the odds of mothers having 'laissez-faire' parenting styles between those who 'never' drink and those who 'always' drink.

We also ran an ordinary least squares (OLS) regression with the parenting style serving as the dependent variable and parental drinking behaviour when the child is age 16 as the independent variable. We included controls for the child's gender, ethnicity, religion, parent's employment status, family income and parents' ethnicity. While the father's drinking behaviour was not significant in this model, the mother's drinking behaviour was, with a coefficient of .222. With the parenting styles arranged from 'tough love' (1) to disengaged (4), this coefficient indicates that as the mother's drinking increases, the parenting style 'increases' – or, rather, becomes worse. The effect of the mother's drinking behaviour was the second strongest predictor, with gender being the strongest with a coefficient of .395. Thus girls are significantly more likely to have 'tough love' or 'authoritarian' parents, while boys are more likely to have 'laissez-faire' or 'disengaged' parents.

The impact of parental drinking behaviour during adolescence (age 16) on the offspring's drinking behaviour at age 16 and 34

Our analysis suggests that a mother' s drinking behaviour when her child is 16 years old has a small impact on her child's drinking behaviour at that age. The odds of children being binge drinkers when they are aged 16 increases by 1.39 times for every category increase in how much the mother drinks when the child is age 16, when controlling for all other factors. However, this variable barely reaches statistical significance, and fails to attain significance when social and peer influence is taken into account. The drinking behaviour of the teen's girlfriend or boyfriend has the strongest impact on the teen's likelihood of being a binge drinker. Specifically, the odds of cohort members being a binge drinker when they are aged 16 increases by 1.87 times for every category increase in how much their girlfriend or boyfriend drinks, when controlling for all other factors. Similar results were

found for the likelihood of drinking depending on how much the teen's best friend drinks.

However, the odds of cohort members becoming binge drinkers when they are aged 34 is significantly impacted by the amount that their mothers drank when they were 16 years old, as the odds of becoming a binge drinker rise by 1.31 times for every category increase in how much mothers drank when the child was 16, when controlling for all other factors. Interestingly, there was no statistically significant link between a father's drinking and the increased likelihood of his children drinking hazardously as an adult. Gender, ethnicity, employment and having children had a demonstrable effect on the likelihood of binge drinking at 34: males, British ethnicity, the unemployed and those without children are much more likely to be binge drinkers than people without these characteristics.

Key protective factors between parents' drinking behaviour and offspring drinking

Our analysis also identified a number of factors that appeared to protect offspring from drinking hazardously as adults.

Gender

Gender appears to have an impact in predicting against binge drinking at the age of 34, with women being 63.8 per cent less likely to binge drink than men in the exact same circumstances.

Ethnicity and religion

A second protective factor worth consideration when looking at binge drinking age at 34 is the ethnicity of cohort members' mothers. By far the largest proportion of all binge drinkers (over 97 per cent) had mothers of British ethnicity. Those who had mothers of non-British ethnicities are 47.7 per cent less likely to be binge drinkers at age 34 than those with British mothers.

When looking at the cohort age 34, it is observed that the majority of religions serve as a protective factor against binge

drinking: 88 per cent to 100 per cent of cohort members participating in the religions did not binge drink. There is only a small difference in the type of religion and the strength of religion as a protective factor, with the highest rate being among Buddhists at 26.7 per cent.

2 Findings: Family interviews – parents who drink 'harmfully'

This chapter presents the findings of our qualitative research based on in-depth interviews with 50 families in 11 different locations across the UK. We recruited families who had been referred to or sought assistance from alcohol support programmes provided by Addaction and Adfam's partners, because of 'harmful' drinking – drinking that has led to negative consequences for themselves or their families. As discussed in greater detail below, our sample includes a wide range of different 'types' of problematic drinkers, from those who are severely dependent on alcohol, to those who binge drink at night and at weekends.

Our key objectives in these interviews were to understand the impact that harmful drinking could have on children, and on parents' parenting ability, and to analyse the effectiveness of family-based interventions. For the latter question, we were particularly interested in how family-based interventions supported parents to be better parents and supported children to prevent intergenerational harmful drinking. Thus, as well as speaking to parents about their parenting skills, we also sought to interview young people when possible, paying careful attention to ethical issues. We attempted to involve spouses and partners, and in some cases parents or other family members such as siblings. The person referred to us was always the parent who was receiving support for 'harmful' drinking; they are referred to below as the principal interviewee. To protect their anonymity, families will be referred to by number, from 1 to 50.

In most cases, the family was interviewed together rather than individually. Although this may have influenced what was said, with some family members less willing or able to speak openly than they would have done if they had been interviewed separately, in general, researchers felt that the presence of the

person with alcohol difficulties did not overly influence the other family members. While it can be hard for families and especially children to talk about these issues, the recruitment method (with families receiving support) means that the people in our survey had had some experience of discussing their harmful drinking. In some instances, families said that during the research discussion they raised issues that had never been collectively talked about before.

It should also be noted that in some but not all interviews a support worker was present in the room. That may have influenced what was said, but as many of the key workers were also involved in family support, Demos feels the impact was limited. Interviewees often turned to the support worker for help in describing what they wanted to say. When they were asked to rate services, there was no marked difference to the evaluations, whether a support worker was present or not.

Full details about the methodology and recruitment method are included in the technical appendix at the end of this report.

Family profile

Among the parents and families that we interviewed, there was a preponderance of single parents and women. In only nine of the 50 families was the parent with alcohol difficulties a male. It is unclear if this profile is representative of those accessing family-based support services in England and Wales, as overall statistics are not available. This prevalence of women could be partly explained by the fact that male parents who are harmful drinkers often leave or are ejected from the family home. It may also be true that women are either more likely to seek help or more likely to be identified as parents with alcohol problems through contact with midwives, doctors, schools or social services either during pregnancy or because they play a more prominent role in childcare. However, it is worth noting that a majority of all Addaction service users (which is not limited to those receiving 'family-based' support) are male: for the period 1 April 2011 to 31 March 2012, out of 26,856 in total, 18,948 (or 70 per cent) were male and 7,908 were female.[46]

Only one of the 50 principal interviewees referred to Demos was non-white. Clearly, this cannot be because problematic alcohol behaviour only exists in white families. One explanation could be that in some black or Asian communities, alcohol difficulties may be addressed within family circles without recourse to outside help, for which there could be a stigma attached. Another explanation that must be considered is that services are failing to reach non-white communities where help is needed.

Teenage pregnancy was frequent among our sample: one-quarter of the mothers referred to us (10 out of 41) had their first child before they were 21, many of them at age 16. Tales of abusive or explosive relationships, multiple or short-lived partnerships, and traumatic splits were commonplace: only one-fifth claimed to be in a stable relationship. Many spoke about estrangement from siblings and parents. Four times as many people said they were raised in difficult circumstances with parents separated or bereaved than those who said they had a good upbringing.

Almost half of the principal interviewees claimed to have suffered violent or sexual abuse from a parent or partner, and some also spoke of violence (rape or abuse) against themselves or a close relation. Depression is a common illness, with several people having tried to commit suicide. Mental health issues from agoraphobia to bipolar conditions, obsessive-compulsive behaviour and panic attacks were also frequently mentioned. Other kinds of addiction (drugs, food) were fairly common, and some spoke of learning difficulties.

As would be expected, given the family nature of our research, the parents with alcohol difficulties were mainly in their 20s, 30s or 40s. Worklessness was a common theme, with few people in full-time employment, often citing health reasons. For some, the lack of purpose results in boredom. One mother (30) said she's got 'nothing to get up for. My life consists of getting up, being sick, watching telly, making the tea; then I get depressed and want to go back to bed.' Around one-fifth were volunteering or studying as they move towards re-entering or entering the labour market. Only 14 per cent of total service

users for Addaction reported being in regular employment: 10.7 per cent reported being long-term sick or disabled, 26.8 reported being unemployed and seeking work, while 5.6 per cent were unemployed and not seeking work.[47]

Drinking histories

Experiences of harmful drinking were varied in everything from drinking patterns to quantities, behaviour, family history and impact. Harmful drinking ranged from daily and significant over-consumption to binge-drinking interspersed with long periods of abstinence (one person (13) described it by saying, 'I didn't have a problem with alcohol, I had a problem in alcohol.') Some families showed destructive drinking behaviours that stretched back generations, while others are the only ones in the family who drink harmfully.

Around half (52 per cent) of the principal interviewees were abstinent as part of their support programme. A small number had cut down or were drinking in what they described as a controlled fashion; the rest were drinking hazardously, above weekly limits, with occasional episodes that led to negative consequences for themselves or their children. The majority of principal interviewees had started drinking very young, usually at around 11–13 years old. One person (35) claims to have had her first drink aged 2 and have been 'paralytic drunk' by age 11.

For some, drinking started as moderate and social (like a 'normal teenager' (20)), with problems developing later. Often, drinking escalated as a result of relationship breakdown or some other traumatic experience. Key triggers included relationship breakdown or violence, past traumatic experience (often including sexual abuse), postnatal depression, lack of confidence, mental health problems and bereavement.

One woman (13) claims to have been a 'straight A student' until sexual abuse when she was under 10 sent her 'off the rails' into drug and drink abuse, crime, miscarriages and abortion: 'There isn't anything in this world I haven't experienced.'

The mother of one woman (23) reacted to the death of her husband (the woman's father) by drinking so much that she almost died. She survived, but was no longer able to parent in an effective manner. The women said as a child she was 'running wild' by 11, and blacking out from alcohol at 13: 'Our lives were totally unmanageable.'

Some say their drinking crept up on them, and because everyone around them drank heavily, they thought such behaviour was normal. One person (26) who spent much of her life as an ex-pat in Africa said: 'Of course it just was the norm there to have your drinks every day when you finish, at the golf club; I didn't think anything of it until I came back to this country.'

Despite massive alcohol consumption and a chaotic life, some failed to see the extent of their problem for a long time: 'I still didn't know I was an alcoholic. I thought an alcoholic was someone who slept under cardboard' (23). For some parents, harmful drinking was always a problem for other people. One (36) said she believes she is 'allergic' to alcohol: 'I'm just one of those people for whom one drink is too much and 100 is never enough.'

One mother (19) says her family has 'a gene, an addictive personality' that she shares with her parents and most of her nine siblings:

My two elder sisters, they don't think they've got a problem but when they go out they get absolutely comatose… I've got an alcohol issue and my sister below me, she's got an alcohol issue and my brother, he's dabbled in all sorts of trouble. Another sister died of a drugs overdose. [Another sister]'s got a drink problem there as well. The sister below [her] has overdosed, so did my youngest brother a few weeks ago.

