Hidden Harm

Identifying a way forward for Somerset

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Chapter 1 Introduction

Background

In 2007/08, the Somerset Drug and Alcohol Action Team (DAAT) commissioned Evidence Base Ltd to conduct a study of Hidden Harm research, policy and practice. The principal aim of this study was to gather sufficient evidence to enable the Somerset DAAT to develop a local strategy to identify and tackle Hidden Harm within the county. The key objectives of the project were to:

- Investigate the national context and legislation/guidelines;
- Produce an overview of Hidden Harm literature and research, including national charity projects and campaigns;
- Clarify the definition of Hidden Harm to be used in Somerset;
- Contact other counties (similar to Somerset) to determine how they have assessed levels of Hidden Harm;
- Identify lessons learnt from other counties (similar to Somerset), including examples of good practice and initiatives that haven't worked well;
- Develop proposals for a way forward.

Defining Hidden Harm

The Advisory Council on the Misuse of Drugs (ACMD) defines Hidden Harm as:

> Parental problem drug use and its actual and potential effects on children
>
> ACMD, 2003

By '*problem drug use*', we mean drug use with serious negative consequences of a physical, psychological, social and interpersonal, financial or legal nature for users and those around them (ACMD, 2003). Such drug use will usually be heavy, with features of dependence.

The term '*problem drug use*' is often interchanged with the term '*substance misuse*'. In the context of Hidden Harm, both terms refer to the misuse of illicit drugs, for example heroin, cocaine, crack, amphetamines, benzodiazepines, LSD, methadone and ecstasy, as well as the misuse of prescription drugs and solvents. However, the term '*substance misuse*' is taken to specifically include alcohol. It is widely accepted that the definition of Hidden Harm should include problem alcohol use. In light of this, it is suggested that Somerset should consider using the term '*substance misuse*' for the purpose of clarity in its definition of Hidden Harm:

Proposed definition of Hidden Harm for Somerset:

Parental substance misuse and its actual and potential effects on children

Estimating the Scale of the Problem

Many children in the UK live with parents who have substance misuse problems. The exact numbers are unknown, but estimates place the number at around 1.5 million children affected in the UK. The majority of these children (up to 1.3 million) have parents who have alcohol problems. (Alcohol Harm Reduction Strategy 2005 & Government Response to Hidden Harm, 2005).

In 2003, the ACMD estimated that the number of children of problem drug users in England and Wales was between 200,000 and 300,000; about one for every problem drug user. Based on population estimates for 2000, this represented about 2-3% of the 10.6 million children aged under 16 (ACMD, 2003). It is estimated that approximately five times as many children are affected by parental alcohol use (Gorin, 2005).

However, it is acknowledged that these are very conservative estimates and the true figure may well be higher. The data sources used by the ACMD mainly rely on self-reported information. Given the sensitivity of the issues, it seems more likely that drug users will under-report the presence of children within their family. In addition, the available data for England and Wales are based entirely on people in treatment, and make conservative assumptions about the proportions of problem drug users not in treatment.

Estimating the number of children at risk of Hidden Harm is a challenging exercise. As the term itself suggests, the children of substance misusing parents can be difficult to identify. Using records from Children & Families (Social Services) and drug and alcohol services will provide some indication of the extent of ***identified*** parental substance misuse and risk of harm; however, in reality, parental substance misuse affects a much larger number of children. Fear of professional intervention and having their children taken away, stigma, shame and isolation mean that parental substance misuse frequently remains a family secret, with children often sharing the responsibility of keeping it hidden (Gorin 2005). Local service records are also likely to disproportionately represent families that experience poverty, social disadvantage and exclusion and are less likely to identify children living in more affluent families who may experience parental substance misuse (particularly alcohol misuse) and those that move frequently or are homeless.

Chapter 2 Key Messages from Research

Parental substance misuse makes children more vulnerable and can lead to serious harm (ACMD, 2003). Research in the UK and USA shows that parental substance misuse can reduce parenting capacity and is a major factor in cases of child maltreatment.

> While there remains a great deal to be learned about the consequences for children of parental substance misuse, the emerging picture suggests a very significant and sizeable problem, which is getting bigger, and which has a serious impact on child protection and looked after children systems (Phillips, 2004)

However, the impact of drug use on parents and their ability to parent is not uniform and not all substance misuse means that parenting capacity is adversely affected. A study conducted by Barnard & Barlow involving 62 parents and 36 children and young people demonstrated that where drug use is controlled, it is possible for parents to maintain family routines and put children's needs first. However, only in the minority of cases was this consistent or long lasting. Most often, the children were exposed to cycles of relapse and recovery with all the attendant uncertainty and instability.

> There would be times where if I had plenty of drugs or like on a period where I was controlling drugs that I would be acting normal, but they widnae last very long, maybe a couple of weeks (Barnard).

Parents with substance misuse problems have often experienced a number of disadvantages in their own lives including traumatic childhoods and their own parents' substance misuse. Kroll & Taylor's 2008 study found that drug use is often used as a management strategy for other problems, including domestic violence, mental health problems or loss. The presence of domestic violence and parental mental health problems, together with substance misuse, can significantly increase the vulnerability of children (Gorin 2005).

In recent years, a number of studies have been undertaken in order to gain an insight into the experiences and needs of children and families affected by parental substance misuse. Some of the key messages that have arisen from recent research are summarised below.

Impact on Children

> For many children living with parental substance misuse, life can be difficult, dangerous and frightening. (Kroll and Taylor 2003)

Parental alcohol and drug misuse has a huge impact on families in general and children in particular. Most children living with parents who have chronic substance misuse problems will be affected in some way during their childhood and often into adulthood. However, the experiences of children vary greatly. In particular, studies have shown that some children can be remarkably resilient, have strong and enduring relationships with parents and overcome the associated disadvantages (Templeton et al 2006; Gorin 2005). Whatever their experience, one of the key messages from research is that children are aware of problems at home much earlier than parents realise and are much more worried about their parents' substance use than is recognised by adults (Gorin 2005; Kroll & Taylor 2008; Hart & Powell 2006). Recent analysis of data from ChildLine Scotland shows that parental alcohol misuse was children's most frequently reported concern about their parents' health and wellbeing (NSPCC 2006). The NSPCC report (2006) noted that these children tend to demonstrate a sophisticated understanding of factors that contribute to alcohol and drug misuse, such as unemployment or stress, and can often tell ChildLine when the substance problem started, what they thought the cause was, and the effects on their family.

There is currently limited knowledge about why some children are more affected than others by parental substance misuse and how mediating factors impact on outcomes and effective interventions for children. However, it is evident that the extent to which living with parental substance misuse impacts upon a child's health and development is dependent on a wide range of factors. These relate to the type and extent of parental problems, the child's age and needs, family factors (such as levels of social support, stability of the home and routines), community and environmental factors (for example quality of housing and supportiveness of schools) and wider societal influences (such as levels of stigma and social exclusion) (Gorin 2005). Protective factors for children include:

> … high self-esteem and confidence, self-efficacy, an ability to deal with change, a good range of problem solving skills, positive family functioning, a close bond with at least one adult in a caring role, and a good support network beyond the family. (Alcohol Concern 2005)

However, children who live in families where a parent has a substance misuse problem are at a *higher risk* of a range of adverse outcomes in their childhood and through to adulthood. Children are thought to be more vulnerable when alcohol and drug use coexist with domestic violence and where both parents use substances (Cleaver et al. 1999).

Physical and Emotional Neglect

Research with parents, children and professionals highlights a range of ways children's lives can be affected. Whilst an earlier study by Harwin and Forrester (2002) found a clear relationship between the pattern of concern regarding the child and the type of substance being misused, some concerns are the same whatever the

substance involved. Most notably, all substance misuse is linked to a *risk of neglect* of children:

> Neglect is the most commonly experienced form of maltreatment that children may experience and cuts across the use of different types of substances. (Kroll and Taylor, 2003)

A study of social service case files shows substance misuse affected more than one third of cases allocated for long-term social work support (Harwin and Forrester, 2002). In this study, neglect was a common feature of cases involving drugs and/or alcohol. Drug misuse was more commonly associated with concerns about newborn babies and alcohol misuse with cases where there was violence or emotional abuse.

Young people describe parents' failure to shop or cook for them or living in a home that was 'like a squat really' (Bancroft et al. 2004). In studies, children have noted that their parents were often physically or emotionally unavailable to them; in their words "*not there for them*" (Gorin 2005).

> In the morning my mum used to do breakfasts and everything when she was sober. But when it got toward the [end of] the day… she used to drink more and more… if I didn't cook for myself I would have just starved… I was surprised that the social workers didn't do anything… even talk about putting me into foster care. When we were living with my mum and I were looking after her and she was drinking a lot and threatening to take her own life, they came up to visit sometimes to see how she were, but they never ever mentioned even thinking about putting me into foster care. They didn't say 'oh you're in danger' or anything. (Bibby & Becker, 2000)

> Usually one partner is sleeping it off. They don't play with the kids, meals are rarely on time, appointments are not kept. Life revolves around alcohol. The four year old is probably still in pyjamas with no clean clothes and unwashed hair. (Liverpool Drug and Alcohol Team and Barnardos, 2001)

Emotional absence is a recurring theme in studies and Kroll and Taylor (2003) identified a risk to children's ability to form secure attachments if their carers were impaired by substance misuse, and that this could have long-term effects on their emotional health.

Emotional Issues

Studies have shown that parental substance misuse can generate a range of powerful emotions in children and young people including disbelief, anger, despair, intense loneliness, guilt and self blame, fear, uncertainty, insecurity and strong feelings of love and hate (Kroll and Taylor, 2008). Children and young people's accounts reflect high levels of fear, worry and anxiety about their parents' well-being:

> And she'd just disappear and I was always scared in case she was… lying somewhere, dead or something. (Bancroft et al. 2004)

> I was worried that one day my mum wouldn't wake up. (11 year old girl) (NSPCC, 2006)

> I feel scared at my friends house cos I worry about my Dad and is he going to be alright or not going to be alright… cos you might be scared if he's passed out or owt because you don't know. (11 year old boy) (NSPCC, 2006)

Separation from parents is common due to parents spending time in prison, being away from the home acquiring drugs or alcohol, or committing crime. Children may spend periods of time being cared for by family and friends or local authorities. Fear of intervention by local authorities is a constant concern for parents and children.

> I just couldn't tell anybody 'cause it's like… it's hard to tell someone and if they find out they like phone the police and you might get took off your mum and your dad and the police will get involved and that. (12 year old boy, Evans 2008)

Children have also expressed fear that drug misuse is "catching" (Kroll & Taylor, 2008)

Physical Harm

Of particular concern is the apparent link between parental substance misuse and physical violence experienced by children. A study conducted by Bancroft et al in 2004 found that violence and other forms of abuse were 'a common theme' in the responses of the young people interviewed and noted the extreme anxiety and fear of living with a parent whose behaviour could be unpredictable and dangerous. Some research suggests that the risk of physical abuse is more strongly associated with parental alcohol misuse (Famularo et al, 1992; Harwin and Forrester, 2003; NSPCC 2006)

Most children who speak to ChildLine about alcohol or drugs in the family do not mention substance misuse immediately, or as their main reason for calling. Instead, children call about the impact these problems are having on their lives, such as physical abuse or domestic violence, revealing only later in the call that these problems are fuelled by their parents' alcohol or drug problems. Children say that fear of violence is made worse by the unpredictability of parents' moods and behaviour. As a result, some children constantly feel they are 'walking on eggshells' (Gorin, 2004).

Drug-Related Criminality and Violence

Accounts from children, particularly in relation to alcohol misuse, describe witnessing or overhearing domestic violence and high levels of relationship conflict between adults (Gorin, 2005). Moreover, the dangers attached to substance misuse can come not only from the parent users themselves but the context in which they function. Children whose parents have drug problems may witness drug taking, see drug equipment, have strangers coming into the household and witness or participate in crime.

> These guys who used to buy stuff off ma uncle, they all burst in and were holding knives up to our throats and that, asking for the drugs and the money and they were sayin' they would cut our throats if they didnae give them it…They were holding the knife right up to my uncle's neck as well, they were just screwy. (Dan, 15 years) (Barnard)

> Like she always used to steal stuff like to get money for it… And I used to always worry what she was gonnae steal next and all the big fights and all that. I felt scared in case she stole something of somebody else's and the Police would come… (Sarah, 15 years) (Barnard)

While such violent eruptions in front of children may seem extreme, Barnard & Barlow's study found that these experiences were reported by a significant minority of children in their small sample.

Poverty and Social Exclusion

Substance misuse can affect parents' abilities to provide basic physical care because money and household items may be used to pay for substances. Many families live in poverty and debt, have poor or temporary housing and have few valuable belongings. In studies, children have noted that gifts that they receive do not last long in the home:

> Sometimes my nan gives me gifts, but I have to break them straight away, otherwise Mum sells them for heroin. (Abbey, 11) (NSPCC 2006)

Role Reversal

Children living with parental substance misuse often step into the adult role, either because they are actively forced to by their parents or because necessity dictates that they look after siblings who are also experiencing neglect. Apart from performing commonplace chores such as cooking or cleaning, some children report that they spend money they earn from part-time jobs on purchasing food for themselves or their siblings. One 12-year-old boy told ChildLine that because his mother was often drunk, he frequently had to make dinner for himself and his little brother. On top of this, he was worried about the family finances: as his mum's

alcoholism escalated, she had begun buying drink with what had previously been earmarked as the family's food money. Some children have even told their counsellors that, in order to provide for themselves or siblings, they have had to resort to shoplifting or begging food from neighbours or friends. Many accounts from children describe how they feel they had to grow up at an early age and have '*missed out*' on their childhoods (NSPCC, 2006).

Disrupted, Chaotic Lifestyles and Lack of Routine

The chronic nature of substance dependency can lead to chaotic lifestyles, a lack of regular routines and unpredictability. Some children experience frequent house moves and change of schools. The NSPCC's report (2006) noted that some children clearly lack the guidance required to stick to routines that will benefit them in the long run, such as having good attendance at school or doing their homework. Even when they want to, they may find that the chaos of home makes it impossible to do so.

> I'd only be [in school] for a certain amount of time and then I'd have to go home and look after my mum…I used to come in from school. I would do the dishes. Put, like, all the clothes in the washing machine. My mum would be lying steaming [drunk] on the couch and I'd have to try and cook dinner. (Bancroft et al, 2004)

Affected Education

Children may lack concentration in school, have problems completing homework or have frequent or prolonged absences. Whilst school can be a place of refuge for some children, others report worrying about parents or feeling excessively tired (Gorin 2005). Reports from teachers highlight that parental substance misuse can lead to underachievement and emotional and behavioural problems for the children:

> She is bringing a lot of 'baggage' to school with her, which is causing concentration problems … her mother realises the importance of having her in school each day and is doing her best. (Hogan and Higgins, 2001)

> His schooling in the last year at primary, it was affected, that's when all the years of our drug taking started to hit him. (Maguire, 2002)

Behavioural Problems

As well as affecting their emotional well-being, parental drug use can lead to behavioural difficulties. These difficulties can cause children to be excluded from school and community facilities; this can create further pressure on children's home life. However, it is important to note that not all children whose parents use drugs will have challenging behaviour (Maguire, 2002)

Secrecy, Stigma, Bullying and Isolation

> They would call out 'There goes the druggie's daughter' or 'Your mum's a skaghead'. Everyone else seemed to know, but we didn't. (FRANK 2005)

Social isolation, school disruption and fear of people finding out, or intervening and making a bad situation worse, are other recurring messages within young people's responses. Sadness and isolation that children may experience can be perpetuated by the stigma and secrecy that surrounds domestic violence, parental substance misuse and ill health. Some children report feelings of depression, difficulties making or maintaining friends, and having a disrupted education, or experiencing stigma and bullying.

> Well me brother I was quite concerned about, because my brother used to get bullied and that and I used to get bullied as well and my mam was always upstairs taking heroin and there was no-one to look after me or my little brother. (14 year old girl) (NSPCC Consultation, 2006)

Children living in small, rural communities can be particularly susceptible to the stigma associated with having parents that misuse drugs (Kroll and Taylor, 2008).

Parental substance misuse can restrict children's social lives, play opportunities, and disrupt special occasions. All these experiences can act to make children feel profoundly isolated (Gorin, 2005). One of the young people supported by the Arbelour Trust summed up the pressures: 'I just knew to keep it quiet…' (Corbett 2005). Yet if all the professionals involved with the family collude with the secrecy, even if well intentioned, the child risks being unable to trust their own perceptions and may be confused and saddened as a result (Kroll 2004).

Multiple problems caused by parental substance misuse

While the impact of parental substance misuse will vary from one child to another, research has shown that these children are likely to be experiencing a number of inter-related problems that have a tendency to compound each other, including domestic violence, neglect, stigmatisation, bullying, anger management issues, and behavioural problems at school:

> "I'm getting abused by my dad,"' Anita told ChildLine on her first call. "When he gets home from work he's had alcohol and hits me. Today he hit me when I dropped a bit of eggshell in his breakfast. He's been like this since Mum left last year. She had a good reason to go – he hit her too. I look after my little brother, who has Down's syndrome. My dad isn't so harsh on him. Other kids pick on him, though – they pick on me too at school. They call me spazza and say, "Your dad's a psycho and your mum left because she doesn't love you". (NSPCC, 2006)

> My mum and dad are alcoholics. I've run away a few times and they always say they worry about me but then they batter me. They spend all the money on drink. There's no soap in the house and all my clothes are too small. I lost my girl friend because she said I smell. Others call me names and make fun of me. It hurts. (Paul, 14) (ChildLine 1997)

Long Term Impact on Children

Little is known about the longer-term impact on children who live with parents with substance misuse problems. The available research suggests that they are more likely to experience social exclusion into adulthood and they are at higher risk of becoming involved in crime and taking drugs (Kearney et al. 2005, Gorin 2005). This is likely to be due, in part, to the normalisation of drug use and offending behaviour through their home life experiences. Adolescence is a time of particular vulnerability in this regard. In Kroll & Taylor's study (2008) children reported using alcohol/drugs themselves as a way of coping with life with a drug using parent. A recent study with 15- to 27-year olds whose parents had substance misuse problems highlights the poor prospects many young people feel they have. Of the 38 young people who took part, 12 had serious drug problems themselves (Bancroft et al, 2004).

Summary: Impact on Children of Parental Substance Misuse

- Physical & emotional neglect
- Physical & emotional abuse (or threats of maltreatment)
- Emotional issues (feelings of fear, anger, guilt, embarrassment, shame, secrecy, rejection, loss of love, loss of self-esteem/confidence, loss of normal family life, fear of losing parents, loss of childhood)
- Development delay
- Problems developing/maintaining peer relationships
- Play opportunities and friendships affected
- Social exclusion and isolation, stigma, bullying
- Emotional and behavioural problems
- Affected education
- Exposure to illegal substance and criminal activity
- Role reversal – undertaking domestic/caring tasks/parental responsibilities
- Frequent moves and changes in carer/s and schools
- Inconsistency of parenting and boundaries, unpredictable moods
- Disrupted routines and family occasions

Resilience, Love and Loyalty

Despite the often overwhelming nature of the problems they experience, children often demonstrate remarkable resilience in the face of the disruption, distress and danger associated with parental substance misuse (Bancroft et al 2004, Templeton et al. 2006). Relationships and dynamics within families are often complex and this is reflected in children's feelings. While children report very mixed emotions about their parents – anger, pity, contempt, frustration – most do not reject them. In fact, children frequently describe close relationships with parents, and feelings of love and loyalty that are strong and enduring (NSPCC 2006, Gorin 2005). They also often express a desire to help their parents overcome problems. Some children, however, may feel torn between love for parents and a dislike of parents' behaviour or restrictions placed on their own lives (Gorin 2004).

