

# Parental substance use: through the eyes of the worker



**Adfam**

Families, drugs and alcohol

# Foreword

It is now ten years since the publication of the Advisory Council on the Misuse of Drugs seminal report: 'Hidden Harm – Responding to the needs of the children of problem drug users'.

This report set an agenda for change in both specialist drugs services and the universal services which support children and families affected by problem drug use. It marked the development of specific services which provide advice, support and advocacy for this group of children and families with discrete vulnerabilities. The report also led to policy development, research initiatives, and strategic direction.

However, whilst all of this has been of significant importance, it is the frontline practitioners, their strengths and challenges from which we need to learn.

This Adfam report is a very important addition to our knowledge about the impact of working with parental substance use, the challenge of alcohol problems and impact on parenting capacity.

It gets to the heart of practice issues, including partnership working, information sharing, thresholds, and the need for strategic and local ownership of the agenda. Most importantly it provides a cogent insight into the central questions of workers' attitudes and skills, the concept of professional judgment and confidence in other services.

In the report we see that many parents with drug and alcohol problems are all too aware of the consequences of their behaviour and can be helped to take appropriate steps to minimise the impact on their children. However many may be unable or unwilling to face these consequences and this has significant implications for child wellbeing. We also see the inherent opportunities and challenges faced by children, families and workers.

It reminds us that we cannot allow this agenda to be dissipated by policy changes and fiscal constraint. We must continue to concentrate our efforts on helping these very vulnerable members of our society. Positive parenting is a basic human right to which we are all called to contribute.

## **Joy Barlow MBE**

*Strategic Advisor, STRADA (Scottish Training on Drugs and Alcohol)*

*Member, Advisory Council on the Misuse of Drugs (1990-2002)*

*Member, Prevention Working Group, Hidden Harm*

## **Acknowledgements**

Steering Group members:

Joy Barlow, STRADA

Kathy Evans, Children England

Professor Judith Harwin, Brunel University

Joanna Manning, Children's Society

Maria McCaffrey

Anthony Nagle, London Borough of Islington

Emma Pawson, National Treatment Agency

Dan Richter and Natalie Wood, Phoenix Futures

Lisa Scott Keen, Barnardo's

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# Executive summary

## Background

It is known that the number of children affected by parental substance use is significant, and that the effects on them are equally serious.

Hidden Harm identified 250-350,000 children affected by parental drug use in the UK<sup>1</sup>, and was the first major research to focus on their needs rather than those of the substance user. A third of the adult drug treatment population have childcare responsibilities, at least 120,000 children are living with a parent currently engaged in treatment<sup>2</sup>, and there could be five times as many children affected by parental alcohol misuse as drugs<sup>3</sup>.

Though harm to children is not inevitable<sup>4</sup>, parental problem drug use can be associated with neglect, isolation, physical or emotional abuse, poverty, separation and exposure to criminal behaviour. Longer-term risks include emotional, cognitive, behavioural and other psychological problems, early substance misuse and offending behaviour and poor educational attainment<sup>5</sup>. In 2007-09 22% of Serious Case Reviews mentioned parental drug use, and 22% parental alcohol use<sup>6</sup>.

The Government's 2010 Drug Strategy identifies 'the capacity to be an effective and caring parent' as a key outcome in a recovery-focused treatment system; the Department for Children, Schools and Families (now Department for Education) published Joint Guidance on Development of Local Protocols between Drug and Alcohol Treatment Services and Local Safeguarding and Family Services in 2009; and many regions in England have their own Hidden Harm strategies.

Despite a wealth of knowledge around the impact of parental substance use and a proliferation of policy initiatives and regional strategies aiming to address it, much less discussed are the experiences and attitudes of the people working in this complex and challenging area on a day-to-day basis. Recognition in research, strategy or protocol does not necessarily mean that the appropriate action has been taken, so this report aims to share the experiences and realities of safeguarding practice through the eyes of the frontline worker.

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<sup>1</sup> ACMD (2003) *Hidden Harm: Responding to the needs of children of problem drug users*

<sup>2</sup> National Treatment Agency (2009) *Moves to provide greater protection for children living with drug addicts* (media release)

<sup>3</sup> Turning Point (2006) *Bottling it up: the effects of alcohol misuse on children, parents and families*

<sup>4</sup> Department for Children, Schools and Families (2010) *Working Together to Safeguard Children* pp.270

<sup>5</sup> Social Exclusion Taskforce/Cabinet office (2007) *Reaching Out: Think Family – Analysis and themes from the Families at Risk Review*

<sup>6</sup> Department for Education (2010) *Building on the learning from Serious Case Reviews: a two-year analysis of child protection database notifications 2007-2009*

### Key questions:

- What enables drug and alcohol treatment agencies to play a significant, positive role in meeting the needs of parental substance users and their children?
- What tools do practitioners in children, family and universal services need to equip them for work with these families?
- What would enable the full complement of local services which come into contact with these families to work more effectively in partnership?

### Aims:

In light of a Governmental drive towards localism, more local areas will inevitably be approaching their priorities in different ways. The report, therefore, aims not to establish one perfect model, but to identify the common strengths and barriers encountered by practitioners in local approaches to parental substance use. The report focuses on both alcohol and drugs, as the emphasis is on children and local practice over the differences between individual substances.

### Methodology:

Research was undertaken through four focus groups across the country, a follow-up online survey, in-depth interviews and examination of existing literature. Practitioners involved were from a variety of backgrounds in the statutory and voluntary sectors.

## Practitioners' arguments: summary of findings

### 1 **Protocols and guidance** are not all derided by workers as 'red tape' or 'top-down bureaucracy'.

In fact, frontline practitioners valued them insofar as they made clear the different roles and responsibilities of different local agencies working in partnership to safeguard children. Accountability was a key consideration for workers.

If properly designed and embedded, with the requisite managerial support and multi-agency training, protocols can provide the framework in which effective work can flourish; they do not run counter to trust in professional judgment and service flexibility.

### 2 **'Partnership work'** is not a distinct area of practice but a function of a much wider matrix of interactions between services and practitioners.

Successful partnership is dependent on a number of considerations: mutual awareness and understanding between different local services and practitioners, including around thresholds and criteria for intervention; good training provision, especially multi-agency and focused on embedding protocols; a skilled, confident workforce well supported by the highest levels of management; and a good model of continuous professional development.

- 3 Information sharing** is an ongoing process and one ‘weak link’ can break the whole chain.

Decisions as to whether intervention is needed by children’s social care are only one part of what should be a broader, ongoing assessment process informed by the knowledge of a number of different agencies.

Information sharing is subject to an ‘all or nothing’ or ‘weakest link’ model of failure: as long as just one local agency is absent from the process – no matter how many others are properly engaged in partnership – there may be vital breakdowns in the flow of information.

- 4** Parental substance use must be **‘owned’ as an agenda from as high a local level as possible** – up to and including local Directors of Children’s Services – and be included in managerial supervision as a matter of course.

Managers also need to allow time and capacity to build partnerships between practitioners in different services, rather than assuming that they will form out of everyday work or through knowledgeable and dedicated frontline staff. Just as staff time may be allocated to training needs, hours out ‘in the field’ or paperwork, activities pertaining to partnership should be explicitly planned for.

- 5 There must be clear leadership of individual cases**, for example through a keyworker who coordinates services around a family and ensures that partnership work is happening, and is effective.

Practitioners reported uncertainty over which professional or service was ‘leading’ on a case, and into whose domain the family fell most urgently. This could be exacerbated by uncertainty over which services were designed to work with which families, and at what point.

- 6 A full picture of local service provision** is a crucial element of any frontline professional’s portfolio of knowledge.

Practitioners are not always aware of the full local picture of support in terms of what services are available, and what exactly they do. This confusion can be particularly pronounced with small or voluntary sector services, which can be poorly understood by other local professionals.

There was consensus amongst practitioners that they cannot be all things to all families, and that substance use in particular is a specialist area of practice: one worker cannot know everything, but they can know who else to turn to in the local area.

- 7 Mutual understanding of thresholds and criteria** is similarly vital. Referrals need to be made with full knowledge of what reaction can be expected from the partner service, and why.

A sense of clarity over roles and responsibilities must be achieved between different practitioners and their organisations across local areas. Drug workers in particular reported inconsistent and unpredictable reactions from social services when making referrals about substance-using parents. There were calls for greater flexibility in family support (such as that provided at Sure Start Children’s Centres), for example around set limits on timescales or the age of children.

**8 Physical meetings between frontline workers facilitate effective partnership.**

Though a seemingly obvious point, this still merited emphasis from many practitioners. ‘Hubbing’ services (locating them on the same premises), multi-agency training, joint visits to families, work shadowing and professionals’ peer networking were all praised highly for allowing practitioners to share knowledge, expertise and concerns.

**9 Practitioners were confident of their own skills, but this did not always transfer to confidence in other local services.**

Again, this hints at a disconnect in mutual understanding across different services. The ‘family focus’ of substance misuse treatment services was reported to have improved over the last decade, but there were still concerns over whether staff in universal and social services had the requisite knowledge of drugs, alcohol and addiction to work effectively with families for whom substance use is a problem, or to make appropriate referrals.

**10 Parental substance use falls into the remit of anyone working with children, parents and families, therefore no professional is immune to the need for knowledge in this area.**

In particular, substance use and its impacts on children and parenting need to form part of qualification and ongoing professional development for social workers. This is not to say that all workers must be experts, but they must be comfortable and confident with the presenting issues.

**11 ‘Professional judgment’ is not an unqualified good.**

More and more emphasis is being placed on ‘professional judgment’, especially for social workers, over and above a ‘tickbox culture’ and procedural compliance. But we must be sure that a workforce in whose professional judgment we put an increasing amount of trust is up to the task. This means ensuring that workers are indeed equipped with all the tools they need to make difficult decisions – including an understanding of the nature of addiction, recovery and the impact of substance use on parenting and children – and are fully supported by their management to do so.

**12 There is great demand for training by practitioners.**

This is not only for its role in building practitioners' knowledge (for example substance use and 'Hidden Harm' training for staff in universal services) but also which build mutual understanding of roles and responsibilities, such as multi-agency training courses focused on embedding local protocol and which include the use of live, anonymised case studies to show the levels at which different services would 'intervene' in the same case.

**13 Low-level support is needed for parents with substance use problems.**

With good reason, many conversations about safeguarding take place outside the remit of social services, as problems are not 'serious' enough to merit official intervention. But effective early intervention requires the availability of services working with problems below crisis thresholds: for example, with drinking and drug use which is not necessarily classified as 'addiction', but which can still present difficulties for children and parenting.

Currently there is a lack of these services, particularly around alcohol, and the situation is worsening as budget cuts focus scarce resources into higher threshold work. A lack of low-level support is a clear barrier to effective early intervention which can prevent the consequences of a parental addiction being visited upon the child.