Over half (54 per cent) of the principal interviewees spoke of having parents or grandparents with alcohol problems, so they grew up thinking adults being drunk was normal. In some cases, they may also have inherited or adopted similar parenting behaviour.

One father (22), an alcoholic like his father and brother, describes one of his first drinking experiences:

When I was a young boy, right, we ended up buying two bottles of whisky and ended up pure steaming, fell asleep on a canal bank. I woke up and my brother was unconscious and I couldn't wake him… We had to carry him, I don't know, a quarter of a mile away from the house, and we bumped into the police… This was 6 or 7 in the morning. Police radioed for an ambulance. By this time we got to the house… my Dad was sitting outside of the front door, sleeping on the steps; he was steaming out of his mind… [They] took my brother away to the hospital… he was near enough dead, my dad ended up going to hospital as well. After that I think it was just drink, drink, drink from then on.

While drinking is often described as initially a fun, confidence-inducing experience, for most harmful drinkers it ends up being an isolated, depressed activity. 'In the end I became a miserable drunk,' said one mother (48), who was for many of her 20 years of drinking a 'happy drunk'. Many described drinking as a joyless experience that often happens alone, behind closed doors. Suffering from depression or agoraphobia, some said they need a drink to leave the home, even for everyday tasks such as shopping. There are many reasons not to drink once out of the home, however. After coming around in hospital or in unpleasant surroundings, several said they feel safer drinking at home. It was also cited as being much cheaper.

Parenting behaviour

Across all of our interviews, Demos noted a tendency for parents to be permissive in parenting their children, driven either by apathy while drinking or guilt. Some said they don't feel justified in telling their children off because they themselves behave badly (when drunk). Others try to make up for their drinking behaviour by spoiling their children with gifts or treats (which they often can't afford). One father (22), whose son said he gives him anything he wants, said: 'I just... feel as if I'm not giving enough time to the [kids]. I feel selfish. I spend my money on drink when I should be spending it on them.'

Often a structured life is lacking. According to a close family member, one young girl who lives occasionally with an aunt has more respect for her aunt than she has for her mother. This is because the aunt does not drink and is not embarrassing, but also because there are reliable mealtimes and bedtimes and rules. 'It's empty promises' with her drinking mother (47).

Some noted their children seem to prefer it when they drink as discipline is laxer, and find it difficult to adapt to an abstinent parent. As one mother put it: 'The kids think it's fun when I'm drunk because they can get whatever they want' (4). One mother (7) said she is a fairly strict loving mum, but drink changes that. 'I neglect them,' she says, occasionally omitting to bathe them or cook for them. At times, she has forgotten to take them to school.

The research revealed variations in the degree of warmth between parent and child. Of course, personality and upbringing determine to some extent how comfortable people are expressing love and emotion, but problematic alcohol consumption does play a role. When drunk, a few parents said they became more affectionate or sentimental, but more said they became distant or disengaged.

Overall, it appeared that drinking led to erratic parental behaviour (from cloying and emotional to angry) and lack of consistency, as well as failure to enforce discipline or stick to commitments.

Most parents want to be the best parent they can be. Reflecting on her upbringing, one mother (12) said she is trying to raise her children in a different way from the one she grew up in:

Even though my Mum & Dad loved me, they didn't show a lot of love. I've sort of seen that I'm like that with my kids as well. I've turned that round and shown them a lot more affection.

Some, however, simply do not have a concept of the 'right way' to parent: for example being unaware of the importance of play for young children. One mother (43), now abstinent, said she didn't know about foetal alcohol syndrome and drank

through all her pregnancies. Many of her children have ADHD and she feels guilty to the point of tears. Touchingly, her 15-year-old son, present at the interview, insisted she shouldn't blame herself for the trouble he and his siblings get into. She is now trying to educate her own daughter, also a drinking mother.

Some claimed that drinking had no effect on their parenting abilities, as they were rarely drunk in front of their children. However, when pressed, they often admitted to the consequences of their drinking:

I wouldn't say it's affected my parenting as I can still feed them, still clothe them, do all the things a parent should do, but it's probably affected my parenting in that I was a little bit short-fused, which has settled down a lot since the GP put me on anti-depressants. (15)

One mother (25) said 'the kids don't normally see me drink', and found it upsetting to realise they understood more than she thought. She describes her son making sick noises over the bin, noting 'he learnt that off me'. Even very young children appear perceptive to the cause of their parents' behaviour, with one mother (15) describing her 8-year-old son sniffing her glass to check what she was drinking.

Demos found that children's experience of parenting, when they were able to express it, largely reflected what their parents said. Differences where they happened were a matter of degree and Demos is inclined to believe that the parents accurately depicted their own parenting styles as far as they were able. In some instances children were protective, giving a more positive rating of parenting skills than the parent concerned.

Impact on children of parental drinking

Though they may deeply regret it, parents' alcohol abuse has real impacts on children. Demos interviewed families with children of all ages. Where there were teenagers, some parents (particularly those who had battled to stop drinking or cut down) expressed the hope that their example would be enough to put their children off drink. However, this appears to be wishful thinking.

The majority of teenagers whose families took part in this survey had at least tried alcohol. In some cases their drinking had become problematic and led to negative consequences. However, drinking parents often said they do not feel they have the authority to forbid their children alcohol.

Some families spoke of parents who were still drinking welcoming the opportunity of a new drinking partner. As one teenager (19) put it, 'If I was my age now and she was drinking, I think we would have been drinking together and that would have been really bad. I would have ended up like her.'

Other effects on children range from the emotional effects of watching a loved one hurt themselves, to the stress of taking on what would normally be parental activities – from paying bills to babysitting younger siblings, as well as looking after the parent.

One daughter (26) said:

I became a 'mother' at the age of 14… In some ways it did help, because I picked up responsibility of paying my Mum's bills and rent. So when I did move out I did know how to do it already… I did get bullied in school for it because I was working, supporting [younger brother]. I thought it was normal but they knew it wasn't.

One son (47) whose mother has been clean for almost a year says he has taken up semi-professional football: 'I don't think I would have been playing football' if mother were still drinking, he said. 'I wasn't having a life of my own' then. Some parents allow the relationship with their children to be reversed: 'Sometimes he can be like the adult, telling me off,' says one mother (11) of her 13-year-old son.

One daughter has an obsessive-compulsive disorder, which her mother (40) attributes to stress: 'She felt like she had to look after me.' She 'knew something was wrong, but she didn't know why'.

Many parents said although they could be aggressive while drunk, it was never to their kids. Few in our survey confessed to physical or emotional abuse. However, judging from the experience of parents whose own parents were alcoholics, such

abuse is common in families where there are alcohol difficulties, even if unintended.

Among the families who spoke to Demos, the most frequently cited consequences of alcohol misuse include children being taken into care or put on the at-risk register; becoming aggressive or developing emotional problems themselves; developing drug or alcohol problems themselves; or being reclusive. Also common was estrangement, and neglect where children occasionally miss meals, bath time or school. Foetal alcohol syndrome, premature birth and ADHD were also prevalent.

Other problems include getting into trouble at school and with police, being sent to prison, being secretive, being tired at school and suffering embarrassment. One 13-year-old (28) was getting help overcoming being 'dark-minded' and thinking obsessively about murder and death.

These effects can be mitigated if there is a parent or responsible adult without alcohol or other problems who can relieve pressure on the child or help in his or her upbringing. Other factors such as the level of household conflict and family income may also play a role.

There were few positive effects of parental drinking on children, but sometimes families come through a painful process stronger. One grown-up son (36) said the experience of fighting to get his younger brother out of care brought them together. 'We are a lot closer than my friends' families,' he said.

Interventions

The families who participated in this survey had or were taking part in a variety of family-based support programmes (see box 1 for a brief description of each programme). As mentioned at the beginning of the chapter, one of our aims in these interviews was to learn what kind of support was provided to parents and children and whether this was perceived as helpful. While it was beyond the scope of this report to provide a detailed and comprehensive analysis of programmes' effectiveness, some feedback we received from parents and children is instructive.

Box 1 **Family-focused intervention programmes**

The Moving Parents and Children Together (M-PACT) Programme, devised by Action on Addiction (Wiltshire)

M-PACT is a short, structured intervention designed to help children (aged 8–17) whose parents have drug or alcohol problems. It is delivered over eight weeks, with sessions lasting 2.5 hours. Children and parents work separately and together as family units with trained practitioners to find ways to improve family life for all. The programme offers the opportunity 'to support children to talk about their experience and how they have been affected'. In some cases not all adults will have stopped drinking or taking drugs, but M-PACT supports the family to reduce the risks of harm and improve the safety of the home environment. The data from centres delivering M-PACT across the UK are collated centrally, so lessons learned from them can benefit others throughout the UK.[48]

Holding Families, devised by Early Break, the Young Person's Drug and Alcohol Service for Bury, Rochdale and East Lancashire

Designed to help children, parents and families with problems linked to parental substance misuse, Holding Families works with family members individually and together. Over five months, the specific needs of the family are addressed, with recourse to external agencies that offer help. One of the key objectives is to make parents realise the impact of their behaviour on children ('make the voice of the children be heard by the parents'), giving them a strong incentive to address their behaviour. Holding Families' support may begin with drug and alcohol misuse but offers a progressive holistic approach addressing many areas of families' needs. Holding Families is used as an example of good practice on the National Treatment Agency for Substance Abuse and C4EO website.

Addaction Glasgow Pregnancy & Early Years

This programme is a city-wide service for pregnant women and those with very young children, offering outreach, one-to-one keyworkers and intensive support. Rather than a heavily prescriptive programme, it is a flexible service that can vary between an eight-week intensive 1–1 programme and help seeing a doctor. Currently, the programme's focus is on mothers, with children benefitting indirectly. However, this focus is shifting, with work alongside the charity Children 1st and the prospect of employing people trained to work with children.[49] *The impact of the programme is measured through 'key indicators', such as the baby's birth weight, if the baby has withdrawal symptoms and whether the mother smokes.*[50]

Breaking the Cycle, devised by Addaction (Cambridgeshire, Cumbria, Devon, Tower Hamlets)

With the Breaking the Cycle programme, workers provide an individually designed care package that takes into account the needs of the whole family and is signed and dated by the client. This package includes a wide range of services to help people overcome their problems (such as personal counselling, relapse prevention, detox or help with accessing other services, such as housing associations or health clinics). The team in Cambridge provides services that not only deal with the causes of their addiction but also help with the effects, through advocacy in meetings with the social services and help back into the workforce, among others.[51] *In Cumbria there is a more focused multi-agency response, where clients work with schools, carers and nurses.*[52]

Bristol Drugs Project

Bristol Drugs Project is an independent agency delivering accessible and confidential information, advice and counselling services to drug misusers, their relatives and friends, and to other professionals working with drug misusers. They also provide a Family Support Service that provides

support with drug or alcohol misuse for parents, as well as support for parenting in general including a women's drop-in, support for fathers and a mentoring programme for 8–16-year-olds whose parents use drugs or alcohol problematically.[53]

Child & Adolescent Mental Health Service

The Child & Adolescent Mental Health Service (CAMHS) is a NHS-led service designed to support and help young people with emotional, behavioural and mental health difficulties and their families. Services include psychiatry, occupational therapy, clinical psychology, social worker interface, psychotherapy and counselling.