> We all cope in all sorts of ways….but lots of children are good at it. Children don't necessarily get upset and in a state about it. They can do fine with it. Some do get upset and they need support and caring because it is such a big thing. It is definitely a big thing for children. (Mullender et al. 2002)

A Joseph Rowntree Foundation study of children living with parents who had substance misuse problems highlighted this sense of love and loyalty, noting that children often recognise that their fragile or wayward parents 'cared *about* them even when they did not care *for* them' (Bancroft et al. 2004). The NSPCC noted that this is a sentiment that ChildLine hears time and time again, and while the knowledge that they are loved helps young people to cope with their responsibilities, it also adds to the complexity of their situation. Children will almost always choose love and loyalty over what many others would argue are their long-term best interests. And almost all the children that ChildLine talks to about these issues fear the consequences of talking to Social Services or a teacher about what is going on in their lives. For example, a ChildLine Scotland study found that, out of the 9,363 calls from children who talked about parental health issues such as alcohol, drugs, and depression, only 1% of children had spoken to statutory services. Children with adult roles want their problems to be solved, but are desperately afraid of getting their parents into trouble, or of causing the break-up of their families (NSPCC 2006).

Support Services - Children and Young People's Perspectives

When children have problems at home they are most likely to approach informal sources of support first, such as family and friends. Some children may approach professionals particularly if they know and trust them, such as supportive teachers and school counsellors. (Kroll and Taylor 2008). Children also favour the use of helplines because of the confidentiality they allow. Helplines and websites that give children access to on-line counsellors (e.g.There4me.com[1]) are an effective means

[1] There4me.com is an interactive website designed specifically for 12-16 year olds. It offers information, advice and support, including secure email to the NSPCC and real time online support

of responding to children's immediate needs. However, they are not able to provide ongoing, face-to-face or specialist support for children and therefore are not seen as a long-term solution to the problems experienced by children with substance misusing parents (Gorin 2005).

In studies, children often say they want someone to talk to, who they trust, who will listen to them and provide reassurance and confidentiality. They want help to think through problems and be involved in findings solutions to help them cope. Children also mention that they would welcome opportunities to have time away from home, participate in fun activities and to get to know other children experiencing similar problems. However, Gorin found that children's most persistent plea is for more age-appropriate information to help them understand what is going on in their family (Gorin 2004).

While some children will not talk to anyone about the problems at home or may be scared to tell anyone, they are often desperate for someone to notice (Kroll and Taylor 2008). Boys in particular may find it hard to talk about problems and they are more likely to leave talking to someone until nearer crisis point than girls (Gorin 2004).

Lack of communication is a major barrier to children and young people getting the help they need (Gorin 2004). There are problems of communication between parents and children and professionals. Within families this is often because of a shared desire to protect one another; secrecy and shame surrounding problems; parents finding it hard to know how to talk to children; and feeling too upset themselves to talk about problems. However, not talking to children may perpetuate their confusion and isolation and lead to misunderstandings (Gorin 2004).

Children's accounts of contact with professionals are mixed, but many report negative experiences (Gorin 2004, CSCI 2006, Kroll & Taylor 2008). Children say that professionals do not always talk to them in a language they can understand; they are often afraid that professionals will not believe them; and they are not confident that professional action will make things any better: "I just thought, "they can't do anything"" (Kroll & Taylor, 2008). In many cases, children are worried that involvement with professionals will make things worse. According to Gorin's research, children's biggest criticisms about social services were concerns about confidentiality and a lack of information about what was going on (Gorin, 2005b). Children's accounts of coming into contact with professionals suggest that, in some cases, the professionals involved did not speak directly to children (or the parents prevented the professionals from speaking to the children) (Kroll & Taylor, 2008). Children say that they want to be respected and taken seriously by professionals. Where action is taken in their family, they want to be involved in decision-making. Having time to build up relationships of trust and 'going at their pace' is also important to these children:

> It's important that they [children] feel that they are there of their own will … that if they want a break or somebody makes them upset they don't have to stay. Because if they're there and a subject really hurts them and they feel trapped … the next time they won't go back … (Templeton et al, 2003)

When looking to provide support services for these vulnerable children, it is important to bear in mind that children's experience of and response to parental substance misuse varies. Support to these children needs to take account of their individual circumstances and attributes (Maguire 2002). Children mention a need for confidential support such as helplines, as well universal and specialist support that can work with children alongside those for parents (Gorin 2004).

In Kroll & Taylor's study (2008), respondents identified a need for more support services for the children and young people of substance misusing parents. In their experience, support for children and young people was not forthcoming unless (or until) they developed specific problems of their own, such as substance misuse, offending, etc.

Summary – Children want:

- Parents to receive the help and support they need
- Someone to talk to who listens, who they can trust, who reassures them about their worries, and who keeps information confidential
- Help to think through problems and be involved in findings solutions to help them cope
- To be informed at all times and involved in subsequent decision-making
- Age-appropriate information (verbal and written) about parental problems
- Confidential support, such as helplines and websites
- Universal and specialist support for themselves and their families
- Respite from the home situation
- Opportunities to get to know other children experiencing similar problems
- Children want to have fun!

A message to professionals from 'Harley' aged 15:

> They should be helping the parents....& help the children get through what's going on in the house...they should sit down & listen to children who have been through it instead of thinking 'It's our rules, we have to do it by our rules' & not listen to children ...they should listen to what the children think & what the children feel ....just because people are children doesn't mean they don't know what's right & what's wrong...we know 'cos we've seen it...they don't know what it's like living with someone who's been using... (Kroll & Taylor, 2008)

The Parents' Perspective

In order to safeguard children, it is clear that the problems that undermine a person's capacity to parent need to be recognised and addressed, whether this is the substance misuse itself or other inter-related factors, such as domestic violence and mental health problems. Yet studies that have consulted substance misusing parents have found that they often do not receive the support they need for their role as parents (Maguire 2002, CSCI 2006, Gorin 2005, Kroll & Taylor 2008).

For some adults that misuse substances, being a parent can actually form a barrier to them seeking help; many fear losing their children.

> I didn't feel I could tell anybody… that I had to sort it myself. As a single parent I wouldn't tell anybody anything, wouldn't go for help at all. I thought (drug treatment) services would inform social services.
>
> You'd have social services banging down the door (to take the kids) and then ask questions later.
>
> It feared me, me alone I could have gone, but with the kids I was afraid [of social services involvement] I'd have gone if I had assurances that they wouldn't be involved.
>
> It was the main reason I didn't go for help. If it had just been me that would have been OK, it wouldn't have affected anyone else, but it's the kids, it's their happy home and I wasn't prepared to risk it.
>
> Cairns, 2007

When substance misusing parents are engaged with a service, asking for details about their children can make them feel nervous and put up barriers:

> Very nervous, it would imply that the kids are not OK, they'd be checking up on you, recording it, it could be used against you in the future.
>
> Asking those questions put up a barrier.
>
> It's how and when those questions are asked. They asked me about my kids before they'd even asked me what drugs I was using.
>
> Cairns, 2007

These findings highlight the importance of timing when and how to ask questions about children. Cairns (2007) suggested that discussions around childcare should commence as soon as a therapeutic relationship is established between the client and worker.

When asked whether support around their children would have made a difference to their drug treatment, all respondents bar one in Cairns' study replied in the affirmative and thought that support would have helped a lot:

> A lot actually, the logistics of running a family and trying to come off, you need tips or advice around that.
>
> Support with the family may have encouraged me into treatment earlier.
>
> Practical support, like childcare or a crèche.
>
> Cairns, 2007

When asked whether they were given advice about safe storage of drugs by drugs workers, five respondents in Cairns study replied in the affirmative, including one who was also given advice by Social Services. However, one respondent could not remember such a conversation, and three were definitely not given any advice. This finding highlights the inconsistency in advice and support given to substance-misusing parents.

Kroll & Taylor's 2008 study presents a valuable insight into the experiences of parents that have accessed drug and social services in the county of Devon and parents' suggestions of how these services could better meet their needs. The study revealed that the thresholds set for services vary, affected by factors such as prevalence, location, expertise, and interpretations of 'significant harm'. As a result, some parents fall through gaps in services: "[I was] not good enough, not bad enough…"

Those parents seeking help often encountered long waiting lists for help. Some parents that were able to engage with a service felt that there were too many appointments and meetings, which actually undermined engagement. Those living in rural areas found that limited access to public transport was not only a burden on attending appointments and meetings, but also militated against punctuality; something which was very much considered in a negative light by the service staff.

In terms of the support that they need, parents mentioned that they need to feel listened to and would like the drug workers to come and visit them occasionally. Parents noted the importance of the personality of the worker and the need to build a relationship of confidence with the parent. They want workers to be honest, straight and non-judgemental; inform them about confidentiality, roles, boundaries, consequences; and give them the time to talk about their experiences. They highlighted the importance of the key worker who orchestrates inter-agency communication on their behalf. They felt that there is currently a shortage of staff: key workers have too many clients and more specialist workers with drugs awareness are needed (midwives, health visitors, social workers). Similar to the findings of the Maguire study (2002), parents identified a need for more drug

awareness training for workers and guidance on how to respond to children and families affected by drug use.

Parents also noted that their need for support extended beyond immediate recovery/drug use management: just because the drug misuse is managed, this does not mean that the problems have disappeared. There is also an unmet need for extended family support. Parents recognised that kinship carers (who are predominantly grandparents) rarely get support when they take over. Family-focused interventions are required, rather than just treating the drug user.

Cairn's 2007 study consulted parents with substance misuse problems in three High Focus Areas: Plymouth, Devon and HMP Eastwood Park in Gloucestershire. The following suggestions were received from respondents about the help that should be available to parents that misuse substances and who should deliver that help:

> Services need to be women friendly and provide childcare. To see a worker you need a babysitter, and money for petrol and parking.
>
> Specialist parenting workers. Parents as peers. More aftercare services.
>
> Social Services are seen as the devil, more contact with Social Services needed, Social Services placements at treatment agencies, assertive outreach to help before it gets to crisis point.
>
> Agencies need to work together and not duplicate. One person should coordinate all the care, someone who knows the roles and workings of all the agencies.
>
> There should be someone to act as a buffer between user and services, someone who can discuss things before they reach crisis point, not jump the gun, and think about alternatives without all the paperwork straight away.
>
> Knowing what's expected of you. Social Services need to lay it out for people: This is what they expect, if you do this, this and this, they'll applaud you. They won't have this litigious attitude towards you - and take your kids away. They expect people to know by magic, but a lot of them are from deprived backgrounds and don't know what good parenting is.
>
> Cairns, 2007

Respondents agreed that multi agency input was important but felt that it was best provided in one location, within treatment services.

Supporting Parents, Safeguarding Children

> It's always about the children. There doesn't seem to be anywhere or anything specifically for [parents]. Ensuring the needs of the child are really being met, marrying the two sets of needs together and meeting them all could be difficult but then there's a tension anyway, because the children come first, and I think that's right anyway. You could say though that if you don't meet the parents' needs you won't meet the children's. (Head Teacher) (CSCI, 2006)

In 2006, the Commission for Social Care Inspection (CSCI) noted with growing concern:

- the adverse impact of the increasing separation of children's and adults' services on the strategic planning, commissioning and delivery of services for families;
- the considerable growth in the numbers of parents with children on the child protection register that have serious problems of their own; and
- the increasingly high thresholds of eligibility operating across services for both adults and children, in both health and social care.

In response to these concerns, the Commission conducted a special study to assess the extent to which agencies are being effective in ensuring that problems that undermine people's ability to parent their children are recognised and addressed – whether they come to the attention of adult services or children's services. The Commission wanted to identify steps that those taking on leadership roles in the new services can take to ensure that:

- all services recognise the impact of adult problems on children's welfare and their role in safeguarding children;
- those working in adult social care respond appropriately to the needs of adults as parents;
- those working in children's services ensure parents receive the help they need; and
- there is an adequate range of relevant services to those parents needing help with their parenting.

The following is a summary of the evidence gathered by the Commission and key messages for policy and practice:

How are parents' needs identified and addressed when planning and delivering services?

- There was no evidence of a strategic approach to the identification of needs, to resource allocation, or to service development.
- Information on parents' support needs is not routinely collated. When it is collected it is not used systematically to inform the planning and commissioning of services.
- The responsibility for information gathering continues to be seen primarily, if not exclusively, as a 'children's services' responsibility.
- There is some way to go to ensure that all those providing services, including health and housing, recognise their role:
    - in identifying how the issues for which they are responsible can adversely impact on children; and
    - in addressing those issues in ways that support people in their parental roles.

Do the services provided meet parents' needs?

- Young people and parents provided evidence that many parents get too little help, too late.
- Most of the parents we interviewed thought that their needs had not been properly recognised, and that when services were provided they were not always relevant to them.
- Young people echoed these concerns. They had strong views about the importance of helping parents, both in their own right and in relation to children's needs. They recognised that parents need clear messages about what needs to change, and help to do so.
- Professionals also recognised that the related problems of high thresholds and resource shortfalls mean that services often fail parents and children.
- Respondents identified a particular need for effective mental health services and services for those who misuse alcohol and drugs.

What facilitates good intra- and inter-agency working in relation to supporting parents, and what gets in the way?

- The following factors facilitate effective intra- and inter-agency working:
    - strategic leadership;
    - good quality data about needs;
    - the involvement of people who use services in their development;
    - an understanding of how resources might best be targeted;
    - an understanding between agencies of their respective roles and responsibilities; and

- clarity that all agencies have a contribution to make to supporting parents.

- Across all services, high thresholds of service eligibility, developed in service 'silos', get in the way of effective collaboration between agencies. In particular, they get in the way of developing a strategic approach to early intervention.
- Things that facilitate good working include:
  - well-informed commissioning strategies;
  - clear and comprehensive protocols, clarifying expectations and providing guidance; and
  - strong leadership.
- The study highlights several effective models of working at a local level. There are others. The 'active ingredients' in these models are those listed above. They need to be understood and used to inform the mainstreaming of good practice.

What are the lessons from this study for policy, practice and future research?
This study suggests that the solutions to problems at the front line rest primarily with strategic leadership, effective systems and a joined-up approach to commissioning and service development. The introduction of Local Safeguarding Children Boards provides a good opportunity to get to grips with some of the issues identified in this report. With a statutory duty to safeguard and promote the welfare of children, and a clear line of accountability from front line services, there is an opportunity to develop and implement strategies that will drive good practice in all those areas identified above.

Messages for policy
Changes in government policy provide a number of opportunities to strengthen the support provided to adults who are experiencing difficulties in caring for their children. These include:

- Reaffirming the 'family support' responsibilities of the new Directors of Adult Social Services as part of their brief to take a strategic overview of commissioning services for adults (Department of Health 2005a)
- Taking advantage of the redevelopment of the Children in Need survey to explore the possibility of ensuring that all councils collect a core 'minimum data set' on parents' needs.
- Reviewing and amending the eligibility criteria for adult services to ensure that the needs of parents are appropriately recognised (Fair Access to Care Services – FACS) (Department of Health 2005b)
- Ensuring that the first Children and Young People's Plans address how support services for parents should interact with care services for children, to ensure that the opportunities for joint working in the interests of both are realised, and mainstreamed into practice.36
- Incorporating into Children's Trust arrangements a reciprocal recognition of the importance of aligning parts of children's services planning and commissioning with

relevant parts of commissioning for adult services, particularly in the areas of disability, mental health and substance misuse.

Messages for Local Safeguarding Children Boards (LSCBs) and Directors of Children's Services.

- LSCBs should establish robust performance management systems that ensure they have the information they need to develop and deliver effective services, and to monitor their effectiveness in securing good outcomes for children. This should include information on the needs of parents as well as those of children.
- LSCBs need to be proactive in making sure that they realise their potential for change, and to minimise risks. This requires strong leadership and an active approach to the management of change. New Boards might benefit from undertaking an audit of key areas of their operation, using a tool such as that developed by Morrison, Lewis and Horwath (2005). This includes taking steps to ensure that people who use services are meaningfully consulted about service development.
- LSCBs should be active in engaging with parents and young people, as well as front-line practitioners in all partner agencies.
- Involving Chief Executives and Councillors with lead responsibilities for adults and children in discussions about resource allocation, eligibility criteria and service responses for groups of parents with care needs that impact on the welfare of children. This may lead to setting up pooled budgets or joint posts in some circumstances.

Messages for practice

The good practice examples from agencies involved in this study point to a number of essential ingredients for effective parental support at an organisational level. These include:

- A clear and explicit vision of the importance of supporting parents. This will be particularly important in a time of considerable change in both children's and adults' social care, and in health.
- Effective leadership that ensures all agencies recognise their role in family support.
- Information systems which routinely identify the support needs of parents in an area.
- Information not only about the needs of those parents with children on the child protection register, but about all parents whose children are in need as a result of parental stress.
- Good analysis and use of information to inform commissioning, planning and delivery of adults' and children's services, across all agencies.
- Mechanisms to ensure that agencies work together effectively. These may vary, but useful components appear to be:
    - mechanisms which involve parents e.g. partnership boards;

- clear protocols providing guidance and clear governance about the respective responsibilities of health and social care agencies. These should ensure compliance with the requirements in the guidance on Assessments for Children in Need and FACS stressing the importance of children's and adults' services working together; and
- mechanisms to ensure that protocols are implemented and adhered to, for example, via checklists for staff or internal audits of files.

- Ensuring that effective local initiatives or pilots are 'mainstreamed' and replicated across other partnerships within an area.
- Making sure that managers make full use of previous research into 'what works' in effective partnerships.

The Families' Perspective

It is estimated that 45% of children with parents that misuse drugs end up living with other family members or friends (Evans 2008). It is widely acknowledged that extended family can be an important source of support for these vulnerable children, protecting them from the effects of parental substance misuse (Maguire 2002). Grandparents are seen as being particularly key in keeping children safe, either by stepping in at times of crisis or as permanent substitute carers. The '*Forgotten Families*' report by Adfam and Grandparents plus (2006) notes that an estimated 200,000 grandparents in the UK have their grandchildren living with them. One of the main causes of this is drug or alcohol misuse by the children's parents. However, the effect on grandparents' physical or emotional wellbeing can be extreme, and many report feeling isolated, stigmatised, stressed and depressed. Many have little financial support and endure financial hardship. At the launch of the Adfam and Grandparents plus' *Mind the Gap* resources in March 2007, a grandparent involved in the Mind the Gap project, spoke of her experiences of raising four grandchildren:

> I started looking after my four grandchildren when my daughter died after using crack cocaine. I cannot describe how it feels to lose a child in that way. For years I brought up four grandchildren, in a two bedroom flat, initially with very basic financial support. Whereas if I had been a foster carer, social services would have had to ensure that my accommodation was adequate for these children, I would have received a foster carers allowance, and the professional support that comes along with being a foster carer. I want to ensure that my grandchildren don't fall into the same cycle of drug abuse and I need real support to do this.

While grandparents often become the primary carers of these children, many lack adequate support. Grandparents often lack knowledge about their rights and responsibilities; have access to very little information; are unaware of sources of help or support; and often want guidance about the day-to-day practicalities of living with children and young people (Family Rights Group, 2001).

The *Forgotten Families* study (2006) found that grandparents worry about asking social services for help as this may be perceived as "not coping". Furthermore, they usually get a raw deal with carer's assessments and training: 77% of kinship carers receive no training (compared with 21% of non-relative carers) and nearly one quarter have no link worker (compared with 5% of non-relative carers). The study also found that social services appear not to understand the wider issues grandparents face in relation to substance use; and substance misuse services rarely provide support services for misusers' families.

