NEWS AND BEST PRACTICE IN SUPPORTING FAMILIES AFFECTED BY DRUGS AND ALCOHOL

families upfront

JUNE – AUGUST 2013 ISSUE 9

> In Focus: parental substance use

> Family support and drug prevention

> Substance use and social work

★★★★★ ADFAM CONFERENCE 2013 SPECIAL ★★★★★

Adfam for professionals

We care, for the better.

{ Shocking images and distressing real-life stories should be avoided in school drug education }

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{ Workers were able to map the child's experiences onto the adult's cycle of change }

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{ Social workers have described feeling de-skilled and unequipped to deal with the issues presented by parental substance use }

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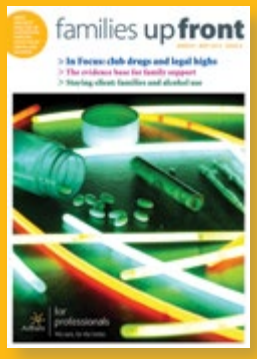

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RECENTLY I attended a Global Addiction conference in Pisa, where it was really interesting to see the international perspective on substance use and how other countries view topics like recovery and family support.

What stuck out most clearly for me was that families were hardly mentioned. It was disappointing not to meet an 'Italian Adfam' or similar, like we're lucky to have Scottish Families Affected by Drugs (SFAD) or the Family Support Network in Ireland. This isn't to say family support doesn't exist across Europe and beyond, but it wasn't visible enough for me to find it – a problem many family members experience themselves when looking for support.

So although part of me was heartened to see how far we've come in this country compared to others, I don't think it would make many families feel better to know simply that people in other countries might have things even worse. It's not 'all relative'. The same goes for substance users in countries like the Ukraine, where a tiny 1% are in treatment: this doesn't mean we have to be 'grateful for what we have', and there is no excuse not to be unceasingly ambitious for service users and their families. Each family's case needs to be looked at according to its own specific circumstances, and families must be supported through the significant harms they experience, whether this is at home or abroad. And whilst it's far beyond Adfam's means to start an international 'movement', it has made me think more deeply about how since drugs are a global problem, family support should be a global issue too.

And a final note for those of you reading this in a spare moment at our annual conference – welcome! We hope you find this magazine and the conference both interesting and useful for your practice.

Vivienne Evans *OBE, Chief Executive, Adfam*

Adfam's services include:

- **Policy briefings** to help keep the sector better informed
- **Training** for families and professionals
- **Publications** for family members and people working with them
- **Consultancy** around providing the best possible services for families
- **Regional forums** for family support professionals

Experts propose drug consumption rooms for Brighton

Vigorous debate was ignited recently when the Independent Drugs Commission for Brighton and Hove proposed the introduction of drug consumption rooms (also known as 'shooting galleries') so local drug users could have a safe, clean space to inject drugs without fear of arrest and under the supervision of medical professionals.

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The Commission's chair, Rob Jarrett, said: "I think from our perspective we see the health benefits of accepting drug use is going to happen and it might as well be happening in a place that can be monitored. Our primary concern is the health of the people to make sure they don't kill themselves". Although supported by drug policy campaign groups such as Release, the suggestion faced opposition from many voices in the media and politics, including ex-Health Secretary Andrew Lansley, who claimed that "drug injection rooms risk encouraging illicit trafficking and carry a significant risk of harm in local communities".

'It's not fair' on kinship carers

New research by the Family Rights Group and the University of Oxford has called on central Government to institute a financial allowance to family and friends carers.

Joan Hunt, who compiled the *It's just not fair: support, need and legal status in family and friends care* report, said that children growing up with relatives are "virtually indistinguishable from those in foster care" and face many of the same challenges relating to abuse, neglect, parental substance use and domestic violence.

The Government published statutory guidance in 2011 requiring local authorities to publish policies on family and friends care, and stating that support should be based on need rather than legal status. But the research found that over a third of local authorities had not even produced such guidance – 18 months beyond the given deadline – and progress in practice is slow elsewhere. Hunt argued that "support bears little relationship to the extent of need but is primarily determined by whether the child happens to be in the care system or not."

The research also identified an 'imbalance of power' between carers and local authorities, and found that many families lacked the legal and practical information to make informed decisions in the early stages of their caring responsibilities.

www frg.org.uk

Challenge to minimum pricing in Scotland defeated in court

A legal challenge by the Scotch Whisky Association (SWA) seeking to block the Scottish Government's plans to introduce minimum unit pricing (MUP) for alcohol has failed.

The plan is to introduce a minimum price of 50p per unit, which would raise the minimum price of a bottle of wine to £4.69 and whisky to £14. The Alcohol Minimum Pricing Bill passed through the Scottish Parliament in May 2012, with 86 votes in favour, one against and 32 abstainers. For now the Government looks set to continue with its plans, but the SWA has already pledged to appeal against the ruling, and it looks set for a long battle.

Alcohol Focus Scotland has claimed that MUP in Canada has successfully saved lives and should be adopted as soon as possible. Their Chief Executive Dr Evelyn Gillan said: "the alcohol industry has consistently opposed minimum unit pricing as they oppose any measures that are likely to be effective. Thankfully, today the public interest has prevailed over the profits of the big alcohol corporations."

For the rest of the UK, although nothing on minimum pricing was included in the Queen's Speech, Health Secretary Jeremy Hunt insisted that the Government is yet to make a firm a decision.

Family Lives launches online chat

Family Lives has added a live chat function to its portfolio of free advice for parents and families, which already includes messageboards, a helpline and relationship support groups. It is aimed at people who wish to ask an expert about 'any family issue' and all conversations will be completely confidential, aside from serious safeguarding concerns or life-threatening situations. The service will be open 7 days a week and can be accessed online at ***www.familylives.org.uk/how-we-can-help/online-chat***.

New naloxone kits

Martindale Pharma has released what it claims to be the world's first licensed naloxone product for use by non-healthcare profession individuals in a community setting. Naloxone is a heroin 'antidote' which aims to reverse the effects of an overdose for long enough for emergency services to arrive, hence saving lives.

Previously, the medicine was only available on prescription to individual users, but this has been criticised for begging the question of who would administer it in an emergency; in 2012 the Advisory Council on the Misuse of Drugs called for it to be made more widely available. The new product, Prenoxad, will be available to those at risk of opiod overdose and their 'nominated client or representative'.

It is still far away from 'over the counter' medicine however: although it can be supplied to families and friends, this must be with the written consent of the person for whom its use is intended, and the prescriber must assess their 'suitability and competence' to administer it in an emergency.

Abstinence up, completions down in Payment by Results pilots

Almost 10,000 service users have now been engaged in the eight pilot sites redesigning their treatment systems around Payment by Results. Treatment providers in areas including Oxford, Bracknell Forest and Stockport are being funded based on the outcomes they achieve for their clients.

Five outcomes are being measured: abstinence from all presenting substances; successful completions of treatment 'free of dependency'; resolved housing issues; cessation of injecting; and improved quality of life, as measured by the existing Treatment Outcomes Profile form. With 11 months of data to draw on, the results have been mixed: although there have been modest increases in abstinence rates (5% higher than the national average), successful completions are 'significantly below the rest of the country' and quality of life has fallen from the baseline measures taken in the pilot areas.

Whilst the data release states that 'it is too early to judge how well the pilots are performing', it does admit that the fall in completions is 'particularly concerning' because it is consistent across the five client complexity groups being measured. There are also worries over treatment for problem drinkers, as performance for alcohol clients is now 15% below the national average, and 11% below the baseline performance of the PbR pilot sites.

Short-term offenders set for probation

Under measures set out in the Queen's Speech, offenders sentenced to less than 12 months in prison will receive supervision on release into the community, and probation for people serving one to two years will be extended from six months to a full year. Currently probation is only offered to offenders serving more than 12 months in prison, and it is hoped that these new measures will reduce reoffending by targeting the most prolific reoffenders and those caught in the 'revolving door' of frequently coming in and out of custody. However, the Howard League for Penal Reform seized on the announcement as "an admission of the abject failure of short-term prison sentences".

The supervision market will also be opened up to private providers and charities, who will be paid based on the reductions in reoffending they achieve. The Offender Rehabilitation Bill also sets out plans for mandatory drug treatment appointments and drug testing regimes which cover Class B drugs as well as heroin and cocaine.

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PHE appoints Drug Recovery Adviser

Dr Tom McLellan, an internationally recognised addiction expert, has been appointed by Public Health England to provide independent advice on its work to tackle drug misuse.

He has previously served as Deputy Director of the White House Office on National Drug Control Policy and as Editor-in-Chief of the *Journal of Substance Abuse Treatment*, and won the Life Achievement Award of the American Society of Addiction Medicine.

Dr McLellan described it as an "honour and a privilege to be working with Public Health England to support their important efforts to reduce the enormous burden of addiction on individuals and communities". Professor Kevin Fenton, PHE's Director of Health and Wellbeing, said McLellan "will provide immensely valuable input to our developing programmes of work and to the continued building of the evidence base".