Overall, feedback on interventions varied widely among the families we interviewed. One participant (36) remarked that a possible reason why treatment so often fails is because practitioners are looking for a single solution for all alcoholics, whereas there are many different types of harmful drinking. For example, some people found the shared experience of group therapy positive, while for others the stress of speaking in public can trigger an impulse to drink. Some benefit from the tight community and lifelong fellowship of Alcoholics Anonymous, while others find its methods inflexible and unhelpful.

Only a few people in our sample self referred to the alcohol support services they were receiving. According to frontline workers, it often takes 'external triggers' (e.g., incidents involving police, social services or schools), health concerns or pregnancy for health care specialists or alcohol support services to get involved. Some people veer away from seeking official help because of the possible consequences: children could be taken into social services, or professionals could lose their licence to practise. 'A lot of middle class people will move heaven and earth to avoid treatment' because of medical records, which makes it hard to get work, said one mother (36).

The most commonly cited route into help was through a GP; even if many people also said GPs either have little time or a

lack of understanding of alcohol difficulties. Another common route is via social services. Some were pressed into seeking help by other family members.

Demos' research suggests that people often remembered the individuals they worked with, rather than the service, noting for example that 'Sue helped here', rather than 'Addaction helped'. Alcohol misusers and their families often appreciated most the help they were given with matters not directly related to the alcohol itself, but with problems associated with it: violence, debt, mental health issues and so on. People also concentrated on specific actions, and whether these were helpful or unhelpful, rather than specific programmes.

Good support is most importantly non judgmental, consistent and stable. Practical solutions are appreciated most, followed by understanding and friendship – someone to talk to. A key aspect of well-appreciated support is having 'someone to talk to, day or night' (3). Given the high degree of worklessness, and the fact that boredom is often cited as a reason to drink, giving people 'something to do' (48) is also important – from practical help towards finding a job such as computer classes, to stress relief like reflexology or yoga. For some, being able to access support services from home was important because of the need for childcare, lack of a car and poor public transport networks.

Unfortunately, such help appears to be rare and the route towards it is often littered with stressful and unsuccessful attempts to address the problem. Many people said it is difficult to access appropriate support when they are struggling, and the system only kicks in when the situation is desperate. One single mother (11) described dressing in a suit to see the council when she was homeless, and feeling that she had hurt her chances because she dressed smartly. Another (45) described being told that if she split up with her violent partner she would not be entitled to a new family home. That changed after she was so badly beaten up the council worker didn't recognise her. One single mother (31), who has managed to control her drinking and now has a part-time job, says she has

never had anything that's properly helped us… We are always in the middle of things and people don't know where to put us. They only come when the police or social services get called or in hospital.

Some spoke of finding the courage to address their problems, only to find there is a long waiting list to get help. Other problems include transport costs to meetings (particularly in rural areas), discomfort in group meetings, lack of childcare, and lack of follow-up care.

A major issue for people on the cusp of recovery was the lack of help, for example with mental health issues, for people still drinking: 'The councillor won't see you while you're drinking; it's a vicious circle: no one will see you because you're drinking but you're drinking because you need help.' (17)

Social services were criticised by many of the parents we interviewed. This is unsurprising given their role, which is focused on protecting children rather than supporting the alcoholic. Common complaints included being judgemental, ignorant of alcohol-related problems or unprofessional (not turning up for meetings or cancelling at the last minute). In some areas, there appears to be a high turnover of personnel, which leaves a lack of depth of understanding of the problems and little opportunity to build a relationship of trust. Some of this may be related to the high number of clients assigned to each social worker. As one frontline worker reported to us, the average caseload for one of their workers was below ten while social workers were expected to manage caseloads of 40. Many people said once they had fallen foul of social services, it is very difficult to get them back onside, causing much family trauma:

Once they're in you can't get them out, can you? They judge you on everything. They won't listen to a word you say. They've got their own mind on things and that's that. They make you feel like a nobody, a shit mother. I went to the doctor [who then referred her to social services] for help because I was depressed and they just made the situation a hundred times worse. (17)

Some complained that social workers either lack experience or default to harsh outcomes for fear of making mistakes: 'People

are just ticking boxes these days. They are not allowed to use their own judgement because if the slightest thing goes wrong, they are looking after their own backs' (11). One mother (36) said that if she 'hadn't been a middle-class mother with a fair amount of education behind me' she 'wouldn't have fancied [her] chances' of getting her son back after he was taken into care: 'They got me so terrified about what they could do if I didn't behave.'

There was some criticism of counselling services, which addressed 'silly issues' (28) rather than the practical concerns that are uppermost in people's minds when they first start seeking help. Others found it somewhat of a game: 'I saw every psychiatrist, psychologist, counsellor from here to Timbuktu. None worked because I would always know what they wanted to hear,' said one person (13).

Residential detox received a mixed response, with many appreciating the experience but failing to remain abstinent. One mother (30) said she enjoyed the respite, but it didn't address the underlying problems: 'I love it in there,' she said. There is 'nothing to worry about. But then I come out and nothing has changed.' Whether family needs are addressed depends on the services available in their area, and the funding criteria attached to those services.

The most common support for children came in the form of mentors or specialist help at school. Some attended sessions intended for young carers, or saw psychologists. Many of the children were not able to express fully how these interventions had helped, because of their age. Some said it was nice to have someone to talk to and some liked meeting children experiencing similar difficulties. Many enjoyed getting out of the house and trying new activities, some of which are designed to relieve the stress of being a young carer or just to open up new horizons. However, some said there is a stigma attached to services such as CAMHS, so some children reject it. Aware of this, some professionals claim to be aunts or other relatives, but in tight communities this deception may be difficult. Some parents complained that services stop in the school holidays.

Many children were unaware that external help is available for them. A few mentioned the telephone helpline service Childline as being widely advertised, but they did not call for various reasons. One grown-up daughter (26) said because her parent was a functioning drunk and the family was not destitute, it felt overly dramatic to seek help. Another (19) said she was trying to deny there was a problem. She also said she did not speak to the school about her mother's alcohol problems because she had seen what happened to her cousin and she thought going into care would have been a worse outcome: 'I didn't want to leave my Mum.'

One troubled teenager (31), who is sometimes violent towards his mother, had a mentor for a year. He says it was 'OK' but the mentor is the 'opposite person to me', so he got bored. The mentor took him to play golf, which was 'quite fun'. But they only have £50 a month to do things, so 'if you wanted to do one good thing, then we have to do crappy things' for the rest of the month.

Another teenager (43) described the help he used to get through the local council's young people's service: 'I used to ask him anything. He grew up in the same area. He wasn't stupid. He were like an older brother.' Funding stopped last year, so there was no more boxing, canoeing, go-karting and so on. Since then, activities without the mentor include 'crawling around the park, drinking, smash a window or a car', and the boy has got into trouble with police – to his surprise, 'I didn't know it was a crime because no one told me it was wrong. I just thought it was a laugh.'

Family-based intervention can bring families closer together by improving communication and making parents aware of the impact they are having on their children: '[Through participating on the programme] I have got to know what the kids think about my drinking,' said one mother (41). 'Before coming here I felt like my kids were strangers.'

A real motivation for many to address their alcohol difficulties was facing up to their parental responsibilities. One mother (27) described regaining the trust of her son so she could

help look after her grandson as being 'a big step' and one of her goals. Another (8) describes having to be sober to look after her grand-daughter, or risk her being taken into care, as the catalyst for addressing and overcoming her problem. 'If I lost my kids there would be nothing left for me,' said one mother (45).

The shock of discovering his son was feeling like he had done growing up was enough to make one of our interviewees (42) stop drinking: 'In family meetings [my son] said he felt lonely and isolated, and that is exactly what I felt when I was a kid.' That night was the last time he had a drink, four years ago.

Conclusion: policy recommendations

Reducing parental alcohol misuse must be a priority for policy makers and those in the alcohol industry. It is critical to reduce the harms suffered by families and children. It is also critical to help parents be better parents, which our research suggests could be one of the most effective ways of minimising the number of people who are 'hazardous' or 'harmful' drinkers – both now and in the future.

Our policy recommendations are aimed at a wide range of stakeholders. National government has a role to play in setting the right priorities and levels of funding. New local public health boards and local authorities will be responsible for allocating local area public health budgets, including information campaigns in local GP surgeries and commissioning more intensive family intervention projects for those 'at risk'. There is also a significant role for the alcohol industry, which has a motivation to minimise the harms caused by alcohol by targeting those who drink hazardously. Perhaps most importantly, we speak directly to all parents in the hope that our research will help them understand the impact of their behaviour and modify it if necessary.

While our overarching theme is to help all parents be better parents we do not advocate doing so in an overly patronising way. It is difficult enough being a parent, even when the stresses of daily life are relatively light. For families struggling with mental health issues, debt, lack of self-confidence, children getting into trouble with police, worklessness and a whole host of other issues, the very last thing they need is someone telling them they are a bad parent.

However, approached in a positive way, many parents welcome support that improves their parenting style. Often this simply involves explaining to parents that parenting style and

consumption of alcohol have an impact on their children's drinking behaviour; sometimes it requires more frequent but light-touch interventions, such as encouraging children to speak about their feelings or confronting parents with the impact of their behaviour and levels of alcohol consumption through identification and brief advice (IBA). For some families who have extensive and complex problems, which include 'harmful' drinking, more intensive 'whole family'-based support is required, including parenting classes and workshops.