**14 'Early intervention' refers to stopping problems from becoming serious. But in the context of addiction, recovery and relapse, it can also mean preventing problems from escalating *again*.**

Preventing problems from escalating before they become serious is a major goal, but it does not always take into account the management of long-lasting issues and vulnerabilities which can present, fall away and re-present in the future. With a problem as complex and long-lasting as addiction, one time-limited intervention cannot be relied upon and needs to be supported by other forms of long-term support at a more informal level.

**15 The voluntary sector forms a vital component of the local support system.**

Practitioners were of the mind that the threshold for accessing support in the voluntary sector was both lower and more flexible than 'official' services. Services such as peer networks and recovery groups can be a vital source of support for parents before, during and after engagement with statutory services.

**16 Expectations should be realistic**

Practitioners felt that risk to children can be minimised, but not eliminated entirely, and that public expectations of safeguarding (and of social work in particular) are extremely high. Working with parents who use substances can mean trying to support – and challenge – some

very complex service users, and outcomes will not always lead to 'happy families'. This shows the need for workers to have confidence in their own skills and a structure of proper managerial support.

**17 Children whose parents use drugs and alcohol are subject to a unique set of challenges and vulnerabilities which necessitate the availability of support for them in their own right.**

The well-documented impact of parental substance use on children has not been satisfactorily translated into the availability of local services to support them.

'Hearing the voice of child' and ensuring they are not 'invisible' are consistently put forward as routes to improving services, but this cannot be done without *supporting* the child as well. And given the very specific set of issues suffered by children affected by parental substance use, this is best provided in a support service geared specifically towards their needs.

Supporting children is not only necessary during their parents' treatment or other contact with services: the effects of parental substance use can be long-term and have a delayed onset, so support should be available throughout childhood. Lapse and relapse are often features of recovery and children need to be supported through these processes too. Unfortunately, such support is not widely available.

**18 Support structures in the wider family must be engaged**

Assessments of parental substance users and their children must take into account the support structures in place within the wider family context and the recovery capital they can provide for substance users, as well as the needs that these other relatives may have. This includes grandparents in particular, who often provide care for children whose birth parents use drugs problematically. Practitioners may have certain assumptions about the 'kind of family' a parental substance user is a part of, which should be dispelled pending an appropriate assessment.

**19 Cuts represent a risk to the availability and quality of support for these parents and children**

Funding cuts can harm partnership work firstly, and most obviously, by taking away services which were previously available; but they can also harm it through the loss of experienced staff and by causing a move towards more inward-looking, and less collaborative, working practices, both as a response to worries over organisational health and increased workloads in times of increased need and oversubscription.

According to practitioners, cuts are more likely to fall on precisely the kind of low-level support service that is needed for early intervention and ongoing work with substance using parents. When funds are scarce, they are more likely to be reserved for services working at relatively serious thresholds.

## 20 Parental substance use is a silent factor in many Government priorities and should be brought to the fore.

Troubled families, the revision of statutory safeguarding guidance, relationship support, early intervention, recovery from addiction, adoption and fostering have all received significant attention from the Coalition Government. But despite the immediate relevance of parental substance use issues to these agendas, it has largely remained on the periphery of discussion. This should be rectified urgently.

The ongoing redesign of public services under both the Coalition's austerity and effectiveness measures will also result in shifting accountabilities across the state sector. There is a risk that the pace of change could result in a vacuum of leadership on safeguarding issues, which must be avoided.

### Calls to action

#### Government

- With the dissolution of the National Treatment Agency in April 2013, **clarify leadership** of safeguarding in drug and alcohol treatment services.
- **Publish data** on the number of people in treatment with childcare responsibilities, including the extent of under-reporting of this information by treatment agencies.
- Re-emphasise parental substance use in priority policy areas where it is of crucial importance, including **troubled families** and **early intervention**.
- Make the role and accountabilities of drug and alcohol treatment services in safeguarding a clear part of **statutory safeguarding guidance**.
- Commission **Hidden Harm: 10 years** on from a relevant, qualified body. A decade after its publication, the learning and statistics from *Hidden Harm* are still used as the most robust available, and its figures have not been extensively built on or revised. Any such review should include reference to alcohol as well as illicit drugs.

#### Professional bodies

- The **College of Social Work**, the **British Association of Social Workers** and the **Chief Social Workers**, when appointed, must emphasise knowledge of parental substance use as a key element of effective practice and continuous professional development.
- There should be arrangements for **compulsory pre-qualification training** for social workers on parental substance use.

#### Service providers and managers

- Implement **management and supervision processes** which have an explicit and standing place for parental substance use issues.
- Ensure effective **referral chains** with local family support services to so that anyone looking after children – particularly grandparents – has access to appropriate support.

- Make arrangements for partnership work across organisational boundaries more explicit, by introducing more **co-located services, joint visits to families, job shadowing, induction meetings** and regular **practitioners' forums**.

### Local authorities

- Identify parental substance use as a **local priority** and provide **strategic leadership** in implementing effective practice.
- Ensure that **services working below crisis levels** with children and families are still available locally, and that evidence is gathered to support their continued provision.
- Subject **decisions on cuts** to the scrutiny of other local services to reflect the impact on partnership work that the decision may have.
- If funding and/or services are cut, **convene systems-level 'exit interviews'** to ensure that local practitioners and service managers are aware of any changes in responsibilities and service design.

### Local Safeguarding Children's Boards

- Include a representative from local **drug and alcohol treatment agencies**.
- Use their position to **improve the recognition of parental substance use** issues across the whole range of local services coming into contact with children, families and drug and alcohol users.
- Provide **multi-agency training** on parental substance use and monitor its uptake and effectiveness.

# Introduction

## Background

How best to support people to overcome addiction and keep children safe from harm are two constant areas of debate in both public and policy circles, and have merited a huge amount of attention in national strategies and initiatives. The crossover of these two issues – the impact of parental substance use on children – has also been relatively well documented, most notably in the Advisory Council on the Misuse of Drugs' 2003 report *Hidden Harm: Responding to the needs of children of problem drug users*.

We know that the number of children affected by parental substance use is significant, and we know that the effects on them are equally serious.

- *Hidden Harm's* estimate, now a decade old, is that 250-350,000 children in the UK are affected by parental drug use<sup>7</sup>.
- A third of the adult drug treatment population have childcare responsibilities; at least 120,000 children are living with a parent currently engaged in treatment<sup>8</sup>.
- Parental problem drug use is associated with neglect, isolation, physical or emotional abuse, poverty, separation and exposure to criminal behaviour. Over the longer term there is an increased risk of emotional, cognitive, behavioural and other psychological problems, early substance misuse, offending behaviour and poor educational attainment<sup>9</sup>.
- Parental substance use is a common feature in Serious Case Reviews: in 2007-09 22% mentioned parental drug use, and 22% parental alcohol use<sup>10</sup>. This is at the very serious end of the spectrum; a wider point is that having a family member who is a frequent drinker is a strong predictor of young people's drinking<sup>11</sup>.
- Research suggests there are up to five times as many children affected by parental alcohol misuse as drugs<sup>12</sup>, but they tend to come to the attention of services later<sup>13</sup>.

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<sup>7</sup> ACMD (2003) *Hidden Harm: Responding to the needs of children of problem drug users*

<sup>8</sup> National Treatment Agency (2009) *Moves to provide greater protection for children living with drug addicts* (media release)

<sup>9</sup> Social Exclusion Taskforce/Cabinet Office (2007) *Reaching Out: Think Family – Analysis and themes from the Families at Risk Review*

<sup>10</sup> Department for Education (2010) *Building on the learning from Serious Case Reviews: a two-year analysis of child protection database notifications 2007-2009*

<sup>11</sup> Joseph Rowntree Foundation (2011) *Young people, alcohol and influences*

<sup>12</sup> Turning Point (2006) *Bottling it up: the effects of alcohol misuse on children, parents and families*

<sup>13</sup> Office of the Children's Commissioner (2012) *Silent Voices: supporting children and young people affected by parental alcohol misuse*

These issues have been recognised in a number of official strategies:

- The Government's 2010 Drug Strategy notes that parental substance use 'may lead to harm, abuse or neglect', and identifies 'the capacity to be an effective and caring parent' as a key outcome in a recovery-focused treatment system.
- The Department for Children, Schools and Families (now Department for Education) published *Joint Guidance on Development of Local Protocols between Drug and Alcohol Treatment Services and Local Safeguarding and Family Services* in 2009.
- Many regions in England have their own *Hidden Harm* strategies.

## The eye of the worker

Much of the research and discussion around safeguarding has tended to focus on 'what went wrong' in the cases of most serious harm or neglect, rather than the experiences of the often challenged and heavily scrutinised workforce involved with the protection of children on a day-to-day basis. With increasing levels of localism and a new era of 'professional judgment' being ushered in by the Munro Review of Child Protection, the skills, knowledge and confidence of the workforce will become more and more crucial to outcomes.

This report, therefore, will look at the interplay of a number of key issues:

- What can be done to enable drug agencies to play a significant part in meeting the needs of parental substance users and their children?
- What do staff in universal services – not just social workers, but also midwives, health visitors, doctors, teachers and others who come into contact with parents and children affected by substance use problems, just as they come into contact with all kinds of parents and children – need to equip them with the skills and knowledge they require?
- What factors help and hinder effective partnership between local services in addressing problems of parental substance use?

## Localism and systems change

The Coalition Government's localism agenda represents a significant political shift, of which the consequences are still being played out. Local Authorities will have a freer hand in designing, funding and implementing local services thanks to the Localism Act (which 'will trigger the biggest transfer of power in a generation, releasing councils and communities from the grip of central Government'<sup>14</sup>), the recommendations of the Munro Review of Child Protection, the extensive slimming down of *Working Together to Safeguard Children* and other statutory guidance, and a wider Government emphasis on local devolution and professional judgment over and above central direction.

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<sup>14</sup> Department for Communities and Local Government (2011) *Power shift from Whitehall to communities gets underway* (press release)

The focus of this report, therefore, is not on finding one perfect local approach and recommending its implementation across the board: it is about looking for the common elements of effective work and success and the themes identified as important by frontline staff.

## What's new?

Of course, child protection, safeguarding and parental substance use are not new areas of policy or practice: quite the contrary. But just because something is said (or recommended), does not mean it has been done; in fact, some of the more important points made here by practitioners relate precisely to the gaps and inconsistencies between what is thought, assumed or recommended to be done, and what they report as the realities of frontline practice.

In many ways, this report is not about safeguarding as it is often understood. It is about what happens *before* a child needs to be 'protected', and about early intervention; the professionals spoken to, therefore, include a range of practitioners wider than just those working at high thresholds of neglect, abuse and risk.

## Methodology

Adfam ran four focus groups across the country, selected to reflect a number of geographical, structural and organisational differences. They encompassed a mixture of large, small, rural and urban communities in both the North and South of England, and varied in their local service design in relation to substance use and parenting: for example one area had a dedicated Parental Substance Use Coordinator employed at local authority level, one large treatment provider had a contract to run a number of services across a whole local area, and another had a well-established service for working directly with the children affected by parental substance use. To allow attendees to speak candidly at the meetings it was agreed that their locations would not be identified in the report.