Pickles hails troubled families progress

Latest figures show that 35,618 families have been engaged in the troubled families programme during its first year – 6,217 shy of the Government's original target. 1,675 have been successfully 'turned around'.

Responding to the news, Local Government Secretary Eric Pickles praised the programme for "transforming the lives of families we have too often not got to grips with in the past", and said that "many services have been set up from scratch over the past year, so it is remarkable to already be reaching a quarter of the families who need help to change".

Diary

● Skills Consortium Conference

The conference will focus on the practical applications of workforce development for the drug and alcohol sector, and highlight examples of new projects and resources useful to practitioners. There will be presentations from Public Health England, treatment providers and others, and a series of interactive workshops.

28 June, London, £65/£95
www.skillsconsortium.org.uk

● The road to recovery for women and children

This 5th annual conference, organised by the Brighton Oasis Project, aims to address and debate the issues affecting female substance misusers, including the contribution of women's services, safeguarding, the support needs of children and recovery for women. There will be a number of presentations, workshops and an address by local Green Party MP Caroline Lucas.

5 September, Brighton, £140
www.oasisproject.org.uk

● Early intervention: joining up services, targeting support

This event will examine what early intervention will look like in a reformed public health system, and discuss the work of the Early Intervention Foundation, which is chaired by keynote speaker Graham Allen MP. Sessions will focus on local leadership, commissioning, provision of parenting support services and the dissemination of best practice.

10 July, London, £228
www.westminsterforumprojects.org.uk

This year Adfam is really emphasising its capacity building work: we are supporting more family support practitioners than ever and our regional development team is growing, allowing us to reach more local services.

PEER MENTORING

The Adfam Professionals Peer Mentoring Programme has been designed to support isolated practitioners by matching them with those who have been working in the field for a while and are willing to provide a source of support. We have received a great deal of positive interest in the scheme, and are currently piloting it with 12 mentors.

Our 12 mentors come from varying backgrounds across the country, including experienced prison workers, well established family support groups, local authorities, and carers' centres. Our mentees come from similarly varied backgrounds, with a significant number applying from within prison services. They have spoken about the desire to have someone neutral that they can talk to, who can listen and understand, and having a supportive, safe and open environment where issues can be discussed in a productive manner. All 12 mentors have attended a full day of training in London, enabling them to consolidate their own experience by learning the basic mentoring skills necessary to translate it into the right environment for their mentee to thrive. Feedback from the training has been extremely encouraging, with one mentor testifying that "I really enjoyed the training. It's given me the motivation and confidence to give it a go".

As the scheme is currently a pilot, we will be using the experiences and feedback of our mentors and mentees to help shape and develop it going forwards. If you're interested in getting involved in the scheme, either as a mentee or as a mentor, there is still time to get involved.

More information and the application forms are available at www.adfam.org.uk/professionals_peer_mentoring.

Regional Development Team

As part of the growth of the Regional Development Team, I joined Kate Peake (nationwide) and Alexis Woodward (South West) in April as the Family Support Development Coordinator for the London Borough of Greenwich.

Using a Big Lottery grant, I will be working closely with the drug and alcohol services in Greenwich to complement existing family support and to facilitate further development. Through support in the form of training, resources, best practice and events the aim is to build a strong and self-sustaining family support network.

The community is at the core of any service providing support for local people and strong community links are vital to building successful family support. I will therefore be working alongside community groups and organisations to build a support network rooted in the local area to help increase positive recovery capital. The aim is to achieve a family support network that has clear referral pathways, is easily accessible, and meets the complex and varied needs of local families.

In their respective regions, Kate and Alexis support organisations to influence local structures and I will be offering similar support to families in Greenwich.

A key purpose of the service is to ensure the voices of family members are heard by policy makers, commissioners and service providers in Greenwich. To achieve this I will be offering support, training and resources to enable family members to be heard and ensure that services are responsive to their needs.

The 2010 Drug strategy put the spotlight on recovery for users and this same thinking can be applied to families. So the whole Regional Development Team will be developing Family Champions training, in order to motivate and inspire families to help others dealing with the impact of a loved one's addiction. The final aim is to create and nurture a network of Family Champions so that the project becomes self-sustaining.

My overall mission is to provide family members with the tools and resources they need to build a community-based family support network and achieve 'whole family recovery' which is tailored to the needs of those within the community. I look forward to working with the families, community and service providers in Greenwich to achieve this aim.

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ANNUAL CONFERENCE HIDDEN HARM: 10 YEARS ON

Adfam's 2013 conference will focus on parental substance use, and we want to stimulate as much learning and debate as possible. If you are on Twitter, you can follow along and contribute with #hiddenharm10.

The 'Reach Out' project: support for families in Surrey

Julia Nuttall, Senior Practitioner for Groups and Networks, gives an overview of her work alongside Southern Addictions Advisory Service (SAdAS).

A brief history

Our project is called 'Reach Out' – and it really does, delivering counselling and support groups to the families and friends of substance misusers across Surrey, as well as providing services for drug and alcohol users themselves.

We are funded by the Big Lottery Fund, which supports two Senior Practitioners (one for groups, one for counselling) and an Administrator.

What we do for family members...

We offer 12 weeks of counselling to explore families' issues, which often focuses on how they cope with their loved one's using and how they recognise their own needs and responsibilities.

My role is funded to set up eleven Family and Friends Support Groups across Surrey (one group in each district). I work with SAdAS (Southern Addictions Advisory Service), who were successful in getting the funding to deliver this project. We have developed terms of reference for the groups we run, which makes sure there is a consistency in quality for all family members.

We have a broad and inclusive understanding of 'family' to include any adult who is affected by someone else's drug or alcohol use. Each group can have up to two people from the same family attending and we have had various combinations including both parents of adult users, grandparents, a parent with their adult child's spouse, and a parent with a child who does not use substances.

...and how we do it!

These groups run twice a month and are facilitated by two group workers, mainly volunteers recruited and trained by SAdAS. There is a loose format to the groups, which usually start with a check-in from the group members, leading to a discussion of the issues arising. The second half of the meeting is on a focussed theme or activity (as decided by the group membership), encouraging engagement on a personal level. We do not tell people what to do or what decisions to make, even though family members often ask for solutions.

> We do not tell people what to do or what decisions to make, even though family members often ask for solutions

We try to build families' self-awareness so that they can explore workable solutions to problems – a much more sustainable approach. Some of the resources we have made include topics such as 'tough love', co-dependency, setting goals, boundaries, assertiveness and the different stages of coping. We have a dummy 'drugs box' for education purposes and we invite guest speakers in recovery to come and share their journey with the group, which has been very powerful.

These groups are now operating across Surrey, and now that they are becoming more established, we are working with 'graduate' members to set up networks of people who have moved on after attending their group. These graduate members have valuable resources, skills and life experiences that they can use to help others at earlier stages of their recovery journey.

It's an exciting time to see how family members are growing in skills and confidence and wanting to use their experience to help others in their communities.

How do we work in partnership with drug and alcohol services?

A key partner of SAdAS is the Surrey Carer Liaison Officer, funded by the Surrey DAAT, who works alongside treatment agencies to support service users' families.

We are delighted to have the use of two venues which are the premises of statutory drug and alcohol teams. This means that family members dropping off their child, partner or friend at the treatment clinic will come into contact with staff, posters and leaflets telling them what support is available for them.

We also work in partnership with our SAdAS internal teams (outreach, wellbeing, tenancy support etc.) as well as GPs, Guildford Action (a local charity), Probation and the Police.

I feel privileged to witness the strength and resilience of family members in making positive changes in their lives. I have seen and heard how difficult and distressing it can be living and loving someone in active addiction, but I have also seen courage and strength overcoming fear and guilt.

Our top 3 challenges

1. ***Recruiting groupwork volunteers***
   We recruit via the 'Do It' national volunteer database (www.do-it.org.uk) and via colleges offering counselling training, but we don't have as many volunteers as we need.
2. ***Retaining family members***
   We find that family members often attend a group during a crisis and do not return. We're actively engaging family members to get their feedback so we can adapt the support groups to meet their needs.
3. ***Finding venues for the groups***
   which are in the heart of the community and feel 'neutral' is a challenge. For example, I have encountered a GP surgery which has not responded to enquiries about hiring a room even though it hires out to the local drug and alcohol team, who run prescribing clinics in the surgery. We find that churches are the most available venues for groups.

Find out more at
www.sadas.org.uk

Better than the cure: drug prevention and demand reduction

Adfam looks at the state of drug education and the role of families and support services.

SOME people might forget that the Government's 2010 drug strategy has *three* main strands: as well as building recovery, it also focuses on restricting supply and reducing demand. But whilst recovery has been embraced by the sector and has set the tone for the whole debate about service redesign, the other two themes seem to have been relegated to the peripheries of debate and focus. With 'restricting supply' this may be understandable, being primarily a matter for law enforcement; but what of reducing demand?