Research has shown that grandparents, and other kinship carers, need more advice and information about their entitlements, the law, benefits, complaints procedures, their options, and how to talk to the children about their parents' problems.

> I needed advice on whether or not to inform the children about drugs, or where their Mum was at the time i.e. in jail. (Adfam and Grandparents plus, 2006).

Yet those who have accessed support have expressed how beneficial they have found the support:

> I am so glad of their support (the support group), and am delighted to give my support and knowledge to other grandmothers. But none of us would be able to without the brilliant counsellor who runs the group. (Adfam & Grandparents plus, 2006)

Children, parents and family members also recognise a need for family-focused intervention, rather than just treatment for the drug user, including training and guidance on how to respond to the needs of children and families affected by parental drug misuse (Kroll & Taylor 2008, Maguire 2002).

What does research tell us about what needs to be done?

- **Joint working between adult and children's services**
  The responsibility for safeguarding children must be multi-agency. There is a need for joint-working and effective communication between children's services and adult substance misuse services in order to support the children and families of substance misusing parents (n.b. some authorities have a link worker that works part-time in social services and part-time in drug and alcohol services).

- **Joint training**
  Professionals working in both adult and children's services need to understand the impact that parental substance misuse can have on children. Staff should receive training on drug awareness and on supporting children affected by parental substance misuse.

- **Family focused services**
  At present, services are often focused on the drug user. There is a need for family focused services that support all members of a family affected by parental substance misuse. These services need to focus on prevention, rather than crisis intervention.

- **Family friendly addiction services**
  Services offering support to substance misusers need to become family friendly. This includes the provision of childcare or a child friendly environment.

- **Listening to parents and children**
  It is important to listen to parents with substance misuse problems and their children in order to understand their experiences and support needs. Children have specifically expressed their wish to be listened to, even though they may not always be forthcoming. Workers need to be equipped with the skills necessary to build a relationship with the children, based on trust and empathy.

- **Support to children's education and social life**
  Children whose parents misuse substances are at risk of being socially excluded from school, leisure and youth activities. There is a need for practical support to encourage children's school attendance and participation in youth services.

- **Respite and emotional support**
  Parental substance misuse may create emotional and behavioural difficulties for children. Children may also have caring responsibilities. Opportunities for support and respite from the family home should be offered to these children. This could include individual, group or peer support.

- **Parenting support**
  Practical support to parents in their family home could help promote children's well being, encourage routines and promote parent and children's engagement with services. Parents may benefit from talking to a confidante about the impact of their drug use on their children and their parenting role.

- **Outreach approach**
  Services offering support to children and families affected by parental substance misuse should encourage these families to use their service. This could be facilitated by providing childcare, prioritising self referrals, working with these families in the place they find most suitable (often their home), offering a range of support through one service, providing a non-judgmental service and minimising waiting times. The provision of outreach services would be particularly of value to families living in rural areas where limited public transport provision may hinder service engagement.

- **Needs Assessments**
  Services in contact with children and/or substance misusers should be aware that children affected by parental substance misuse may be 'Children in need'. They therefore may benefit from an assessment of their need for support. When children are placed with relatives, the children and the relatives caring for them should be entitled to a full assessment of their needs.

- **Challenge discrimination and stigma**
  There is a need to challenge the discrimination and stigma associated with drug users. Services' ethos and attitude of workers should not judge children and their parents. Drug education in schools could be used to discourage the demonisation of drug users and their families. Schools' anti-bullying policies should recognise this form of bullying and seek to address it.

- **Support to relatives**
  At present, there is little local support for relatives affected by parental substance misuse, particularly kinship carers. Relatives would benefit from a one-stop approach to meeting their needs. This service should provide, or help relatives access services that provide, practical and emotional support. This support could be provided through a Carers' network. The provision of financial support to relatives who care for children on a full time basis urgently needs to be reviewed. Delays in payments of welfare benefits need to be eliminated and relatives should receive additional financial support to recognise their caring role.

- **Data Recording & Information Sharing**
  When adults come into contact with local substance misuse services, there needs to be the systematic recording of details of any children that these adults may have. Information systems should also routinely identify the support needs of parents (above and beyond their substance misuse). There needs to be effective information sharing procedures in place between adult and children's services. The information recorded should be systematically used in the planning and commissioning of services.

- **Greater awareness**
  There needs to be a greater awareness and understanding amongst local services of the experiences and support needs of children and families affected by parental substance misuse.

Chapter 3 National Legislation, Strategy & Guidance: An Overview

In recent years - most notably, since the publication of the ACMD's *Hidden Harm* report in 2003 - Government has acknowledged the need to address the issue of Hidden Harm in a number of policy, strategy and guidance documents. One consistent link that has been made in Government guidance is the importance of adults' and children's services working together in order to minimise the risk of harm to children with substance misusing parents. This section provides a chronological overview of the key national documents that address the issue of safeguarding children with substance misusing parents.

Legislative Background: Children's Act 2004

All services (including services specifically for adults) have a duty of care towards children as part of the Children's Act 1989. Section 11 of the Children's Act (2004) outlines a 'duty to co-operate' amongst key people and bodies to promote the welfare of children.

As part of the Children's Act (2004) the Government expects that by 2008 every local authority should secure arrangements that produce integrated working at all levels, from planning through to delivery, with a specific focus on improving outcomes for children and families. These arrangements are most commonly referred to as Children's Trusts.

All local authorities have further been required to establish Local Safeguarding Children's Boards (LSCBs) that have the responsibility of ensuring that all member agencies are complying with national legislation to safeguard, and promote the welfare of, children. The role of the LSCBs is therefore crucial for adult services who so often are not routinely engaged within the normal children's services network.

Young People's Substance Misuse Delivery Plans – DAT Guidance 2001

Home Office

The DAT guidance on *Young People's Substance Misuse Delivery Plans* notes that most young people will not be vulnerable throughout their whole childhood, but will go through periods of vulnerability. Young people requiring targeted interventions to prevent or treat substance misuse are a subset of this group, including children of drug misusing parents.

Tier 2 (targeted) interventions build on the activities of Tier 1 (universal) and focus further on identifying those young people who may be considered more vulnerable to

substance misuse because of their living situations, histories, particular locations or a combination of risk indicators. Activities under Tier 2 (targeted) interventions include the development of screening (non-medical) assessments, assessment tools and procedures for all vulnerable young people including children of drug misusing parents. The guidance notes the need to make provision of an appropriate intervention or package of care for all young people identified as being at risk of developing problems with substance misuse.

Fair Access to Care Services - Guidance on Eligibility Criteria for Adult Social Care, 2002

Department of Health

In May 2002 The Department of Health issued statutory guidance to councils called *Fair Access to Care Services - Guidance on Eligibility Criteria for Adult Social care.* Under this guidance, all councils were required to revise their eligibility criteria for adult community care services by April 7 2003. It was envisaged that implementation would lead to fairer and more consistent eligibility decisions across the country. The guidance includes a section on 'Children and Families' in recognition of the fact that, in order to safeguard and promote the welfare of children, adults may need to be supported in their parenting responsibilities:

> **Children and Families**
> In the course of assessing an individual's needs, councils should recognise that adults, who have parenting responsibilities for a child under 18 years, may require help with these responsibilities. In this respect, in addition to the provision of adult care assessment and support, councils should be prepared to address their duty under the Children Act 1989 to safeguard and promote the welfare of children in their area.

Hidden Harm: Responding to the need of children of problem drug users, 2003

Advisory Committee on the Misuse of Drugs (ACMD)

In response to concerns regarding the children of drug misusing parents, the ACMD produced a report in June 2003, which collated evidence about the extent and nature of the impact on babies, children and young people with parents that misuse drugs. The report outlined a series of 48 recommendations covering broad areas of policy and practice.[2] From the inquiry, six key messages emerged:-

1. We estimate there are between 250,000 and 350,000 children of problem drug users in the UK – about one for every problem drug user
2. Parental problem drug use can and does cause serious harm to children at every age from conception to adulthood

[2] The 48 recommendations are set out in Chapter 7.

3. Reducing the harm to children from parental problem drug use should become a major objective of policy and practice
4. Effective treatment for the parent can have major benefits for the child
5. By working together, services can take many practical steps to protect and improve the health and well-being of affected children
6. The number of affected children is only likely to decrease when the number of problem drug users decreases

ACMD, 2003

In the same year the ACMD published *Hidden Harm*, the Scottish Executive published a good practice guidance for working with children and families affected by substance misuse entitled *Getting our Priorities Right*.

ACMD Hidden Harm Working Group, 2004

Hidden Harm's publication and dissemination generated considerable media interest and proved to be the most widely distributed ACMD report to date. The ACMD felt so strongly about the findings of the report that they decided to establish a specific Working Group to monitor and promote the implementation of the recommendations - the first time that such a Group had been set up by the ACMD.

In 2005/06, the Working Group paid particular attention to the wider Every Child Matters Change for Children Agenda, with the aim of ensuring that the needs of children born to and living with parents that misuse drugs are clearly represented and fully integrated within this programme of change. In February 2007, a follow-up report to Hidden Harm was published by the ACMD (see below for details).

Government Response to Hidden Harm

In 2005, DfES published its response to the ACMD's *Hidden Harm* report. The report included a progress update for each of the 48 recommendations, including an outline of which Government department has lead responsibility.

In its response to Hidden Harm, Government states that it will make sure that obstacles, such as parental problem drug use, do not stop children from achieving positive outcomes. To do this, it will bring about closer working between professionals, develop systems which help earlier identification of children at risk and, above all, involve children and young people and listen to their views. Where necessary it will legislate to put in place more effective and accessible services focused around the needs of children.

For those children and young people who are at risk of harm or have been abused or neglected, *Every Child Matters* will put in place a stronger statutory and multi-agency

framework to protect them, and provide services and support for them and their families.

The Scottish Executive also responded to the original Hidden Harm report, publishing '*Hidden Harm Next Steps: Supporting Children – Working with Parents*', in 2006.

National Service Framework for Children, Young People and Maternity Services - Maternity Services, 2004

Department of Health

The framework acknowledges that some women are disadvantaged because they have multiple social problems and may find it difficult to access and maintain contact with maternity services. This applies to those who feel they have stigmatising conditions, such as misusing drugs, alcohol or other substances. The framework notes that the inter-agency working required to support these women is underdeveloped and needs addressing (5.2). In particular, women who have substance misuse problems are at greater risk of problem pregnancies and their care should be provided by an integrated multidisciplinary and multi-agency team (7.10).

One marker of good practice specified in the framework is that maternity services are commissioned within a context of managed care networks and include a range of provision for routine and specialist services for women and their families, such as services for women and their partners who are substance misusers.

Every Child Matters: Change for Children – Young People and Drugs, 2005

DSCF

This document sets out how those responsible for delivering Children and Young People's Services and the Drug Strategy co-operate and plan holistic responses for young people who are using or otherwise affected by drug misuse.

The section entitled 'Targeted interventions with vulnerable young people', states that a key area for development is targeted interventions within generic children and young peoples' services for those most at risk from drugs. It notes that particular consideration needs to be given to provision for 'at risk' groups, including children of problem drug users and that protocols should be in place to provide prompt access to specialist services where required:

Children of problem drug users.

Hidden Harm, the report issued by the Advisory Council on the Misuse of Drugs, estimated that between 200,000 and 300,000 children in England and Wales have one or both parents with serious drug problems. Parental drug problems are associated with a range of poor outcomes for children and young people, including early drug misuse. Adult drug services and early support services, such as Sure Start, play a key role.

Children of parental drug users are a key group within the national Drug Strategy's key performance indicator (KPI) on young people. Guidance has been issued to all DATs locating this KPI within the wider change for children agenda, entitled 'Every Child Matters: Change for Children - Young People and Drugs'.[3]

Integrated Care Pathways Guide 8: Problem Substance Use in Pregnancy and Reproductive Health, 2005

Effective Interventions Unit, Scottish Executive

This guide can assist agencies to develop local Integrated Care Pathways (ICPs) for specific processes and procedures involved in the management of problem substance use during different phases of the reproductive health cycle. There is a range of policy and guidance documents which outline standard professional practice for the management of high risk pregnancies. Local areas produce local guidelines and protocols to meet local circumstances and needs.

Planning and delivery of health and social care during pregnancy should focus on the needs and safety of the woman and baby. However, a wider supportive family-centred approach will encourage the best possible outcomes. It is particularly important to engage fathers in the assessment and care process. The fears and aspirations of problem substance users who are expecting a baby should be taken into account when planning and delivering their care. Some women may be reluctant to engage with services through fear of child protection issues. Local ICP development groups should consider providing service information leaflets about what local services are available and what local agencies do, and do not do.

Working Together to Safeguard Children, 2006

HM Government

Local Safeguarding Children's Boards (LSCBs) are taking on the responsibilities of the old Area Child Protection Committees (ACPCs) and the new wider safeguarding agenda, including children in need. The most widely used definition of 'safeguarding' is as follows:

[3] Letter to DATs from Vivienne Evans, Chair of the ACMD Hidden Harm Working Group, March 2006.

> All agencies working with children, young people and their families take all reasonable measures to ensure that the risks of harm to children's welfare are minimised, and when there are concerns about children and young people's welfare, all agencies take all appropriate actions to address those concerns, working to agreed local policies and procedures in full partnership with other local agencies.
>
> Safeguarding Children: A Joint Chief Inspectors Report (2002)

Whilst the principles of child protection are generally familiar, the principles of safeguarding go one step further. The term 'safeguarding' encourages a wider, more preventative approach to meet the needs of children. This involves agencies working more closely together in an attempt to alleviate problems before they occur. Whilst the principles of child protection are generally underpinning all adult drug services the challenge is now to move towards 'safeguarding' affected children.

The final version of the statutory guidance for LSCBs, entitled '*Working Together to Safeguard Children*', was published in September 2006. Chapter 3 provides a positive opportunity to ensure that the recommendations of *Hidden Harm* are implemented in local areas through joint working on policies, protocols and training. In terms of the scope of the LSCB's role, the guidance notes that LSCBs are responsible for responsive work to protect children who are suffering, or at risk of suffering, harm due to parental substance misuse and to develop appropriate local protocols for inter-agency working in order to carry this out.

> **Chapter 3: Local Safeguarding Children Boards**
>
> **Scope of the role of LSCBs**
>
> Paragraph 3.14 states: The third area is responsive work to protect children who are suffering, or at risk of suffering, harm, including:
>
> - children abused and neglected within families, including those harmed:
>   - as a consequence of the impact of substance misuse".
>
> **Policies and procedures function**
>
> Paragraph 3.19 states: "This includes ....agreeing inter agency procedures for s47 enquiries and developing local protocols on key issues of concern such as:
>
> - children living with domestic violence, substance abuse or parental mental illness".

Chapter 11 on '*Safeguarding and promoting the welfare of children who may be particularly vulnerable*' includes a section on '*Children of drug-misusing parents*' which references the ACMD's *Hidden Harm* report. The guidance clearly sets out the role and responsibilities of the LSCBs in addressing this issue, including the need for inter-agency protocols and joint working:

Children of drug-misusing parents

Paragraph 11.52 states: "It is the responsibility of LSCBs to take full account of the particular challenges and complexities of work in this area by ensuring that there are appropriate:

- LSCB policies and procedures in place;
- inter-agency protocols in place for the co-ordination of assessment and support, particularly across adult drug services and children's services;
- close collaboration with local DATs/CDRPs and local drug services, as well as a number of other agencies including health, maternity services, adult and children's social care, courts, prisons and probation services".

In addition to the above, the guidance contains other specific references to children living with parental substance misuse:

Chapter 2: Roles and Responsibilities:

Health Services

Paragraph 2.34 acknowledges that "all health professionals who work with children and families" should be able to "contribute to planning support for children at risk of significant harm, e.g. children living in households with domestic violence or **parental substance misuse**."

Alcohol and drug services

Paragraph 2.96 states that "Where children may be suffering significant harm because of their own substance misuse, or where **parental substance misuse** may be causing such harm, referrals need to be made by Drug Action Teams or alcohol services, in accordance with LSCB procedures. Where children are not suffering significant harm, referral arrangements also need to be in place to enable children's broader needs to be assessed and responded to".

Chapter 9: Lessons from Research and Inspection

Emotional abuse

Paragraph 9.7 states that "There is increasing evidence of the adverse long-term consequences for children's development where they have been subject to sustained emotional abuse, including the impact of serious bullying. Emotional abuse has an important impact on a developing child's mental health, behaviour and self-esteem. It can be especially damaging in infancy. Underlying emotional abuse may be as important, if not more so, than other more visible forms of abuse in terms of its impact on the child. Domestic violence is abusive in itself. Adult mental health problems and **parental substance misuse** may be features in families where children are exposed to such abuse".

Common Assessment Framework, 2006

DCSF

The common assessment framework (CAF) is a crucial component in the Every Child Matters: Change for Children strategy to achieve a greater focus on preventing things from going wrong in children's lives rather than on dealing with the consequences once difficulties have occurred (DfES, 2004). In addition to supporting earlier intervention, the CAF aims to improve multi-agency working, helping practitioners to undertake assessments in a more consistent way and ensuring more appropriate referrals, and to reduce bureaucracy for families by decreasing the amount and length of any further assessments. The CAF is a nationally standardised, holistic approach to assessing children's needs and deciding how they can be met. It has been developed for use by practitioners in all agencies working with children, young people and families, and can be used for any unborn baby, new baby, child or young person with additional or unmet needs, i.e. those at risk of poor outcomes.

The CAF was piloted during 2005-6 and over two thirds of local authorities chose to use the CAF during the trial year. All local authorities are expected to be working towards implementing the CAF between April 2006 and the end of 2008.

A common assessment may be needed if parents have problems, such as substance misuse, that might impact on the child. The CAF provides a holistic, child-centred approach that ensures it is not substance misuse alone that is assessed, but rather assessment of children's needs and their family's ability to meet them.

Further details of the CAF are available from the Every Child Matters website. As part of its Parenting and Alcohol project, Alcohol Concern has produced a briefing paper which looks at how practitioners working with children, young people and/or families can use the common assessment framework to identify the potential impacts of parental alcohol misuse. Guidance is offered on setting the context for an assessment with families, so that questions can be asked more openly and family members feel comfortable responding.

National Drug Treatment Monitoring System (NDTMS), 2006

National Treatment Agency for Substance Misuse (NTA)

In order to respond to the recommendations of the ACMD's report 'Hidden Harm', ministers have requested that the National Treatment Agency (NTA) facilitates the collection of data about the children of clients presenting to drug treatment services. To support this, the data item '*Parental Status*', previously listed in the core dataset documentation as being optional, is now considered mandatory. The NTA expected that submission of this data would begin to take place from all providers during the course of 2006/07, once any necessary change had been made to their submission mechanisms (e.g. clinical software packages) (Letter from Paul Hayes, Chief Executive, NTA, April 2006).

Models of care for treatment of adult drug misusers: Update 2006

National Treatment Agency for Substance Misuse (NTA)

This is an update of Models of Care (2002) to provide national guidance on the commissioning and provision of treatment for adult drug misusers. One of the key differences between Models of Care 2002 and the Update 2006 is more focus on harm reduction with interventions integrated into all tiers. The Update 2006 also advocates a harm reduction approach is adopted with service users' families and significant others (e.g. minimising risks to the children of drug-misusing parents) (section 3.2.1).