In the preceding chapters we presented our research showing that the frequency of drinking by parents – particularly mothers – as perceived by their children is correlated with the decreased likelihood of being a 'tough love' or effective parent. This provides further evidence to previous research suggesting that parental drinking habits do have an impact on their children's drinking habits when they are adults. However, it is not enough for parents simply to wait until after the kids are in bed to open the bottle; as our interviews with families suggest, children are more aware than they often are given credit for. Nor does this mean that parents can never drink in the presence of their children. But it does mean that parents should bear in mind how frequently they are drinking – particularly in front of their children.

Efforts to reach the families in the middle need to be stepped up through information campaigns aimed directly at parents, and by training service providers to identify problems better and provide brief guidance. Parents need to recognise and understand that their parenting style has an impact on whether their children drink excessively as teenagers and as adults.

Too many children in the UK are growing up with a parent who misuses alcohol but are overlooked by services often because harmful drinking is easier to disguise or ignore than drug problems. Some families collude to hide the problem for fear of social stigma or because the involvement of social services could potentially lead to children being taken into care. Many more may not be aware of the help on offer or how to access it: as one recovering alcoholic (44) put it, 'The only AA I knew existed was the breakdown cover.'

Target information and awareness campaigns at parents

Given the evidence, parents need to be better informed about the impact their drinking can have on their parenting ability and their children's habits. They should also be aware of how parenting styles in general can influence whether their children drink excessively when they are teenagers and adults.

In the early years (ages 0–5), the most important element of parenting is the warmth and affection that a parent gives to their child; at 10 years old, and until the age of 16, the most important aspect of parenting becomes the consistent enforcement of discipline. While this might come naturally or seem like commonsense to many parents, the explicit evidence-based connection between parenting and child's outcomes is less well known. Making the connection more explicit will hopefully spur parents on to improve their parenting styles, ultimately helping children.

There are a number of organisations and websites that provide advice to the public about alcohol consumption, such as NHS Choices, Alcohol Concern, Family Lives and Netmums. Yet, with the notable exception of the alcohol awareness charity Drinkaware, there are few advertising campaigns that target parents specifically about their own alcohol consumption and the impact that parenting in general may have on their children's alcohol consumption. Government and industry awareness advertising tends to focus on unit labelling campaigns, which target current drinkers and the harms they may experience themselves. For example, while there is some focus on familial engagement, the Coalition Government's Change4Life campaign of 'unaware' drinking is mainly geared towards individual adults.[54]

Drinkaware, on the other hand, provides support and advice to parents on how to talk to their children about alcohol on its website.[55] This is an example of a message to parents from Drinkaware's campaign:

Don't feel hypocritical for drinking when you have told them they can't. Instead, explain that alcohol is only for adults because their bodies have finished growing, and even adults have rules about how much they can drink.

Drinkaware's advice to parents is the correct approach and should be continued. However, leading companies in the alcohol industry should do more to coordinate and spearhead information awareness campaigns aimed at parents. They could do this through a national level campaign and targeted local area campaigns in the UK or at the European level through the EU Alcohol and Health Forum.

The EU Alcohol and Health Forum

While our research in this report and in *Under the Influence* was based exclusively in the UK, it is likely that parenting and parental alcohol consumption have similar impacts across European countries. However, further research is needed in this area to help determine the scale and impact of parental alcohol misuse – particularly among new EU member states in East and Central Europe.

Through the EU Alcohol and Health Forum, industry companies make commitments to contributing towards social awareness and mitigating health harms related to alcohol consumption. This research report was part of SAB Miller's commitment to the EU Alcohol and Health Forum. Industry companies are now working together through the EU Alcohol and Health Forum to target underage drinking. However, at present there are no initiatives aimed at parents in particular. Demos' research suggests that focusing on parenting can reduce problematic alcohol consumption overall, including underage drinking. Moreover, the findings of our research could be used to shape responsible consumer communications at the EU level.

The Public Health Responsibility Deal

As noted above, the Drinkaware website includes advice to parents about their alcohol consumption and how to speak to their children about alcohol. However, more needs to be done, particularly in areas of the UK that have high levels of parental alcohol misuse and alcohol-related harms.

On the back of this research, alcohol industry representatives should support and pledge to fund and/or lead targeted information campaigns aimed at parents in local areas that are particularly in need.

The Public Health Responsibility Deal could provide an obvious and effective avenue for industry companies to commit to this type of initiative and campaign. The more companies within the alcohol industry commit to such information campaigns, the more effectively will these messages spread through society and have a beneficial impact on reducing parental alcohol misuse.

Delivery of these information campaigns requires extensive local partnerships, including new local health and wellbeing boards, local authorities, charities, schools and employers. Schools, parent–teacher associations and employers may all play a role at providing information to parents about effective parenting and alcohol consumption.

At a strategic level, in devising these campaigns and effective messages, advertising companies that have worked on behaviour change campaigns – including the Drinkaware campaign – should be brought in as stakeholders and consultants, alongside the Government's Behaviour Change Unit.

These information campaigns would provide a good opportunity to clarify advice to parents on how to speak to their children and teenagers about alcohol, as well as the best approach to allowing their teenagers to drink alcohol under parental supervision. Demos' research suggests that at the age of a teenager's typical initiation to alcohol (between 13 and 16 years old), consistent and strict discipline, combined with limiting the availability of alcohol to teenagers, is the best approach to ensure that children do not develop a hazardous relationship to alcohol. Information campaigns for parents should take a clear and unequivocal line on this point.

Identification and brief advice

In addition to information awareness campaigns, our research suggests that identification and brief advice could help to get

parents thinking about their alcohol consumption levels and modify their behaviour. As noted in *The Government's Alcohol Strategy*, IBA is a quick and simple intervention for those who drink above the guidelines but are not accessing alcohol support services. According to *The Government's Alcohol Strategy*, IBA 'has been proven to reduce drinking… at least one in eight at-risk drinkers reduce their drinking as a result of IBA'.[56] However, the *Alcohol Strategy* makes no mention of whether IBA includes specific advice to parents about the impact of parenting on their children's alcohol consumption, and the impact of their own alcohol consumption. IBA should include this information where the recipients are parents or have childcare responsibilities. Local health and wellbeing boards in local areas with high levels of parental alcohol misuse should especially prioritise the use of IBA with parents.

Emphasis and investment in early identification

Researchers and policy makers continue to stress the importance of early identification in order to improve child outcomes. Two major government reviews in the past two years have looked at the importance of early intervention: Graham Allen MP's *Early Intervention* and Frank Field MP's *The Foundation Years*.[57]

We now know that the type and quality of parenting in the first three to five years of a child's life are incredibly important in determining whether they experience good outcomes in health, educational attainment, employment and a variety of 'character skills'.[58] Demos research in *Under the Influence* suggests that this is also true for determining a child's relationship with alcohol when they are teenagers, and later in life as adults.[59]

First and foremost, parents – mothers in particular – must understand the impact that consuming alcohol can have while they are pregnant, and the risks of foetal alcohol syndrome. While the evidence around foetal alcohol syndrome remains contested, some research suggests that it can lead to poor brain development, for example of the prefrontal cortex, which can lead to diminished ability to process and deal with complex and emotional situations.[60] This heightens the risk of

intergenerational cycles of substance dependency, as children learn to deal with stress and difficult situations through self-medication – behaviour that is often learned by watching their parents. The risk of foetal alcohol syndrome is well known, and midwives and GPs are already trained to speak to expectant mothers about alcohol consumption. However, one keyworker who supports pregnant or young mothers who are drug and alcohol abusers said she suspects many alcohol problems pass under the radar because they are hard to spot, even by professionals. She notes that far more cases of drug abuse than alcohol abuse are referred to her, despite alcohol abuse being a more prevalent problem in the community.

Training for midwives and GPs to recognise parents who may be misusing alcohol and to advise them or refer them to services if needed should remain critical. This must be done in a sensitive manner that does not lead to demonising parents.

Given the frequency of contact, the midwife is a key contact point, with the potential of intervening before the child has been harmed. However, midwives should also focus on providing advice to parents – particularly mothers – about parenting and alcohol consumption in the years after their baby is born. For the most part, advice is limited to behaviour for the duration of the pregnancy. But there is no reason why midwives cannot provide advice about parenting style during the early years and its connection to their child's life outcomes.

For those towards the at-risk end of the spectrum, the intensive Family Nurse Partnership programme has demonstrated a range of positive outcomes in the USA. The Family Nurse Partnership programme targets young mothers from deprived communities that are perceived as being at risk. The programme entails working 1–1 and includes teaching and guidance on mothering skills. To reach families in the middle, a light-touch form of Family Nurse Partnerships could be developed for GPs and midwives trained to identify parents with an unhealthy relationship to alcohol. The Government's commitment to double the number of Family Nurse Partnerships in England and Wales suggests it recognises the potential these partnerships could have.

Another source of referrals to alcohol support services has come through Sure Start centres. Schools also have a role, and training should be given to teachers in identifying children who may be struggling with issues related to their parents' drinking and how to deal with them. However, evidence suggests that education programmes that are specifically about alcohol and drinking have little to no impact on decreasing the likelihood of children drinking hazardously later in life. Instead, the evidence suggests that education programmes that do not mention alcohol specifically, but are aimed at teaching 'life skills', do have an impact.[61]

Thus, education programmes aimed at improving alcohol outcomes should be evidence-led: industry and government should stop funding programmes that are not supported by evidence, and combine their efforts to support those that are. There are already efforts to do this currently being led through the Public Health Responsibility Deal.

Further to these general recommendations regarding information and early identification, more specific actions are required for 'at risk' families where alcohol problems are more entrenched and intermixed with a wide range of other problems, including mental health issues, experience of abuse, single parenthood and teenage parenthood, criminality and worklessness.

'At risk' families and family-based interventions

Our research with families and frontline workers of family-based alcohol programmes suggests there are three key aspects for good family-based support for parents with alcohol problems:

- consistent and trusting personal relationships between the key worker and the family
- tailored, personalised support based on the specific situation of the family
- ongoing support, even if this is light touch

In addition, we strongly recommend all alcohol support initiatives aimed at parents should emphasise parent–child engagement sessions so that the child's voice can be heard. A significant amount of literature and key documents, including the recent Children's Commissioner's report *Silent Voices*, highlight the importance of giving children a voice to help understand the impact that parental substance misuse has on them, and what types of support are desired.

Our research suggests that giving children a voice can help parents to recognise the impact of their behaviour and convince them of the need to seek help. When some parents who had taken part in family-based support discovered that their children were more aware of their drinking than they realised, and they understood the full impact it had on their children, they were able successfully to address some of their problems.