Practitioners in attendance at the half-day focus groups (approximately 40 in total) represented a variety of services in the statutory and voluntary sectors, including drug treatment agencies, social workers, youth offending teams, nursing and midwifery, domestic violence agencies, Sure Start centres and other children and family services, hospitals, housing support, wraparound support services and more.

To facilitate discussion at the focus groups, Adfam created a number of broad, representative case studies (see appendix I).

Participants in the focus groups were then contacted again via online survey (see appendix II) and interviews for further thoughts on responses to children affected by parental substance use in their local area.

# Findings

## Protocols and guidance

Over the years, individual child tragedies have prompted national reviews and inquiries, resulting in calls for action. In response, legislation has been passed; rulebooks have expanded; more procedures and processes have been introduced and structures have been changed. But the fundamental problems have not gone away<sup>15</sup>.

*“Protocols and guidance are only as good as people’s use of them and the staff implementing them”* – focus group

**Why are they important?** Because they provide the framework in which everyday safeguarding decisions are made: what information and actions to record; when to make referrals, and to which services; what information to share, when, with whom and with what consent; the roles and remits of different professionals, including safeguarding leads; and much more. Protocols and guidance are only frameworks however, and there are limits to how much control can be designed into a system focused on a group of people with such complex needs as those affected by parental substance use. Guidance documents should only be seen in the context of the workforce enacting them, and it is hard to pin the blame for poor practice on a paper protocol; Ofsted states that ‘failure to implement and ensure good practice rather than an absence of the required framework and procedures’<sup>16</sup> is the key issue.

In the focus groups and survey, practitioners expressed some scepticism of protocols and guidance in operation locally, in terms of whether and how they are used, to what extent their creators understand the realities of frontline practice and how important they are overall. They were generally rated as less important than other factors such as effective training, relationships with fellow professionals and managerial support, and focus group feedback contained widespread scepticism of how grounded in the realities of frontline practice they were: “they’re something that people above hang onto, saying ‘this is how we’re doing things’” without being mirrored in practice, for example.

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<sup>15</sup> Department for Education (2011) *A child-centred system: the Government’s response to the Munro review of child protection*

<sup>16</sup> Ofsted (2010) *Learning lessons from serious case reviews 2009-10*

Practitioners' opinions differed on the interaction between protocols and workers' professional judgment: one said, for example, that good relationships between staff can flourish "in spite of protocols and guidance, not because of them", but others felt that "there is scope to promote joint working in protocols but it's up to the workers to enact it". Skilled practitioners can negotiate systemic barriers and 'find a way' to work effectively, but a 'good' protocol alone can still be hindered by a lack of cooperation on the front line, and does not automatically engage the workforce without proper efforts to put it into practice.

Nevertheless, over a third of the practitioners surveyed still said protocols and guidance were of critical importance and they were even rated more highly than personal judgment, albeit in a small sample, in shaping effective local responses to children affected by parental substance use. Child protection decisions can have serious and sometimes grave consequences, and ones that practitioners have to face at a personal level; as one remarked; "I don't want my name coming up in a murder case". In this respect, many perceive guidance, protocols and paper trails as useful safety nets to lessen the perceived pressure of disproportionate individual responsibility. One noted improvement of an increase in protocols and guidance was that "if something went wrong now, it'd be easier to identify where mistakes were made".

This is not to say that practitioners seek to avoid accountability; more that confidence in the systems of which they form a part helps decisions to be made with a good level of self-assurance. "It's important to share the burden because it's safer that way", as one practitioner remarked: exposure to blame, when the welfare of vulnerable children is at stake, is no small consideration and work in this area can be emotionally challenging. The importance of working with confidence came up time and again in the focus groups, and adherence to well-designed and properly embedded local protocols was said to contribute to this.

#### **Key points:**

- People working in social care need – and value – organisational and administrative structures which help them to do their jobs and, in particular, make lines of accountability and responsibility clear. Guidance and paperwork does not always constitute 'bureaucracy', and doesn't necessarily get in the way of effective practice.
- It is not necessarily the fault of the protocol itself if it is not implemented.
- Protocols and professional judgment are not mutually exclusive. If properly designed and embedded, protocols can provide the framework in which effective work can flourish.
- Protocols and guidance may be ineffective if simply introduced or imposed by managers or large bodies with which practitioners share no affinity; they should therefore have extensive input from frontline practitioners from the beginning and throughout. In the same way that service user involvement is now embedded in many drug and alcohol recovery services, the involvement and support of frontline practitioners should be ingrained into the design of the services they work in.
- In order to be effective, protocols need to be multi-agency and secure buy-in from senior management in different local services – up to and including local authority level – and must be backed up by multi-agency training and embedded into continuous professional development for practitioners.

## Partnership work

Despite considerable progress in interagency working...there remain significant problems in the day-to-day reality of working across organisational boundaries and cultures, sharing information to protect children and a lack of feedback when professionals raise concerns about a child.<sup>17</sup>

*“The tail end of poor communication is ineffective intervention and the scary prospect of something terrible happening”* – focus group

**Why is it important?** Effective partnership work, in essence, means that families’ needs are identified in the first place, and then met by the appropriate service or professional in a timely, joined-up and effective way. It’s almost a truism that partnership work is vital. But from a systemic point of view, the key questions concern how it can be designed into a local system, who drives it, and what creates the environment in which it can flourish. Families with problems as complex as addiction – and often accompanying issues such as mental health, domestic violence, neglect, poverty and housing to varying degrees – will likely be involved with a number of services at the same time. The Common Assessment Framework (CAF) form, for example, contains six fields marked ‘other services’ for the lead professional to complete, on top of a GP and an education provider, so it is vital that they all work well together.

But partnership work is not one single, standalone item to be targeted for improvement, and cannot be discussed as if it were a distinct area of practice. It is a function of a number of constituent elements which, when combined, result in effective practice. Key factors include communication and information sharing; mutual awareness and understanding between different local services and practitioners, including around thresholds and criteria; good training provision, especially multi-agency and focused on embedding protocols; a skilled, confident workforce well supported by the highest levels of management; and a good model of continuous professional development.

## Information sharing

*“Information sharing has improved, but barriers remain in terms of when it is shared”* – focus group

A ‘weakest link’ conception of partnership work and the flow of information emerged from the focus groups – that is, regardless of how many services are working effectively together, a single one outside the group could still hold vital information that the others do not. Practitioners made comments such as “no matter how many services are at the table, the one that’s missing could be

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<sup>17</sup> *The Protection of Children in England: A Progress Report*, The Lord Laming, 2009

the most important”, or “you might have a brilliant picture of a family in terms of school, health and drug treatment, but you might still not have buy-in from someone crucial like children’s services, so you miss out on key information”. The location of the communication breakdown was not consistent across professional and regional boundaries, and reports from focus groups varied widely: “I can’t see a route where a treatment worker would talk to a school”; “GP surgeries are difficult to engage with”; “probation don’t turn up to case conferences”; “social services are reluctant to engage with drug treatment”; “adult mental health services [are] the most difficult to engage in partnership working to safeguard children”, and so on.

One practitioner made the point that “schools are the only place children are seen every day, but they often miss the chance to make an early referral”. Similarly, “schools have a good window to see children every day – like if they’re coming in hungry every morning, that’s a good chance to spot the warning signs”. Practitioners in drug and alcohol treatment services and children and family services were generally unaware of safeguarding or parental substance use leads in local schools; in fact, only one survey respondent said they could identify the relevant lead. It is of course possible for school staff to pick up (and pass on) concerns about the welfare of a child without necessarily relating it to parental substance use, but there was a call for greater knowledge of substance use in general amongst people working in universal services such as education and healthcare.

#### **Example: a single service provider**

In one focus group area, a single treatment provider was contracted to deliver a large number of services. Whilst not standing as a recommendation for a uniform approach to commissioning on a local or regional basis, the staff from these services found clear value in commonly understood information sharing policies, procedures, assessments (including home visits forms, alcohol use audits and parental capacity tools) and open channels of communication between colleagues on the same payroll and with the same organisational aims. The success of this approach is largely based on mutual professional understanding and the use of effectively embedded common processes, so can be replicated in other areas without necessarily needing a single overarching service. There is also the consideration that managerial drive across one single organisation can be easier to embed into practice than the same task across many different agencies; regardless of local set-up, it is important to secure managerial focus on parental substance use across all service providers.

#### **Key points:**

- As long as just one local agency is absent from the information-sharing process – no matter how many others are properly engaged in partnership – there may be vital breakdowns in the flow of information.
- Universal services should recognise their key role in safeguarding and are a good source of information that other professionals in specialist services may not possess; for example, schools are the only place where children are seen on a daily basis during the week.
- Practitioners should feel that they are working towards the same, common goals, even if they do not work in the same organisation. Information sharing and mutual understanding

of roles and responsibilities should be equally effective between different agencies as they are within them.

## Coordinating partnership – when is it successful, and why?

The introduction of ‘Hidden Harm’ specialist posts is welcomed, particularly those with a focus on ensuring effective joint working across children’s and adults’ services<sup>18</sup>.

The benefits and opportunities of localism mean that success does not have to look the same everywhere, and many different factors and approaches can contribute to an effective partnership response. Across the survey and focus groups, different models were in operation and each received their share of praise and criticism.

In the focus groups, many of the problems discussed relating to partnership work centred around a lack of clear leadership in case management: “there needs to be a designated person to pull everything together, but this needs intensive work”. One attendee explained that “the CAF [Common Assessment Framework] lead is decided at the Children, Young People and Families meeting, which is administered by a single point of contact” – so far so good – “but attendance here depends on capacity”. This seemed to be the crux of the issue. Similarly, “deciding on the care coordinator is important, but it depends on where the first point of contact lies and the trigger event”, so leadership was not decided according to a specific strategy but more on a case-by-case basis. There is increasing recognition of this issue in policy and guidance – for example the FIP model and the ‘troubled families’ programme, which both deliberately rely on a central keyworker role to coordinate the actions of a number of different services around the family.

Despite some negativity around partnership work, there were also a number of positive comments about the progress of responses to children affected by parental substance use: “the process is joined up and free-flowing”; “whenever I have had to contact social services, the exchange of information between services flows easily and efficiently”; “there is much more inter-agency working now”; “there’s better awareness that [safeguarding] is everyone’s responsibility”; and “there’s a panic to do inter-agency working as soon as someone says ‘safeguarding’”. There is clearly progress to build upon but, as will be discussed below, practitioners often moderated positive comments with disclaimers that they could only speak for themselves, or that they were not optimistic about their own positive experiences being mirrored elsewhere.

There were wide variations in experiences of referrals to social care, with answers from within the same local area encompassing the whole range of responses from “very effective” to “normally good but it depends on the social worker” and “slow and reluctant to act”. This inconsistency was reflected elsewhere: “it depends who the workers are – some are fantastic and some you have to keep ringing”; “there doesn’t seem to be any pattern to it”.