With regards to treatment engagement, the guidance suggests that a range of interventions to support engagement could be explicitly commissioned, including services for the children of drug users (3.9.2). Referencing the ACMD's Hidden Harm report, the guidance acknowledges that the needs of the children of drug-misusing parents require greater attention. Furthermore, during drug treatment delivery, the wider needs of the client, including support with parenting, need to be addressed:

> *Drug treatment delivery*
> The children, carers or significant others of service users should also be considered during care-planned treatment. The needs of the children of drug-misusing parents also require greater attention (ACMD, 2004).
>
> During this phase, clients should begin to receive other interventions to meet their wider needs. These interventions could include improving housing status, getting other healthcare needs met by other health specialists (e.g. liver disease and dentistry), help with children and family issues, and provision of assistance to enable service user back to work or education. These nondrug treatment interventions should be set out in the client's care plan and links made with appropriate services to ensure the client receives them. This includes the initiation of elements of community integration.

In terms of risk assessment, the guidance notes that one of the main areas of risk requiring assessment is the risk of harm to others (including harm to children). If risks are identified, risk management plans need to be developed and actioned to mitigate immediate risk. If a service has concerns about the needs and safety of children of drug misusers, local protocols should be followed; for example if there are concerns about risk of significant harm, social services would normally be involved in further assessment of risk. The guidance notes the need for cross-agency work to safeguard children:

> Issues of risk highlight the need for appropriate information sharing across services and therefore the need for cross-agency policies and plans, and for clarity with a client around the limits of confidentiality.

The section on '*Quality Requirements for Providers*' mentions the following requirements to reduce drug-related harm to others:

QRP 4: Reducing drug-related harm to others

- Drug treatment providers ensure that drug service users' significant others have access to support and interventions to reduce harm related to drug misuse. This includes intervening to reduce the risk of (significant) harm to the children of drug misusers and ensuring partners and families of service users have access to support in their own right
- Drug treatment providers work within Area Child Protection Committee guidelines

Hidden Harm Three Years On, 2007

ACMD

In 2007, the ACMD Hidden Harm Working Group published a follow-up report, entitled 'Hidden Harm Three Years On: Realities, Challenges and Opportunities'. The report demonstrated that the original Hidden Harm report has had a significant impact on policy and practice at national, regional and local level. This impact is not yet consistent across all four countries and all 48 recommendations, but there is evidence of positive progress in all parts of the UK.

The report demonstrated that children can experience improvements in their lives and those of their families, when the complexity of 'Hidden Harm' is grasped and co-ordinated responses between and across adults' and children's services are developed and put into practice. The challenge is to integrate the specific needs of children of problem drug users into both the change for children's programmes and the drugs (and alcohol) strategies in the four countries of the UK, and to maximise implementation of this integration at regional and local level. The report noted that it is critical that an explicit focus on keeping these children safe from harm is embedded within the change programmes for children's services, in particular within their outcomes frameworks.

The report also noted that adult drug treatment services need to understand the complex relationship between drug dependency and parenthood, and develop responses on the basis of this. Therefore, treatment services have a role both in providing treatment programmes tailored to parents, and in working collaboratively with children's services to enhance parenting capacity and enable children to flourish.

Safe. Sensible. Social. The Next Steps in the National Alcohol Strategy, 2007

HM Government

This strategy reviews progress since the publication of the *Alcohol Harm Reduction Strategy for England* (2004) and outlines further national and local action to achieve long-term reductions in alcohol-related ill health and crime. The strategy includes a section on *Alcohol misuse by parents*, which stresses the importance of adult and children's services working in close partnership to ensure that the best possible service is delivered to families with children.

The strategy references the revised guidance document *Working Together to Safeguard Children*, which recommends the establishment of inter-agency protocols for coordinating assessment and support between adult drug services and children's services as well as collaboration with other agencies, such as health, maternity, social care, courts and the prison/probation services. The strategy notes that the need to identify and respond to parental substance misuse is included in the Common Assessment Framework (CAF) for children's services. In the section entitled '*Taking Responsibility*', the strategy identifies LSCBs as having the responsibility for "Safeguarding and promoting the welfare of children including those cases where parental alcohol misuse is a factor".

Hidden Harm Self Assessment Tool, 2007

Substance Misuse Team, DCSF

In September 2007, the national Substance Misuse Team published a self assessment tool designed for use by partnerships to assess their strengths and weaknesses in terms of the Hidden Harm agenda. The tool was developed as part of the DCSF High Focus Area (HFA) programme on young people and substance misuse. The programme started in April 2005 and, from September 2006, it was delivered across the country on a thematic basis; Hidden Harm being one of the key themes.

The Hidden Harm Self Assessment Tool, launched in September 2007, was tested and further developed over a one-year period. The Tool takes into account the 48 key recommendations from the original Hidden Harm report (ACMD, 2003) and the subsequent progress report (ACMD, 2007). The three key sections of the assessment document are as follows:

1. **Strategic Commitment** - Who currently 'owns' the agenda at partnership level? How is it prioritised within local plans? What processes are in place to assess the scale of the problem? Is there a framework for performance monitoring delivery across a range of services (adult & children)?

2. **Identification & Interventions** - How and where are children identified? What responses are available ranging from early intervention to crisis intervention services for those children and families affected? What protocols are required to ensure that responses are appropriate?

3. **Workforce** - How do we skill up practitioners to embrace and work with this agenda more effectively? Does the staffing setup in partner agencies facilitate better engagement with this client group (children and families)?

The tool is intended for use by local partnerships, specifically LSCBs to get a clearer picture of local strengths and needs and to enable a coherent plan of action to be drawn up to ensure that the needs of both children and families of substance misusing parents (including alcohol) are adequately identified and met. The Substance Misuse Team stressed that the overall assessment 'results' are less important than the discussions that they hope the tool will generate to stimulate further action.

Safeguarding the Children of Substance Misusing Parents: Guidance for Adult Drug Services, 2007

Substance Misuse Team, DCSF

Whilst the work on the DCSF Hidden Harm theme was not exclusive to adult drug services, the initial mapping work revealed that there were inconsistencies in the way adult treatment agencies request, record and subsequently action information from clients about children. Most agencies do routinely ask questions about any children as part of the initial assessment process and as part of the ongoing care. Most agencies have child protection policies which are followed when it becomes apparent that a child may be at risk of serious or significant harm.

What is much less clear is what action should be taken, if any, when a client discloses that they have children living with them but no other information is available in terms of the well-being of those children. Because of this, guidance for adult substance misuse services was put together in an attempt to clarify statutory requirements and also to outline a proposed model to ensure the needs of affected children are met. The guidance describes the role of adult substance misuse workers in the context of 'safeguarding' and recommends the use of the Common Assessment Framework (CAF) for all clients with parental responsibility for children.

In addition to the legislative background, the guidance outlines a step-by-step process in the form of a flowchart which should be adopted by all substance misuse services to ensure the needs of their client's children are addressed.

Hidden Harm Training Course (for Adult Drug Services), 2007

Substance Misuse Team, DCSF

This one-day training course, developed by the national Substance Misuse Team, is specifically tailored towards adult substance misuse services covering the key aspects of safeguarding the children of problem drug users. Adult substance misuse services have a unique and specific role to play in this process in terms of identifying children in the family.

The course was piloted in four areas across the country: Redcar & Cleveland, Rochdale, Bradford and South Tyneside. Seven downloads from the Every Child Matters website make up a complete one-day course which partnerships may wish to use to deliver in-house training.

Safe. Sensible. Social. Alcohol Strategy Local Implementation Toolkit, 2008

Alcohol Concern, Home Office, Department of Health, DCSF

Alcohol Concern has worked with the Home Office, Department of Health and DCSF to produce a toolkit for developing local alcohol strategies. The toolkit can assist local partnerships to tackle alcohol health and social care harms at local level, in line with the national alcohol strategy.

The toolkit acknowledges the fact that one of the biggest risks alcohol causes to children is through parental drug and alcohol misuse, and that local partnerships should take this issue into account when developing local alcohol strategies (see section entitled *Targeting parents whose drinking is causing risk to the wellbeing of children*). The toolkit suggests a number of possible activities to address parental drug misuse:

Possible activity to address parental alcohol misuse	Outputs/outcomes
Develop clear protocols through the Local Safeguarding Children Board for identifying and intervening in cases of parental alcohol misuse, including protocols that set out arrangements between alcohol services and child protection services	1. Implementation of agreed protocols 2. Increased referrals between child protection services and alcohol services
Provide training for all relevant workers (e.g. health, social care, probation) to identify and address parental alcohol misuse	1. Increase in numbers trained 2. Increase in interventions offered to parents 3. Increase in numbers of parents receiving alcohol interventions

Develop family-focused alcohol treatment services	Increase in numbers of families in treatment
Provide support for children in heavy drinking environments (e.g. confidential child-specific services)	Increase in numbers of children receiving support
Offer parenting training and support for families (e.g. through Sure Start Plus family centres)	Increase in numbers of parents receiving training and support

Think Family: Improving the life chances of families at risk, 2008

Social Exclusion Task Force, Cabinet Office

The Social Exclusion Task Force has been leading a cross-government review of policy on families at risk which includes parental substance misuse as a key driver of poor family outcomes. On 10th January 2008, Ed Miliband and Beverley Hughes launched a new approach to local services to improve support for the most disadvantaged families and prevent problems passing down from excluded parents to their children. The focus of *Think Family: Improving the Life Chances of Families at Risk* is less on the level of support for families at risk and more on the way that support is provided, ensuring that adult services support whole families not just individuals. The *Think Family* approach encourages local services to adopt the following basic principles:

- **No wrong door** – contact with any service offers an open door into a system of joined-up support, e.g. a probation officer or housing officer identifies the adult language difficulties of a client and refers them to English for Speakers of Other Languages (ESOL) training;
- **Look at the whole family** – services working with both adults and children take into account family circumstances and responsibilities, e.g. an alcohol treatment service combines treatment with parenting classes while supervised childcare is provided for the children;
- **Provide support tailored to need** – tailored and family-centred packages of support are offered to all families at risk, e.g. a Family Intervention Project works with a family to agree a package of support best suited to their situation;
- **Build on family strengths** – practitioners work in partnerships with families recognising and promoting resilience and helping then to build their capabilities, e.g. family group conferencing is used to empower a family to negotiate their own solution to a problem.

In supporting and enabling local services to put these principles into action, the *Think Family* approach:

- **embeds early intervention and prevention** within the existing system of support and extends tailored family services to reach a wider range of vulnerable families, in part through continued investment in existing projects shown to work including Family Nurse Partnerships and Family Intervention Projects;
- extends the logic of co-operation behind Every Child Matters to adults services so that **all services share responsibility for family outcomes**, encouraging and empowering frontline staff to innovate and cooperate in response to whole family situations.

The DCSF has committed a total of £16m to establish a series of Family Pathfinders to test and develop the 'think family' model and generate and share evidence of what works on the ground.

Drugs: Protecting Families and Communities. The 2008 Drug Strategy

HM Government

The ten-year drug strategy (2008-2018) aims to restrict the supply of illegal drugs and reduce the demand for them.

The four strands of work within the strategy are:

- Protecting communities through tackling drug supply, drug-related crime and anti-social behaviour
- Preventing harm to children, young people and families affected by drug misuse
- Delivering new approaches to drug treatment and social re-integration
- Public information campaigns, communications and community engagement

The key focus of this latest strategy is protecting families and strengthening communities. The strategy acknowledges that Government has sometimes focused too much on the individual drug user and not enough on their family and the wider community. In response, one of the key differences that the new strategy brings is:

> More focus on families, addressing the needs of parents and children as individuals, as well as working with whole families to prevent drug use, reduce risk, and get people into treatment.

Key policies in the Drug Strategy include:

- Focusing on the families where parents misuse drugs;
- Intervening early to prevent harm to children;

- Prioritising parents' access to treatment where children are at risk; and
- Providing intensive parenting guidance and supporting family members, such as grandparents, who take on caring responsibilities.

Drugs: Protecting Families and Communities. Action Plan 2008-2011

HM Government

The Drug Action Plan includes three strategic objectives under the theme ‘Preventing harm to children, young people and families affected by drug misuse’, which are:

- A new package for families;
- Mainstreaming prevention;
- Making improvements to the treatment system for young people.

21 key actions are set against these strategic objectives, details of which can be found at Appendix A.

Chapter 4 National Charity Initiatives, Projects & Campaigns

The Children's Society: Stars National Initiative

The concept of STARS evolved from a consultation process in Nottingham focusing upon gaps in local service provision. This process highlighted drugs as an increasing concern, particularly relating to parental use. The few services available to children affected by parental substance misuse were often family centred, rather than child centred.

The STARS National Initiative aims to ensure that every child affected by an adult's substance use in the UK, has access to specialist services, and receives child focused responses to their needs. In order to achieve this, the Initiative aims to: build capacity and competence amongst child care professionals; offer information to children and professionals; ensure this group of children's voices are heard and included in policy and provision; and support the development of services for this group across the UK. STARS holds regular forum meetings for children and practitioners and has a website offering information and guidance for children and young people, parents, and practitioners. The practitioners section of the website is designed to give practical tips about how to safeguard children and young people and raise awareness about the issues they face. It includes guidelines, policies, sample job descriptions, and team development packs/training courses.

The STARS project also works to contribute to the overall objective of The Children's Society in this field, to ensure that children and young people who are affected by drugs, alcohol and substance use enjoy the same rights to home, family life, protection and support as any child. This is done by:

- Raising the profile of children and young people whose parents use substances as a group with distinct needs from young people who use substances themselves and parents whose children use substances.
- Demonstrating that this group of children require, have the right to and benefit from stand-alone support services.
- Promoting children and young people's views to other children and young people, professionals and decision makers at local, regional and national levels.
- Demonstrating models of good practice.
- Challenging the poorer practices that have been allowed to perpetuate with this group of children and offering practical ways – via training, consultation and dissemination – of promoting good outcomes for children and young people whose parents use substances.[4]

[4] Stars Evaluation Report, 2004

As part of the STARS project, nine children and young people aged between 8 and 16 have created a DVD, which records the impact of parental substance misuse upon them, from their perspectives.

National Children's Bureau: The Children of Drug Misusing Parents Project

The Department of Health provided funding for the National Children's Bureau (NCB) to undertake a project between 2003 and 2006 which focused on those children who were 'in need' as a result of parental drug misuse and the response of agencies from the point of referral through to permanency planning for those who could not safely remain at home. These were the children in need of tier 3 and 4 services and, therefore, where there was some involvement from children's social services.

Two local authorities were selected to work in partnership with the NCB, and provided access to case files and staff in order for the project staff to gain an understanding of the key issues and to work together on developing their practice. One authority was a large county, and two locality offices within children's social services were selected for particular focus. The other was a small unitary authority. Interestingly, the issues that emerged were almost identical. Project activities included: mapping the extent of the demand; case studies; interviews; documentary analysis; development activity; and evaluation.

Following on from this work, the Department of Health funded the NCB to publish *Adult Drug Problems, Children's Needs: Assessing the impact of parental drug use - a toolkit for practitioners* as a next step in supporting local areas to respond to the problem of parental drug misuse. The toolkit is designed to support practitioners in their work with families where parents misuse drugs and there are concerns about child welfare. It focuses on drugs rather than alcohol, although alcohol use is acknowledged as often being part of a wider pattern of substance misuse. The toolkit, which was published in 2006, is aimed at all practitioners involved with such families. Although the main practitioners are likely to be children's social workers and substance misuse workers, primary care and school staff often have a role, as do criminal justice agencies, obstetric or paediatric teams from NHS hospital trusts and a wide range of voluntary and community services.

The toolkit contains:

- Summaries of the key messages for practitioners
- Tools and tips to support effective practice
- Useful information about a range of relevant topics
- Training and development activities
- Practice examples from around the UK

Turning Point: Bottling it Up Campaign

Turning Point's 'Bottling it Up' campaign was launched in May 2006. The following is a summary of the campaign's background:

- 'Bottling it Up' forms part of a bigger campaign regarding the effects of parental substance use on families;
- Adult services missed the fact that the adult's were parents;
- An increase in alcohol misuse was evident in drug services;
- Children are affected by alcohol 5 times more than drugs – no document pulled together information such as Hidden Harm which exclusively covered drugs;
- Alcohol services have no capacity or resources to work with the children;
- The aim of 'Bottling It Up' was to raise awareness (through campaign) and then take action.

Thanks to the support of everyone that got involved in the campaign through writing to their MP, contributing their experiences to the 'Bottling it Up stories or signing the petition, Turning Point has had a number of successes with the Bottling it Up campaign:

- Turning Point has received a grant of £1.25m from the Big Lottery Fund to run a three year pilot project called 'Base Camp'. Three sites across the UK will now have workers dedicated to working with whole families affected by parental alcohol misuse. They will be looking to find the best ways of working with families affected by this issue.
- Turning Point has received senior political support for the campaign, with Tony Blair mentioning the issue in a speech he made on social exclusion, and Cherie Blair supporting the campaign at an event held by Turning Point at the Labour Party Conference 2006.
- The Government recognised the importance of tackling this issue in the Alcohol Strategy 'Safe. Sensible. Social' launched in June 2007.

During the course of the campaign, Turning Point received a number of email testimonies from people with experience of parental alcohol misuse, either as a child, family member, or as a parent themselves. These testimonies were collected, anonymised and delivered to the Prime Minister Tony Blair to highlight the real effects that this issue has on families across England and Wales. Extracts from these testimonies have been published on the Turning Point website.

Alcohol Concern: Parenting and Alcohol Project

Alcohol Concern's Parenting and Alcohol Project aims to strengthen and develop the capacity of alcohol professionals and parenting professionals to work with parents who have alcohol-related problems, to protect and improve the quality of life and

opportunities of their children. The project offers training to alcohol professionals as well as parenting professionals on working with problem-drinking parents to protect and improve the quality of life and opportunities of their children. The project also provides a resource base for professionals and a source of expertise to bring about policy reform in this area.

The project's website, funded by The Parenting Fund, has a range of resources for professionals, including a series of toolkits for supporting children affected by parental alcohol misuse which are individually targeted at Teachers, School Nurses, Practice Nurses/General Practitioners, Health Visitors, Social Workers, and Alcohol Workers. The toolkits are designed in direct response to the needs and issues faced by professionals in touch with children.

It is hoped that these toolkits will assist in increasing the confidence of professionals in applying their own skills and abilities in support of children who live with parents who misuse alcohol.

A series of briefings and guidance for professionals working with parents who misuse alcohol are also available to download from the project's website:

NSPCC: The impact of parental substance misuse on children

The NSPCC is one of five children's charities involved in a project funded by the Department of Health to look at how the voluntary sector can build capacity to respond effectively when substance misuse is a concern. As part of this project, the NSPCC is developing a multi agency training pack focusing on the impact on children of living with parents who misuse substances. Contributors include representatives from Health, Education, Children's Services, LSCBs, the Prison Service, Specialist Drug and Alcohol Services, and the NSPCC. At the time of writing, the pack is in the final edit stage and due to be released shortly. For further information, contact Melanie Pace at mpace@nspcc.org.uk.

Adfam Projects

Adfam is a national organisation working with and for families affected by drugs and alcohol. They provide direct support to families through publications, training, prison visitors' centres, outreach work and signposting to local support services. As the voice of families, it provides consultation on best practice in substance-related family work and has written several guides for professionals and commissioners. The Adfam website has been created to provide families with information to help them deal with the problems they face on a daily basis.

The following are some recent examples of Adfam projects:

We Count Too

Produced by Adfam, PADA and Famfed in 2005, *We Count Too* provides essential guidance on the types of services which families need. Through in depth research and consultation with family members, support groups and DATs across England, the guidance identifies how services can be commissioned and developed to help families in the most supportive and accessible way. This is a useful guide, especially for more established groups looking to improve, or re-assess, their approach to service provision.