The Government defines demand reduction as 'creating an environment where the vast majority of people who have never taken drugs continue to resist any pressures to do so, and making it easier for those that do to stop'. Its more specific aims include breaking intergenerational paths to dependency; intervening early with children, young people and adults; enforcing effective criminal sanctions to deter drug use; and providing good quality education and advice so that young people and their parents are provided with accurate information to actively resist substance misuse.

The state of play

Andrew Brown, Director of Programmes at Mentor, the drug and alcohol education charity, argues that the Government's attitude towards drug education has generally been "ambivalent". Nowhere is this clearer than in the long delays in publishing the Government's response to the PSHE (Personal, Social and Health Education) review, and its final conclusion that PSHE would not, after all, become a compulsory part of the national curriculum, and did not have to cover drugs and alcohol – as many in the sector, including Adfam, had called for. As Brown sums up, "in terms of drugs and PSHE, they're a non-compulsory topic in a non-compulsory subject...the Government's message is that if schools want to do it, they can see the value, but there is a lack of real drive". So it was left to Diana Johnson MP to lead the issue in Parliament, who introduced a Private Member's Bill calling for relationship, drugs and alcohol education to be included in the national curriculum. But without Government support, Brown says, this is effectively "dead in the water".

> Lessons need to be based on "credible facts" so that children don't get unreliable information from elsewhere

If we add to this the ongoing fragmentation in the state school system – the growth of academies and the birth of free schools, both operating with greater levels of autonomy from state or Local Authority control – drug education looks to be on shaky ground. "The fear that we all have", Brown explains, "is that drug education will be reduced to a one-off intervention". But according to the latest research by Sheffield Hallam University, this is exactly what 60% of schools provide: lessons which specifically address drugs and alcohol are given once or less per year. "Tokenism seems to be the order of the day", he says, and without anything like a standardised framework, many head teachers will be tempted to default to the old approach of one-off lessons or visits from ex-users, drug services or families who have been affected by addiction.

The role of family support

Family support services may have a number of roles in engaging with drug education and demand reduction initiatives locally. Although their clients will already be dealing with entrenched issues, it doesn't mean prevention work is outside their scope: parents dealing with one child's drug use may be concerned about how their younger siblings will understand it; grandparent carers may have deep-rooted fears that their grandchildren will 'go the same way' as their substance-using parents; and having seen the impact first-hand, many family support practitioners are passionate about preventing others from experiencing this in the future. Family support services have reported receiving increasing calls about 'legal highs' from parents worried that their teenage children are at risk of using them, and in need of information about these substances.

Over half of secondary schools, and a third of primary schools, work in partnership with at least one external provider to deliver drug education, and family support services will be part of this cohort. However, the success of these partnerships will vary, and it's important that the involvement of family support services is planned properly, delivered according to the best available evidence, and evaluated for its impact. Newcastle PROPS, one such service based in the North East, agrees that lessons need to be based on "credible facts" so that children don't get unreliable information from elsewhere.

The Drug Education Forum has published extensive guidelines on the evidence base and the most effective elements of practice: some of this can make for quite surprising reading, and may run counter to many people's understanding and experiences of drug education. The Forum's guidance bluntly states that 'particular caution should be used when visitors [delivering drug education in schools] have firsthand experience of problematic drug use', and 'shocking images' and 'distressing real-life stories' should be avoided. Aims and content should be agreed between

schools, teachers and visitors in advance, and all should be sensitive to any distress shown by pupils during the session, which may be due to drug issues in particular students' own lives or within their families. This guidance serves to illustrate even more sharply the need for a robust and meaningful overall drug policy within schools, of which education sessions are merely one part.

Parenting

Families and parents often take the blame, however unfairly, when a child experiences problems with drugs and alcohol. Friends and neighbours are unlikely to sympathise that 'their drug education was never good enough' or 'the Government should be providing more leadership on the issue'. Though not the deciding factor in determining young people's use of drugs or alcohol, parenting can and does have an impact on how children understand and behave around substance use issues, and the choices that they make[1]. Demand reduction and prevention, therefore, is an issue relevant to every household, and something that parents need to engage with positively.

But in the same way that having one lesson a year in schools is unlikely to produce the desired results when it comes to drug education and prevention, neither is parents having one 'big talk' with children. There needs to be ongoing dialogue within families about drugs and alcohol. Many parents find the latter more difficult: whilst messages about drugs can be applied quite consistently, for example focusing on dangers and illegality, alcohol is much less clear-cut. Parents may struggle to formulate coherent arguments in the face of mixed messages about alcohol in the media and society at large, and they can be vulnerable to 'but you drink' responses.

Beyond prevention

It's easy to reduce discussions of demand reduction to debating the best sort of school-based drug education, and looking

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to parents to 'set a good example'. And of course, these are important – school in particular represents the best opportunity to reach large numbers of children in a structured, evidence-based way. However, the discussion should go much wider than this: first and foremost, we cannot restrict 'demand reduction' to those people who have never used drugs, and must also look to engage young people who have already started experimenting or even developed problematic patterns of substance using behaviour *(see diagram)*. As argued in Adfam's 2012 discussion paper *Demand reduction , drug prevention and families*, delaying the onset of substance use, and using less, are legitimate goals in their own right as they reduce risk and harm for young people.

Looking ahead

Despite a lack of Governmental drive, it would be wrong to think that drug education has been completely mothballed. It is an area of extensive work by a number of different organisations: Addaction and the Amy Winehouse Foundation have recently teamed up to launch their Resilience Programme; Action on Addiction and Place2Be have announced their own intervention for children affected by parental substance use; the Angelus Foundation wrote in *Families UpFront* Issue 7 about their 'legal highs' classes in schools; and Adfam, DrugScope and Mentor have recently been funded by the Department for Education to build on the previous work of the Drug Education Forum. But it remains to be seen whether the 'many flowers blooming' approach will work, or if differences in approach will be reflected in years to come by widely divergent rates of drug use across different local areas, or even school catchments. Major questions also remain about how newly appointed or elected decision-makers – including Police and Crime Commissioners and Directors of Public Health – will understand and prioritise the need for demand reduction services, and how cuts to young people's services in general might affect demand for drugs, as identified by the UK Drug Policy Commission's *Domino Effects*[2] last year.

As Brown says, "it's a messy world out there" in demand reduction; but there are many people out there dedicated to cleaning it up.

1 See, for example, Demos (2012) *Feeling the Effects*

2 UK Drug Policy Commission (2012) *Domino Effects: the impact of localism and austerity on services for young people, and on drug problems*

Type of substance use	Aim	Appropriate interventions
Never taken drugs	Continue to not take, or delay first use as long as possible	Universal
Tried drugs once or a few times	Choose not to take again	Targeted
Regular but non-dependent drug use	Stop using as soon as possible	Specialist

Universal interventions *are those designed to reach whole populations of people. These might include the Talk to FRANK service, Health Visitors and the school science curriculum.*

Targeted interventions *are meant for specific sub-groups of people, according to identified risks or support needs. These include the Troubled Families programme or Sure Start centres.*

Specialist interventions *work with people at a high level of need, such as dependent drug users, and services to support them (including treatment) are often commissioned at the local level.*

Your organisation

Recently published resources on third sector issues and charity governance.

1 April 2013 Welfare Reforms and what they mean for Voluntary Organisations NCVO

This discussion paper provides a brief overview of the Government's welfare reforms – including the introduction of Universal Credit and the replacement of the Disability Living Allowance with the Personal Independence Payment – and the issues they raise for the voluntary sector. It suggests that a significant number of people will be worse off or may not be able to access the new benefits, leaving the voluntary sector to play a crucial role in supporting people through the transition and with emergency care. The briefing also argues that the cumulative impact of these tax and benefit changes has not been fully assessed by the Government, which means the impact may have been underestimated. Voluntary and community organisations anticipate an increase in demand for support, advice, information and emergency relief, which will place additional strains on resources which are already being limited by funding cuts.
www.ncvo-vol.org.uk

2 Funding Family Support Adfam

This discussion paper sets out the challenges currently facing the voluntary sector as a whole – including reduced local authority funding and increasing demand for support – from the perspective of services for families affected by drugs and alcohol. Adfam surveyed 44 such organisations, and findings included that three-quarters felt their level of funding was insufficient for the services they provide; 9 in 10 reported that demand for their service had increased over the last two years; two-thirds have increased their use of volunteers in the same period; and some services had made increased use of joint funding bids and considered merging or joining consortia. The paper also shows how services are adapting their arguments to funders and using evidence of their impact to support funding bids.
www.adfam.org.uk

3 The Public Health Reforms: What they Mean for Drug and Alcohol Services DrugScope

This report summarises the key structural changes taking place in the public health sector (particularly the abolition of the National Treatment Agency and the transfer of its responsibilities into Public Health England) and what they mean for providers of drug and alcohol support services. PHE will coordinate further with Police and Crime Commissioners (PCCs), Directors of Public Health (DPHs) and the Health and Wellbeing Boards (HWBs), which will be organised by local authorities. The report highlights potential avenues for support services and their service users to influence these new local bodies in order to secure funding and promote the value and benefits provided by family support. It concludes that while there is still uncertainty over many issues, the potential also exists to increase support for families as commissioning discussions will now take place in a localised context as part of the public health debate.
www.drugscope.org.uk