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<sup>18</sup> ACMD (2007) *Hidden Harm Three Years On: Realities, Challenges and Opportunities*

### **Example: the Local Coordinator approach**

One local area employed a Parental Substance Misuse Coordinator, who shared time between children’s social care, drug and alcohol treatment services and the neo-natal unit of the local hospital. This post was highly praised by practitioners from a variety of services, who valued the clear ownership of the parental substance use agenda: “the leadership of a local authority-based Parental Substance Use Coordinator has made a big difference to how services communicate with each other...the approach was much more piecemeal before”. The identification of leadership at both a practice and structural level removed some of the key barriers often referenced by frontline professionals, particularly uncertainty about who was in charge of leading or coordinating family work. The coordinator also acted as a valuable ‘sounding board’ for workers’ concerns, especially regarding which referrals may be necessary. In terms of replicating this success elsewhere, with or without an individual employed by the local authority to work precisely in this capacity, the availability of a sounding board for safeguarding concerns and questions about ‘to refer or not to refer’ and the clear location of the lead worker for parental substance use issues are the obvious starting points.

### **Key points:**

- A keyworker has a central role not only in working individually and intensively with families, but also in coordinating services around them to ensure that partnership working is happening, and is effective.
- Clear ownership of the parental substance use agenda is valued at service manager and local authority level.

## **Building professional relationships**

*“Relationships with other services are built through working with mutual clients”* – focus group

Professional relationships between individual practitioners were commonly cited as vital in partnership work; but again, this does not lead itself to easy replication elsewhere and the recommendation that ‘practitioners should get on better’ begs the question. Multi-agency training, forums with attendance from all relevant local agencies, better understanding of what different services offer and ‘hubbing’ more services (i.e. locating them on the same premises) were all cited as key in improving relationships. These all share the crucial common factor of practitioners physically meeting each other: “it’s really important to meet with workers from other services and reinforce the importance of a family focus”.

One service which works extensively with parental substance users and their children took visits from student social workers to improve their understanding of drug and alcohol treatment; one such placement worker rated the experience extremely positively. “[Drug and alcohol services and social services] have conducted many joint visits and there are clear lines of communication”; “lots of new

social work students visit our service so they have a better understanding of what treatment involves”.

One drug worker spoke positively of links with the local probation service: “probation [workers] site themselves within the [young people’s drug service] here quite a lot...there’s that informal relationship already”, which was in contrast to complaints of poor information sharing between these services in other areas.

**Key points:**

- The ability to meet together *physically* is valued by practitioners and facilitates the development of working relationships.
- Work shadowing, joint visits to families, multi-agency training and ‘hubbing’ services – locating them on the same premises, at least some of the time – are all conducive to effective partnership work.

*Adfam spoke to a Parental Substance Use Coordinator, employed by the local authority to lead the agenda across a whole borough.*

**On the problems identified prior to appointment:**

*“There were issues around communication between drug treatment agencies and children’s services, and some concerns about over-optimism with substance-using parents”*

*“In treatment services there was a tendency to ask the basic questions about children that you have to ask, tick the box and move on”*

**On the key features of the Coordinator post:**

*“The relationship base – having someone there who people know and recognise”*

*“Being accessible to as many people as possible”*

**Tips for the workforce:**

*“Prejudice [from workers] actively reduces the chances of success for families – you can’t write them off immediately”*

*“Frontline social workers can’t be experts in absolutely everything they come across”*

*“Treatment workers need to feel more comfortable talking about parenting, not just safeguarding – if you’re not looking at parenting, you’re missing a huge part of the picture”*

*“Make it clear what you expect from [parents] and why, and give clear timescales for change”*

**On training:**

*“You can throw as much parental substance use training as you want at frontline practitioners, but they’ll forget it if it’s not embedded into daily practice”*

*“Managers themselves need to come on parental substance use training – it’s not true that you get to manager level and automatically know everything you need to”*

**On early intervention and low-level support:**

*“A massive amount of the contact I have from social workers is about binge-drinking parents...a lot of them will never be ‘dependent’, but they’ll always have problems”*

*“Services for harmful and hazardous drinkers are decreasing, and alcohol services weren’t funded anyway”*

**On challenges for practice in the current environment:**

*“With services overstretched and caseloads too high, supervision becomes more and more cursory”*

*“When you’re trying to improve responses to parental substance use and money’s being taken off you, ‘challenging’ isn’t the word – it’s impossible at times”.*

***The full interview is published as Appendix III.***

## Management support, supervision and leadership

Direct managerial oversight through supervision and case directions has failed to provide an appropriate level of oversight and challenge...there was insufficient recognition of the risks some children and young people were exposed to.<sup>19</sup>

*“The confidence of the workforce is directly related to the level of support they feel from above”* – focus group

**Why is it important?** Frontline practice does not exist in a vacuum and the leadership of senior members of staff has a key role to play both in effective practice with substance using parents and in embedding a culture within which parental substance use, and its effects on children, are emphasised as of paramount importance. Similarly, ongoing supervision of staff to ensure that they

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<sup>19</sup> CQC/Ofsted (2012), *Inspection of safeguarding and looked after children services: Wiltshire*

are effectively supported in a challenging area of work, and that their concerns are heard, is a vital part of creating and maintaining a competent workforce. With safeguarding guidance being dramatically trimmed down by Government and increased concentration on workers' 'professional judgment' in social care settings, effective management of practice is becoming even more important.

Discussions of management support and leadership were some of the most contentious at the focus groups, and practitioners expressed a broad spectrum of criticism and praise between the different areas. One group agreed that managers had "come through the ranks and understand workers' concerns" whereas others thought that "managers who have never been on the shop floor are making bad decisions about frontline services". That is not to say that every manager needs to have been promoted up the career ladder after many years as a hands-on worker; but practitioners need to know that their concerns are acknowledged and appreciated by an understanding management structure which allows adequate space and time to hear them, and the empathy provided by experience was valued. It is due to this 'disconnection between frontline experience and organisational decision making' that Eileen Munro recommended each local area create the post of Principal Child and Family Social Worker, whose job is to relate the views of frontline social workers to all layers of management<sup>20</sup>.

Opinion differed as to whether parental substance use was a priority agenda at the local level. One drug service practitioner argued that "people say we're in a 'checkbox culture'. But is there a checkbox for parental substance use? I don't think there is". Another remarked that parental substance use "isn't on anyone's agenda very strongly" outside one small service working specifically with children affected by parental substance use, and that "as you go up the management chain, parental substance use becomes a smaller and smaller issue". On the other hand, workers from a different area remarked the opposite and praised the positive impact of a Parental Substance Use Coordinator employed by the local authority.

There were also varied reports relating to leadership longevity. One drug worker said "I *would* take my concerns to my line manager, but I can't keep one for longer than 3 months...turnover of management makes it difficult to stay professionally supported", and this situation harmed the quality of supervision relating to safeguarding. A more informal peer network was relied upon in this case, where fellow professionals can meet and share concerns. The 'under the radar' nature of this professional network, however, has possibly negative implications on accountability and management because it does not involve strategic leadership (and in fact exists because of the very absence of managerial drive and space to discuss these issues) and discussions can be undocumented.

But in another area, noting the 'churn' of frontline staff in social care, a practitioner remarked that this turnover was less applicable to managerial posts and therefore there is no excuse for the importance of safeguarding and parental substance to drop down the agenda – that is, frontline staff turnover should not diminish the importance of safeguarding as it should be constantly pushed from managerial levels to everyone below. But rather than being a priority consistently translated

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<sup>20</sup> Professor Eileen Munro (2012) *Progress report: Moving towards a child centred system*

from above, one practitioner argued that “there’s not enough focus and incentive from the management side”.

An area with a single, large service provider noted a “good depth of training and space from management” and a “massive amount of training and support on safeguarding”. In this case, there was only one organisation that required this managerial focus in order for it to positively affect practice, and this could have been more difficult if this buy-in was needed across a range of agencies with different priorities, management structures and training provision. So, especially from a statutory perspective, the way to replicate this would be to ensure that the message was being transmitted from the highest possible level – up to local authority Chief Executives.

### Key points:

- Parental substance use needs to be led by commissioners, managers and beyond – not just taken on by knowledgeable and dedicated frontline staff.
- Parental substance use should be covered in supervision not only with drug and alcohol practitioners, but also universal services working with families where this may be an issue. This should include the ‘troubled families’ workstream.
- Workers need the full backing and support of their managers, and the space to develop as professionals – ‘trusting their judgment’ should not equate to leaving them unsupported and isolated.
- There need to be feedback mechanisms which ensure that staff in managerial positions remain fully aware of the challenges of frontline work, and of the impact that organisational decisions have on practice.
- Managers need to allow time and capacity to build partnership work, rather than assuming that it will form out of the activities of everyday work. This can be through joint training, job shadowing, visits (and joint visits to families), practitioner forums and other schemes.
- Just as staff time may be allocated to training needs, hours out ‘in the field’ or paperwork, activities pertaining to partnership work should be explicitly planned for.
- Substance use and safeguarding should be embedded at all levels of practice in social care – including training, work experience, induction and everyday practice.

## The skills, knowledge and confidence of the workforce

Predicting the likelihood of future harm to a child with complete accuracy is impossible...social workers are therefore literally being asked to do an impossible job<sup>21</sup>.

*“Outcomes are dependent on the skill level of the practitioners themselves”*

– focus group

**Why is it important?** If we are asking practitioners involved in child protection decisions to be more confident in their own professional judgment – as the Munro Review has done – and if we want to create a system in which they have more freedom to do this, we need to have confidence that practitioners will indeed make the right call. Put more simply, we need to know that they are good at their jobs. Family support and substance use are complex areas of practice involving a great deal of skill, nuance, empathy, knowledge and experience (for example knowing when parenting is still a risk despite ‘stable’ substance use, or being confident that not all parents who use drugs are automatically a risk to their children), and there should be a quality workforce delivering it. One cannot look to design success into a system without accounting for the individuals who populate it.

The key questions, then, are whether the drug and alcohol workforce is ‘good enough’ at working around family and parenting support; whether children and family workers (including social workers) are proficient in their knowledge of drug and alcohol issues; and whether the relationships between the two sectors are good enough to secure the best possible chance of positive outcomes for children affected by parental substance use. Previous research has reported feelings of uncertainty across traditional boundaries of expertise: ‘all the staff from non-childcare agencies felt that they lacked experience and training in child protection issues and the majority of childcare workers felt vulnerable in relation to knowledge about drugs and alcohol’<sup>22</sup>. A study of nearly 300 newly qualified social workers also found that over 60% did not feel adequately prepared to identify substance use problems and associated risks, or discuss the types of support available<sup>23</sup>, and the Children’s Commissioner has similarly noted that there is a lack of pre- and post-qualification training for social workers around substance misuse issues<sup>24</sup>.