Bouncing Back! Prevention Programme

The Bouncing Back! Prevention programme has been supporting good practice with families in the field of substance misuse prevention and awareness. The aim of the programme has been to pilot and develop good practice, knowledge and expertise to engage vulnerable family members, carers and parents in drug education initiatives.

The programme has recognised the links between positive parenting education and drug awareness. Parents, carers and family members who are supported in improving relationships within the family and their own confidence and self-esteem, are more likely to communicate effectively about drugs with their children.

A report that explains the Bouncing Back! project and its outcomes has now been launched with the assistance of Parmjit Dhanda MP, Under-secretary of State for Children, Young People and Families and the families involved in the six pilot projects.

Including Diverse Families Capacity Building Project

'*Including Diverse Families*' is a 3-year project funded by the Big Lottery Fund to help develop the awareness, understanding and skills of existing family support services and groups to work with the following under-represented groups:

- Men
- People from minority ethnic groups - including refugees and asylum seekers
- People living in rural communities
- Lesbians, gay men and bisexual people

The work is focused in the South West and London; the two regions which have been identified as having proportionally fewer services than many other parts of the country. The project's aims are to:

- Increase the awareness, understanding, and skills of the substance misuse family support sector in meeting the family support needs of these under-represented groups

- Develop and enhance the confidence, knowledge and skills of family support services in the South West and London to provide quality services to these under-represented groups
- Facilitate and draw on existing good practice in meeting the needs of these under-represented groups and to encourage the involvement of family members affected by someone else's drug and/or alcohol use in the development of quality services.

The project co-ordinators, based in the South West and London, are working closely with several organisations and/or groups and offer expert support and guidance to help services embrace under-represented groups. The co-ordinators will use the time spent and lessons learnt with the organisations/groups to develop a toolkit and training package to be disseminated to family support services and organisations across the two regions.

In the South West, the project is currently gathering existing good practice on how to engage and work with black and minority ethnic families. Further details on the project are available from Shameem Nawaz, Community Development Co-ordinator (South West), Email: Shameem Nawaz, Tel: 020 7553 7657 / 07809 764 576

Adfam, Grandparents Plus and Mentor UK: Mind the Gap Grandparents Project

During 2005-2007, Adfam, Grandparents Plus and Mentor UK worked together, with funding from the Department of Health, to assess the needs of grandparents who are bringing up their grandchildren, so that they can help protect their grandchildren from developing problems with drugs and alcohol.

Having worked closely with grandparents around England, they have produced the '*Mind the Gap*' resources for grandparents who are bringing up grandchildren and professionals who work with these grandparents, containing:

- a staff training pack for a half day training session for staff and volunteers working with grandparents who are bringing up grandchildren;
- an information leaflet for grandparents;
- a DVD about the experiences of grandparents;
- services assessment tools to help improve how well services currently meet the needs of grandparents bringing up their grandchildren;
- a directory of services for grandparents bringing up their grandchildren; and
- policy recommendations for changes in policy and practice in working with grandparents.

Barnardo's 'Fit for Purpose' Learning and Assessment tool

Barnardo's have produced this tool to enable services (its own and others) to assess their capacity to respond to children, young people and families affected by substance misuse. The tool was developed and piloted in six Barnardo's services and was used by the North East region when developing their planning for *Hidden Harm*. It is currently being used to assess all Barnardo's services in Wales. For further information, telephone 0207 843 6335.

ENCARE

ENCARE is a European network for children affected by risky environments within the family. The network was launched in May 2004 and is currently a collaboration between 23 European countries. To date, ENCARE has undertaken 5 projects focused on children living with parental alcohol misuse and/or parental domestic abuse, organised 2 international symposia and facilitated in creating national networks across European countries. One of the main sections of the ENCARE website focuses on children living in families where there is parental alcohol misuse. The website summarises the nature and extent of the problem and the impact on children, and includes a list of published articles and a discussion board.

Chapter 5 Examples of Good Practice

Governance Arrangements

Plymouth

Plymouth was one of the authorities involved in the DCSF High Focus Area (HFA) programme on young people and substance misuse. Through their work on the HFA programme, they discovered that there are various models for LSCB; in essence the seniority of the members dictates their approach. Those with less senior membership have first hand knowledge of the subject area, but may not be able to commit their organisations and may be less comfortable with strategic decision making. Those with more senior members are empowered to commit their organisations and are comfortable with strategic decision making; they may not always be familiar with detail of the subject area

Plymouth LSCB is interesting in that the members are very senior (the Chair is Chief Executive of the Authority). Following a HFA presentation they focused on the Hidden Harm Agenda. Given the seniority of membership and the wide brief they chose to form a subgroup. Learning from the experience in other areas they set very careful Terms of Reference for the sub-group. In order to retain the senior input the subgroup was restricted to meet on three occasions. It was acknowledged that whilst a practice forum might be useful, this was not the right vehicle. The LSCB appointed a Hidden Harm lead who Chaired the sub group. This gives the conduit back to the LSCB and ensured the agenda remained alive within the LSCB after the sub group ended.

For further information, contact Dave Schwartz (tel: 01752 307489; email: dave.schwartz@plymouth.gov.uk)

Sunderland

The Sunderland LSCB also has a multi-agency Hidden Harm sub-group. The Terms of Reference for the group can be found at Appendix B.

Strategic Plans

Brighton and Hove

The Brighton and Hove Children and Young People's Trust Partnership includes a *Hidden Harm* Adult Service and support for affected children and young people within its Children and Young People's Plan (CYPP) 2006-2009:

> Priority 5: *To ensure that all young people & parents gain information, advice & support on alcohol & substance misuse* includes the following targets:

- Develop supportive services for parents/carers using substances through the development of a new Hidden Harm Adult Service by September 2006 (Parents of Children at Risk (POCAR))
- Provide interventions to 65 young people who have parents/carers that are problematic substance users in 2008/9

Supporting Improvement Plans identified include:

- Alcohol Action Plan
- A Strategy to Reduce Health Inequalities in Brighton & Hove 2005
- Brighton & Hove Sexual Health Policy
- Community Safety, Crime Reduction and Drugs Strategy
- Drug & Alcohol Action Team Young People's Plan

By June 2007, the partnership was on schedule to achieve its target of at least 91 parents or carers with problematic substance misuse accessing specialist treatment. For young people, the 2006/07 target of 41 receiving therapeutic interventions was achieved. Patched CRI offers advice, information and support service to the friends, families and carers of substance misusers and to anyone in the wider community experiencing the effects of someone else's substance misuse problems. In 2006-07 Patched met most of its annual targets in both the local community and in Lewes Prison.

For further information, contact Clare Hardman, Social Inclusion Project Officer, Brighton and Hove Children and Young People's Trust (tel: 01273 545402; email: clare.hardman@brighton-hove.gov.uk; clare.hardman@bhcpct.nhs.uk)

Inter-agency Working – Protocols and Guidance

Southwark

The Southwark Safeguarding Children Board has produced a series of Joint Service protocols in order to safeguard children and unborn babies. These Joint Service Protocols give guidance on how services should work together to safeguard and support children whose parents or carers are affected by mental ill health, substance misuse or domestic violence. The protocols reference each other in acknowledgement of the fact that the issues they address are often inter-related and parents/carers and their parenting capacity can be affected by multiple issues.

The *Joint Service Protocol to meet the needs of children and unborn children whose parents or carers have substance misuse problems* was drafted jointly by Southwark Council, South London and Maudsley NHS Trust, Kings College NHS Trust, Guys and St.Thomas' NHS Foundation Trust, Southwark Primary Care NHS Trust and

Community Drug Project on behalf of the inter-agency Southwark Safeguarding Children Board, which agreed the protocol in January 2006.

To support the development of inter-agency partnership working in the specified areas of Mental Health, Substance Misuse and Learning Disability, the Southwark Safeguarding Children Board has set up a **Safeguarding Vulnerable Children Sub Group**. The primary focus of the Group's work is to strengthen assessment and safeguarding procedures between Adult Services and those agencies that provide services in the community to children in need who are identified as particularly vulnerable.

Mainstreaming Work with Children affected by Parental Substance Misuse

Nottingham

Two 'Hidden Harm' posts have been established in Nottingham under the management of Local Authority Children's Services, in order to implement the targets in the Young People's Substance Misuse Plan relating to children affected by parental substance misuse. One post has responsibility for Adult Drug and Alcohol services and the other for Children's Services. These posts are managed by the Young People's Strategic Lead for Drugs and Alcohol. The team focuses on ensuring consistent and joined-up approaches are delivered across the workforce in mainstream services.

In order to support the process of mainstreaming work with children affected by parental substance misuse, all specialist services and posts within Nottingham have collaborated together and developed a **Core Offer** to the emerging Children's Centres in the city. This includes the above posts, the city's STARS Project (run by The Children's Society), Compass Young People's Drug and Alcohol Service, Regents House family support service, the Specialist Midwife in Substance Misuse and Head 2 Head (CAMHS service for under 18-year-olds).

For further details, contact the Nottingham Young People's Drug & Alcohol Strategic Lead (tel: 0115 9151961)

Maternity Services

Southampton

Southampton's Tier 3 community drugs service, New Road, has a team of three child protection leads. One of these is a specialist in pregnant drug users and is the link worker with the midwifery service. A part-time specialist midwifery post is also in place.

Pregnant women presenting to ante-natal services are routinely tested for Hepatitis C with their informed consent (they could refuse this, although few do in practice). In 2006, three pregnant women, who were tested and found to have Hepatitis C, had not known beforehand that they were infected.

Drug users, who reveal their pregnancy, or the existence of children, normally have a home visit by the drugs worker, who will carry out a risk assessment of the child (if the child or children is at home with the drug using parent). Referrals are made to a drugs link worker, who is funded by the Drug Action Team and employed within Children's Services. She often makes joint visits to the home with the drugs worker. Young carers of drug-using parents are also referred to the Young Carers project worker (although the drug using parents are not always keen to see their child regarded as a 'carer').

Southampton also has other projects which work with pregnant drug users. For example, the 3D Project provides services in an outreach centre for women and girls working in the sex trade (all of whom are Class A drug users). These services include education and learning programmes, drugs counselling and support and a place of safety. No Limits, a young people's advice, information and counselling support service, provides a Tier 2 open access substance service for under 18s, and a substance transition service for 18-25s, both commissioned by the Drug Action Team. These projects work regularly with drug using women who are repeatedly pregnant and whose children often have a care order 'in utero'.

These integrated services reflect a high level of partnership working which ensures that pregnant young women who are drug users receive an appropriate care package whether they present as drug users to maternity services or as pregnant women to drug services.

For further information, contact Judith Morrison, Performance Manager and Young People's Commissioner, Southampton Drug Action Team (tel: 023 80 832646, email: judith.morrison@southampton.gov.uk)

South Tees

A copy of the South Tees LSCB's multi-agency protocol for professionals involved in the care of substance using pregnant women can be found at Appendix C.

Leeds

An example job description for a Specialist Midwife recruited by the Leeds Mental Health Teaching NHS Trust can be found at Appendix D.

Devon & Torbay

Devon and Torbay have recently published 'A guide to drugs and alcohol in pregnancy'. The guide was written by Liz Collins, Specialist Midwife, Drugs & Alcohol and Judith Ward, from the Devon Partnership Trust, with support from staff from Devon CYPs, Devon DAAT, Devon Partnership Trust, Torbay DAAT and Torbay CYPs. Written in an informative, supportive and non-judgemental way, the booklet is designed to help an expecting mother to make decisions about managing their pregnancy if they are using illegal or street drugs or alcohol. The booklet provides information and advice on the effects of drugs and alcohol on pregnancy and ways in which local services can support them.

Specialist Services

Middlesborough

Families First is a specialist family support services for families affected by substance misuse. The team provide a service offering advice, social work interventions and family support on issues relating to substance misuse.

The project has been operational since April 2006 and is currently seeking funding for longer term continuation.

The project has two key elements:-

1. Family support service working intensively with families where there was a likelihood of a baby/child being removed due to substance misuse issues. This element of the service is primarily based on the 'Option 2' model from Wales.
2. Social support team for adult substance misuse services, including access to residential rehabilitation.

The team involves 16 staff from both adult and children's services working together to make and sustain change wherever possible. The team use a solution-focused approach in working with families. The aim of the work centres on changing behaviours and improving family functioning.

The Families First intervention is usually for a period of between 6 weeks and 3 months. Once this intervention is complete a 'maintenance plan' is agreed with the family in order to assist the parents in maintaining the changes they have made.

For further details, contact Suzy Kitching, Team Manager (tel: 01642 354070, email: Suzy_kitching@middlesbrough.gov.uk)

Slough

The **Barnardo's Parental Substance Misuse Service** is non-judgemental and committed to working with, and supporting parents and/or expectant mothers through pregnancy, aged 16+ in the Slough area, where drugs/alcohol are having a negative impact on themselves, their children and the family environment. The overall aim of the Barnardo's service is to work directly with parents to ensure positive outcomes for children.

The main focus of the service is on harm reduction, in relation to reducing the harm in which parental drug/alcohol misuse can have on children, and the capacity to parent effectively to ensure their children's basic needs are being met. All referrals to the service are via Slough Children's Services and priority is given to families where there is:

- a child protection concern directly relating to the Childs safety
- a child protection concern relating to the safety of other family members i.e. Domestic Violence and Mental Health
- concerns around the impact of drug/alcohol misuse on the unborn baby during pregnancy
- two or more parents/family members in the home with problematic drug/alcohol misuse

The Barnardo's team works alongside other agencies to ensure appropriate, and continuity of support and care, to enable parents in reaching the best possible outcomes for themselves and their children.

Further details of the service, including feedback from services users, are available from the Barnardo's website.

Bristol City

The main aims of Bristol's *Service for children affected by parental drug and alcohol use* are:

- To work with children to help them understand parental substance misuse and the effects and consequences on them;
- To work with them in their own communities, assessing need and enabling them to enjoy positive life experiences; and
- To work towards reducing the numbers of children and young people who have started to replicate parental patterns of substance misuse

The service is available for children and young people whose parents misuse drugs and/or alcohol and who have an allocated social worker. The referral criteria are as follows:

- Child/ young person aged 5 -13
- Home address in Bristol
- Allocated social worker
- The child/ young person and their parent/carer has agreed to the referral

Further details of the service are available from Danielle Andrews (tel: 0117 3772997; email: danielle_andrews@bristol-city.gov.uk).

North Somerset

Cosmic (Children of Substance Misusing Carers Project) and the Northern Lights Project provide services for children and young people in North Somerset whose parents or carers are misusing drugs and alcohol. Support is provided in a number of ways, including one-to-one meetings with a project worker; opportunities to join group meetings; or attend residentials. A range of fun and educational activities are provided including day trips; craft activities; outdoor pursuits; cookery and food sessions; and workshops to help aid or calm feelings of anger and other emotions. The project workers see children at home, in the community and at school. Children and young people can be referred by parents, teachers, social workers, health workers or they can refer themselves. The project workers aim to see the children and young people referred as soon as possible, but it depends on the length of the waiting list. Contact: Helen Roy, Cosmic (tel: 01934 421944; email: helen.roy@n-somerset.gov.uk; Katie Naylor, Northern Lights Project, tel: 07767 671675, email: katie.naylor@n-somerset.gov.uk

Option 2

Option 2 is a solution focused and goal oriented model of intervention for working with families in crisis. Launched in 2000 by Cardiff Social Services, it quickly won the Community Care award for child protection. Option 2 focuses on exploring people's strengths and values, using them to develop motivation and set achievable measurable goals. It has proved to be a particularly successful and powerful approach to working with families who are having difficulty.

There are teams across the UK who have been trained in and are using the Option 2 model in a variety of settings; big teams and small teams, working in hospitals, children's services and substance misuse teams. In Bristol, for example, the team is based in hospital based social services; in Middlesbrough Option 2 is part of a Families First Project; Norwich has Option 2 as part of the Family Assessment and Support Team; Conwy has Option 2 based in Conwy Care and Housing; whilst in Cardiff and the Vale of Glamorgan, Sheffield and Newcastle, Option 2 is part of children's and adults substance misuse services.

While the different projects in this network use the model in a remarkable variety of different settings and with a wide variety of funding streams, all the teams share the

view that if families are at all capable of looking after their children, then the professionals should do what they can to enable them to do that. If families are not able to look after their children for whatever reason, then the professionals should make the process as transparent and honest and as caring as possible to parents and to children. Representatives from the teams using the Option 2 model meet twice a year and operate as a national 'virtual team' sharing skills and resources and supporting each other in this groundbreaking work.

Further details of Option 2, including example stories of the impact that Option 2 has had on families experiencing problems with parental substance misuse, feedback from parents and professionals, Powerpoint presentations, tools and resources, details of consultation and training, and publications are available from the Option 2 website.

Linkages with other services

Lancashire

The Lancashire School Effectiveness Service, in conjunction with Lancashire County Council and Metamorphoses has recently published '*Good Day at School? Responding To Hidden Harm*'; guidance for Lancashire schools on meeting the needs of children and young people in problem drug using families.

The guidance acknowledges that, as a service available to all, schools have a key contribution to make if all children - including vulnerable groups - are to be healthy, stay safe and enjoy and achieve in life. It is important that every child and young person is able to make a positive contribution to their communities and to economic activity. The guidance includes:

- an overview of the key issues and the impact on children of their parents' problem drug use
- a set of key principles and examples of good practice which can be used for planning, implementing and reviewing policy and practice in schools; and
- practical advice on how schools can support children affected by their parents' problem drug use.

London

"Safety and support for all through the development of inclusive and responsive services for people affected by drugs, alcohol and domestic violence"

Stella Project
Separate Issues Shared Solutions

As the leading agency addressing drug and alcohol related domestic violence and abuse, the Stella Project works across all 33 London boroughs for positive, sustained improvement in the way services are delivered to survivors, their children and perpetrators of domestic violence affected by problematic substance use.

The Stella Project is a partnership between the Greater London Domestic Violence Project (GLDVP) and the Greater London Alcohol and Drug Alliance (GLADA). During 2002, discussions between GLDVP and GLADA identified gaps in the current service provision for both survivors and perpetrators of domestic violence who are problematic substance users. GLDVP and GLADA therefore decided to create the Stella Project in order to find positive and creative ways to work towards more inclusive service provision.

The Stella Project works firmly from the perspective that there is not a simple causal link between substance misuse and domestic violence; drug or alcohol use should never be accepted as an excuse for violent or abusive behaviour and neither should survivors' substance use be used to justify the use of violence against them.

For further details of the Stella Project, including papers and research reports, training programmes, toolkits, and networking opportunities, visit the Stella Project website.

Chapter 6 Progress and Challenges

Since the ACMD's original inquiry in 2003, the issue of Hidden Harm has become more widely acknowledged, with increasing levels of activity at the national, regional and local levels to address this issue. This report has given some indication of the range and extent of recent work to address Hidden Harm, including national strategies and guidance, charity campaigns and projects, and research studies. As a result of this work, this type of harm is becoming less 'hidden' and ignored.

At the national level, the UK Government in England and the three Devolved Administrations all responded to the publication of *Hidden Harm* and took action to integrate the recommendations within mainstream policy developments, particularly the emerging children's services change programmes. Scotland and Wales were initially ahead in terms of their approach to managing and integrating this complex issue; particularly with regard to the need for a coherent and joined-up approach between children's services and adult drug services. However the recent publication of the 2008 Drug Strategy, which acknowledges the need to focus more on families rather than individual drug users, should firmly entrench this cross-cutting issue into mainstream policy and practice across England.