4 The Code of Good Impact Practice NCVO

This report looks into the measurement of impact by non-profit organisations and how they prove they are making a difference for the individuals they seek to help. The guide suggests that there is a great deal of confusion and often contradictory advice over good impact practice, but many organisations understand that there is a general need for it. The guide, therefore, sets out to provide agreed guidelines for focusing on impact by setting out a cycle of activities and principles to follow, including focusing on purpose, identifying desired impact, collecting information, communicating results and reviewing findings.
www.ncvo-vol.org.uk

5 Blueprint for Shared Measurement NPC

The idea behind this report is that solving complex social issues requires partnership and collaboration between different organisations, which therefore need a shared understanding of their common goals, and would benefit from measurement tools which can be used across a range of services working towards similar aims. Other major benefits of shared measurement are that it saves organisations the expense of designing their own specific tools; helps to create an evidence base of 'what works'; and improves the consistency and comparability of impact data. Based on case studies of 20 different shared measurement systems – including the Outcomes Star, for example – the report identifies the main hallmarks of successful shared approaches and illustrates how they can be built and expanded. There are also recommendations for charities, funders and Government, and the report advises that sector bodies should champion shared measurement within their networks.
www.thinknpc.org

#FAIR4FAMILIES

Are you concerned about cuts to family services, tax credits and child benefit?

Text **FAMILIES** and your name to **88802** to back the campaign*

We want the government to be **Fair4Families** and protect them from further spending reductions and provide those families who are struggling financially with the necessary support.

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In Focus
Parental substance use

IN this issue of *Families UpFront* we consider one particular category of 'families affected by substance use' – children whose parents problematically use drugs and alcohol. Here at Adfam we always stress the fact that many people, and many types of families, are affected – indeed the fact that substance use can affect any family is one of our core messages. Sometimes the public and media interest in children who are adversely affected by parental substance use means that all the other family members (such as adult siblings, mums and dads and grandparents) don't get the coverage or support they need and deserve – we have used previous issues of *Families UpFront* to redress this balance by looking at grandparent carers (all the way back in our first issue) and supporting men affected by someone else's substance use (issue 2).

However, given our recent publication of *Parental substance use: through the eyes of the worker*, in which we use the experiences and opinions of frontline practitioners to fashion an understanding of the realities of working with this set of complex parents, we feel it is time to focus on how parental substance use can affect children and how practitioners can adapt their practice to work effectively with both child and parent.

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Our *In Focus* section is about what works. This edition identifies, explores and celebrates the innovative and effective practice of our colleagues throughout the sector – from the NSPCC's excellent work with the Parents under Pressure programme (page 14) to Blenheim CDP's views on recovery, parenting and children (page 16). In line with our conference this year we are also focussing on 2003's seminal *Hidden Harm* report, and the progress that has, or has not, been made on its recommendations (page 20).

Joss Smith *Director of Policy and Regional Development, Adfam*

Setting the scene

Key background information on parental substance use and its impact on children.

The numbers

The 2003 Advisory Council on the Misuse of Drugs report *Hidden Harm* estimated that 250-350,000 children in the UK are affected by parental drug use. According to the NTA, more than half (105,780) of the treatment population are either parents or live with children. When alcohol is brought into the equation, this inflates the number further – treatment provider Turning Point estimated that 1.3million children are affected by parental alcohol misuse.

Parental substance use is also a common feature in Serious Case Reviews (the studies undertaken at Local Authority level when a child dies or comes to serious harm) – 44% mentioned alcohol or drug use in 2007-09. It also features in up to half of cases where children become subject to a Child Protection Plan.

These examples are at the most challenging end of the spectrum. Substance use can also affect children and families at levels which are not 'serious' enough to merit the attention of support services, especially for alcohol: having a frequent drinker in the house is a strong predictor of young people's drinking behaviour, for example.

Key impacts

So the numbers are evidently significant. But what of the effects? It would be wrong to say simply that 'drug users are bad parents' and build policy and practice around this assumption. It's important not to generalise about families experiencing problems with substance use. However, these children are undeniably exposed to certain risks and vulnerabilities which must be recognised.

Parental substance use is associated with neglect, isolation, physical or emotional abuse, poverty, separation and exposure to criminal behaviours. There are also different impacts from conception all the way through to adolescence and beyond: drugs can cause physical harm to babies in the womb; parenting can be compromised in the important period after birth when attachments are being formed; young children's cognitive and emotional development can suffer; and as they grow up, these children face increased risk of early substance misuse, offending behaviour and poor educational attainment. Given that drug use is associated with a number of other vulnerabilities, including poverty and social exclusion, it's important to recognise these risks for children too.

Strategy

The impact of parental substance use on children is a powerful argument that many people want to embrace: nobody is going to say that these children are not important, and 'Hidden Harm' has been the subject of a number of official strategies, policies and announcements over the years.

In its 2010 Drug Strategy, the Government stated that 'the capacity to be an effective and caring parent' is a key goal of recovery-orientated drug treatment; the Department for Children, Schools and Families (now the Department for Education) published guidance on how local areas should develop joint protocols between drug treatment and children and family services; and many local areas have their own Hidden Harm strategies. However, local practice and implementation varies widely.

Treatment and beyond

Of course, it's not all up to drug treatment services to identify parents and support whole families. Partnership and coordination is absolutely critical across whole local areas: the role of social workers can be particularly important, but professionals in housing, domestic violence, mental health, maternity and criminal justice all have roles to play before, during and after treatment, and even if the parent never accesses structured support for their substance use.

Focus on the child

It's also important to remember that whilst treatment is a protective factor (NTA evidence shows that parents in treatment who live with their children have better treatment outcomes and fewer drug-related problems), progress in treatment does not necessarily equate to progress in parenting, and family relationships can improve without a change in levels of substance use. A treatment agency which covers parenting in its services is not the same thing as supporting children in their own right, and service provision specifically for children affected by parental substance use remains patchy.

What works?

This is one of the key questions regarding parental substance use and in many cases it remains unanswered – or at least, any answers there are have been inconsistently put into practice.
A number of specific interventions exist which work with parents, children and whole families, both separately and together. Action on Addiction's M-PACT (moving parents and children together) programme, for example, works with children affected by parental substance use and their families; several more examples of good practice are set out over the coming pages.

Further information

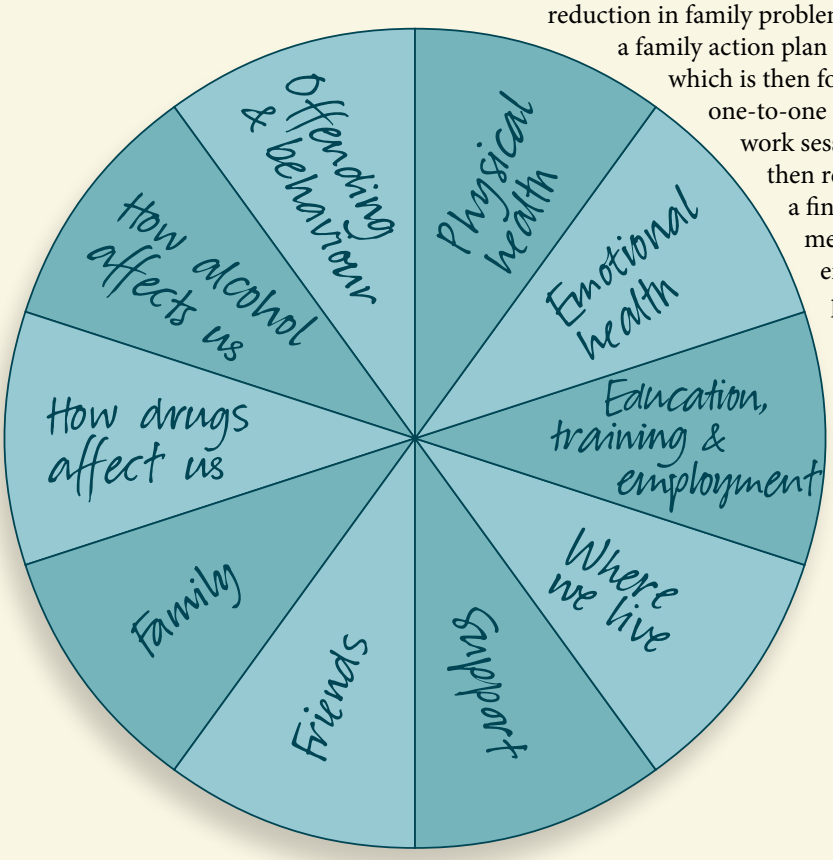
- *Hidden Harm: Responding to the needs of children of problem drug users* (ACMD, 2003)
- *Parental substance use: through the eyes of the worker* (Adfam, 2013)
- *Silent Voices – Supporting children and young people affected by parental alcohol misuse* (Office of the Children's Commissioner, 2012)
- *Stars National Initiative* – www.starsnationalinitiative.org.uk
- *Children of Addicted Parents and People* – www.coap.org.uk

Holding it together

*Families UpFront speaks to **Vicky Stewart**, Development Officer for Holding Families, an intervention supporting families affected by parental substance misuse.*

THE Holding Families programme began in 2005 when it was piloted by Early Break (a young people's drug and alcohol service) in collaboration with Bury Drug and Alcohol Service, Child and Adolescent Mental Health Services (CAHMS) and Children's Social Care in response to the Hidden Harm agenda. "There was a great deal of parental substance misuse in the areas covered by these organisations", Stewart explains, "and they were seeing more and more young people presenting with the associated problems." The model, therefore, aimed to improve family relationships, support parents to stop using drugs or alcohol and encourage family recovery from substance use.