Some improvement on these points was noted at the focus groups. Practitioners reported that knowledge of parenting issues had increased in drug and alcohol treatment organisations, and the focus on the child had improved significantly over the last decade: one attendee stated that “there has been a significant shift towards a greater child focus over the last six years” (the length of their

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<sup>21</sup> Forrester (2010) *Hidden Harm: working with serious parental drug misuse* in Barlow (ed.) *Research highlights 53: Substance misuse – the implications of research, policy and practice*

<sup>22</sup> Kroll and Taylor (2004), *Working with Parental Substance Misuse: Dilemmas for Practice*, *British Journal of Social Work* 34:8

<sup>23</sup> Forrester and Galvani (2011) *How well prepared are newly qualified social workers for dealing with substance use issues? Findings from a national survey in England*, *Social Work Education* 30:4

<sup>24</sup> Office of the Children’s Commissioner (2012) *Silent Voices: supporting children and young people affected by parental alcohol misuse*

tenure), and another contended that “there is better awareness that [safeguarding] is everyone’s responsibility”. A drug worker in a different area felt that “the attitude of substance misuse workers has changed drastically over the past few years and takes a much greater account of family and surroundings”, which was mirrored by drug workers elsewhere who thought that “practitioners now look at the whole picture about the family and not just the substance”. Even at the simplest level, many noted having moved on from questions on whether clients have children at all, to more detailed assessments of if, where and how often they have contact with children. However there was still some resistance noted, particularly the perception that ‘working with the family’ constitutes extra work: “it needs to be stressed that looking at the family doesn’t double workload or mean workers are all meant to become ‘family therapists’. It makes work more effective”.

However the reverse (i.e. children and family services and wider social care staff increasing their knowledge of substance use) was not reported as widely, with comments such as “social services are reluctant to engage with drug treatment”. A lack of substance use awareness in social services could lead to assumptions relating to abstinence from drugs or alcohol and downplaying progress in other areas: comments from substance use workers included “social services are not great at recognising problem substance use and exhibit simple flaws in knowledge”; “they want people to come off methadone immediately”; “they don’t credit progress with one drug because of light use of another”; “they expect immediate alcohol detox” and “children’s services can at times set unrealistic goals of parents to stop their substance misuse, and this has a detrimental impact on the treatment provided”. In particular, expecting immediate abstinence from alcohol was noted as a basic factual error due to the acute dangers associated with withdrawal. Prejudice was also noted by one midwife: “there are colleagues I’m ashamed of, who feel that [drug using] women can’t parent and don’t ‘deserve’ to have children”. Progress was noted in other universal services however, for example the police – one practitioner noted that “they don’t automatically swipe all the booze from a house like they used to” when making an alcohol-related enquiry or arrest.

These points, of course, must be qualified: it is not proposed that social workers must become overnight experts in all of the complex issues and behaviours they encounter on a daily basis. As is clear from the rest of this report, a referral to a different local partner with specialist expertise may be more appropriate in helping parents and children get the support that they need. What is suggested, however, is that parental substance use is both prevalent and serious enough in concerns over children’s welfare that social workers and frontline staff in universal services must have access to training on drugs, alcohol and their impact on parenting and children, alongside a sufficient managerial emphasis on these issues and a full understanding of wider support structures in the local area.

Practitioners at the focus groups generally had high levels of confidence in their own judgment, experience, approach and practice: “when I talk about [my work], I think: ‘I can’t believe I can do that’”. However, this was not always mirrored in confidence in the effectiveness of other services, the overall local approach or a vision for the future of safeguarding: “[relationships between services] are very positive but I can only speak of my own experiences”. Practitioners were often very confident in their *own* ability to deal with a case, but less so in the response they would get from other services. This suggests that the drug and alcohol workforce still feels isolated from their ‘mainstream’ partners in children and family services, despite repeated attempts to remedy this –

for example the National Treatment Agency's *Joint guidance on the development of local protocols between Drug and Alcohol Treatment Services and Local Safeguarding and Family Services*.

### Key points:

- A workforce in whose professional judgment we put an increasing amount of trust must be up to the task. If a previous system of over-reliance on processes and paperwork is to be changed into one of greater flexibility and professional discretion, the workforce needs to have all the requisite tools available to them to make these important decisions.
- Recognition of children and parenting issues has improved within drug and alcohol treatment services, and treatment is gaining much more of a 'family focus'
- Despite some noted improvement, social workers and other practitioners in the statutory sector would still benefit from more learning on substance use and its impact on children and parenting.

## Training

Multi-agency training...provides opportunities to develop intra- and inter-agency networks, recognition of expertise, and an understanding of the limitations and legal frameworks in which [practitioners] work. It helps participants see through the lens from which other agencies view the world; and is an opportunity for participants to challenge each other in a safe environment<sup>25</sup>.

*"Good training improves awareness and acts against workers who are afraid to ask the right questions"* – focus group

**Why is it important?** It is difficult to put 'training' under one heading, as it is geared towards a variety of different outcomes: it could be designed to educate social care staff or practitioners in universal services on the effects of different drugs, or how substance use impacts on children; it could aim to embed local protocols, especially if delivered in a multi-agency setting; or it could concentrate on helping workers understand each others' roles and responsibilities better. And training is not simply a matter of induction or of learning something once, with the assumption that it will be implemented from thereon in: it is a part of ongoing professional development as practitioners upgrade their skillsets according to specific areas of expertise, new learning or to refresh multi-agency focus on parental substance use through collaborative learning. Especially as

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<sup>25</sup> Nicholson (2010) *The role of training in changing the lives of children affected by parental substance misuse* in Barlow (ed.) *Research highlights 53: Substance misuse – the implications of research, policy and practice*

budget cuts bite and social care and safeguarding reforms are implemented, new training programmes will be necessary for professionals to understand any changes in local set-up and where their roles fit into the fuller picture.

Practitioners had different opinions and experiences of training, but there was consistently a hearty appetite for it in the survey and focus groups: not just in terms of the knowledge gained from such courses, but also for a networking function which helps workers from different services meet each other in a multi-agency setting. Given the repeated assertions of the importance of professional relationships in partnership work and referral processes, this seems an important point. Increased understanding of other services in the area streamlines the process for both families and professionals; indeed, one survey respondent named “training to raise awareness of the roles and remits of all professionals” as the main thing needed to improve the knowledge, skills and confidence of the workforce, and comments such as “[the workforce needs] more training, more often” were common.

It was also noted that some sectors and services – such as midwifery, social services and teachers – have overarching professional bodies which represent them, and administrate (sometimes mandatory) training programmes for their members; but “these don’t necessarily include parental substance use”. Indeed, one of the only six recommendations in Hidden Harm not accepted by the Government – out of forty-eight – stated that parental substance use training should be a part of pre-qualification social work training<sup>26</sup>.

Once professionals had been engaged in work and emphasis on parental substance use, even after initial resistance, it was reported that enthusiasm was quite easy to grow: “training from the Local Safeguarding Children’s Board on parental substance use is very useful and whets people’s attitudes for more”, one worker noted, and a practitioner from another area remarked that “once reluctant services have made the first step they tend to get more keen”. This hints that the perceived gulf in areas of expertise between substance use workers and children and family workers is not as insurmountable as is often thought, and is at least partly an issue of confidence; this fits with previous research, which has stated that ‘effective work with families affected by drug misuse is synonymous with effective work in general’<sup>27</sup>; and ‘conflict resolution, anger management, couples counselling, parenting skills training...are available in most practitioners’ toolboxes’<sup>28</sup>. Similarly, one substance use practitioner was adamant that “it’s all about parenting”, whether or not drugs are a factor in the family environment.

### Key points:

- Practitioner confidence is vital for effective work, and is in turn determined by the level of management support they feel and the quality of training made available to them.

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<sup>26</sup> Advisory Council on the Misuse of Drugs (2003) *Hidden Harm: Responding to the needs of children of problem drug users* (recommendation 31)

<sup>27</sup> Forrester (2010) *Hidden Harm: working with serious parental drug misuse* in Barlow (ed.) *Research highlights 53: Substance misuse – the implications of research, policy and practice*

<sup>28</sup> Velleman and Templeton (2007) *Understanding and modifying the impact of parental substance misuse on children*, *Advances in Psychiatric Treatment* 13

- There needs to be more compulsory training on substance use for practitioners working in universal services, especially social services – possibly even at pre-qualification stage – so that different organisations are working from the same knowledge base. This has been called for elsewhere, for example by the Advisory Council on the Misuse of Drugs<sup>29</sup> and treatment provider Addaction<sup>30</sup>.
- Multi-agency training and protocols - properly embedded through continuous professional development and managerial drive - can help services and practitioners understand how they all pull towards the same goals, and reduce misunderstandings about ‘conflicting’ areas of work. They can also strengthen the ‘weakest link’ in partnerships bemoaned by practitioners, and improve relationships between services.
- To replicate the positive links built through work with mutual service users, multi-agency training should include the use of live, anonymised case studies: as well as illustrating when different agencies would intervene with a family, these also help practitioners build a better understanding of what each other’s work actually entails.

## Mutual understanding

Uncertainty about which agency was supposed to be doing what with whom, and about who was the actual client, often led to inaction<sup>31</sup>.

*“Other professionals aren’t always aware of the local services on offer, so the right referrals aren’t always made”* – focus group

A consistent message from research, which has been reinforced in every high profile inquiry on child protection, is that children are best protected when professionals are clear about what is required of them individually, and how they need to work together<sup>32</sup>.

**Why is it important?** Safeguarding is ‘everyone’s business’ but the number of different professionals, organisations and sectors involved in working with vulnerable families entails a variety of working practices; different members of the same family may need different services for a number of (often complex) needs, and practitioners need to be aware of what support services are

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<sup>29</sup> ACMD (2003) *Hidden Harm*

<sup>30</sup> Addaction (2012) *A better future for families: the importance of family-based interventions in tackling substance misuse*

<sup>31</sup> Kroll and Taylor (2000) *Invisible Children? Parental Substance Abuse and Child Protection: Dilemmas for Practice*, Probation Journal 47:2

<sup>32</sup> Department for Education (2012) *Working together to safeguard children* (draft of revised edition)

available locally, what they do, when, why and who for. To ensure that families are supported by the right services, at the right time, according to their present (and possible future) needs, practitioners in the full complement of local services – whether statutory, voluntary, universal or specialist – working with issues of substance use, healthcare and children and family support need a comprehensive understanding of each other’s work and how their different contributions feed into the same high-level goals, such as the safety of children. As far back as 1989, research was proposing that ‘all agencies who work with drug users should develop clear guidelines about the services they offer, their policies and practices and resources so that available services can be used more effectively’<sup>33</sup>; but according to the focus groups, either these guidelines had not been drawn up, or they had not been effectively communicated across the necessary range of local support services.

A common point at the focus groups was not just whether families themselves are aware of services available to support them, but rather whether local *practitioners* were in fact in possession of a full picture of the existence, availability and nature of services in their own area. Practitioners recalled “misconceptions about what different organisations actually provide”, and “building a network of local services and knowing what they provide” was noted as crucial elements of training courses, even without taking into account the actual course content.

As well as being important for partnership work, understanding of the local picture of service provision also means practitioners can refer families onto the right place, even if they are not (or cannot be) involved in supporting the family themselves: “it’s important to know when someone else is better placed to work with a family than you are”; “one worker doesn’t need to know everything, but they need to be aware who does”. As well as leading to families not receiving the support that they need, a lack of mutual understanding can also lead to tension between professionals who see each other’s remits from different perspectives, particularly in relation to information sharing: “what *you* think you need to know might not be what another service thinks you do”, as one practitioner explained.