Focusing on key aspects of the Hidden Harm agenda, the following sections summarise progress made to date and common challenges.

Joint Working between Adult and Children's Services

At the local level, the ACMD (2007) found that *Hidden Harm* has had a significant impact on joint working in relation to the planning and commissioning of services for children affected by parental substance misuse across the UK. The strongest picture emerges from Scotland, where *Hidden Harm* has been used to build on work already underway as a result of the performance target in the Drugs Strategy and the subsequent publication of *Getting Our Priorities Right*. In contrast, the picture in England has been patchy. While there is evidence of some excellent and innovative joint working in some parts of the country, other areas seem to be struggling with issues of governance and ownership of the issue. The ACMD's follow-up work in 2007 noted that, at the local level, best progress is being made where multi-agency arrangements exist at both strategic (i.e. planning) and operational (i.e. protocols) levels. The challenge is to anchor multi-agency working in mainstream and routine practice.

However, ensuring joined up approaches to service provision is hard. Organisational boundaries, professional and agency cultures, sources of funding, differences in statutory function and performance assessment all conspire to undermine collaborative working. Common challenges for joint working between adults and children's services are summarised below:

- Different focuses and priorities
- Gaps in worker knowledge and confidence
- Engaging with adult clients and sustaining trust vs. acting on child protection concerns
- Confidentiality issues vs. risk to child
- Information sharing between agencies
- Differences in timescales (need to move quickly with children)
- Balancing parent's capacity to change with long-term risk to child

Sarah Gorin, 2003

Research has shown that substance misuse is often one of a number of inter-related problems that a parent is experiencing. In order to safeguard children, it is important that local services acknowledge parental problems commonly associated with substance misuse, including domestic violence and mental health problems, and develop a holistic approach to supporting parents, children and families. This presents a further challenge for multi-agency working.

Specialist Services for Children and Families

Specific support for children and families affected by parental substance misuse does exist, but the coverage in England is patchy. There are some dedicated workers housed in adult substance misuse or family support services, and there are a small number of projects specifically set up to work with children. Children of substance misusing parents may also access help through local young carers' projects and these have been found to be very popular with children (Gorin, 2005). Other services for children include the STARS National Initiative, which is run by The Children's Society and funded by the Government (see Chapter 4 for further details).

For many local areas, the challenge is to provide specialist services in a climate of financial constraint (see section on Funding for further discussion). Kroll & Taylor's 2008 study noted that there is currently a lack of resources for children and families in contrast to individual drug users in Devon. Professionals identified a need for more therapeutic services for children; and that detox/rehab should be more timely and child friendly. Both parents and professionals noted that there was a need for more specialist workers, including specialist midwives, health visitors and social workers and 'twin trained' (drugs and childcare) professionals in Devon as well as a need for specialist services for children and families.

Maternity Services

The ACMD has noted that maternity services continue to make significant progress in terms of responding to *Hidden Harm*. Key markers of progress include a number of areas reporting well-established and mainstreamed posts and protocols; and evidence of a range of creative approaches to improving access to antenatal care for pregnant drug users (ACMD, 2007).

Training & Workforce Development

The ACMD's original *Hidden Harm* report (2003) revealed that only 30% of drug agencies provided training on working with clients with dependent children and 65% of local authorities provided training in managing families with substance misuse problems. The recommendations by the ACMD on pre-qualification and in-service training for social care workers on potential harm to children of substance misusing parents was declined in the Government response (Gorin, 2005). Instead the Government (via the Department of Health and The Parenting Fund) has funded voluntary organisations to develop guidance, toolkits and training resources, including the NCB's *Adult Drug Problems Children's Needs* toolkit for practitioners; Alcohol Concern's *Parenting and Alcohol Project*; and the NSPCC's training pack on parental drug misuse (see Chapter 4 for further details).

A high priority has been given in Scotland to training and workforce development specifically in relation to improving skills, knowledge and expertise in responding to the needs of children of substance misusers, directly linking this into child protection training. The Scottish Executive currently funds Scottish Training on Drugs and Alcohol (STRADA) to provide specific training modules for drug and alcohol treatment service providers and generic services staff, on working with children of drug and alcohol-using parents. Practice-based workshops have also been developed for more specialist workers. The Scottish Executive has also funded STRADA, in collaboration with Dundee University, to provide child protection training to 2,500 qualified social workers, with a strong focus on the children of substance-misusing parents (ACMD, 2007). The ACMD notes that there is evidence of positive commitment to training in relation to Hidden Harm in some local authority areas in England, but the extent of its coverage is uneven.

Lack of professional knowledge and confidence amongst adult workers when dealing with families with substance misuse problems can be a barrier to children accessing the services they may need. They may not identify potential problems for children or may lack understanding of child protection procedures. The role of adult workers is further complicated by the need to balance the development of fragile relationships with clients, whilst ensuring the safety and welfare of children. Training and workforce development is vital in this area in order to ensure that all adult drug workers understand the relationship between drug dependency and parenthood; the need for drug users to be supported in their parenting responsibilities; and how to safeguard the children of substance misusing parents.

Academic research and national guidance has shown that there is a need for cross sector training in order to break down organisational barriers and develop a common approach to addressing the issue of Hidden Harm. However, such training has yet to be delivered in many areas within England. In Kroll & Taylor's 2008 study, professionals identified a need for more multi-disciplinary training, both specific (e.g. Hidden Harm training) and basic (e.g. how to communicate with children).

Data Recording & Information Sharing

The ACMD's original Hidden Harm inquiry in 2003 found that substance misuse services did not always routinely ask for, or record, information about children; almost a third (32%) of drug agencies did not even record data on the number of clients' dependent children. In addition, a large proportion of local authorities were unable to provide data on the number of parents with alcohol or drug problems or could not distinguish between the two problems. The Government response to the report in 2005 accepted that drug treatment agencies and local authorities should record minimum standard data on children of drug using parents.

In terms of data recording, one of the key markers of progress in this area is the requirement from the NTA for all regions in England to collect data on the children of problem drug users. However, the ACMD (2007) notes that the data being gathered in Scotland since April 2006 on the children of substance misusers are the most robust of the four countries and may offer a model for the other administrations to consider. For the ACMD, it remains a matter of concern that currently there is no requirement in the UK for Safeguarding/Child Protection Units or Services to routinely record and monitor the extent of parental substance misuse as a significant contributory factor in referrals for case conferences and child protection registrations. An equal concern is the absence of a requirement for, and national guidance supporting, the routine recording and monitoring of referrals to Local Authority Children's Services for children affected by parental substance misuse.

In order to safeguard children with substance misusing parents, it is vital that local authorities have efficient data recording systems, which routinely record and monitor children of problem substance misusers and that this information is shared between adult and children's services. In Kroll & Taylor's 2008 study based in Devon, professionals mentioned that they have experienced problems regarding information sharing and confusion about confidentiality when trying to support children with substance misusing parents. They noted that they particularly found it hard to access information from GPs, schools and the police and these barriers to information sharing have impeded effective intervention, particularly for children. In order to support children in need, the professionals identified a need for better information sharing and joint working before the child protection stage is reached. Adult and children's services not only face the challenge of improving multi-agency data recording and information sharing, but they are also challenged to systematically use this information to inform the planning and commissioning of services.

Research & Evaluation

In recent years, a considerable amount of research has been undertaken in the UK by academic institutions and national charities on parental substance misuse and its impact on children. A number of studies have been based on qualitative research involving direct contact with children and young people and the parents. These studies have given a valuable insight into the impact of parental substance misuse on families; their experience of accessing local services and their needs in terms of service provision.

What appears to be less widely available is information on 'what works' and the findings of service evaluations. Does working with the family unit or children individually achieve the best outcomes? Several models are currently being piloted (Evans, 2007). It is important to ensure that the messages from research on the needs of children and families experiencing parental substance misuse and examples of 'what works' are widely disseminated to managers and practitioners in relevant fields.

Assessments

The introduction of the Common Assessment Framework (CAF) was considered by the ACMD (2007) to be a marker of progress in terms of the early identification of children with substance misusing parents. However, the extent to which local professionals use the CAF appears to vary from one area to another. Furthermore, there appears to be mixed feelings amongst local professionals regarding the CAF and the role of assessments in general. Kroll & Taylor's 2008 study found that assessments in cases of parental substance misuse varied in quality and rarely reflected the 'holistic' nature of the assessment framework. Professionals noted that there is currently insufficient assessment of the impact on the children of substance misusing parents.

Funding

One key challenge for local authorities is the difficulty of securing long-term funding to cover all aspects of service provision, including evaluation. Not only is there a general lack of available funding, but also the nature of funding for many services is short-term. This leads to problems with planning, staffing, maintaining services beyond an initial start up period and creates continual work to secure new contracts. The issue of funding has been further compounded by the reduction in the Young People and Substance Misuse budget in England from 2006/07. According to a number of DATs and local services, this has created significant constraints for existing and future investment in this field, as well as reducing the potential to identify new funding to mainstream short-term funded projects (ACMD, 2007).

Rurality

Kroll & Taylor's 2008 study highlighted the challenges of supporting children and families affected by parental substance misuse in rural areas. In the study, professionals mentioned that their ability to penetrate rural communities is limited: the rural dimension contributes to the 'invisibility' of these vulnerable children and drug misusing networks often close ranks.

The rural context also presents barriers to accessing services, including drug treatment and access to chemists. To support children and families in rural areas, professionals in Kroll & Taylor's study identified a need for rural clinics and joint agency outreach.

Engaging with Families

As previously mentioned, a large proportion of parents who misuse substances are not in contact with specialist support services. Barriers to accessing services include fear of losing their children; lack of childcare facilities; concerns that they and their children will face discrimination; procrastination due to drug use; and lengthy waits for appointments (Maguire 2002).

For professionals, engaging with families experiencing substance misuse problems can be a real challenge. In Kroll & Taylor's 2008 study, professionals mentioned that they are often distrusted by parents and they find this difficult to overcome, despite enormous efforts. They suggested that there is a need to restore traditional casework methods (e.g. observation, empathy, establishing rapport) in order to engage families. Cairn's study in 2007 also suggested that it is important to discuss childcare as soon as a therapeutic relationship is established between the professional and parent, although it was acknowledged that this presents a conflict with the NDTMS expectation that detailed questions concerning children and childcare are asked at assessment.

Awareness and Prioritisation of the Issue

In a climate of competing pressure on resources, lack of recognition of the scale and impact of substance misuse on children means that it is not necessarily viewed as a priority in some local areas. There is a need to raise awareness amongst providers of children's services and adult services of the potential and actual risks of harm to children with substance misusing parents and Government guidance on safeguarding these vulnerable children. The ACMD notes that the challenge is to embed the needs of these children into both children's strategies and drugs strategies (ACMD 2003, 2007).

Chapter 7 Developing a Way Forward for Somerset

Following the completion of this study, a workshop was convened in May 2008 involving key stakeholders from a range of organisations across Somerset. The purpose of the workshop was to present the findings of the Hidden Harm study and to discuss how best the issue could be taken forward in Somerset. Stakeholders were given a copy of the ACMD's 48 recommendations and were asked to discuss these recommendations in terms of Somerset current position and areas for future action. The table below sets out the comments and actions as agreed at the workshop. In October 2008, a working group will be convened to coordinate the feedback and plan further action.

Hidden Harm 48 Recommendations (ACMD, 2003)

Notes from Somerset's multi-agency Hidden Harm meeting held 13 May 2008, presented to the DAAT on 10 June 2008

The 48 recommendations are tabled separately below, followed by the information gathered at the meeting, and action points arising.

1 All drug treatment agencies should record an agreed minimum consistent set of data about the children of clients presenting to them.
Turning Point: there is a minimum data set attached to NDTMS. Turning Point's assessment process includes completion of a section on the number of children living with parents. RIO: previous research indicated that SDS clients had in excess of 800 children. It would be helpful to update this information now the new adult service is in place. However, double counting may occur if both parents are in treatment. Turning Point needs to be able to clarify this data. Adults need to be linked together data-wise so a complete family picture is seen. Contact Point: If a child/young person's information is flagged on Contact Point, any agency working with the parents would not show. Information sharing between agencies needs to be standardized, so there are rigorous joint working procedures, and other agencies are always contacted when children are involved, egg a red hazard notification is required on all agencies' databases if the child is subject to a child protection plan.
Actions: • Turning Point to provide a definitive number of (a) parents that they work with who are caring for children, and (b) total number of children being cared for by their client group. • CYPD (Information Managers) to be approached to agree standards for information sharing about children at risk.

2 Whether a client or patient has dependent children and where they are living should be included as standard elements in the National Drug Misuse Treatment System in England and Wales and in the Drug Misuse Databases in Scotland and Northern Ireland and should be recorded in the same way to allow comparisons between regions.
Not discussed.
No actions.

3 Problem drug or alcohol use by pregnant women should be routinely recorded at the antenatal clinic and these data linked to those on stillbirths, congenital abnormalities in the newborn, and subsequent developmental abnormalities in the child. This would enable epidemiological studies to be carried out to establish relationships between maternal problem drug use and congenital and developmental abnormalities in the child.
This information is recorded, but is not always disclosed by the pregnant woman so is ad hoc. This data will be linked into the Child Death Review process, but where a child survives but suffers health problems there is no clear data pathway from the antenatal clinic to other agencies. DAAT Adult Treatment Needs Assessment 2007/08 highlighted audit work undertaken by the Head of Midwifery at Taunton & Somerset NHS Foundation Trust. This revealed that, between January and December 2006 for women in the Taunton catchment area, 37 had misused drugs during pregnancy, 144 had misused drugs before becoming pregnant, 477 records did not have this field completed and 2,700 were presumed to have no drug problems. A similar snapshot on alcohol misuse revealed 2,397 records were blank, 164 were recorded as 'not known', 843 were recorded as 'light' alcohol use, 85 were recorded as 'moderate' alcohol use, and 14 were recorded as 'heavy' alcohol use. The need was identified to formulate and adopt an agreed definition of substance misuse and within that a tool to identify the 'type' of drinker/drug user, egg problematic, social.
Actions: • Formulate, agree and adopt an agreed definition of substance use for multi-agency reference • Develop a method of referencing maternal substance misuse with health problems in surviving children

4 Studies should be urgently carried out to assess the true incidence of transmission of hepatitis C between infected female drug users and their babies during pregnancy, birth and infancy.
Not discussed.
No actions.

5 A programme of research should be developed in the UK to examine the impact of parental problem drug use on children at all life stages from conception to adolescence. It should include assessing the circumstances of and consequences for both those living with problem drug users and those living elsewhere, and the evaluation of interventions aimed at improving their health and well-being in both the short and the long term.

Not discussed.

No actions.

6 The voices of the children of problem drug users should be heard and listened to.

The advocacy service, MAZE, the mentor project, PROMISE, and the Young Carers' project provide services that listen to young people. It would be good to use these existing channels in order to reach (and listen to) children with substance misusing parents. It is likely, however, that opportunities to hear the voices of those aged under ten years are very limited (although linking with the Think Family initiative may assist).

The new adult treatment service (Turning Point) has merged three client databases – what detail is available from them? What services are they linked to?

Some schools have counseling services that children will be accessing. Most of the resources for children are in schools, egg the average school has 20 non-teaching staff. Would CHIPS/Children's Society be able to help with the under 10s? They have four Area Development Officers across the county. We could link in and find out what's happening and potentially influence what they are providing. As well as providing the opportunity for children and young people to voice their concerns, it is important to have a willingness to act on what they are saying. What is shared with a worker on a 1:1 basis needs to be acted upon at a managerial level. Better liaison between schools, especially primary and secondary, would be helpful. Secondary schools ought to think about other children within that family as well, i.e. are there younger siblings in the family that are being affected?

Actions:

- Make links with colleagues involved with Think Family
- Ask MAZE, PROMISE and Young Carers if they can share data regarding children of substance misusing parents
- Turning Point to consider how their data might help
- Contact CHIPS/Children's Society
- Raise profile of Hidden Harm in schools

7 Work is required to develop means of enabling the children of problem drug users safely to express their thoughts and feelings about their circumstances.
See recommendation 6 above.
Actions: see recommendation 6 above.

8 The Department of Health and the devolved executives should ensure that all maternity units and social service children and family teams routinely record problem drug or alcohol use by a pregnant mother or a child's parents in a way that respects privacy and confidentiality but both enables accurate assessment of the individual or family and permits consistent evaluation of and comparisons between services.
There is a County Information Sharing Protocol – but there is a need for an agreement about what information is shared regarding substance misuse. Confidentiality shouldn't be an issue once this is achieved. Specialist midwife/care pathway planning has not yet been completed.
Action: ***** Ensure the future protocol for working with expectant mothers who misuse substances includes the requirement to record and intelligently share information with other agencies.

9 The National Treatment Agency and the devolved executives should ensure that all specialist drug and alcohol services ask about and record the number, age and whereabouts of all their clients' children in a consistent manner.
Not discussed.
No actions.

10 When revising child protection policies and procedures, full account should be taken of the particular challenges posed by parental problem drug use, with the consequent implications for staff training, assessment and case management procedures, and inter-agency liaison.
A recent Serious Case Review, plus this self-assessment, shows there is a need for a new Somerset Protocol that will link with the south west procedures.
Action: ***** Produce protocol.

11 Reducing the harm to children as a result of parental drug use should be a main objective of the UK's drug strategies.
Agreed.
No actions.

12 The Government should ensure that the National Children's Service Framework and equivalent strategic arrangements in Wales, Scotland and Northern Ireland, identify children of problem drug users as a large group with special needs that require specific actions by health, education and social services.
Agreed.
No actions.

13 The National Treatment Agency, the Welsh Assembly Government and the Scottish Executive should ensure that services for adult substance misusers identify and record the existence of clients' dependent children and contribute actively to meeting their needs either directly or through referral to or liaison with other appropriate services, including those in the non-statutory sector. This should include protocols that set out arrangements between drug and alcohol services and child protection services.
Agreed.
No actions.

14 Whenever possible, the relevant Government departments should ensure there are mechanisms in place to evaluate the extent to which the many initiatives outlined in this chapter benefit vulnerable children, including the children of problem drug users.
Agreed.
No actions.

15 All Drug Action Teams or equivalent bodies should ensure that safeguarding and promoting the interests of the children of problem drug users is an essential part of their area strategy for reducing drug-related harm and that this is translated into effective, integrated, multi-agency service provision.
Agreed. This agenda needs to be taken up by the Adult Substance Misuse Commissioners.
Actions: • Hidden Harm to be included on the next agenda of the Adult Treatment Group. • Turning Point staff should receive Child Protection Training.

16 All Drug Action Teams or equivalent bodies should have cross-representation with the relevant children's services planning teams in their area.
This is already provided by SCYPP.
No actions.

17 Drug misuse services, maternity services and children's health and social care services in each area should forge links that will enable them to respond in a co-ordinated way to the needs of the children of problem drug users.
A Somerset protocol needs to be developed, that takes account of the serious case review recommendations and the new role of specialist midwives. Yeovil DC has a pain nurse whose skills are used with pregnant drug-users, but there aren't other equivalents around the county. Turning Point would carry out weekly drug screens on pregnant clients, but there needs to be a protocol about which agencies would be notified of the results. The client would need to sign a consent form in order for the information to be shared. A member of Turning Point staff will have a countywide link role to Children's Social Care and maternity services.
Actions: • Turning Point to send Linda Barnett a copy of their current information sharing protocol. • New protocol must address this recommendation.