Now seven years later, the service is delivered in Bury, Rochdale and East Lancashire and offers a mixture of group and individual one-to-one work for each family member. The programme runs for six months at a time, starting with an engagement period where practitioners go into the family home, meet families and get to know them and their situation. Practitioners use the **Holding Families Wheel** (below), which measures different elements of the family's life (such as physical and emotional health) on a scale of zero to three. "This helps to decide where attention should be focused", Stewart explains, "and the aim is to reduce the family's 'score' by the end of the process", which reflects a reduction in family problems. Initially a family action plan is created, which is then followed up in one-to-one and group work sessions, and then reviewed in a final family meeting at the end of the programme.



Families can get involved with the programme either through self-referral or referral from other professionals or organisations, including probation and drug and alcohol services.

> *the service can offer early intervention for families, as well as supporting those who have had children removed or who are on child protection plans*

"The beauty of Holding Families", Stewart thinks, "is that it works with children at every level of safeguarding threshold: this means the service can offer early intervention for families, as well as supporting those who have had children removed or who are on child protection plans."

Service user groups and drop-ins can be accessed by parents who have completed the Holding Families community programme or who are potential future clients. Following feedback, it has now been built into the programme that families are followed up six months after closure, hopefully to see sustained change.

Stewart believes that "Holding Families stands out amongst other services because of its unique focus on the children – it puts them at the heart of the process and ensures their voice is heard". She explains that "a relationship is steadily built up between the child and their children's worker", to a point where one-to-one meetings can take

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place in a neutral location (often using school facilities). Family meetings bring the whole family together and the child prepares what they want to say to their parents; these only begin once a relationship has been developed between the child and their designated worker, and "it's this meeting that motivates parents to make changes because they hear their child's voice".

A coordinator is responsible for synchronising all the work with families, and monthly review meetings are held to bring together all the practitioners involved in each case. Holding Families staff also attend all case conferences, core groups and Child in Need meetings, whilst initiating Common Assessment Frameworks where required.

Adapting the model

The Holding Families model was recently adapted for a pilot project in HMP Buckley Hall, a category C prison in Lancashire, so that work could be undertaken with fathers in custody whilst their families were supported in the community. The pilot was a success: all eight families engaged were abstinent and have not reoffended since release, plus two prisoners were moved down to category D prisons.

Stewart is clearly proud of Holding Families and all that it has achieved: "I could talk about it for days!"

the community-based service has helped 176 families, 324 children and 215 parents since the 2005 pilot

The community-based service has helped 176 families, 324 children and 215 parents since the 2005 pilot. She suggests that "it is an excellent, evidence-based model which works and has proved effective", with both independent evaluations (by Salford University) and internal measurement systems showing improvements in areas like family vulnerabilities, safeguarding status and school attendance.

Looking to the future, she hopes that by developing relationships with GPs and making direct contact with prisons and local authorities, the programme will be able to expand. In the meantime, work is ongoing on numerous other projects including a peer mentoring scheme, Open College Network accreditation for participants in Substance Misuse and Parenting, training courses for professionals, and a programme manual for practitioners working with children. The model has now been developed into a package for other prisons, services and local authorities so that it can be delivered in other areas and help to improve the support available for families affected by parental substance use across the country.

Contact Vicky Stewart for further details on 0161 7233880 or vstewart@earlybreak.co.uk.

www.earlybreak.co.uk

Under Pressure

***Gwynne Rayns** from the NSPCC discusses specialist interventions for babies and infants.*

IN recent years there have been some promising developments in service provision and understanding of "what works" for substance misusing parents and their children. Great strides have been made in relation to effective treatment for adults. However, relatively little robust research exists on interventions for drug and alcohol misusing parents with babies and infants.

Like all parents, those with drug and alcohol problems still want the best outcomes for their children. Pregnancy and early parenthood are crucial opportunities for engaging with substance misusing parents, with the unborn child or infant being a potential motivator for behaviour change. Research shows that pregnancy and the first two years of life are a particularly important developmental phase; a relationship with a primary carer that is sensitive and responsive to the infant's needs is crucial.

Parenting capacity can be compromised when problems associated with crime, social isolation and illicit drug use coalesce

While not all parents who use substances are unable to provide the necessary care for an optimal outcome for their children, parental substance misuse is a factor in one in four child protection plans.[1] Parenting capacity can be compromised when problems associated with crime and illicit drug use, social isolation, depression and anxiety coalesce. Mothers who struggle to manage their substance misuse during pregnancy can be left with a profound sense of guilt. Some parents, from chaotic and dysfunctional environments themselves, may fail to recognise the impact of their substance misuse on their children.

© JON CHALLICOM / NSPCC (POSED BY MODELS)

As part of the NSPCC's commitment to developing the evidence base around early intervention, it is running a new programme for parents in drug or alcohol treatment, Parents Under Pressure. Originally developed in Australia, Parents Under Pressure was designed for methadone-dependent mothers with children aged two to eight years. Early evidence from a randomised controlled trial showed it reduced child abuse potential, parenting stress and child behaviour problems.[2]

The NSPCC is now delivering Parents Under Pressure in 11 locations across the UK for parents of newborn babies and infants under two-and-a-half.

The programme is a manualised home-based intervention, underpinned by an ecological model of child development. It targets multiple dimensions of family functioning, such as the psychological functioning of family members, the parent-child relationship and social contextual factors such as social isolation, accommodation and financial issues.

The key mechanisms for achieving change in families are the ecological approach, therapeutic alliance with parents and a focus on mindfulness to help improve parental affect regulation.

The NSPCC is working with the University of Warwick Medical School to evaluate the programme in the biggest study of its kind in Europe.

www.nspcc.org.uk

1 Advisory Council on the Misuse of Drugs (2004) Annual Report 2003–4.
2 See www.pupprogram.net.au.

Emma's story

Emma* was referred to the NSPCC's Parents Under Pressure (PUP) programme following the birth of her first child, Hamish, who was the subject of Social Services Child Protection Procedures due to having Foetal Alcohol Spectrum Disorders (FASD).

Emma's dad abused alcohol when she was growing up and she started drinking when she was around 12. As an adult she drank two ciders every evening after work and would binge drink at weekends.

Emma, 40, was in shock when the unplanned pregnancy was confirmed at 25 weeks and she had been drinking heavily. She stopped drinking on learning she was pregnant but relapsed two weeks before the birth.

Alcohol was at the centre of her life but she continued to deny the extent and seriousness of her drinking. Since Hamish was born, Emma has changed her lifestyle and worked hard at staying sober. She hid a couple of one-day relapses but shortly after confessed as she was riddled with guilt. Her PUP practitioner worked to help her understand that if she carried on drinking she could put his safety at risk and wouldn't be emotionally available to Hamish, so their relationship and his early development could suffer.

A turning point was when Emma realised she needed Antabuse and Campral to help her manage her addiction to alcohol. She was also prescribed medication following a diagnosis of depression. Emma's PUP practitioner encouraged her to identify clear goals to work on during the 20 weeks of home visiting. These focused on lifestyle changes and meeting Hamish's needs, and included abstaining from alcohol, attending all health, social work and addiction appointments and developing support networks through attending mother and baby groups. As well as weekly home visits, the NSPCC supported Emma with regular texts and telephone calls.

Emma was filled with guilt about Hamish's diagnosis of FASD and wanted to minimise any further ill effects. Her PUP worker helped to manage these emotions and used them to encourage Emma to make positive changes in the future rather than focusing on things she couldn't change. Emma was also encouraged to use mindfulness – combining meditation, breathing techniques and paying attention 'in the moment' to change the way we think, feel and act – to bond with Hamish and she used mindful play to maximise this bond and understand Hamish's early communication.

A new health visitor assigned to Hamish said he wouldn't know that Hamish was affected by FASD because he was more than meeting his developmental milestones.

Emma has successfully completed the PUP programme and met the goals she set for herself. Her confidence as a mum and her belief in her ability to remain sober have grown, and social workers are preparing to remove Hamish's Child Protection Plan.

Her partner James said that Emma is a different girl and a natural mum, and that the birth of Hamish and her stopping drinking have completely changed their lives for the better.

** Names and other identifying features have been changed to protect the identity of the family.*

Emma said: "Without the support of the NSPCC and other agencies I wouldn't have my baby. Parents under Pressure really helped manage my depression and anxiety and helped me build an attachment to Hamish. Without that his development would have been affected."