Focus on parenting

The majority of family-based intervention programmes that we analysed in our research included some element of instruction or classes on parenting styles and techniques. Often, families were assessed when they were referred to programmes and it was determined whether parenting classes should be offered and/or encouraged. Given the sensitivity and stigma attached to being a bad parent, there is a risk that this element of support may be under-delivered. However, given the evidence of the importance of parenting to children's outcomes, providers of family-based programmes should strongly prioritise and require the majority of service users to receive advice on parenting techniques. Consideration should be given to make this as non-judgemental as possible – for example, emphasising useful parenting 'advice' and 'techniques', as opposed to 'classes'. Communications around such programmes to parents and families should always include sufficient recognition of the stresses and difficulties of parenting, and the fact that all parents can improve their parenting abilities.

Support parents through an individually tailored service

Our research suggests that there are often a number of interrelated problems within families that suffer from a range of problems including 'harmful' drinking that need attention and practical solutions, such as debt help, childcare and dealing with social services. There is also often significant overlap and crossover between different services, with many offering the same thing. This duplication can be confusing and overwhelming to at-risk families and parents. Effective key workers can help to reduce the burden of this, as can support workers who are comfortable working in an ad hoc and reactive manner. Too much bureaucratic prescription is likely to have a negative impact on a key worker's ability to work effectively for a family.

As mentioned in the previous chapter, families and parents with alcohol problems were more likely to discuss support through individual personalities rather than organisations or programmes. A well-trained support worker who has a good and trusting relationship with the family was more important than the most rigorously evidenced support 'programme'. Clearly, the quality of the programme and the training is important, but the personal relationship must be considered first and foremost.

Related to the need for flexibility is the need to recognise that programme requirements for when support stops often do not make sense. For example, once a parent stops drinking then a support charity like Addaction cannot continue to see them, even if the stresses that led to drinking remain. In another example, Addaction workers have to stop seeing parents on the programme if their children are taken into care. While these programme requirements make sense on paper and in some situations, in other instances the sudden stopping of services could lead to a relapse and the cycle continuing once again. Light-touch support, even after a parent quits drinking – or, on the other end of the spectrum, has their children taken away – could help to ensure that parents stay on the right track.

In tight funding conditions, many local authorities may shy away from the expense of offering individually tailored help, particularly to families whose members are struggling, but not enough to draw attention (and funding from the 'troubled families' agenda). While the provision of individually tailored

help may be expensive, it is likely to be cheaper in the long term by reducing costs such as emergency hospital and other expenses related to intergenerational transmission of problems.[62]

Align other services and alcohol support services

The 'harmful' drinking of the parents whom we interviewed for this research were deeply connected with a wide range of other problems, including mental health issues, worklessness and boredom, loneliness and past traumatic experiences. In many instances, our research suggests that different services are not fully integrated in a way that produces the best outcomes.

Of particular note are mental health services. Many people we spoke to said that mental health services would refuse to engage with them unless they were completely sober, but many claimed it was mental health problems that were driving them to drink in the first case. Tackling mental health problems first and foremost, or at least at the same time as tackling alcohol misuse, must be a priority for policy change. Moreover, frontline workers argued that many in the mental health field were not adequately trained to understand and deal with alcohol misuse issues, which could lead to insensitive and inappropriate interactions and support. Because of the large number of people with alcohol problems, and the embeddedness of alcohol in British culture, knowledge about alcohol misuse should be equally embedded throughout relevant support services, including mental health support and welfare-to-work providers.

Another prevalent issue is the lack of employment. In many of the families that we interviewed, entrenched worklessness appeared to lead to a life filled with little purpose and few positive activities. Parents spent days sleeping, watching daytime television and drinking alcohol. Many suffered from agoraphobia and were confined to their homes.

This pattern of living, and lack of positive activities, structure and purpose appeared to make it significantly more difficult to break the pattern of harmful alcohol consumption. To be sure, there are many parents who hold down full-time jobs and yet still have significant problems with alcohol. But the

impact of worklessness and boredom appears to be a significant contributor to entrenched alcohol problems. Many recovering alcoholics spoke about the importance of filling the day with positive activities, and breaking the pattern of life they had adopted while drinking.

It is difficult to know which should come first: should an alcohol problem be tackled before taking up work, or can a job help to give purpose to those struggling with alcoholism? Clearly, this depends on the individual in question. For those with severe alcohol dependency, this dependency must be tackled first – though the introduction of some positive activities, such as volunteering, could be pursued. For others, going into employment would appear to provide the structure and motivation they need to help them also tackle the patterns of living that underline their alcohol abuse.

Alignment of children and adult's services is also recommended. One keyworker told us that it had been difficult to fund family support because it falls between children and adults services, neither of which feels fully responsible. Understanding the different needs within a family is also crucial. Those in some services we spoke to, used to dealing primarily with adults, had recently taken on support workers for children, or were investigating the possibility of doing so, to be able to help families as a whole.

A mechanism to connect with providers of private care is also needed. To avoid the risk of losing their licence to practise, some professionals prefer to pay for individual private care, where alcohol problems can be dealt with discreetly. Such services don't always come with monitoring of follow-up care or support for the family.

Also to note is the value of aligning alcohol services with prison services, as Action on Addication's M-PACT programme is doing. One of the families (27) we interviewed was introduced to the family-based support programme while the father was incarcerated. He signed up initially to see more of his family, but the benefits have been far greater. The whole family spoke of having a better understanding of each other, including the impact of the drug and alcohol abuse. This, together with

practical advice, such as teaching the importance of family time or addressing problems by writing them down, has helped the family cope with stresses such as the father coming out of prison: 'I miss M-PACT,' said the daughter; 'It's like a crutch, you're leaning on them,' said the mother.

Coordinate with those working on the 'troubled families' agenda

As mentioned in preceding chapters, the Coalition Government's 'troubled families' agenda is now the main 'home' for family-based interventions in England and Wales. The relationship between the 'troubled families' agenda, and ongoing family intervention partnerships (or FIPs) mentioned in *The Government's Alcohol Strategy*, is unclear. The 'troubled families' initiative is where the bulk of the money currently is and will be for the future. The impetus behind the 'troubled families' agenda could lead to the provision of personalised, effective support to those families and children who are most at need.

The 'troubled families' agenda is based on the idea of providing comprehensive, 'whole of family' support for those families with multiple problems that cost the state large amounts of money. While alcohol and drug misuse are 'third tier' criteria for identifying 'troubled families', it is likely that alcohol misuse will factor in many if not a majority of these families, alongside a range of other problems. In this respect the profile of 'troubled families' will be similar to that of the 50 families whom we interviewed for our research. Thus, the interventions provided as part of the 'troubled families' agenda should take into account the lessons discussed in this report, as well as the experience and expertise of charities and organisations providing family-based interventions across the UK. Those responsible for delivering the 'troubled families' agenda must work closely with local health and wellbeing boards, as well as charities already delivering family intervention projects to ensure efforts are properly joined up and coordinated. One final risk worth mentioning is the stigma that many families might feel by being described as a 'troubled' family or a 'neighbour from hell' as the Prime Minister has been quoted as saying. As seen in our interviews with

families, many have already experienced significant hardships, and already feel stigmatised as a result of their problem and contact with services. The success of the 'troubled families' agenda will require extensive partnership and cooperative working with charities already delivering family-based interventions, as well as efforts where possible to ensure that the initiative does not become stigmitised in the actual delivery.

Technical appendix

This report aimed to build on the research presented in the Demos report *Under the Influence*,[63] and further consider the impact of parental alcohol consumption on parenting styles and children's drinking levels at 16 and 34 years old.

In particular, we wanted to know:

1 How does parental alcohol consumption affect children's likelihood of drinking at hazardous levels as a teenager and then later in life as an adult?
2 How does parental alcohol consumption, especially at hazardous levels, affect parenting style and their children?
3 What support is most effective in helping families struggling with alcohol difficulties address their issues and be better parents?
4 What constitutes an effective family-based intervention, which prevents alcohol problems becoming inter-generational?

To explore these questions, we deployed a mixed methodology that included quantitative analysis of the Birth Cohort Study (BCS) as well as qualitative interviews with 50 families across the UK, where at least one parent is a hazardous or problematic drinker. Where possible, we interviewed multiple members of the same family, including children. In total we interviewed 89 individuals, including 26 children.

Below we discuss the methodological issues involved in the qualitative and quantitative analyses. For the section on the quantitative analysis, we reproduce some of the relevant details that are included in the technical appendix in the *Under the Influence* report for ease of reference.

Qualitative analysis

Given the family-oriented nature of our research we based our recruitment measure on the perception within a family about whether there is an alcohol problem, rather than on an objective measure of alcohol dependency. The recruitment method devised was therefore to use families who had been referred to or sought assistance from programmes provided by Addaction and Adfam, or their partners.

We interviewed 50 families and 89 individuals in 11 different locations across the UK in June, July, August and September 2012 (table 2). To protect their anonymity, families were referred to by number, from 1 to 50. Each family received a £50 Argos voucher to thank them for their time and contribution.

A key research objective was to better understand the impact on children of parental behaviour with respect to problematic drinking. As well as speaking to parents about their parenting skills, we also sought to interview young people when possible, paying careful attention to ethical issues. Parental agreement was sought in each case, and young children were interviewed in their presence. We also sought to involve partners, and in some cases parents or other family members. Schooling, work or other commitments often meant we were not able to reach our target of interviewing two or three members of each family. In less than half of the interviews (22 out of 50), only one person was present (always the person with the problem with alcohol).

In most cases, all members of a family were interviewed together rather than individually. This was mainly for practical reasons: in situations where families travelled to speak to us, the time constraints on interviewing each person individually would have been too onerous; where interviews took place in the family home, there were not always facilities for private interviews; and separate interviews were not always practical because parents had no provision for childcare. In some cases, the person with alcohol difficulties was in the early stages of seeking help or recovery and did not want their family involved because the problems had not been discussed.

As a result of this approach, necessary for practical reasons, some family members may not have felt completely free to talk

Table 2 **The number of families and individuals interviewed for this study, by location**

	Families	Individuals
Bristol	6	9
Bridgend (Wales)	1	3
Bury	6	13
Devon	4	6
Cambridge	7	8
Cumbria	10	16
Glasgow (Scotland)	6	10
London	6	14
Nelson	2	4
Surrey	1	3
Wiltshire	1	3
Total	50	89

about their experiences and there may be scope for follow-up research with individual family members.