As well as practitioners feeling uninvolved in the information sharing process when they felt they should be, there were also some assumptions that support work was taking place when it actually wasn’t: “a hospital alcohol liaison worker would often assume that services were already working with a family if a parent presented at A&E”; more generally, a different practitioner noted that “services can assume that someone else is already working with the family” without actually knowing that this is really the case or checking to find out.

Focus group participants recalled that categorising families in certain ways – instigating a Child Protection Plan, in particular – can help communication and information sharing; the inverse of this is that without such an official, serious classification, coordination is difficult. Practitioners could remember instances of wanting to keep Child Protection Plans in place even when risk was actually diminished, purely because it makes partnership work easier – it was hard to harness interest and involvement from other agencies without a clear classification to focus the case around.

Survey responses were even inconsistent as to whether some local services were available *at all*, let alone whether their roles, responsibilities and criteria for intervention were properly understood. Practitioners from different organisations in the same areas gave different answers when asked

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<sup>33</sup> SCODA/National Local Authority Forum on Drug Misuse (1989) *Drug Using Parents and Their Children*

whether there was a local service *specifically* for children affected by parental substance use, for example.

**Key points:**

- Mutual learning is a key element of professional development: understanding the local picture of service provision is as much a part of a frontline worker's knowledge portfolio as any other aspect of their job. Training and induction for new staff should also focus on the roles and responsibilities of other support services in the local area, rather than concentrating on the single organisation they have joined.
- The Government has noted that clarity amongst professionals about where they fit into the local system, what is expected of them and the role of other local agencies is vital to effective safeguarding, and this emphasis must be transferred to local protocols, training initiatives and continuous professional development – especially with the ongoing changes happening in local service provision.
- Practitioners are not always aware of the service setup in their own local area, let alone understand how it all fits together and which services work with which clients, how they do this, and why.
- As well as improving partnership working, increased mutual awareness would smooth families' movement into, and through, the local support system.
- To borrow a now infamous political phrase, practitioners need to feel that they're 'all in it together' in the protection of children and have a proper understanding of where they fit into the bigger picture. A sense of clarity, partnership and mutual understanding between professionals must be achieved.
- It is not enough that local managers and commissioners know the layout of the local system and services. It is crucially important that *all staff* have clear knowledge and understanding of the local service delivery model and who is responsible for what.
- Piecemeal commissioning leads a clear path towards a confused local system. Commissioning with reference to the whole range of local services must be the way forward, and should ensure that the remits of different services are known to all.
- Practitioners' assumptions – not only about the family, but also about the work of fellow professionals – can hinder effective and timely work with families.

## Thresholds and criteria

The main difficulties [with inter-agency working] were caused by varying thresholds for intervention between services, confusion about confidentiality, the interpretation of both protocols and the definition of ‘significant harm’, and insufficient assessments of the impact on children<sup>34</sup>.

Serious case reviews identified that thresholds are not understood or embedded across the partnership<sup>35</sup>.

*“People aren’t aware of each other’s thresholds – you have to learn by experience”* – focus group

**Why are they important?** All families have a different makeup and unique characteristics, and may require a number of different services concurrently and in sequence. As well as simpler differences such as the age, gender and location of parents and children, levels of need in other vital areas – including housing, substance use, mental and physical health, childcare, training and education, to name but a few – vary widely and determine to what extent the family ‘qualifies’ for support. Whether or not a family meets certain criteria, or crosses certain thresholds, will decide what support is available to them and when.

The problem of not meeting thresholds of ‘seriousness’ was one of the more common points expressed across all the different focus group areas, and staff from drug and alcohol services expressed frustration about refused social worker referrals: “it feels like, ‘what are you waiting for? Where’s your threshold?’”, one drug worker stated. Practitioners were concerned that something very serious has to happen in order for social services to take note, even if a family is already known to them but has been assessed as not needing immediate intervention; but “when a support plan is put together at crisis point, it can be very hardline or dictatorial”. Thresholds and criteria could also be overly prescriptive and not broad enough to represent real change within families: for example “FIP [Family Intervention Project] thresholds are very precise and the emphasis is on anti-social behaviour”.

The overall impression of thresholds and referral success was one of inconsistency: “sometimes social services come in all guns blazing when we make a referral, and sometimes there’s complete inaction”, remarked one drug worker; there was “sometimes immediate action but sometimes indifference” with cases not noticeably different in terms of risk, and drug service practitioners might have “really heavy concerns” about a family, and “one social worker will take no notice, and another will come in and take away the kids immediately”. This inconsistency was noted not only

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<sup>34</sup> Kroll and Taylor (2008) *Interventions for children and families where there is parental drug misuse*

<sup>35</sup> CQC/Ofsted (2012) *Inspection of safeguarding and looked after children’s services: Cumbria City Council*

between geographical areas but also between different services and even different members of staff; again, the importance of individual professional relationships was cited. Practitioners from substance use services often felt that they were actually in possession of a more realistic picture of family life than social work staff, but felt shut out of the process: “[social workers] walk in with one pair of eyes having given a week’s notice of their arrival and think everything’s fine, but we have four different sources of information about the family: so we keep referring and they keep bouncing back...it’s like playing ping pong”.

Of course, and as is discussed elsewhere in this report, for most families social care is not the appropriate avenue for support, and arguably social services should be ‘freed up’ to deal with more complex child protection cases. But this does not mean that the family should not be engaged with any services at all: assessment should not begin and end with a single decision over whether social services intervene or not. The Government’s draft revised statutory guidance *Managing individual cases* provides a flowchart for assessment which, in the event that no local authority children’s social care support is needed, states that ‘other action may be necessary e.g. onward referral for help to child and family’ – but the guidance goes no further than this. In many cases, this will be the key stage in assessment as services below the threshold of local authority intervention are convened around the family according to professional discretion, local service design and availability, and further considerations of thresholds across a number of other support services<sup>36</sup>.

As well as different services being frustrated by each other’s thresholds and criteria for intervention, some practitioners felt hampered by their *own* service’s limitations, for example time limits on work with families. In these cases, “if you think you can help a family [beyond set age or time limits] then you’ll fight against your own service to do that”.

One participant noted that strictly controlled professional remits can have a similar effect to staff turnover in terms of building a productive, trusting relationship with a client – an example being a new parent moving from pre-birth to post-natal to health visitor jurisdictions within a relatively short space of time. Similarly, three and five year-old children in the same family could fall under the remit of a health visitor and a school nurse respectively, without them necessarily communicating about the situation for the whole family. Open lines of communication and a flexible handover of responsibilities would help smooth the transition between different professional remits.

There were reports of ‘pass the buck’ referrals, when practitioners were not clear what outcomes they were looking for when referring a case to another service or wanted to deflect responsibility. It was also noted that services often depend on referrals from other organisations, but it’s not always clear who should be referring in to whom, and in which circumstances. If social services think it’s a ‘drug issue’ and drug services think ‘parenting issue’, with neither feeling they are best placed to help the family, this results in the dreaded ‘falling through the gaps’. Practitioners need to be supported in understanding the contribution they can make, and how their work can fit in with other services too.

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<sup>36</sup> See also Adfam (2012) *Consultation response: revised safeguarding statutory guidance*

### Key points:

- Though thresholds can be important to a service in putting some limits on who they can and cannot work with, they should not be applied too rigidly, and professional judgment should be used in their application.
- Decisions as to whether intervention is needed by children’s social care are only one part of what should be a broader, ongoing assessment process informed by the knowledge of a number of different agencies.
- Families can ‘fall through the gaps’ where neither drug services nor social services think a family is ‘their responsibility’. Practitioners need to be supported in understanding the contribution they can make, and how their work can fit in with other services too.
- The trend of expert and governmental thinking – most notably in the Munro Review – is towards giving professionals greater freedom to enact decisions based on their own judgment. This would require a more flexible approach to thresholds for work with vulnerable families – for example, the lack of an official designation as a ‘child in need’ or ‘looked after child’ should not necessarily stop a service supporting that family.

## Early intervention and the importance of ‘low-level’ support

Intervention should not wait until a crisis has been reached and damage is apparent<sup>37</sup>.

*“It doesn’t have to be all-singing, all-dancing intervention to be effective”*

– focus group

**Why is it important?** Children who come to harm are not always known to services and do not always meet the thresholds of seriousness needed to trigger prior involvement with social care: 28.7% of children subject to care applications in 2011-12 had never been the subject of a Child Protection Plan, and a further 12.7% had been taken off one previously<sup>38</sup>. Similarly, one fifth of Serious Case Reviews in 2010-11 involved children unknown to social care services<sup>39</sup>. Especially with a renewed political focus on early intervention, the existence of support services outside the realm of crises must be looked at carefully: the gaps between services, the time before they even begin

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<sup>37</sup> Copello and Templeton (2007) *Understanding and modifying the impact of parents’ substance misuse on children*, *Advances in Psychiatric Treatment* 13:2

<sup>38</sup> Cafcass (2012), *Three months in November...three years on: Cafcass care application study 2012*

<sup>39</sup> Ofsted (2011) *Ages of concern: learning lessons from serious case reviews*

and the period after they have concluded their designated work have serious implications on supporting children affected by parental substance use.

As Graham Allen MP has said, ‘we must continue to swat the mosquitoes but we can drain the swamp too’<sup>40</sup>; that is, we cannot only deal with symptoms at the expense of the environment which causes them. However, opinion from the focus groups was that this was precisely the problem: “practitioners tend to focus on the presenting issues [such as] neglect...without considering the cause of these issues”.

When a child has come to significant harm, it is generally quite clear what action needs to be taken: it is *before* they reach ‘child protection’ level where the grey areas lie and where most debate takes place – including at the focus groups. Many practitioners were of the opinion that “the overall response is patchy for lower threshold case work”, or that “if you don’t hit the threshold for ‘dependency’ [on drugs or alcohol], there is nothing”; but they also asserted the importance of such support, in that “it’s important to be aware of possible triggers to relapse which happen outside the duration of specific interventions” and “it’s important to provide support when families start to waver, not just when something goes wrong”. This mirrors the Government’s view on early intervention – ‘what is important is that action is taken quickly so that a problem does not escalate’<sup>41</sup> – and another focus group comment that “addiction is like a slippery slope: if the right support isn’t provided on the way up then they can end up right at the bottom again.” However, research has identified that services designed to help and support children, young people and families below the threshold of social work or statutory intervention are shouldering a disproportionately large burden of cuts<sup>42</sup>.