Whole family recovery

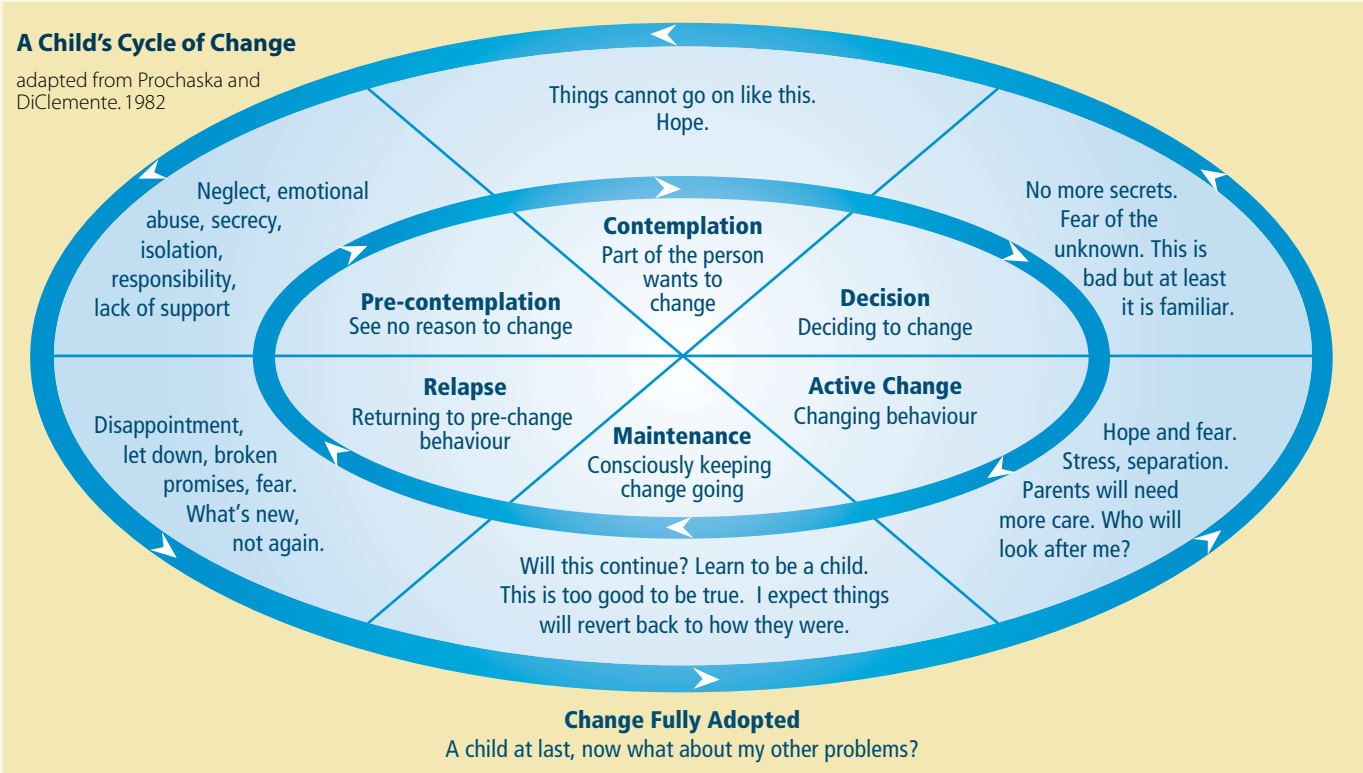
At a time of great changes in the landscape of treatment provision, what can we learn from the experience of one borough's response to Hidden Harm and how best can we focus on the needs of children and young people in a recovery-orientated adult treatment system? ***Jenny Carpenter****, Manager, CASA Family Service, explains.*

THE CASA Family Service, part of London treatment provider Blenheim CDP, has been delivering a dedicated Hidden Harm service in Islington for the past seven years, during which time the borough has seen a real shift in the response of adult alcohol and other drug services to parental substance misuse.

Following the publication of the first Hidden Harm report in 2003, Islington began to develop local services for children affected by parental substance misuse. By 2006, strategic joint commissioning between adult and children's services had embedded working partnerships in practice, with the establishment of a parental substance misuse team in the local authority, CASA Family Service as a voluntary sector partner agency, and a Hidden Harm Steering Group to bring together representatives from adult treatment agencies and family services. There has been a genuine opportunity to build best practice, with the publication of local joint working protocols between adult and children's services and ongoing Hidden Harm training for both, often delivered jointly by Children's Social Care and CASA Family Service. All alcohol and other drug services screen their adult clients for parenting and safeguarding concerns and have good links with Children's Social Care for consultation and referral. Islington was one of nine boroughs inspected for the recent Ofsted report *What about the children?*[1] which identified overall good practice within alcohol and drug services in their responses to the needs of children. Interestingly, the areas identified as needing improvement were around better provision of early support to families and around the need to identify young carers – critical areas which have both been the focus of recent practice developments locally.

To make a real difference, while protocols and frameworks for joint working are an essential part of what is needed, the important shift in responses by adults and children's services has to be in the day-to-day practice of case management and client work. Alcohol and drugs workers should be supported by their service procedures to take a family-focused approach: they may never meet a client's children, but their treatment care planning should take account of the client as a parent and embed the parent-child relationship as

1 Ofsted (2013) *What about the children? Joint working between adult and children's services when parents or carers have mental ill health and/or drug and alcohol problems*



integral to their client's experience and treatment journey. There are two aspects to this – the impact that a client's use of alcohol or other drugs has on their capacity to parent, and the impact of the parent-child relationship on the client's own recovery.

Children and recovery

In recent training sessions with the treatment workforce in Islington, there has been a positive response to using the Cycle of Change model as a basis for helping practitioners hold a family-focused approach with adult clients who are parents. Using Joy Barlow's Child Cycle of Change *(see diagram left)* as a starting point, workers were able to map the child's experience and the parent-child relationship onto the stages of work towards change for adult clients. For example, by understanding what a client may experience at the stage of maintaining reduced substance use or sobriety, workers were encouraged to imagine how that would be experienced by that client's child and what impact the client's experience of parenting would have on their capacity to maintain positive change. The child in this example may be needing to adjust to significant changes in their parent's usual patterns of behaviour and may find any change – even of the positive kind – to be unsettling. Without thoughtful attention to this with the adult client, and specific support in place around parenting and children's needs, it is easy to see how quickly the potential of positive change towards recovery can give way to stressors and potential triggers to lapse, with the added concern for what impact this has on the child.

Where the current rhetoric of the recovery agenda encourages workers to identify a client's 'recovery capital' (the personal and social resources that a person has to call on), there is a clear rationale that for clients who have children, the parent-child relationship is a significant resource, and a family-focused approach around Hidden Harm needs to be understood as integral to the core function of adult services.

This focus on parent-child relationships also helps us to broaden our approach from a safeguarding focus to the better identification of early need for family support. Perhaps it is also true for other parts of the country to say that until now, where adult services have been identifying the need for family intervention, this has largely been limited to safeguarding concerns and addressing *risk* to children. We should move towards a working practice where adult treatment services routinely discuss the offer of family-focused *support* for all clients who are parents. We can assume that where clients are parents, there is likely to have been some degree of impact from their substance use on the relationship they have with their children, and we should offer support accordingly. An added benefit of this approach is likely to be that practitioners find family and children issues more approachable with clients because they are not always framed in child protection terms.

As with any shift in focus or direction, there are challenges for adult treatment services in achieving this. Most notable are the demand of busy workloads and the level of complexity staff are already managing for clients, without also paying attention to children and the wider family. Again, from local experience, this can be alleviated to some extent by support from a Hidden Harm working group at the borough level, where all services have representation and there is space to address the challenges as they arise. Simple measures can sometimes go a long way to help in practice; an example from Islington is that workers in adult services have asked for specific prompts about children and family life to be added to their assessment paperwork. Where we can be thoughtful enough with the systems of support to staff, we are far more likely to establish a working practice that holds a client and their family in mind regardless of whether they are presenting to an adult or child focused service.

The final word should go to a borrowed quote from the Betty Ford Foundation: "Children deserve to be a part of recovery. They have unwittingly been part of the 'addiction experience'."