In some cases interviewees talked about things they had never shared before. Sometimes they prefaced their comment, 'I don't want to be horrible' (27) or similar, and they would be encouraged to 'just be honest please' (38). Many children spoke up to contradict their parents.

It should also be noted in some but not all interviews a support worker was present in the room. That may have influenced what was said, but for the reasons mentioned in the previous chapter Demos feels the impact was limited.

We created an anonymised note-based transcript (as opposed to verbatim) of each interview, and separate researchers coded them in two separate processes to extract the key themes.

Quantitative analysis

In *Under the Influence*, we used two datasets: the BCS and the Avon Longitudinal Study of Parents and Children (ALSPAC). The ALSPAC dataset allowed us to analyse the impact of parenting style in the early years of a child's life and the child's

behaviour with respect to alcohol consumption as a teenager. While it would have been interesting to explore a link between parental alcohol consumption during the early years and parenting style, and children's drinking outcomes, we decided to forgo the ALSPAC dataset because of its restrictive terms of use. Thus, our quantitative analysis in this report is based solely on the BCS.

The Birth Cohort Study

The BCS began in 1970 when data were collected for 17,694 babies born in one week of the year from all across the UK.[64] The study asked questions relating to the health, education, social and economic circumstances of each child, or cohort member. It also obtained information on the parents, including parenting strategies and lifestyle choices. Since 1970, seven waves of follow-up data have been collected, though this study needs only to use information obtained from wave 3 (cohort member aged 10, in 1980), wave 4 (cohort member aged 16, in 1986) and wave 7 (cohort member aged 34, in 2004/05). This study had high response rates[65] over the 30+ years of following the cohort members, as 86.5 per cent of original participants were surveyed in wave 3, then 70.1 per cent in wave 4, and 58.3 per cent by wave 7. We used these data to answer questions 2 and 3 of those listed at the start of this appendix.

Variables

This section describes the three different types of variables that we used for the analysis.

- *Dependent or outcome variables.* As with *Under the Influence*, our main dependent variables for this research are the children's drinking levels at the ages of 16 and 34 years old. However, for this report, we use parenting style as a dependent variable of one of the analyses, exploring the impact of parenting alcohol consumption on parenting style.

- *Independent variables or regressors.* These include those aspects of the children's lives that we explored to discover if they have an effect on the outcome variable. In *Under the Influence*, the main regressors were the parenting styles used to raise the child at different ages (see below for more information on the parenting typologies). In this report, the main regressor is parental drinking behaviour at the age of 16.
- *Control variables or covariates.* Covariates account for all other things that may have an impact on the outcome variable. Controlling for these allows us to assess the effect of the regressor as close to independently as possible.

Dependent or outcome variables

Excessive drinking at age 16 and 34 for children

We used data from the BCS waves 4 and 7 as the outcome variables when determining the probability that a person will binge drink at ages 16 and 34, respectively. Specifically, we used the cohort members' self-reported number of units of alcohol drunk in the previous week as a direct measure for determining excessive drinking. In line with the Department of Health's definition, we considered a man to drink excessively if he drank over 21 units of alcohol in one week, and a woman to drink excessively if she drank over 14 units of alcohol per week. This outcome variable was naturally dichotomised, as we put respondents into two groups, binge drinkers and non binge drinkers, depending on whether the number of units of alcohol consumed in the previous week was above or below the government definition of excessive drinking for men and women.

Parenting style

While parenting style was our main independent variable in *Under the Influence*, here it serves as one of our dependent variables. In *Under the Influence*, we found evidence to suggest that parenting style has an impact on children's drinking behaviours in adolescence and adulthood. In this report we wanted to explore the impact of parental alcohol consumption on parenting style (and thus on children).

We used the same indicators and questions from the BCS as we had used in *Under the Influence* in order to construct the four parenting styles. We determined the level of warmth between the teen and parents through an index of measures, coded with low value responses indicating a lack of warmth, and high values representing more closeness and warmth between the teen and parents. Questions in the warmth index include how often the teen ate a meal at home with their parents; whether they felt their parents were loving and caring; if they felt they could talk to their parents; how often they did fun things with their parents; and the teens' feelings about living with their parents.

We also created the index of rules using measures answered by the teen about their parents, and included questions about how strict are the parents with them; whether the parents ask who the teen is going out with; whether the parents ask where they are going; how the parents would feel if they saw the teen smoke; and if the parents would be upset if the teen was caught shoplifting an item worth less than £10.

Parenting typologies

Using the indices of parental warmth and rules created for the three age groups of the children, we derived parenting style 'typologies'. These separate the full range of parenting styles into four categories, or 'quadrants', based on the scores of the warmth and rules indices at a given time. The four quadrants are made up of parents who are 'above average' or 'below average' in various combinations of the parenting style measures. The four categories are:

- 'tough love' – high rule enforcement, high warmth
- authoritarian – high rule enforcement, low warmth
- laissez-faire – low rule enforcement, high warmth
- disengaged – low rule enforcement, low warmth

Table 3 shows the indices we used to identify parental warmth and rule-setting.

Table 3 **The warmth and rules indices used to identify parental warmth and rule setting when child is 16 years old**

Warmth indices
Measures in index:

1 I do outdoor recreations with my parents
   - Rarely or never, Sometimes, Often
2 I sit down and eat a meal at home with my parents
   - Rarely or never, Sometimes, Often
3 My parents are understanding, I can talk to them
   - Rarely or never, Sometimes, Often
4 My parents are loving/caring/look after me
   - Not at all, Not very much, Quite a lot
5 My parents are helpful/good in a crisis
   - Not at all, Not very much, Quite a lot
6 I do things with both parents together
   - Rarely or never, Sometimes, Often
7 My feelings about living with my parents
   - Somewhat unhappy, Happy, Very happy

Rules indices
Measures in index:

1 How strict are your parents with you?
   - Not at all, Not very much, Quite a lot
2 Do parents ask who you are going out with?
   - Rarely or never, Sometimes, Often
3 Do parents ask where are you going?
   - Rarely or never, Sometimes, Often
4 Would your parents be upset if you were caught shoplifting something under £10?
   - Not at all, Not very much, Quite a lot
5 In the past 4 weeks I have had drinks with my parents' knowledge
   - Often, Sometimes, Never
6 My parents are overprotective
   - No, Sometimes, Yes
7 How would your parents feel if they saw you smoking?
   - Somewhat happy, Unhappy, Very unhappy

Although these categories are given titles instead of maintaining their true numerical values, thereby appearing to be nominal or 'categorical' variables much like race or gender, they are not. In actuality, these are numerically ordinal variables, much like ages grouped into categories, or income put into brackets. We created the parenting typologies using numerical

scores on indices, and therefore the units they comprise are numerical and have specific values. Moreover, as we defined each typology using the 'top' or 'bottom' quadrant of the two indices from which they are derived, they are all evenly sized and spaced. Analogously, income is an obvious numerical value, and levels may be grouped to appear as categories. The categories may be defined with even sizes, such as the top and bottom 33rd percentiles. Even if different numbers of people fall into each category, they are evenly sized by definition, and spaced equally.

Independent variables or regressors

Our main regressor in this report was parental drinking behaviour. The measure of parental drinking behaviour is based on BCS wave 4 when the parent's child was 16 years old. Specifically, we chose an indicator based on the perception of the 16-year-old regarding how much or how often their parent (separate questions for fathers and mothers) drank alcohol, with the answer choices 'never', 'often', 'sometimes' and 'always'. While there may be concerns about how a child's perception matches the reality of parental drinking behaviour in measurements of unit consumption, it was felt that it is a particularly useful measure because it highlights the link between the child's perceptions and then their own drinking behaviour.

Control variables

We included several control variables on the children, their parents and background factors from childhood and/or adulthood in the models. The purpose of a control variable is to account for variance in the outcome that may not be due to the independent variables, which in this case is parenting style. Therefore we coded all available measures on the child's background, family and adult life status for inclusion when applicable and available.

We used the following variables as controls in the analyses, as they are factors on the cohort members that may relate to future drinking behaviours:

- child's gender
- child's ethnicity
- child's religion
- father employment
- mother employment
- family income
- mother ethnicity
- father ethnicity

Missing data

For both datasets, we only included cases where 70 per cent or more of the questions with which we built our parenting typologies were included. If a case had a smaller proportion than this we excluded it because of the bias it could cause. Reliability tests were run to check if there were non-random or systematic missing data, and if the missing cases were somehow related and could alter the outcomes. While 70 per cent is not a good retention rate, it is worth noting that the missing 30 per cent is very likely to include the most troubled individuals suffering from drug and alcohol addiction, homelessness or criminality as these are the most likely group to drop out or lose touch with the study. Therefore, it is likely that the inclusion of the missing 30 per cent would actually strengthen and amplify our findings.

The results

The effect of parental drinking behaviour on parenting style when the child is 16 (BCS wave 3, 1986)

To explore this question we ran four logistic regression models for each parenting type, 'tough love', 'laissez-faire', 'authoritarian' and 'disengaged'.

The analyses showed connections between parental drinking behaviour and the likelihood of being either a 'tough love' parent or a 'laissez-faire' parent. There were no statistically significant correlations between drinking behaviour and the likelihood of being either an 'authoritarian' or a 'disengaged' parent.

'Tough love' parenting

The strongest effect was seen with respect to being a 'tough love' parent. The analysis reveals that the odds of having a 'tough love' parenting style when children are aged 16 decreases by 26 per cent for every increase in how much the father drinks when the child is age 16 ($p = .037$), and 38 per cent for every category increase in how much the mother drinks when the child is 16 ($p = .003$), when controlling for a variety of demographic factors, including the teenager's sex, ethnicity and religion, and the parents' ethnicities and employment, and the family income. Put differently, the odds of being 'tough love' parents decrease exponentially by 26 per cent for fathers, and 38 per cent for mothers, every time the drinking behaviour changes from 'never' to 'sometimes', 'sometimes' to 'often', and 'often' to 'always'. Thus there is a reduced likelihood for parents having a 'tough love' parenting style depending on their level of drinking, even when all other things are held constant.

The only stronger predictor of whether parents exhibit the 'tough love' parenting style is the gender of the teenager. If the child is female the odds of parents having a 'tough love' parenting style are 1.73 times greater than if the child is male, when controlling for all other factors ($p = .012$). This is a 73 per cent increase in likelihood for girls to have 'tough love' parents than for boys in the exact same circumstances.

The model is statistically significant in its entirety, at a $p=.0001$ level (table 4).