‘Early intervention’ is generally understood to mean intervening before a potential or nascent problem becomes serious: in this context, it could mean before a parent’s substance use problem becomes serious or before it starts to have a detrimental effect on the wellbeing and development of their children. But as well as widespread sponsorship of early intervention before problems become serious in the first place for a family – for example through effective post-natal support and in helping early attachment form between mother and baby – there was also discussion at the focus groups of the value of services which stop problems from becoming serious *again*: a practitioner stated that “if someone is stable and disengaged from ‘official’ services, they’re still vulnerable to trigger events involving parents and relationships and need somewhere to go without a really serious event occurring”. So as well as targeting families who are as yet unknown to social care and other support services, there needs to be a corresponding concentration on those who have had sporadic or ineffective contact with such services in the past but have lost contact with them, or have been deliberately discharged.

But as discussed above, practitioners noted a disconnect between the ‘crisis-level’ support of social care and the more ongoing, low-level services provided in the local area, for example parenting support or mutual aid: “cases tend to be of a serious nature before reaching social services, so their

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<sup>40</sup> Graham Allen MP (2011) *Early intervention: The Next Steps*

<sup>41</sup> Department for Education (2012) *Managing individual cases: the framework for the Assessment of Children in Need and the Families* (revised edition, draft)

<sup>42</sup> Family and Parenting Institute (2012) *Families on the front line? Local spending on children’s services in austerity*

staff don't tend to be aware of lower-level support for families", as one focus group attendee put it. This could be particularly important when families have shown improvement and do not necessarily need intensive work, but would benefit from being in touch with services which support them to maintain the changes they have made: 'family support is crucial even when the family is no longer identified as 'in crisis'...this is a crucial element in supporting a family and parent's recovery, as the strain on relationships can increase the pressure on relapsing'<sup>43</sup>.

Practitioners in statutory and universal services – not just social care, but the wider realm of any professional coming into contact with children – must understand their role in safeguarding. This is applicable both in terms of referrals through local protocols which bridge the gap to specialist services for more intensive interventions, and also in providing lower-level support and activities – school, clubs, sports or culture – within which children can develop a sense of self and self-esteem<sup>44</sup> and thereby ameliorate the effects of parental substance use. Safeguarding should not be seen as the preserve of a specialist workforce dealing in niche areas or only with children at immediate risk of harm, but as 'everyone's business' across the whole spectrum of statutory and voluntary service provision.

#### Key points:

- Effective early intervention requires the availability of services working with problems below 'serious' thresholds: for example, with drinking and drug use which is not necessarily classified as 'addiction', but which can still present difficulties for children and parenting.
- A lack of support for problems below crisis level runs contrary to political focus on early intervention.
- Safeguarding is not the sole preserve of specialist workers: it needs full buy-in from services outside the orbit of crisis, and proper links between services dealing with different threshold levels.
- Preventing problems from escalating before they become serious is a major goal, but it is also necessary to account for the management of long-lasting issues and vulnerabilities such as addiction, which can present and re-present in the future.

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<sup>43</sup> Houmøller *et al* (2009) *Juggling Harms: Coping with parental substance misuse*

<sup>44</sup> Copello and Templeton (2007) *Understanding and modifying the impact of parents' substance misuse on children*, *Advances in Psychiatric Treatment* 13:2

## The role of the voluntary sector

The majority of children's services and many family-focused services are located within the non-statutory and charitable sector<sup>45</sup>.

*"Peer-led services are particularly useful for relatively stable families who need low-level, ongoing support that isn't time-limited"* – focus group

**Why is it important?** Statutory services – and particularly social services – cannot be all things to all people at all times. By their very nature, they tend to not become aware of problems until they reach a relatively serious level, and this point does not serve as a recommendation that already stretched social care services – care applications are rising year on year and are now 62% higher than five years ago<sup>46</sup> – should suddenly move the goalposts of intervention and begin work with a huge tranche of families whose problems may or may not escalate to a serious level at some point in the future. But as far as parental substance use is concerned – though it is important not to generalise – it seems reasonable to say that someone should be supporting these families, and at least keeping an eye on possible risk factors.

But who discovers these problems before they become serious, and who provides support to manage them, remain key questions: and it is here where the voluntary sector often plays a key, positive role. Some practitioners put forward the view that voluntary sector services and more informal peer-led settings are vital in bridging the gaps between the more rigid threshold or longevity requirements of statutory support: "with simple, informal community services, you're not on a ticking clock", as one put it.

Peer support and mutual aid – especially the kind provided relatively informally in the voluntary sector – was praised as being of significant value at the focus groups. This is particularly true of work below prohibitively high thresholds as discussed above, as mutual aid and 'recovery communities' amongst stable or ex-substance users performs a valuable therapeutic role. Even without publicising parenting support work as an aim, peer groups and mutual aid provide it nonetheless, for example in work around triggers to relapse which could otherwise cause a major event that would draw the attention of social care: "'parenting work' might not be an explicit part of this peer support but you'll often find they'll talk together and support each other – I think it works really well".

It was also put forward that voluntary sector services are less threatening to families and are viewed "less suspiciously" than statutory services: "the voluntary sector is working in the middle of the system to cushion the blow of working with so many statutory and treatment services", one support worker stated. Voluntary services are important "when families have had enough of professionals", another added.

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<sup>45</sup> ACMD (2007) *Hidden Harm Three Years On: Realities, Challenges and Opportunities*

<sup>46</sup> Cafcass (2012) *Three weeks in November...three years on: Cafcass care application study 2012*

### Key points:

- There is a lack of services available for drinking and drug use at a level below serious dependence, so families are unable to access support for this.
- Peer support and mutual aid can perform integral roles in recovery from addiction. From a safeguarding perspective, they often provide a pillar of support in dealing with a new life after engagement with more 'official' services such as drug treatment has ended.
- A lack of low-level support, which is often provided by the voluntary sector, is a clear barrier to effective intervention which can prevent the consequences of a parental addiction being visited upon the child.
- Continued, low-level support work can prevent problems from re-presenting as a response to changing life circumstances, stress (for example in efforts to retake a parenting role) or the course of addiction as a condition involving lapse and relapse.
- With a problem as complex and long-lasting as addiction, one time-limited intervention cannot be relied upon to secure long-lasting outcomes, and needs to be supported by other forms of long-term support at a relatively more informal level.
- Non-statutory services have a vital role in shepherding families and children to other sources of support.
- If social work 'relaxed' its thresholds then staff would quite possibly be overrun by new cases which did not actually need the level of intensive support statutory services are often designed to provide; so support at the rungs below child protection thresholds needs to be increased. Many services in the voluntary sector, although disparately, provide precisely this.

## Engaging the family

One fundamental change that is needed is for all to have realistic expectations of how well professionals can protect children...we cannot know for sure what is going on in the privacy of family life<sup>47</sup>.

*"You can empower families to make better choices, but you can never guarantee you'll secure a good outcome"* – focus group

**Why is it important?** An issue often under-represented in debates over strategy and implementation is the importance of the relationship between a family and the professional(s) working with them on an interpersonal, therapeutic level. A trusting and productive relationship between practitioner and service user is the cornerstone of effective work: "it's not about the

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<sup>47</sup> Professor Eileen Munro (2012), *Progress report: Moving towards a child centred system*

‘primary presenting need’: it’s about the worker who has the best relationship with the family”. Similar views on the importance of the relationship between client and worker have been put forward in research: project MATCH, for example, suggested that the professional preparation of the therapist and the relationship they are able to establish are at least as important as the type of intervention they are delivering in determining positive outcomes for people addicted to alcohol<sup>48</sup>.

In discussions of partnership work, information sharing and confidentiality, it’s commonly asked which service has the most information on a family, who they are sharing it with and why. However, this question can also be directed at members of the family themselves: they are the ones with the most complete picture of their own situation, and in many cases what services know is, at least to start with, based on what the family chooses to tell them. The collection of information is particularly sensitive to the service user’s wishes, and can make protocols and procedures almost redundant: for example, if a social care practitioner is instructed by local guidance to collect information on the frequency, quantity and pattern of a parent’s substance use, drug history and any concurrent mental health or domestic violence issues<sup>49</sup>, then it is still up to the parent to disclose the information they think appropriate. “The family always holds the fullest picture of their own situation”, as one practitioner summarised it. This chimes with previous research, which has found that ‘some of the greatest barriers to intervention were presented by the parents and young people themselves, who often made it difficult for professionals to gain access to them’<sup>50</sup>.

We have previously discussed how a lack of understanding between professionals of how different services work can hinder effective intervention and partnership work; however, even when services *do* communicate well and know exactly when someone different would be well placed to provide support, practitioners found it challenging to ‘sell’ other support services to their clients, especially those not motivated to change. How services present each other to clients, then, was of significant importance: as one worker from a domestic violence service noted, “I spend a lot of time trying to convince my clients that social services aren’t trying to take their children away”.

Practitioners explained a suspicion of social services from the families they worked with, who feared ‘official’ intervention; however, this could drip down to professional practice as workers in substance use services could be reluctant to make referrals in the fear that this would jeopardise their relationship with the client. It was thought that a referral to social services could undo work in gaining a client’s trust: “for some clients, as soon as you mention services they pack up and disappear – then you’re left with all sorts of concerns for the child”. Similarly, focus group participants felt that “parents who feel that referrals and information sharing is coming from one direction can disengage themselves and their children from that service”, and “everyone’s had that typical blackmail from clients, [who say] ‘I won’t come to your service if you get social work involved’”.

The cases above could be examples of client manipulation rather than workers in drug services deliberately ‘taking sides’ or colluding with clients to hide risks to children. However, research in the

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<sup>48</sup> Project MATCH research group (1997) *Matching alcoholism treatments to client heterogeneity: Project MATCH post-treatment drinking outcomes*, *Journal of Studies on Alcohol* 58:1

<sup>49</sup> See, for example, Hartlepool Local Safeguarding Children Board (2009) *Substance Using Parents & Carers Assessment Tool*

<sup>50</sup> Kroll and Taylor (2010) *Interventions for children and families where there is parental drug misuse*

past has included interviews with drug workers who felt that 'if we refer [families] to social services because of our concerns, we may lose that therapeutic relationship with the parents'<sup>51</sup>, and expressed a desire to protect clients who are already stigmatized and discriminated against<sup>52</sup>. A variety of complex factors feed into the vital – and possibly controversial – area of drug service clients being 'protected', including professionals fully understanding other services and 'selling' them appropriately and positively to clients, as mentioned above; a true concentration on the welfare of the child, even if it means workers facing up to the reality that their support for the parents has not had the desired influence on behaviour; and the brokerage of honest and challenging therapeutic relationships with parental substance users who know the expectations made of them, and the consequences should they not make the required changes. It is hoped that there have been improvements in these areas since the cited research was published some time ago, but a 'lack of challenge' remains a commonly identified failure across a number of different services in Serious Case Reviews, even now<sup>53</sup>.

In many cases the engagement of the family must also reap benefits *quickly*: "children's needs are paramount and you can't work with parents forever if you don't progress – even a small delay can significantly harm children's development at a crucial stage", one practitioner noted. There was agreement at the focus groups that "for young children, a short length of time is a big section of their life" or, as the revised *Working Together to Safeguard Children* puts it, 'every day matters'<sup>54</sup>.