CASE STUDY

A local adult alcohol service identified with a client that his drinking was putting his two young children, aged two and five, at risk of emotional harm and straining his relationship with his partner to breaking point. With his agreement, they referred him and his family to CASA Family Service, where they were given support tailored to their needs:

- **Both parents came to regular parent sessions to address their joint parenting of the children, their hopes and fears for the future of their family and their different experiences of being parented in their own families.**
- **The parents brought the children for whole family sessions, where workers found creative ways to help everyone name feelings in the family, particularly worries and fears and what these made people think and do.**
- **The five year-old had a series of individual therapeutic support sessions over the period of his family's engagement with the service.**
- **The mother was referred to CASA Families Partners and Friends service, which provides dedicated support for adult family members and significant others affected by someone else's alcohol and other drug use, where she received one-to-one support.**

The father continued with his engagement with the adult alcohol service throughout this time and was able to experience his partner and children's needs as motivations towards his own reduction in use. With the ongoing support of the adult and family services, including close collaboration and joint reviewing with both services, not only did the family go from strength to strength with the children thriving at home and school, but their father also found work and described having a renewed sense of purpose. He went on to maintain long-term sobriety and both he and his partner expressed a renewed enjoyment of their life together.

www.blenheimcdp.org.uk/the-casa-family-service

Parental substance use: the challenge for social work

***Daisy Bogg** gives a social worker's perspective on Hidden Harm.*

IN February 2013, Adfam published a new report *Parental Substance use: through the eyes of the worker*, which drew on the experiences of practitioners across the country and asked – what has changed over the last decade? It found that whilst some progress had been made following the publication of the original *Hidden Harm* report, this had not kept its momentum over time and it called for an understanding of drug and alcohol issues to be a key part of social work practice and training[1].

It is estimated that 350,000 children are living with parents affected by drug misuse and up to 1.3 million children are affected by parental alcohol use. Reports also estimate that between 50% and 90% of social work child care teams' caseloads include parental substance misuse, and social workers routinely grapple with a whole range of challenges in their day-to-day practice as a result.

Working with individuals who use substances is notoriously challenging, and there can be a lack of training and development for practitioners working outside specialist teams. This has an impact in terms of both the knowledge and the capabilities that social workers need to develop in order to effectively engage with and support affected families. Social work has been shown to have a real contribution to make in this area[2], however social workers have described feeling de-skilled and unequipped to deal with the presenting issues[3,4].

The impact of substance misuse can vary significantly and the task for social work is to identify, assess, and where appropriate, intervene, to minimise this impact. In order to do this effectively, practitioners need to be able to recognise both the risks and the strengths within the family environment, and undertake a complex balancing act. Parental substance use, whether it is drugs or alcohol, can give rise to a whole host of difficulties for both the parents and the children; however harm is not the inevitable outcome, and the skill of the practitioner is to recognise which are immediate concerns and which risks can be mitigated with appropriate support.

> *the needs of a child change over time as they move from a state of total dependence through to adolescence and adulthood*

While safeguarding and protection need to be considered, the impact of a parent's substance use can affect children and young people in wide-reaching ways and developing a concept of what constitutes 'good enough' parenting in these cases can be a highly complex task[5]. While safety should always be the immediate concern, social workers also need to be able to engage with both child and family to identify the wider impacts of a parent's substance use and how it may be affecting the child or young person involved.

At each stage of childhood parental substance use can have a negative impact, the extent of which depends on the individual situation and the external resources available to the parent and the family. This might include support from services, but more often than not is derived from the extended family and wider social network. Kinship care is common in families where parents have periods of chaotic substance use[6], with grandparents and other relatives stepping in when the parents themselves lack the appropriate parenting capacity[7]. This means that social workers are likely to need to interact with a range of individuals or groups involved in the family situation, each of whom may have competing priorities which need to be considered.

The age of the child will be an important consideration: the needs of a child change over time as they move from a state of total dependence for all of their day-to-day needs, through to a young person seeking guidance and support as they move into adolescence

1 Adfam (2013) *Parental substance use: through the eyes of the worker*

2 Galvani, S & Forrester, D (2011) *Social Work Services and Recovery from Substance Misuse: A review of the evidence*

3 Galvani and Forrester (2008) *What works in training social workers about drug and alcohol use: A survey of student learning and readiness to practice*

4 Hayden, C (2004) *Parental substance misuse and child care social work: research in a city social work department in England*, Child Abuse Review, 13:1, 18-30

5 Alcohol Concern (2011) *Toolkit for Social Workers: Assessing risk and good enough parenting*

6 SCIE (2012) *eLearning: Parental substance misuse* (online resource)

7 Kroll (2007) *A family affair? Kinship care and parental substance misuse: some dilemmas explored*, Child and Family Social Work 12:1

8 See Bancroft, et al / Joseph Rowntree Foundation (2004) *The Effect of Parental Substance Abuse on Young People*

9 Cleaver et al (2011) *Children's Needs - Parenting Capacity: Child abuse: parental mental illness, learning disability, substance misuse and domestic violence.* (2nd Ed)

and adulthood[8]. What a parent offers at each developmental stage varies, and how their substance use impacts on their ability to provide what their child needs is also likely to change.

To what extent substance use impacts on parenting capacity will depend on a range of variables – the parent and child's overall physical and mental health; whether the parent is able to maintain daily routines and structures; the support available to them; the parent's experience of, and tolerance to, the substance(s) being used; and whether the father or mother, or both parents, are having difficulties. There is evidence to suggest that *which* parent is affected is an important factor: there are associations between *paternal* alcohol use and domestic violence or physical abuse, whereas *maternal* alcohol use is more closely associated with issues of neglect[9].

Social workers need to consider the whole circumstances of each case to inform any decisions and/or actions, and to do this they will need to either develop, or access elsewhere, particular knowledge and skills. The pattern and type of substance misuse, and whether the parent's use is dependent, hazardous or recreational, are key pieces of information that a social worker will need, and which can help to inform the assessment process. The developmental needs of the child or young person and the stability of the family's wider social support network will also need to be considered, as these may help to mitigate some risks that would otherwise be viewed as unacceptable. Issues such as whether the child or young person takes on a caring role if or when their parents are incapacitated also need to be considered, along with any risks relating to the child or young person's own likelihood of developing difficulties in the future.

Substance misuse, by its very nature, is a chronic relapsing condition, and individual and family situations can change rapidly. For social workers this means that they need to recognise, assess and balance a whole range of risks and needs. It may well also be the case that there are already a number of organisations and professionals involved with a family: the parents may be accessing treatment or have come to the attention of criminal justice agencies; there may be concerns raised at school; or the parent may have other health concerns. Serious Case Reviews have highlighted that communication and effective working across agencies is vital in such cases, and the revised *Working Together to Safeguard Children* guidance, published earlier this year, reasserts the importance of multi-agency cooperation where parental substance misuse is identified as an issue, with the explicit expectation that local areas will have in place a range of services to intervene early and support parents to address problems relating to substance use[10]. For the professionals involved, being clear about roles and responsibilities is vital, and communication can make a very real difference to the experiences and the outcomes of both the child and the family.

Whether the parent's use is dependent, hazardous or recreational, are key pieces of information that a social worker will need

Social work with affected families is a complex task: it involves interacting with individuals, families and communities on multiple levels, and balancing a whole range of risks and needs. While the welfare of the child or young person is considered paramount and enshrined in law, what this actually means in reality can be less than clear. Being clear about roles and responsibilities is vital, but is just one of the challenges experienced by social workers in practice who may have to overcome resistance from parents, manage the expectations of the wider family, respond to the demands of their own organisations, develop effective working relationships across agencies and professionals and apply the legal framework, all while continuing to support both the child and the family and making sure that the child's voice is being heard. This is not an easy task, and without supervision, support and appropriate knowledge and capabilities, it is likely that social workers will continue to feel ill-equipped and unprepared to intervene and deliver the best outcomes for children affected by parental substance misuse.

10 Department for Education (2013) *Working together to safeguard children*

Daisy Bogg, Co-Chair, Social Perspectives Network & independent Social Worker. Member service development officer, The College of Social Work (views expressed are not necessarily the view of TCSW)

Daisy Bogg Consultancy Ltd, www.daisy-bogg-consultancy.co.uk

Further reading

BASW (2012) *Pocket guides: Alcohol and other drugs* and *Children, families and alcohol use*

Smeaton, E (2011) *Dealing with parental substance misuse.* Community Care magazine (online), 11 March 2011

Hidden Harm: past, present and future

***Vivienne Evans OBE** has worked in the field of substance misuse policy for over 40 years, and was heavily involved in the original Hidden Harm inquiry. Families UpFront gets her thoughts on its impact, legacy and future.*

THE term *Hidden Harm* resonates with anyone working in families, drugs and alcohol. It's become shorthand for a whole set of issues relating to parental substance use and safeguarding; it can be seen in local strategies and even job titles; and as is illustrated throughout this magazine, it has resulted in a number of changes to practice and the creation of various interventions to support children and families.

But it wasn't always this way – what were things like beforehand?

"The focus had always been on the individual drug user, and people didn't even ask if they had children", says Vivienne Evans. Currently Adfam's Chief Executive, she was a member of the Advisory Council on the Misuse of Drugs during the research undertaken for *Hidden Harm* and chaired the working group which examined how its recommendations were being implemented. At the time, she was working as Head of Education and Prevention at DrugScope: "teachers used to come to me saying 'we know we have children whose parents use drugs but we don't know what to do'". The fact that teachers – not drug and alcohol workers, for example – were bringing up these concerns clearly showed that "it really is everyone's business", she says.

So what did she find on the implementation group?