18 Every maternity unit should ensure that it provides a service that is accessible to and non-judgemental of pregnant problem drug users and able to offer high quality care aimed at minimising the impact of the mother's drug use on the pregnancy and the baby. This should include the use of clear evidence-based protocols that describe the clinical management of drug misuse during pregnancy and neonatal withdrawals.
This needs development. Some of this is in place, some not.
Action: ***** Turning Point specialist worker(s) need to build links with specialist workers in the PCT.

19 Pregnant female drug users should be routinely tested, with their informed consent, for HIV, hepatitis B and hepatitis C, and appropriate clinical management provided including hepatitis B immunisation for all babies of drug injectors.

The group did not know if this is happening or not. Turning Point would ask clients as a matter of routine, but would not currently carry out the testing. There are plans for them to provide Hep B immunization in the near future.

Action:

***** The new protocol must address this recommendation, including the recognition of which agency is best placed to carry it out.

20 Every maternity unit should have effective links with primary health care, social work children and family teams and addiction services that can enable it to contribute to safeguarding the longer-term interests of the baby.

The serious case review highlighted this as an issue for development. The link between Health Trusts needs work.

Action:

***** Again, the new protocol must address this issue.

21 Primary Care Trusts or the equivalent health authorities in Wales, Scotland and Northern Ireland should have clear arrangements for ensuring that the children of problem drug or alcohol users in their area are able to benefit fully from appropriate services including those for the prevention, diagnosis and treatment of blood borne virus infections.

There is probably work to be done here.

Action:

***** Seek advice from Ethna Bashford.

22 Primary care teams providing services for problem drug users should ensure that the health and well-being of their children are also being met, in partnership with the school health service, children and family teams and other services as appropriate.

Work such as that of GPs with a special interest, and those providing shared care, is overseen by Turning Point. Multi-disciplinary training must continue.

Action:

***** The new protocol must include this.

23 Training programmes on the management of problem drug use by primary care staff should include information about the importance of recognising and meeting the health care needs of the children of problem drug users.
Not discussed.
No actions.

24 All general practitioners who have problem drug users as patients should take steps to ensure they have access to appropriate contraceptive and family planning advice and management. This should include information about and access to emergency contraception and termination of pregnancy services.
The group didn't think GPs do this, at least no more than for anyone else on their books. Would be relatively easy to ask them – Carol Lennox (DAAT Shared Care Coordinator) to be involved? This could potentially be added to the shared care contract.
Action: ***** Carol Lennox to be consulted, and appropriate action taken.

25 Contraceptive services should be provided through specialist drug agencies including methadone clinics and needle exchanges. Preferably these should be linked to specialist family planning services able to advise on and administer long-acting injectable contraceptives, contraceptive coils and implants.
Condoms are available from Turning Point, but there needs to be discussion with the provider services in the PCT concerning what capacity there may be for other contraceptive services to be delivered through Turning Point (i.e. not just condoms). Turning Point's assessment involves a discussion about sexual health. It is recommended that a sexual health clinic be held at TP offices on a regular basis. It may also be worth linking with PCT public health lead for sexual health as they are involved in the commissioning of contraceptive & sexual health services.
Actions: ***** Consult with PCT (including Michelle Hawkes/Sara Dove).

26 All early years education services and schools should have critical incident plans and clear arrangements for liaison with their local social services team and area child protection committee when concerns arise about the impact on a child of parental problem drug or alcohol use.
Agreed.
Action: ***** To be included in the new protocol when written.

27 All schools should identify at least one trained designated person able to deal with the problems that might arise with the children of problem drug users.
This should link up with LCSB and training of designated teachers.
Action: ***** LCSB to liaise with schools.

28 Gaining a broad understanding of the impact of parental problem drug or alcohol use on children should be an objective of general teacher training and continuous professional development.
Training issue for Vicki Thomas. This is not included in general teacher training as yet.
Action: ***** Contact Vicki Thomas.

29 All social services departments should aim to achieve the following in their work with the children of problem drug users: **An integrated approach, based on a common assessment framework, by professionals on the ground including social workers, health visitors and GPs, nursery staff and teachers, child and adolescent mental health services.**
Action: ***** CAF implementation team to consider Hidden Harm agenda, particularly in Local Service Teams.
Adequate staffing of children and family services in relation to assessed need.
Agreed, but funding influences this.
Appropriate training of children and family service staff in relation to problem drug and alcohol use.
Current systems may not be able to meet capacity, and different levels of training will be required by different staff groups. There is also a need to develop a common, agreed set of terminology (e.g. some people currently use the term 'substance misuse' when referring to drugs and alcohol; others refer to 'substance misuse and alcohol').
Action: ***** New training structure required.

A co-ordinated range of resources capable of providing real support to families with drug problems, directed both at assisting parents and protecting and helping children.
e.g. Young Carers, PROMISE, Early Years, Extended Schools.
Action: ***** To be included in the Parenting Strategy that is currently being written.
Sufficient provision of foster care and respite care suitable for children of problem drug users when their remaining at home is unsafe.
Children's Social Care providing this.
Efficient arrangements for adoption when this is considered the best option.
Not commented upon.
Residential care facilities that provide a genuinely caring environment for those children for whom this is the only realistic option.
Not commented upon.

30 The Government should continue to explore all practical avenues for attracting and retaining staff in the field of child protection.
Not discussed.
No actions.

31 The new Social Care Councils for England, Wales, Scotland and Northern Ireland should ensure that all social care workers receive pre-qualification and in-service training that addresses the potential harm to children of parental substance misuse and what practical steps can be taken to reduce it. Consideration should be given to the inclusion of such training as a prerequisite for registration by the appropriate professional bodies.
Agreed. This is core business for Children's Social Care. Training being delivered. There are growing numbers of children being adopted because of parents' substance misuse
Action: ***** Investigate whether the current training meets these criteria.

32 Residential care for the children of problem drug users should be considered as the option of last resort.
Not commented upon.
No actions.

33 The range of options for supporting the children of problem drug users should be broadened to include: day fostering; the provision of appropriate education, training and support for foster parents; and robust arrangements to enable suitable willing relatives to obtain formal status as foster parents.
Agreed, but SCC don't provide day fostering. All foster parents can access training courses on substance misuse.
Action: ***** Investigate whether the current training meets these criteria.

34 Where fostering or adoption of a child of problem drug users is being seriously considered, the responsible authorities should recognise the need for rapid evidence-based decision-making, particularly in the case of very young children whose development may be irreparably compromised over a short period of time.
Not commented upon. See comments above for Q 31.
Actions as Q31.

35 Drug and alcohol agencies should recognise that they have a responsibility towards the dependent children of their clients and aim to provide accessible and effective support for parents and their children, either directly or through good links with other relevant services.
This is included in the Turning Point specification as part of senior practitioners' roles. Assurance that this is happening can be monitored through contract reviews. All TP staff need CP training as stated earlier. Attendance Officers from schools could perhaps share info with TP and vice versa? PSO would be the person/role to do this? PCSOs might also be linked into this. Crèche facilities for service users at TP would be beneficial to clients, as it would help adults access the service and provide an opportunity to monitor the children at the same time.
Actions: • Turning Point to liaise with CYPD to investigate links to Attendance Officers. • Turning Point to liaise with the Police regarding link to PCSOs. • Turning Point to consider provision of crèche facilities.

36 The training of staff in drug and alcohol agencies should include a specific focus on learning how to assess and meet the needs of clients as parents and their children.

This should be competency based with evidence provided. There should be compulsory child protection induction and training for all service providers. A multi agency based assessment tool should be developed around the needs of HH children – to work out what constitutes a level of concern (a little like a CAF leading to SUST, i.e. a CAF leading to this new assessment tool). The tool would score 'n' and a referral to CSC would need to be made. This needs to take into account children's resilience.

There are lots of substance misusers who are not known to TP. TP basic assessment = children = higher level assessment – needs to be thought through, because it may not be TP who would be best placed to do the higher level assessment. How do we pick up children like the ones in the DVD whose parents are not known to services? What happens if a need is recognized but there is no-one to deliver it? The group concluded that the recognition of these children would need to happen in schools. Schools would benefit from a designated CP staff member in every school. Needs to feed into PSHE pastoral care. Targeted support would work here. Emotional Health & wellbeing workers could also play a part, as could Connexions targeted workers. Parent Support Advisors are also a link between school and home – to give them focus in what they are doing = substance misuse - would be ideal. CP link in school would speak to PSAs.

Actions:

- Turning Point to advise what training is currently provided to staff, with a view to this being linked to LCSB training or revised as necessary.
- Multi-agency assessment tool to be developed.
- Links to schools and other professionals with access to children need to be made so the HH agenda can be highlighted.

37 The possible role of parental drug or alcohol misuse should be explored in all cases of suspected child neglect, sexual abuse, non-accidental injury or accidental drug overdose.

This is an issue for training. Child protection conferences currently recognize that around 20% of cases involve parental substance misuse.

Action:

***** Training course(s) to be revised to take this into account.

38 Child and adolescent mental health services should routinely explore the possibility of parental drug or alcohol misuse.
Should refer this to CAMHS commissioners
Action: ***** Hidden Harm to be on next meeting agenda of CAMHS Commissioners.

39 Acquiring the ability to explore parental substance misuse should be a routine part of training for professionals working in child and adolescent mental health services.
Training for all agencies – LSCB.
Action: ***** Look at list of professionals receiving training and revise as necessary.

40 Given the size and seriousness of the problem, all non-statutory organisations dedicated to helping children or problem drug or alcohol users should carefully consider whether they could help meet the needs of the children of problem drug or alcohol users.
Area Development Officers/CHIPS = should be approached to find out what is available already.
Action: ***** Contact CHIPS/ADOs

41 Drug Action Teams should explore the potential of involving non-statutory organisations, in conjunction with health and social services, in joint work aimed at collectively meeting the needs of the children of problem drug or alcohol users in their area.
ADOs and CHIPS – the voluntary sector should be approached to find out what is potentially out there already.
Action: ***** As recommendation 40

42 Agencies committed to helping the children of problem drug or alcohol users should form a national association to help catalyse the development of this important area of work.
Not discussed.
No actions.

43 Every police force in the country should seek to develop a multi-agency abuse prevention strategy which incorporates measures to safeguard the children of problem drug users.
There is already a vulnerable adults policy as well as the south west CP procedures. The process the same for every occasion, so the group felt it was covered already. PCSOs may need special training. PCSOs with links to Trading Standards need to be involved in this agenda.
Action: ***** Role of PCSOs to be considered and developed as necessary.

44 When custody of a female problem drug user is being considered, court services should ensure that the decision fully takes into account the safety and wellbeing of any dependent children she may have. This may have training implications for sentencers.
TP provide training for Magistrates that includes these issues. This needs to be repeated regularly.
Action: ***** Turning Point to ensure consistent delivery of this training.

45 The potential of Drug Courts and Drug Treatment and Testing Orders to provide non-custodial sentences for problem drug users with children should be explored.
Agreed. DRRs and potentially ARR (alcohol rehabilitation requirements). Also link with arrest referral for alcohol
Action: ***** Turning Point with Probation to explore via provision of DIP

46 All women's prisons should ensure they have facilities that enable pregnant female drug users to receive antenatal care and treatment of drug dependence of the same standard that would be expected in the community.
Not discussed.
No actions.

47 All female prisoners should have access to a suitable environment for visits by their children. In addition, where it is considered to be in the infant's best interests to remain with his or her mother, consideration should be given by the prison to allowing the infant to do so in a mother and baby unit or other suitable accommodation.
Not discussed.
No actions.

48 Women's prisons should ensure they have effective aftercare arrangements to enable appropriate support to be provided after release for female problem drug users with children.
If a prisoner is engaged with the CARAT worker there should be a seamless transition into the community.
Actions: ***** Turning Point with Probation to explore via provision of DIP

Bibliography

Advisory Council on the Misuse of Drugs (2003) *Hidden Harm. Responding to the needs of children of problem drug users*. London: Home Office. www.drugs.gov.uk

Advisory Council on the Misuse of Drugs (2007) *Hidden Harm Three Years On: Realities, Challenges and Opportunities*. London: Home Office. www.drugs.gov.uk

Alcohol Concern (2005) *Parenting, alcohol and treatment service provision.* London: Alcohol Concern

Alcohol Concern (2006) *Hidden Harm issues for professionals working with parents who misuse alcohol*. London: Alcohol Concern www.alcoholandfamilies.org.uk/briefings_good_pract_guidance.htm

Alcohol Concern (2006) Multi-agency working: guidance for professionals working with problem drinking parents. London: Alcohol Concern www.alcoholandfamilies.org.uk/briefings_good_pract_guidance.htm

Alcohol Concern (2006) *Parental alcohol misuse and the common assessment framework*, London: Alcohol Concern www.alcoholandfamilies.org.uk/briefings_good_pract_guidance.htm

Alcohol Concern (2006) *Protective parenting and children's resilience within the context of parental alcohol problems*. London: Alcohol Concern www.alcoholandfamilies.org.uk/briefings_good_pract_guidance.htm

Alcohol Concern, Home Office, Department of Health, Department for Children, Schools and Families (2008) Safe. Sensible. Social. Alcohol strategy local Implementation toolkit. London: HM Government

Bancroft, A. Carty, A. Cunningham-Burley, S. Backett-Milburn, K. (2002) *Support for the families of drug-users: a review of the literature*. Centre for Research on Families and Relationships, University of Edinburgh and Scottish Executive, Drug Misuse Research Programme

Bancroft, Angus, et al. (2004). *Parental drug and alcohol misuse: Resilience and transition among young people*. York: Joseph Rowntree Foundation

Bibby, A and Becker, S (2000) Young carers in their own words. London: Calouste Gulbenkian Foundation

Broad B, ed. (2001) *Kinship Care: the placement choice for children and young people.* Russell House Publishing

Cairns, Claire (2007) *Safeguarding the Children of Substance Misusing Parents: Guidance for Adult Services*. London: DCSF High Focus Area Programme www.everychildmatters.gov.uk

Cairns, Claire (2007) *Hidden Harm: Does asking about childcare responsibilities (still) present a barrier to parents accessing drug treatment services?* London: DCSF High Focus Area Programme www.everychildmatters.gov.uk

Childline (1997) 'Beyond the Limit: children who live with parental alcohol misuse. A ChildLine study. London: Childline

Commission for Social Care Inspection (CSCI) (2006) *Supporting parents, safeguarding children. Meeting the needs of parents with children on the child protection register*. London: CSCI www.pmhcwn.org.uk/files/supporting_safeguarding.pdf

Cunningham, A and Baker, L (2004) *What about me! Seeking to understand a child's view of violence in the family. Centre for Children and Families in the Justice System.* London: Canada. www.lfc.on.ca/what_about_me.html

Department for Education and Skills (2005) *Government Response to Hidden Harm: the Report of an Inquiry by the Advisory Council on the Misuse of Drugs*. Nottingham: DfES Publications www.everychildmatters.gov.uk

Department for Education and Skills, Home Office and Department for Health (2005) *Every Child Matters: Change for Children Young People and Drugs*. Nottingham: DfES Publications www.everychildmatters.gov.uk

Department of Health (2005a). *Final Best Practice Guidance on the role of the DASS.* London: Department of Health.

Department of Health (2005b) *Independence, Wellbeing and Choice. Our Vision for the Future of social care for adults in England* London: Department of Health.

Department of Health, Home Office, Department for Education and Skills and Department for Culture, Media and Sport (2007) Safe. Sensible. Social. The next steps in the National Alcohol Strategy. London: DH Publications

Effective Interventions Unit (2005) *Integrated Care Pathways Guide 8: Problem Substance Use in Pregnancy and Reproductive Health*. Edinburgh: Scottish Executive www.scotland.gov.uk/Resource/Doc/37428/0012628.pdf

Evans, V. (2007) Hidden Harm Three Year On: Realities, Challenges and Opportunities. Presentation to the Royal College of Practitioners

Galvani, S. (2005) Alcohol and Domestic Violence Factsheet. Alcohol Concern

Gorin, S. (2004) *Understanding what children say: Children's experiences of domestic violence, substance misuse and parental health problems*. London: NCB for JRF

Gorin, S. (2005) 'The Stakes are high: The impact of parental substance use on children' in *Child Right*, September 2005

Gorin, S. (2005b) *"You feel like you're always on the second shelf" Children's experiences of parental problems at home*. Presentation to the Hertfordshire ACPC.

Government Response to Hidden Harm: the report of an Inquiry by the Advisory Council on the Misuse of Drugs. Nottingham. 2005. DfES.
www.teachernet.gov.uk/publications

Grandparents plus & Adfam (2006) *Forgotten Families: The needs and experiences of grandparents who care for children whose parents misuse drugs and alcohol*. London: Grandparents plus & Adfam
www.adfam.org.uk/docets/Forgotten%20Families%20Full%20Report.pdf.pdf

Hamer, M. (2005) Preventing Breakdown. A manual for those working with families and the individuals within them. Russell House Publishing
www.option2.org/Publications.htm

Hart, D (2004) 'Care Planning for children looked after as a result of parental substance misuse' in Phillips, R. *Children exposed to parental substance misuse. Implications for family placement*. London: BAAF

Hart, D. & Powell, J. (2006) *Adult Drug Problems, Children's Needs: Assessing the impact of parental drug use: a toolkit for practitioners.* London: National Children's Bureau

HM Government (2008) *Drugs: protecting families and communities. The 2008 drug strategy*. First Edition. London: HM Government

HM Government (2008) *Drugs: protecting families and communities. Action Plan 2008-2011*. London: HM Government

HM Government (2006) *Working Together to Safeguard Children: A guide to inter-agency working to safeguard and promote the welfare of children*. London: TSO
www.tsoshop.co.uk

HM Government (2007) *Hidden Harm: Self Assessment Tool*. DCSF High Focus Area Programme. London: HM Government. www.everychildmatters.gov.uk

HM Government (2007) Hidden Harm Training Course (for Adult Drug Services). London: HM Government. www.everychildmatters.gov.uk

Hogan, D. & Higgins, L. (2001) *When parents use drugs? Key findings from a study of children in the care of drug-using parents*. Dublin: Children's Research Centre: Trinity College

Hogg, C (1997) Drug using parents policy guidelines for inter-agency working. London: Department of Health - This report highlights good practice in drugs services and shows the importance of working together to provide effective services for both the parents and their children.

Kroll, B. & Taylor, A. (2003) *Parental substance misuse and child welfare*. London: Jessica Kingsley Publishers

Kroll, B. & Taylor, A. (2008) *Interventions for Children and Families where there is Parental Drug Misuse*. Unpublished.

Kroll, B. (2004) Living with an elephant: Growing up with parental substance abuse. *Child & Family Social Work,* 9:2, 129–140.

Liverpool Drug and Alcohol Action Team (2001). *In a Different World*. Liverpool Drug and Alcohol Action Team and Barnardos.

Maguire, M. (2002?) Keeping it Quiet. Children and Families in Great Govan affected by Parental Drug Misuse. Stirling: Aberlour Child Care Trust. www.aberlour.org.uk

Morrison, T., Lewis, D. and Horwath, J. *From Area Child Protection Committee to Local Safeguarding Children Boards: An Audit and Preparation Toolkit*. See Morrison, T. and Lewis, D. (2005) 'Assessing the Readiness of Local Safeguarding Children Boards (2005) *Child Abuse Review*, 14: 297-316.

Mullender A., Hague G., Umme I., Kelly L., Malos E. and Regan L. (2002). Children's perspectives on domestic violence. London: Sage

Mullender, A. (2004) Tackling Domestic Violence: providing support for children who have witnessed domestic violence. Home Office Development and Practice Report. www.homeoffice.gov.uk/rds

NSPCC (2006) *Old heads on young shoulders. Helping children and young people whose family circumstances force them into adult roles*. London: NSPCC

Phillips, R (ed.) (2004) *Children Exposed to Parental Substance Misuse: Implications for family placement*. London: BAAF

Prime Minister's Strategy Unit (2004) *Alcohol Harm Reduction Strategy for England*. London: Prime Minister's Strategy Unit.