'Laissez-faire' parenting

The odds of parents having a 'laissez-faire' parenting style when their children are aged 16 cannot be reliably predicted based on the amount that the father drinks ($p = .662$), but the odds of the parents being part of this style increase by 1.47 times for each category increase in how much the mother drinks when the child is age 16, when controlling for all other factors ($p = .013$). This indicates that the likelihood of parents having a 'laissez-faire' parenting style increases exponentially by 47 per cent every time the drinking behaviour of mothers goes from 'never' to 'sometimes', with the same jump between 'sometimes' and 'often', and 'often' and 'always'. There is a 4.66 times increase in

Table 4 **Model of the 'tough love' parenting style**

logistic tough16 fatdrk16 momdrk16 CMsex CMethnic CMchildrelig fatemply16 CMmometh CMfateth momemply16 faminc16

Logistic regression — Number of obs = 604
LR chi2(10) = 61.73
Prob > chi2 = 0.0000
Log likelihood = -297.35266 — Pseudo R2 = 0.0940

tough16	Odds Ratio	Std. Err.	z	P > |z|	[95% Conf.	Interval]
fatdrk16	.7432659	.1059697	-2.08	0.037	.562064	.9828849
momdrk16	.6199407	.0998749	-2.97	0.003	.452083	.8501236
CMsex	1.738455	.3820221	2.52	0.012	1.130091	2.67432
CMethnic	1.0527	.0787728	0.69	0.492	.9090964	1.218988
CMchildrelig	.8906031	.0279864	-3.69	0.000	.8374057	.9471799
fatemply16	.8787473	.0598811	-1.90	0.058	.7688825	1.00431
CMmometh	1.008715	.171032	0.05	0.959	.7235086	1.40635
CMfateth	1.026623	.1610844	0.17	0.867	.7548338	1.396273
momemply16	1.000812	.001128	0.72	0.471	.9986037	1.003025
aminc16	1.094585	.0495718	2.00	0.046	1.001613	1.196186

the odds of a mother having a 'laissez-faire' parenting style between those mothers who drink 'never' and those drink 'always' (table 5).

OLS regression

We also produced a model that includes all parenting styles as one outcome variable, with the father and mother's drinking behaviours as independent predictors and controls. This model is significant (p = .0001), though the father's drinking behaviour itself is not a significant predictor of parents' parenting type. The mother's drinking behaviour is significant, with a coefficient of .222 (p = .001). This coefficient is positive, indicating that as the mother's drinking increases, the parenting style 'increases'. The parenting styles are arranged from 'tough love' (1) to 'disengaged' (4). This shows that for every increase category of the mother's drinking, the parenting style increases by .222. This

Table 5 **Model of the 'laissez-faire' parenting style**

logistic lais16 fatdrk16 momdrk16 CMsex CMethnic CMchildrelig fatemply16 CMmometh CMfateth momemply16 faminc16

Logistic regression — Number of obs = 604
LR chi2(10) = 24.29
Prob > chi2 = 0.0069
Log likelihood = -286.17496 — Pseudo R2 = 0.0407

lais16	Odds Ratio	Std. Err.	z	P>|z|	[95% Conf.	Interval]
fatdrk16	.9359649	.1417101	-0.44	0.662	.6956377	1.25932
momdrk16	1.474523	.2296175	2.49	0.013	1.086675	2.000799
CMsex	.5270479	.1119313	-3.02	0.003	.3475977	.7991407
CMethnic	1.014764	.0875365	0.17	0.865	.8569148	1.201689
CMchildrelig	1.008702	.0308781	0.28	0.777	.9499614	1.071074
fatemply16	.9227761	.0606098	-1.22	0.221	.8113116	1.049554
CMmometh	1.301072	.237665	1.44	0.150	.9095227	1.861183
CMfateth	.7812035	.1530222	-1.26	0.207	.5321459	1.146826
momemply16	.9993684	.0013196	-0.48	0.632	.9967854	1.001958
faminc16	1.013257	.0457343	0.29	0.770	.9274699	1.106979

is a small coefficient, though it is the strongest significant predictor in the model next to the child's gender. In this case, the coefficient for the child's gender is –.395, showing that when the gender of the child is female rather than male, the parenting style 'decreases' (p = .000). In other words, girls are significantly more likely to have 'tough love' or 'authoritarian' parents, while boys are more likely to have 'laissez-faire' or 'disengaged' parents. Child's religion and family income were also significant predictors in the model, but as both coefficients were extremely close to zero, they have a negligible individual impact on parenting style.

Table 6 **Parent drinking in 1986 (child age 16) on child drinking in 1986 (child age 16) with standard controls**

logistic drkwk16all fatdrk16 momdrk16 CMsex CMrace CMchildrelig fatemply16 momemply16 faminc16 CMmometh CMfateth

Logistic regression — Number of obs = 1198
LR chi2(10) = 20.28
Prob > chi2 = 0.0267
Log likelihood = -294.07988 — Pseudo R2 = 0.0333

drkwk16all	Odds Ratio	Std. Err.	z	P>|z|	[95% Conf.	Interval]
fatdrk16	.9359649	.1417101	-0.44	0.662	.6956377	1.25932
fatdrk16	1.298109	.2097727	1.61	0.106	.9457104	1.781821
momdrk16	1.392286	.2412419	1.91	0.056	.991381	1.955314
CMsex	.7677465	.1777364	-1.14	0.254	.4877096	1.208577
CMrace	1.154452	.2475894	0.67	0.503	.7582686	1.757635
CMchildrelig	1.043696	.0345423	1.29	0.196	.9781436	1.113642
fatemply16	1.116498	.0656842	1.87	0.061	.9949044	1.252953
momemply16	1.000099	.001467	0.07	0.946	.997228	1.002979
faminc16	1.015731	.0492016	0.32	0.747	.9237342	1.116891
CMmometh	.8092333	.4051956	-0.42	0.672	.3032941	2.159154
CMfateth	.7188221	.3190738	-0.74	0.457	.3011525	1.715759

The effect of parental drinking behaviour during adolescence (16 years old) on the children's drinking behaviour at the ages of 16 and 34 years old

Parent drinking in 1986 (child age 16) on child drinking in 1986 (child age 16)

The odds of children being binge drinkers when they are aged 16 increases by 1.39 times for every category increase in how much the mother drinks when the child is age 16, when controlling for all other factors (p = .056) (table 6). But it should be noted that this variable is barely reaching statistical significance (generally p = .05 is the cutoff), and the father's drinking did not reach significance.

While there was no significant influence of the father's drinking behaviour on the teen's drinking in the regression analyses, a contingency analysis was also conducted to evaluate this relationship. Results show a significant relationship exists

Table 7 **Parent drinking in 1986 (child age 16) on child drinking in 1986 (child age 16) with social and peer influence controls added**

logistic drkwk16all fatdrk16 momdrk16 gfbfdrk16 bffdrk16 CMsex CMethnic CMchildrelig fatemply16 momemply16 faminc16 CMmometh CMfateth

Logistic regression — Number of obs = 694
LR chi2(12) = 42.10
Prob > chi2 = 0.0000
Log likelihood = -183.16502 — Pseudo R2 = 0.1031

drkwk16all	Odds Ratio	Std. Err.	z	P>|z|	[95% Conf.	Interval]
fatdrk16	1.197751	.2430367	0.89	0.374	.8047267	1.782726
momdrk16	1.140801	.2481055	0.61	0.545	.7448825	1.747159
gfbfdrk16	1.878929	.3781751	3.13	0.002	1.266449	2.787617
bffdrk16	1.745784	.4138689	2.35	0.019	1.096978	2.778323
CMsex	.5926769	.1854421	-1.67	0.095	.3209862	1.094333
CMethnic	1.210276	.2568166	0.90	0.368	.7984769	1.834453
CMchildrelig	1.091619	.0450734	2.12	0.034	1.006756	1.183634
fatemply16	1.107614	.0804055	1.41	0.159	.9607199	1.276968
momemply16	1.000361	.0017026	0.21	0.832	.9970294	1.003704
faminc16	1.035105	.0608734	0.59	0.557	.9224143	1.161562
CMmometh	.7778321	.4520956	-0.43	0.666	.2489695	2.430108
CMfateth	.6853527	.2551152	-1.01	0.310	.3304178	1.421559

($\chi 2 = 12.63$, df = 3, p= . 005), where 2.7 per cent of teens with fathers who did not drink at all were binge drinking, and 9.6 per cent of those who had fathers who drank always were binge drinking at age 16. While this relationship was not strong enough to emerge as significant in the regressions, it is possible that the father's drinking behaviour has a slight influence as a risk or protective factor to their child's drinking at age 16.

When social and peer influence controls are added to the logistic regression model, the significance of the parents' drinking behaviour drops below significance at this age group (table 7). Instead, the drinking behaviour of the teen's girlfriend or boyfriend has the strongest impact on the teen's likelihood of being a binge drinker. Specifically, the odds of the cohort member being a binge drinker when they are aged 16 increases by 1.87 times for every category increase in how much their

girlfriend or boyfriend drinks, when controlling for all other factors (p = .002). This results in a 12.2 increased odds of a teen being a binge drinker if their boyfriend or girlfriend drinks always, compared with if they never drink.

A contingency analysis indicates that the relationship between the drinking behaviour of cohort members at age 16 and their mother drinking is also statistically significant ($\chi 2 = 17.87$, df = 3, p = .0001), though it is weaker than the relationship between the cohort members and their peers. In this case, approximately 4 per cent of teens with mothers who did not drink at all were binge drinking, and 11.5 per cent of those who had mothers who drank always were binge drinking at age 16. While this is not as strong a relationship as those previously examined, it does support the fact that a mother's drinking behaviour may serve as a protective or risk factor to binge drinking of the teenage child.

Parent drinking in 1986 (child age 16) on child drinking in 2004/05 (child age 34)

The odds of cohort members becoming binge drinkers when they are aged 34 is significantly impacted by the amount that the mother drinks when the child was aged 16 years old, as the odds of becoming a binge drinker rise by 1.31 times for every category increase in how much the mother drank when the child was 16, when controlling for all other factors (p = .008). The drinking behaviour of the fathers were just outside of statistical significance, at p = .066, on the logistic regression model.

However, a further contingency analysis suggests that the relationship between the drinking of the cohort members at age 34 and their father's drinking behaviour when they were 16 is statistically significant ($\chi 2 = 49.52$, df = 3, p = .0001), with a visible difference between those who binge drink at 34 with a father who did, and did not, drink when the child was 16. Specifically, just 9 per cent of cohort members who have a father who never drink when they were 16 are binge drinkers, while nearly 24 per cent of cohort members with a father who always drank when the child was 16 are now binge drinkers at age 34. From this analysis, it appears that the drinking behaviour of the

cohort member's father is a significant risk or protective factor to binge drinking at age 34.