Clear markers of progress were found in maternity services – particularly specialist midwives with expertise on parental substance use – and in the growing awareness of drug and alcohol services of the parenting responsibilities of their clients. "I think what we're much more aware of nowadays is the place of parental substance use in wider discussions about neglect", she says, and in terms of setting the direction of debate, "*Hidden Harm* was instrumental in the whole concept of 'think family' as it developed in the 2000s".

There were challenges, she remembers, in operating in a changing environment: "the landscape of social work in particular was changing at its own pace: child protection, and neglect in particular, were high in the public consciousness after the Laming Report [into the death of Victoria Climbié, also published in 2003]."

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There is a continuous challenge, says Evans, of trying to get – and keep – parental substance use on the agenda in a shifting environment, when both policy and practice are subject to a number of pressures from various angles. This reflects a key finding from Adfam's recent *Parental substance use: through the eyes of the worker* report: frontline professionals had a 'weakest link' conception of partnership work. That is, no matter how many different local agencies are working and communicating well together, there can still be one missing piece which could end up being the crucial one. "You really need everyone on board", says Evans; "but keeping a focus on parental substance use in every sector it needs to be can be like spinning plates at times".

This is never truer than now: the drug sector is dealing with the looming shadow of payment by results and the recovery agenda, let alone the dissolution of the NTA into Public Health England; social workers are subject to new, much shorter, statutory guidance and are awaiting the full impact of the recommendations of the *Munro Review of Child Protection*; the education system is fragmenting, with more schools operating outside of local authority control; and the Government is looking to privatise large sections of the Probation service dealing with short-term sentencing for criminals. Public service reforms mean that local systems are full of new decision makers like Police and Crime Commissioners and Directors of Public Health, and the 'age of austerity' is challenging the budgets of all services for vulnerable people. In short, there is a risk that discussions about issues like parental substance use can be drowned out by the noise of change coming from so many different directions.

This fragmentation also harks back to another key issue identified in Adfam's report – leadership, or a lack of it. As Evans puts it: "safeguarding is now much more recognised as 'everyone's business' – but it's still nobody's *responsibility*".

Old challenges, new frontiers

Hidden Harm's impact has been significant in many ways, but Evans steers clear of deeming it an unqualified success. It made 48 recommendations, of which 42 were accepted by Government – one notable absentee being the requirement for social workers to have compulsory pre-qualification training on substance use. "Many of the workforce development issues identified a decade ago are still pressing", she says, "and we

Pages from Hidden Harm: responding to the needs of the children of problem drug users report published in 2003 by the Advisory Council on the Misuse of Drugs

can't rely on policy recognition alone to represent real change; the actions and experiences of workers on the front line will always be what really counts." This mirrors debate around Professor Eileen Munro's review of child protection, which has been heavily sponsored by Government but is now the subject of sector rumblings that practical implementation is a very different beast from simple high-level recognition: *Community Care* magazine reported in February that 'despite ministers agreeing to implement all the [Review's] recommendations, it seems little has changed for many social workers'.

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It is undoubtedly a challenging environment for social workers, even without taking into account local budget cuts: referrals to children's social care are the highest they've ever been, and the spike originally attributed to the Peter Connelly ('Baby P') case is yet to decline.

"What never changes", says Evans, "is the *impact* – the experiences of the children affected by parental substance use will remain the same as time goes on." For this reason, "it's important that there is a strong emphasis on the voice of the children – this can sometimes be lost in policy and practice discussions". She recalls the *Silent Voices* report, published in 2012 by the Office of the Children's Commissioner, as a good example. This is crucial to ensuring that children's needs and experiences are really at the centre of practice: "providing a family-focused service isn't the same as supporting the children, and neither is working on parenting skills in treatment – vital though that is. But services and interventions specifically for children are still patchy".

One regret Evans does have is that "because of the strict scope of the [Hidden Harm] inquiry and the ACMD's terms of reference, it only covered illicit drugs. It was a shame that alcohol wasn't within its remit, as I don't think the children themselves would really discriminate between the impact of their parents' drug use and the effects of alcohol".

Moving on

Looking to the future, Evans says that "we'll always be able to find bits of good and bad practice, but consistency is a different matter". Just as was identified by the *Hidden Harm: three years on* review, "long-term, mainstream funding seems to remain a problem", and may be a particular risk in times of budget cuts. "We don't want a 'brain drain'", she says, "where experienced and knowledgeable staff – specialist midwives, for example – are being lost and we then find there's no easy way to replace them. Practice could really suffer".

Explaining the relevance of parental substance use to different agendas, and bringing it from the edges of debate to the centre, is also important, says Evans. "Politicians are falling over themselves to promote early intervention approaches, and we need to ensure that the links to parental substance use come through strongly in these discussions.

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"The same goes for the troubled families programme – how many of these families have substance use issues? But at the same time, we can't blame every family problem on alcohol and drugs, and we shouldn't generalise. So it's hard to strike that balance".

The recovery agenda is also of particular interest, and has gathered widespread support in Government, on the frontline and within service user groups. The child's voice, however, is yet to be satisfactorily discussed: "what is a child's perception of lapse and relapse?", she asks, "and how do children experience what can be radical changes in parental behaviour as they move through their journey?

"Adfam's default question in discussions about drugs and alcohol is always 'what about the family?' – we need to make sure they aren't forgotten. And so the same goes for debates about recovery: we need to be asking – what about the children?"

Keeping it mainstream: Hidden Harm in Children's Centres

Claire McCarthy, Director of Public Affairs at 4Children, explains how Children's Centres can work with and support parents who abuse substances.

I am certain that the readers of this publication will be all too aware of the sometimes devastating impact parental substance abuse can have on children, potentially causing them a range of complications including undermining their social, physical and educational development. But despite these effects, and the significant numbers of children involved, 4Children's research has found that a worrying 60% of parents believe using drugs or alcohol has no effect on their family[1].

Children rely upon others – especially their parents – for basic emotional and physical availability that is compromised when parents are under the influence of substances. Dependency can threaten a child's safety, as well as impact on the routines which are important for a child. It can also lead to damaging family conflict and to dependent parents diverting necessary finances from their children's care into their drug or alcohol abuse. Tackling parental substance abuse can sometimes be complicated by the fact that children may minimize or deny the effects of the parent's substance misuse, either to avoid getting them into trouble or as a coping strategy.

Alcohol and drug use is starting to become one of the key issues Children's Centres are grappling with, alongside promoting healthy lifestyles and stopping smoking. It is important for Children's Centre staff working with parents who have significant issues with alcohol or drug misuse to make careful observations and assess the potential risk of this behaviour on their child, but it is also essential that they provide a safe and non-judgmental environment in which parents can be supported without feeling stigmatised. Children's Centres working with partner agencies can provide assistance including access to drug and alcohol services, counselling and support to attend meetings or case conferences.

Within Children's Centres, family support teams are trained to provide information, assistance and outreach support specifically to vulnerable families, especially to those with children in need who might benefit from early intervention.

Family support and outreach workers work alongside parents to help them identify how their substance misuse is impacting their family life. For example, they will discuss common signs and symptoms of when substance use can become problematic. Most importantly, they will attempt to work with the whole family to ensure that both the person suffering from substance misuse and their family are supported and protected.

Though it is not always possible to engage parents immediately in new parenting strategies, when it is appropriate, an action plan is set up to help parents increase protective factors that will minimise the risk to children associated with substance misuse, including family conflict, violence, parents being emotionally unavailable and a lack of clear or safe limits. The action plan is also intended to help build the confidence of parents who may otherwise be isolated and feel helpless to challenge their own substance dependency. Substance misuse rarely exists in isolation, so family support teams will also assist and support parents to deal with additional problems, such as providing basic necessities like food and clothing, and helping with housing issues and unstable accommodation.

As Children's Centres are increasingly becoming hubs for multi-agency work, there is enormous potential for them to make a real impact to the lives of parents and children by recognising and reducing the harm of parental substance abuse. Referrals by named Health Visitors for Children's Centre outreach can identify vulnerable families in need of support, and Children's Centre workers are well-placed to provide key referrals themselves to more specialised agencies dealing with substance abuse support. It is important that the strengths of Children's Centres continue to be recognised in this arena, and that all those who may come into contact with families with young children consider linking them into local Children's centre services.

www.4children.org.uk

1 4Children (2012) *Over the Limit: The Truth about Families and Alcohol*

Case study: Jenny's story

Jenny attended a course about dealing with stress at her local children's centre run by 4Children. Afterwards she spoke to the session leader regarding her concerns about drinking alcohol excessively to deal with stress. Jenny worked alongside staff at the Children's Centre and a drug and alcohol worker on a weekly basis to receive support for her alcohol misuse. The Children's Centre also provided her with information and assistance so she could take care of her children properly, ensuring they had regular meals and clean clothes. They encouraged her to attend courses at the centre and bring her children to 'stay and play' sessions so she could meet with other parents in similar situations. After six months she felt less stressed and was able to stop drinking alcohol to deal with her problems. She was taking better care of her children, ensuring they had a stable home environment. Jenny has continued to attend the Children's Centre with her children to receive ongoing support.

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