Social Exclusion Task Force, Cabinet Office (2008) *Think Family: Improving the life chances of families at risk*. London: Social Exclusion Task Force. www.cabinetoffice.gov.uk

Templeton, L., Velleman, R., Taylor, A. and Toner, P. (2003) *Evaluation of The Pilot Family Alcohol Service: Final report*

The Children's Society (2004) *"Stars helps you so don't give up"*. Stars project evaluation report. Leeds: The Children's Society.

Templeton, L., Zohhadi, S., Galvani, S., Velleman, R. (2006) *"Looking Beyond Risk" Parental Substance Misuse: Scoping Study*. Edinburgh: Scottish Executive. www.scotland.gov.uk/Resource/Doc/135124/0033445.pdf

Tunnard, J. (2002) *Parental problem drinking and its impact on children*. Research in Practice

Tunnard, J. (2002) *Parental drug misuse: a review of impact and intervention studies*. Research in Practice

Williams, B. (2004) *Review of projects and initiatives that support children and families affected by alcohol misuse*. London: Alcohol Concern.

Appendix A

Drugs: protecting families and communities

Action Plan 2008–2011

HM Government

“Preventing Harm to Children, Young People and Families affected by Drug Misuse”

PREVENTING HARM TO CHILDREN, YOUNG PEOPLE AND FAMILIES AFFECTED BY DRUG MISUSE					
Strategic Objective	**Key Actions**	**Departmental Owner**	**Outcome**	**Coverage**	**Timing**
A new package for families	36. Establish a cross-government working group to drive forward work on families and substance misuse across the drug strategy	DCSF and other departments	A greater focus on families in work related to the drug strategy, alcohol strategy and related PSAs	England	From July 2008
	37. Publish guidance to help the commissioning and delivery of treatment services with a greater focus on the needs of parents and families	DH/DCSF	Treatment services more accessible to parents, with improved treatment outcomes	England	Late 2008
	38. Encourage better take-up of free childcare for three-and four-year-olds (and two-year-olds in pilot areas) to improve access to treatment for parents	DCSF	Treatment services more accessible to parents, with improved treatment outcomes	England (plus pilot areas for two-year-olds)	From July 2008
	39. All drug-misusing parents with treatment needs to have ready access to treatment, with all problem drug user parents whose children are at risk having prompt access to treatment, with assessments taking account of family needs	DH/DCSF	Treatment services more accessible to parents, and support needs of dependent children identified earlier	England	Ongoing
	40. Encourage closer working between treatment and maternity services	DH	Pregnant substance misusers given better care and support, with less pre-natal harm to children	England	Early 2009

PREVENTING HARM TO CHILDREN, YOUNG PEOPLE AND FAMILIES AFFECTED BY DRUG MISUSE					
Strategic Objective	**Key Actions**	**Departmental Owner**	**Outcome**	**Coverage**	**Timing**
	41. Publish guidance to improve the involvement of family and carers, including in the shaping and delivery of treatment/ support, and the development of family intervention skills of drug misuse workers	DH	Better tailored support that takes full account of family and carer needs	England	Ongoing
	42. Provide intensive support to substance-misusing parents through a range of recently established family interventions, targeting families at risk. To be reviewed and strengthened where necessary, supported by research into what works in family interventions	DCSF	Better understanding of the impact of intervention with families at risk	Some initiatives are national, others are in pilot areas only	From April 2008
	43. Support family self-help groups through work with the third sector to provide improved advice and guidance	DCSF/HO/ DH/other departments	Improved support for families affected by someone else's substance misuse	England	From April 2008

PREVENTING HARM TO CHILDREN, YOUNG PEOPLE AND FAMILIES AFFECTED BY DRUG MISUSE					
Strategic Objective	**Key Actions**	**Departmental Owner**	**Outcome**	**Coverage**	**Timing**
	44. Support kin carers, such as grandparents, who take on caring responsibilities for the children of substance-misusing parents by exploring extensions to the circumstances in which local authorities can make payments to those caring for children classified as 'in need', backed up by improved information for carers, and guidance for local authorities, which may include a specific assessment for kin carers	DCSF	Fewer children unnecessarily taken into care. Keeping children safe and keeping the family unit together	England	From April 2008
	45. Implement measures in the Youth Alcohol Action Plan to reduce the impact of alcohol on young people and families	DCSF	Reduced levels of youth drinking	England	Youth Alcohol Action Plan published April 2008
	46. Examine recommendations relating to families of drug-misusing offenders in *Around Arrest, Beyond Release* fieldwork visits and national seminars. Disseminate a final report highlighting practical solutions to planning and delivery for this group	HO	Improved commissioning and delivery of services for the families of drug-misusing offenders at a local level	England and Wales	Summer 2008

PREVENTING HARM TO CHILDREN, YOUNG PEOPLE AND FAMILIES AFFECTED BY DRUG MISUSE					
Strategic Objective	**Key Actions**	**Departmental Owner**	**Outcome**	**Coverage**	**Timing**
	47. Establish protocols between local Safeguarding Children Boards and adult treatment services to ensure that the needs of children of drug-misusing parents are identified early and that they are supported	DCSF/DH	Safeguarding children of drug misusers	England	End of 2008
	48. Ensure that actions on young carers arising from the cross-government carers review take account of the children of substance misusers	DCSF	Safeguarding of children of substance-misusing parents	England	Revised carers strategy due spring 2008

PREVENTING HARM TO CHILDREN, YOUNG PEOPLE AND FAMILIES AFFECTED BY DRUG MISUSE					
Strategic Objective	**Key Actions**	**Departmental Owner**	**Outcome**	**Coverage**	**Timing**
Mainstreaming prevention	49. Complete the review of substance misuse education, committed to in the Children's Plan, to strengthen the role of schools with an emphasis on primary education, early identification, and provision of in-school support. Continue to support the work of the Drug Education Forum and disseminate findings from Blueprint drug education research programme	DCSF	Improved Drug Education rating with Ofsted, achievement of National Healthy Schools targets	England	Review completed summer 2008. Subsequent actions from April 2009
	50. Ensure that a more integrated approach is taken to local prevention activity with vulnerable young people, through the roll-out of Targeted Youth Support	DCSF/HO	Reduced levels of young people's substance misuse	England	From April 2008
	51. Encourage a local focus on delivery of PSA 14, where appropriate, under the new local performance framework, supported by guidance to directors of children's services signalling their lead role in driving reductions in young people's substance misuse	DCSF	Reduced levels of young people's substance misuse	England	From April 2008

PREVENTING HARM TO CHILDREN, YOUNG PEOPLE AND FAMILIES AFFECTED BY DRUG MISUSE					
Strategic Objective	**Key Actions**	**Departmental Owner**	**Outcome**	**Coverage**	**Timing**
	52. Implement new commitments in *Aiming High for Young People* and continue to use positive activities and Positive Futures to strengthen vulnerable young people's resilience and social and emotional skills	DCSF/HO	Tackling key risk factors among vulnerable young people through reductions in substance use, crime and anti-social behaviour in local communities. Participation in positive activities supports the development of resilience and social and emotional skills	England	From April 2008
	53. Improve identification of at-risk children and early intervention through workforce development, and greater use of CAF, with progress on integrated working reviewed by Children's Workforce Development Council	DCSF	Reduced levels of young people's substance misuse	England	Ongoing

PREVENTING HARM TO CHILDREN, YOUNG PEOPLE AND FAMILIES AFFECTED BY DRUG MISUSE					
Strategic Objective	**Key Actions**	**Departmental Owner**	**Outcome**	**Coverage**	**Timing**
Making improvements to the treatment system for young people	54. Improve the treatment system for young people by: • reviewing young people's substance misuse treatment to ensure that good quality treatment is available to all young people who need it, including those subject to community sentences, assured by an updated NTA and DCSF Memorandum of Understanding; • producing guidance for commissioners, service providers, practitioners and CAMHS to ensure that improved needs assessments and treatment planning processes are in place in all areas	DH/DCSF/ MoJ/YJB	Treatment capacity in each area to match local needs assessments, with improved accessibility, quality and outcomes	England	Guidance in 2008. Review in 2009/10
	55. Improve the National Drug Treatment Monitoring System and outcome measurement of treatment for 16 and 17 year-olds to ensure a more outcome-focused approach, exploring outcome measurement opportunities for under-16s	DH/DCSF	Improved understanding of the effect of treatment interventions with under-18s	England	Outcome monitoring for all 16–18s by December 2008 and for all under-18s in 2009

PREVENTING HARM TO CHILDREN, YOUNG PEOPLE AND FAMILIES AFFECTED BY DRUG MISUSE					
Strategic Objective	**Key Actions**	**Departmental Owner**	**Outcome**	**Coverage**	**Timing**
	56. Improve the transition between secure settings and the community for young people in treatment by: • issuing a revised National Specification for Young People's Substance Misuse Services in secure settings; • wider implementation of NTA guidance; and • ensuring better integration with healthcare	DH/YJB/ DCSF/MoJ	Young people entering/leaving secure settings to have reduced substance misuse levels	England	Programme of work from April 2008 Revised YPSMS specification spring 2008

Appendix B

Terms of Reference for the Hidden Harm Sub-Group of the Sunderland LSCB

Aim & Purposes

The Hidden Harm group is a multi-agency sub-group of the LSCB. Its aim and purpose is to safeguard children and young people by developing and implementing a strategic response to the ACMD Hidden Harm report incorporating the Scottish Executive & English Government responses.

Scope

To ensure that the local authority develops a comprehensive multi-disciplinary range of services and systems which address the needs of children and young people impacted by parental substance misuse.

Functions

- To be accountable to the LSCB
- To contribute to the LSCB business plan
- To develop, oversee and performance manage a comprehensive action plan relating to the Hidden Harm recommendations
- To make recommendations to the LSCB and policies and procedures that impact on children and young people in relation to parental substance misuse
- To consider the implications of new policies, new guidance and research
- To act as an interface between national and regional policy and translate this into local policy and practice
- To raise awareness and profile of Hidden Harm to ensure that children and young people impacted by parental substance misuse becomes a mainstream issue
- To promote active key stakeholder engagement and involvement and to ensure effective links are maintained with other relevant groups and bodies

Meeting Frequency

To meet on a six-weekly basis for no longer than two hours at a time.

Membership

Chair – LSCB Manager
Safeguarding Officer
DAT Lead
DAT Commissioning Manager (adults)
CAF Lead
Adult Drug Treatment provider
Education
Health (inc maternity)
Children & Family Team

Reporting Arrangements

The group reports to the LSCB

Appendix C

SOUTH TEES LOCAL SAFEGUARDING CHILDREN BOARD

MULTI-AGENCY PROTOCOL FOR PROFESSIONALS IN MIDDLESBROUGH AND REDCAR & CLEVELAND INVOLVED IN THE CARE OF SUBSTANCE USING PREGNANT WOMEN

Note that 'substance' refers to both illicit drugs, for example: heroin, cocaine, crack, amphetamines, benzodiazepines, LSD, methadone and ecstasy and to alcohol, prescription drugs and solvents.

AIMS

On a multi-agency basis

- To share all relevant information
- To carry out a preliminary risk assessment
- To plan, provide and ensure that appropriate care and support is provided for families
- To ensure that all professionals involved are aware of the outcome of assessments and the agreed plan of care. In line with recommendations in 'Hidden Harm Appendix 2, e.g. points 8, 10, 18, 20'.

PREPARATION FOR PRIMARY MEETING

The first professional who identifies a substance using parent makes a referral to Social Work Agency and a Primary Meeting is held. In Middlesbrough this is co-ordinated by the Families First Team (01642 354070).

The meeting should be held between the 14th and 16th week of pregnancy.

Those invited should be:

- Health Visitor
- Probation
- Named Community Midwife
- School Nurse if other children are four years or above
- Middlesbrough Children, Families & Learning Family Services – Social Worker identified from Locality Team
- Redcar & Cleveland Children's Social Care – allocated Social Worker if open case, otherwise Access Team (Redcar & Cleveland 01642 771500)
- Any other relevant or involved agency/professional, including Sure Start.

The parent/s should normally be invited to the meeting and helped to participate.

All professionals should contribute relevant information held by their agencies. Health professionals should check whether the Health Child Protection Department at Poole House has relevant information.

PRIMARY MEETING

The purpose of this meeting to share all relevant information, undertake a preliminary risk assessment and plan on that basis. Families First in Middlesbrough co-ordinate and distribute minutes of the Primary Meeting.

Those present should:

- Ensure a Pre-birth Assessment commences no later than 20 weeks into pregnancy to SCUDA guidelines (Appendix) and includes the Risk Assessment Questionnaire.
- Formulate a plan of care and support.
- Make arrangements in respect of future meetings.
- If alternative carer is deemed to be necessary to provide Oramorph and to be key holder, full assessment must be undertaken of their ability to provide safe care.

A referral to children's social care, following normal processes within each Borough, is to be made by the 18th week of pregnancy, after which it will be subject to inter-agency procedures for unborn babies.

AFTER CHILD IS BORN

A pre-discharge meeting should be held within the hospital soon after the birth to ensure that appropriate care will be provided in the community – emphasis on care of child from parents – are they protecting the baby?

If the unborn baby is subject to a Child Protection Plan, it will include the arrangements for an early Review Child Protection Conference. Existing Child Protection Procedures and plan should be followed.

ADDITIONAL NOTES

The Community Midwife will complete a 'Cause for Concern' for all cases with copies to the Hospital Named Nurse for Protection, the Central Delivery Suite.

Health staff should ensure they discuss with the Named Nurse for Child Protection any concerns, which arise between planned meetings.

Notes of meetings should go to all invited, with copies to Health Child Protection Department, Poole House, also the Named Nurse for Child Protection and the Obstetric Consultant at James Cook University Hospital).

Appendix D

JOB TITLE Drug Liaison Midwife

DEPARTMENT Leeds Addiction Unit, 19, Springfield Mount, Leeds, LS2 9NG

GRADE 6

REPORTS TO Clinical Team Manager

ACCOUNTABLE TO Clinical Director

1. JOB SUMMARY AND WORKLOAD MANAGEMENT

The post holder is responsible for the management of a defined caseload, serving women and families who are experiencing difficulties with substance use. The post holder carries continuing responsibility for the assessment of care needs, the development, implementation and evaluation of programmes of care and the setting of standards of care. The post holder will take the lead role in the planning, provision and development of evidence based midwifery practice in relation to substance misuse.

The post holder will provide midwifery expertise through a collaborative approach to care between the Leeds Addiction Unit and the two maternity sites the LGI and St James.

2. ORGANISATIONAL CHART

3. KNOWLEDGE, SKILLS AND EXPERIENCE REQUIRED

Essential

- RM with post registration experience.
- Full UK driving licence.
- Evidence of relevant post registration education.
- Positive attitudes to the client group.
- Degree or equivalent.

Desirable

- Clinical experience in addictions
- Experience in supervising midwifery/nursing students.
- Venepuncture skills.
- Conducting audit.
- Experience of teaching.
- Knowledge of research.

4. COMMUNICATION AND WORKING RELATIONSHIPS

- Liaison with multi-disciplinary team, other professionals, statutory and non-statutory bodies.
- Advise healthcare professionals on the management of pregnant women using drugs/alcohol.
- Able to communicate with service users who may be distressed and who may, on occasion, present with challenging behaviour.
- Ability to supervise midwifery/nursing students on placement.

5. PRINCIPAL DUTIES AND AREAS OF RESPONSIBILITY

- **Clinical**

Expert clinical practitioner uses advanced knowledge and clinical skills

- Develop, assess, plan, implement and evaluate specialist programmes care using advanced clinical knowledge and skills
- Refer parents as appropriate to other members of the multi-disciplinary team
- Provide a clinical lead and role model to the midwifery team by delivering high quality care as an expert practitioner
- Implement, monitor and seek to continuously improve standards and the quality of care, including those national standards
- Maintain a safe working environment
- Supervise and maintain accurate records using the LMT AND LTHT documentation
- Ensure the safe use and efficient management of equipment and supplies
- Promote evidence based practice, wherever possible
- Support patients and their families and ensure they receive required information to enable them to participate on their care delivery
- Develop and implement policy and practice guidelines specific to the clinical speciality.
- Acts in accordance with the NMC codes and rules for midwives
- Liaise with Community Midwifery Services/other agencies (as appropriate) to ensure seamless provision of care delivery
- Work within a multi-disciplinary team to lead the development of the service within Leeds
- Establish and respond to user needs and requirements

- **Education and Training**

- Facilitate training and education of learners and other junior staff
- Actively participate in the development of own personal development plan and performance review
- Participate in national, regional and local conferences.
- Provide education and training to women their families/significant others and their carers.
- Keep up to date with developments, advances within the specialty

- **Leadership**

- Investigate and respond to accidents, complaints, untoward incidents and other significant events in accordance with LMT AND LTHT policies
- Deliver an effective quality service with budgetary constraints
- Provides leadership to the clinical team in relation to substance misuse and the effects to pregnancy, childbirth and the puerperium
- Seeks to improve and develop the skills of others

- **Research and Audit**

- Contribute to the research agenda
- Engage users and carers views on service delivery and development.
- Undertake audit programmes specific to client group, care and developments.
- Participate in research /audit as appropriate.

6. DECISION MAKING AND ADVICE

- Collaboratively plan and implement packages of care with service users in liaison with other multidisciplinary team members. Team meetings and regular clinical supervision will provide the opportunity to discuss service users carefully.
- Provide advice and consultation on all aspects of the care and management of women who use drugs/alcohol during pregnancy, childbirth and postnatally.

7. INITIATING AND IMPLEMENTING CHANGE

- Contribute to the development of the pregnancy and parenting team.
- Participation in clinical audit.
- Collaborate with colleagues in the pregnancy and parenting team in improving care provided for this service user group.

8. HEALTH, SAFETY & RISK MANAGEMENT

The job holder must at all times comply with the Leeds Mental Health NHS Teaching Trust Health & Safety Policies, in particular by following agreed safe working procedures and reporting incidents using the trust's risk incident reporting system.

The jobholder is required to inform the line manager of any safety issues that could affect you or others in the work place. You are responsible for your own Health & Safety and must co-operate with the management at all times in achieving safer work processes and work places, particularly were it can impact on others.

You will be trained in the correct use of any equipment provided to improve Safety and Health within the trust. You are required to use the equipment when necessary and as instructed; it is your responsibility to ensure the equipment is safe to use, prior to its use and must report any defects immediately to your manager.

PLUS FOR SUPERVISORY GRADES

You are required to provide adequate supervision to ensure compliance with safe work practises.

You will be expected to carry out risk assessments, identify hazards in your work place, and evaluate the level of risk associated with identified hazards and implement adequate controls to eliminate or reduce the level of risk.

9. TRAINING AND PERSONAL DEVELOPMENT

The jobholder must take personal responsibility in agreement with their line manager for his or her own personal development by ensuring that continuous professional development remains a priority. The jobholder will undertake all mandatory training required for the role.

10. RESPECT FOR PATIENT CONFIDENTIALITY

The job holder should respect patient confidentiality at all times and not divulge patient information unless sanctioned by the requirements of the role.

11. EQUALITY AND DIVERSITY

The jobholder must co-operate with all the policies and procedures designed to ensure equality of employment. Co-workers, patients and visitors must be treated equally irrespective of gender, ethnic origin, age, disability, sexual orientation, religion etc.

evidence base

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