Similarly, a further contingency analysis demonstrates that the relationship between the drinking of the cohort members at age 34 and their mother's drinking behaviour when they were 16 is statistically significant ($\chi 2=63.94$, df=3, p=.0001), with a large difference between those who binge drink at 34 with a mother who did or did not drink when the child was 16. Approximately 10 per cent of cohort members who have a mother who never drank when they were 16 are now binge drinkers, while over 30 per cent of cohort members with a mother who always drank when they were 16 are now binge drinkers at age 34. From this analysis, it appears that the drinking behaviour of the cohort member's mother is the most significant risk, or protective, factor to binge drinking at age 34.

Other factors include:

- *Gender*: Unlike at age 16, when gender had no impact on the likelihood of being a binge drinker, at age 34 the gender of the cohort member is a strong and significant predictor of binge drinking. Specifically, women are 63.8 per cent less likely to be binge drinkers than men in the exact same circumstances (p = .0001).
- *Ethnicity*: The ethnicity of the cohort member's mother also came into significance in this model, with those who had mothers of non-British ethnicities 47.7 per cent less likely to be binge drinkers at age 34 than those with British mothers (p = .049).
- *Employment*: Those who are employed in some form are 14.3 per cent less likely to binge drink than those who are unemployed (p = .019).
- *Having children*: Those with a child are 11 per cent less likely to binge drink than those with no children. These odds exponentially decrease with every subsequent child the cohort member has, further lessening the risk of binge drinking for every additional child he or she has.

The model is statistically significant in its entirety, at a p = .0001 level.

What are the key protective factors between parents' drinking behaviour, and offspring drinking?

Protective factors at age 16

The only significant protective factor at age 16 was the religion of the cohort member, though this was very weak. To examine this relationship further, and potentially identify a specific religion that protects against binge drinking at age 16, we conducted a contingency analysis. Results indicate there is no significant relationship between specific religions and binge drinking at age 16, suggesting further controls may be necessary for the impact of religion to be isolated as in the regression model.

As social influences are most likely to influence drinking behaviours at age 16 and interfere with the impact of other factors on binge drinking, the relationship between religion and binge drinking is examined at an older age to better evaluate religion's effectiveness as a protective factor. A contingency analysis of religion at age 34 and drinking at age 34 indicates there is a significant relationship between the two ($\chi^2 = 68.84$, df = 6, p = .0001). Results of this analysis show that the majority of religions serve as a protective factor against drinking, with 88 per cent to 100 per cent of cohort members participating in the religions not binge drinking. These religions include Christianity (88 per cent non-binge), Hinduism (93.7 per cent non-binge), Judaism (100 per cent non-binge) and Islam (98.9 per cent non-binge).

Buddhists had the highest rate of binge drinking among the major religions, with 26.7 per cent of Buddhists being binge drinkers at age 34. Sikhs had the second highest rate of binge drinking among followers, with 20 per cent being binge drinkers at age 34. Over 17 per cent of members of other religions and 19.8 per cent of those with no religion were binge drinking at age 34. This initially suggests that no major variation exists between the type of religion and prevalence of binge drinking; however, when the sample of those who do binge drink is examined by religion, 91.3 per cent are part of the no religion category. The second highest group among binge drinkers are Christian, at 7.7 per cent. Every other religion makes up 0.5 per cent or less. Through this analysis, it would seem that religion in general tends to be a

protective factor against binge drinking at age 34, with some religions slightly more effective protective factors than others.

Protective factors at age 34

At age 34, several other protective factors against binge drinking emerged during the regression models, such as gender, employment status, having children, and the ethnicity of the cohort member's mother. To investigate these relationships further, we conducted contingency analyses to assess the association between each and the cohort member's drinking at age 34.

Gender

The contingency analysis revealed a strong and statistically significant relationship between drinking at age 16 and the gender of the cohort member ($\chi 2 = 375.37$, df = 1, p = .0001). Specifically, of those cohort members who are binge drinkers, 68.5 per cent are male, while 31.5 per cent are female. Women are also more likely to be in the non-binge drinking category than men are (88.8 per cent vs 73.5 per cent, respectively). It would appear that being female is a protective factor against binge drinking at age 34. To examine this relationship at a younger age, we ran a contingency analysis between gender and binge drinking at age 16, but as in the regression models, no significant relationship emerged (p = .129). Gender does not appear to be a protective factor against drinking at age 16.

Employment status of the cohort member at age 34

The second protective factor to binge drinking at age 34 is the employment status of the cohort member at age 34. A contingency analysis of this relationship indicates there is a significant relationship between drinking at age 16 and the cohort member's employment ($\chi 2 = 104.28$, df = 6, p = .0001). This relationship is not straightforward, though, as the analysis indicates those who are unemployed are individually the least likely to be binge drinkers (88.4 per cent non-binge), though at the other end of the spectrum, regular employees are second

least likely to binge drink (82.6 per cent non-binge). However, of those who are binge drinkers, regular employees make up the highest proportion, at 35.5 per cent of the total. The second highest group is those who are self-employed with a small business, at 27.7 per cent of those who binge drink; and foremen and supervisors are third highest at 24.8 per cent of the total. Managers at large establishments and the unemployed are tied for fourth highest, at 10.7 per cent of the total each.

So while employment may have a significant relationship with binge drinking at age 34, it is difficult to give the precise type of employment that serves as a protective factor against it. To better evaluate the relationship between employment and binge drinking, we conducted a second contingency analysis, this time evaluating whether or not the cohort member was employed at age 34, and if they were a binge drinker. Again, this analysis produced a significant association, though the relationship is only slightly clearer ($\chi 2 = 63.78$, df = 1, p = .0001). Here, both the employed and unemployed were far more likely to not binge drink (80 per cent vs 88 per cent, respectively), but it seems that of those who do binge drink, the employed make up the vast majority (89.2 per cent). It is possible that this is skewed because of the sample, as unemployed cohort members dwarf in comparison with the employed (1,661 vs 8,004, respectively), and other unemployed cohort members are likely to be transient, and no longer part of the study. Still, it is also possible that employed cohort members have more disposable income to spend on alcohol than their unemployed counterparts.

The number of children the cohort members had at age 34

The third protective factor to binge drinking at age 34 identified during the logistic regressions is the number of children the cohort members had at age 34. A contingency analysis again shows there is a significant relationship ($\chi 2 = 122.78$, df = 10, p = .0001), and affirms the regression results in that the highest proportion of binge drinkers at age 34 are those without any children (30.5 per cent). However, in total, this group comprises less than 1 per cent of all binge drinkers, though interestingly they also made up less than 1 per cent of the total sample at age

34. It is clear still that the number of children, overall, decreases binge drinking as the proportions drop below 2 per cent binge drinking after having five children.

Marriage

While marriage was not identified in the regressions as a protective factor to binge drinking at age 34, the literature on this subject generally suggests it may serve as a protective factor and therefore it warrants further analysis. The contingency analysis supports marriage as a protective factor, as more married people were non-binge drinkers than those who were not married (83 per cent vs 76.5 per cent, respectively) ($\chi 2 = 51.44$, df = 1, p = .0001). However, of all those who were binge-drinkers, 67.8 per cent were married, while 32.1 per cent were not. It is possible that this resulted in the lack of significance during the logistic regression models.

Limitations

Like all research of this type, there are limitations to the study that must be noted. The first is that all measures used as index items and covariates in this research were dependent on the data available in the BCS. While the BCS has a sufficient array of measures to conduct the intended analysis, there are certain 'ideal' measures that we were unable to include. Parenting researchers prefer to use a particular set of measures, which, based on other literature on the subject, is a more accurate way to describe warmth and discipline. Nonetheless, every effort has been made to ensure the theoretical and logical soundness of the indices and covariates used in the models, but the limitation of data availability must still be noted.

There are also limitations inherent to the BCS. For instance, the BCS dataset, which began over 40 years ago, may suffer from a range of time-related issues, including response-rate attrition and the datedness from the early waves of the data collection. Indeed, the two waves employed in our analysis include children who were at the age of 16 in 1986 and 34 in 2004/05. Clearly, there have been a number of social and

cultural developments concerning teenagers and drinking behaviour, such as the emergence and role of social media. This is one inevitable limitation of longitudinal datasets.

We found these results with these specific models, and understand that models using additional measures may yield different results as they include unmeasured confounding factors. Should any researchers wish to have access to the precise coding used in deriving these models in order that they run tests of replicability, we would be happy to share them. Every study faces limitations of some kind, and we would like to note those affecting this research, and suggest that readers take these factors into account when considering the results of the analyses. It is important to note that these findings are not causal and are still, at best, inferential statistical models. Without an experimental study it is impossible to determine the absolute causation of drinking and parenting behaviours. Our efforts constitute a valuable first step in evaluating the relationship between these two factors. Future research could aim to establish causality by running a standardised controlled trial, which remains the 'gold standard' in determining causality. It is also worth reiterating that the missing data from the BCS could have actually strengthened our results, as those individuals who drop out of a longitudinal study are most likely to suffer drug and alcohol misuse, criminality and other problematic behaviours.

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The Government has binge drinking firmly in its sights: earlier this year David Cameron said that binge drinking would be 'attacked from every angle'. While the focus of policy tends to be on tackling public disorder, the worst damage done by hazardous drinking in the UK is in the home. According to the latest figures, more than 2.5 million children in the UK, including 90,000 babies, are living with a parent who is drinking alcohol 'hazardously'.

In *Under the Influence*, Demos research found that parenting style has a significant impact on children's drinking behaviour as teenagers and later in life as adults. 'Tough love' parenting – a parenting style that combines warmth with consistent discipline – is the best protection against young people drinking hazardously. In this report we go further to consider the impact of parental drinking behaviour on parenting style. Based on original quantitative analysis as well as in-depth interviews with 50 alcohol-affected families, our findings suggest that the more a parent drinks, the less likely they are to be a 'tough love' parent.

Parenting can be stressful, and the majority of parents drink alcohol responsibly. But parents need to be aware of the impact their parenting style and how drinking excessively can effect this. This report argues for targeted information awareness campaigns aimed at parents to help them consider their parenting style and the impact of alcohol on parenting ability. The report also recommends that 'family-based' interventions should put more emphasis on parenting advice, to ensure that those struggling with alcohol misuse can still be effective parents.

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