Some service users "know what to say these days and are very canny", managing their contact with services according to what suits their interests; methadone dispensation was brought up as an example in one area (that is, the comparative 'generosity' of different services). Families can choose what to disclose and tailor this to services they think do or don't benefit their interests: one family support practitioner spoke of "Ronseal families", who "do exactly what it says on the tin: they know what to say to each service and know who they need to please"; similarly, "clients give a lot of information when there's something in it for them, like housing, but very little to services they fear". Frontline workers based in a large metropolitan borough paid particular attention to the risks of intra-city movement, as families can move a relatively short distance which completely changes who is responsible for their care and supervision: "migration makes it hard to track people" and ensure that information is accurate and up-to-date. This could be further impacted by increased localism, as different areas have a freer hand in deciding their local set-up and funding levels for different services: an unintended consequence could be a lack of coordination and different systems across local boundaries.

It shouldn't be forgotten that "a desire to change on the part of the service user is still a vital component of a successful intervention": many practitioners argued that "success is based on the client's ability to make changes". The particular difficulties related to addiction were also referenced: as one family support worker stated, "especially with substance use, you always get the feeling that 'you're OK for today' but there's always the chance things will escalate again", and

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<sup>51</sup> Kroll and Taylor (2004) *Working with Parental Substance Misuse: Dilemmas for Practice*, British Journal of Social Work 34:8

<sup>52</sup> Billingham (1999) *Drug-Using Parents: Policy Guidelines for Inter-Agency Working*, Child Abuse Review 8:1

<sup>53</sup> See, for example, Bristol Safeguarding Children Board (2012), *Serious Case Review relating to Child K*

<sup>54</sup> Department for Education (2012) *Working Together to Safeguard Children* (revised edition, draft)

noting a temperance of ambition for substance using families, another stated that “the more families you work with, you get less judgmental – but more realistic”.

This is not to discount the achievements of recovery or the belief that people can indeed change, but practitioners felt that a perfect system can only ever minimise risk: it cannot eliminate it. With issues as complex as parental substance use and the nature of addiction, practitioners were realistic that a good outcome for every family cannot be guaranteed. Just as research has noted that ‘finding the balance between protecting children from harm and keeping families intact is hugely challenging for social workers’<sup>55</sup>, focus group participants sometimes struggled to reconcile their “duty to keep the family together, even with the extended family” with the fact that “this only goes up to a point, and some parents are just not motivated to change”.

### Key points:

- No system can completely eliminate risk – it can only minimise it.
- Factors which mitigate against the manipulation of information by parents and families include, most obviously, effective information sharing between support services. This leaves less room for service users to mislead professionals about their engagement with different services, for example which appointments they have attended and what has been said, meetings with doctors, prescription amounts, and so on.
- A transparent and trusting relationship needs to be built between clients and professionals, including levels of honest challenge and clear timescales for change.

## Engaging and supporting the child

In too many Serious Case Reviews, the child...was not asked about their views and feelings, [and] practitioners focused too much on the needs of parents, especially vulnerable parents, and overlooked the implications for the child<sup>56</sup>.

*“The service for children themselves has been shut down”* – focus group

**Why is it important?** The risks and harms to children affected by parental substance use are applicable across the whole spectrum of youth, from conception through to adulthood, and encompass a variety of impacts on health, education, cognitive ability, relationships, identity, and

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<sup>55</sup> UK Drug Policy Commission (2010) *Getting Serious about Stigma: the problem with stigmatising drug users*

<sup>56</sup> Ofsted (2010) *The voice of the child: learning lessons from serious case reviews*

emotional and behavioural development. There are also key times in the lives of children of drug users during which they may be especially at risk or may be brought to the attention of healthcare workers, including antenatally, in the neonatal period, when parents are using heavily, in withdrawal and outside treatment, during parental separation, when bullying at school occurs, during adolescence and if they start to use drugs or alcohol themselves. This means that in order for the voice of the child to be heard, consulting them – and supporting them – sporadically or as a function of their parents’ circumstances is not sufficient and there must be a service which works with them, and is geared specifically towards their needs, throughout childhood. In these cases ‘short-term intervention...may not be an ideal form of support’<sup>57</sup>.

There is also a need to work with and support children when safeguarding concerns and worries about risk are not pressing: as *Hidden Harm* notes, ‘for many [children], their parents’ drug problem may not expose them to such risk that warrants social services’ intervention yet amounts to a pernicious lack of attention, care and interest that undermines [their] wellbeing and development’<sup>58</sup>. This similarly applies when parents have stabilised their behaviour but retain some vulnerability, or during their long-term recovery. A safeguarding focus is of course paramount, but what also needs to be explored is the impact of recovery on children, their understanding of it and even their own role in it – for example parents rebuilding relationships with children they had lost contact with by design or circumstance. Drug treatment is reported as a protective factor for children<sup>59</sup>, and this would merit more detailed investigation.

Children will still be affected long into their adolescence and beyond, so even if a parent (and their parenting) improves, the children can still be at risk of poor outcomes later in life. Similarly, children ‘coping well’ and with good levels of resilience to challenging surroundings may express this later in life as detachment or difficulty forming trusting adult relationships. This is not to say the ‘damage is done’ but that there should be a recognition that children’s needs do not start and end with the level of their parents’ substance use and can be much more complex, including dealing with the hope of recovery and the realities and challenges of relapse.

Work with children affected by parental substance use also needs to be approached from various angles – for example improving resilience, learning about personal safety or minimising the chances that they will go on to use drugs themselves. In these cases, the benefits or ‘failure’ of support work with children may not be manifest until much later in their youth. There were significant concerns about learned behaviour in older children and the perpetuation of substance use within families, with one practitioner reporting that “industrial decline has led to 2<sup>nd</sup> and 3<sup>rd</sup> generation drug users” and they were always mindful of the risk of intergenerational transfer.

### Key points:

- Gaining the child’s perspective, making sure they are not ‘invisible’ and helping to improve services cannot be done without supporting the child themselves. And given the very

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<sup>57</sup> Houmøller *et al* (2009) *Juggling Harms: Coping with parental substance misuse*, London School of Hygiene and Tropical Medicine

<sup>58</sup> ACMD (2003) *Hidden Harm: Responding to the needs of children of problem drug users*

<sup>59</sup> NTA (2012) *Parents with drug problems: how treatment helps families*

specific set of issues suffered by children affected by parental substance use, this is best provided in a support service geared specifically towards their needs.

- Services which deal specifically with the effects of parental substance use on children should be available in every local area. This does not mean a treatment service with a ‘family focus’; it does not mean the children of substance users ‘being welcome’ at a young carer’s service. These are of course desirable, but are not the same as dedicated support for this very particular group of children, delivered by a workforce with the relevant expertise.
- Supporting children is not only necessary during their parents’ treatment or other contact with services: the effects of parental substance use can be long-term and have a delayed onset, so support should be available throughout childhood. Lapse and relapse are often features of recovery and children need to be supported through these processes too.

## Working with the wider family

The extended family’s involvement in caring for the children and supporting the parents was pivotal to the children’s wellbeing...[researchers] found a clear correlation between the absence of such support and the child being taken into local authority care<sup>60</sup>.

*“It’s different now...people are very actively looking around at whether there’s a family, caregivers and supporters”* – focus group

**Why is it important?** Supporting the child entails supporting the child’s environment. When there is parental substance use, there is a likelihood that friends, the wider family and grandparents in particular will take on a caring role to some degree; almost half of the carers surveyed by Grandparents Plus said the reason behind them taking responsibility for the child was substance use<sup>61</sup>. As one social worker stated, “when looking to place a child [under new care] the grandparents come first”, and it has been set out in statutory guidance that in care proceedings, Local Authorities ‘demonstrate that they have considered family members and friends as potential carers at each stage of the decision making process’.

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<sup>60</sup> Velleman and Templeton (2007) citing Barnard (2003) *Between a rock and a hard place: the role of relatives in protecting children from the effects of parental drug problems*, Child and Family Social Work 8:4

<sup>61</sup> Grandparents Plus (2010) *Family and Friends Care: “What if we said no?”*

At the focus groups, opinions varied as to whether the wider family is a supportive factor or a hindrance to effective outcomes for children affected by parental substance use: in the same local area, a children and family support worker based in a Sure Start centre had the default view of the family as a risk factor (“we’d assume you’ve got this family cycle...if [a parent] has substance use problems then the likelihood is, *their* parents have them too”), whereas a social worker would be keen to involve them in care planning and support and thought that “from a social services perspective, things look better when the grandparents are involved...it reduces the risk on paper”. Similarly, “if the grandparents are involved, one would assume there’s a particular level of good parenting going on”, against the contrary opinion that “the mother could also be using [drugs] because of abuse issues, so the grandchild should not be with the grandparent”.

Of course one should be careful not to generalise when it comes to families affected by substance use: in many cases grandparents and the wider family will indeed be a positive source of support for children, and in others they may form part of a rather more complex tapestry of family problems. So as one practitioner put it, “that’s why you’d need a whole family-based assessment”. Navigating this whole picture, including the caring role taken on by wider family members and their corresponding need for support in their own right, requires the input of a number of services, professionals and skills. Family support specifically aimed at people affected by substance use, and including knowledge on the particular concerns and needs of kinship carers, should form part of any full picture of local service provision for children affected by parental drug and alcohol use, and needs to be commissioned accordingly.

**Key points:**

- Assessments of parental substance users and their children must take into account the support structures in place within the wider family context, as well as the needs that these other relatives may have (for example grandparent carers).

### Supporting kinship carers: a case study

Swanswell is a national charity which wants to achieve a society free from problem alcohol and drug use. It offers treatment and support for people affected by substance misuse. In Barnsley, South Yorkshire, it also operates a Carer Support Service.

Adfam spoke to one of their Senior Practitioners:

*“Grandparents – as well as other family members and friends – play a big part in helping their loved one’s recovery, not only by supporting them through treatment but in some cases, taking over day-to-day responsibility for their children.*

*“However, in Swanswell’s experience, many of those involved in kinship care don’t see themselves as carers. Instead, they feel it’s their family duty to take on responsibility for their grandchildren, or the children of other relatives, to avoid them being taken in to local authority care. That’s why they don’t seek financial help.*

*“Kinship carers turn to Swanswell for help because they can find the social care process of assessments, core group meetings and case conferences daunting. In addition, they need emotional support too because of the strain on existing relationships with the person misusing substances, especially if the kinship carers are being asked to supervise contact with their children.*

*“Kinship carers are often faced with a very difficult decision – altering their own relationship with their son or daughter (or other close relative) because of substance misuse, in order to safeguard the children for whom they have taken on a caring responsibility.*

*“In Barnsley, Swanswell has co-delivered a kinship carer training programme with a Children’s Centre, which focused on understanding substance misuse, safeguarding, boundaries and communication to help tackle some of the concerns raised by kinship carers – it’s been very successful and well received.*

*“Kinship carers are brought to our attention through either Children’s Centres or by the misuser’s worker, as well as through Swanswell’s carer assessments.*

*“One of the benefits of working in an integrated treatment system is that it is a very effective way of ensuring kinship carers and their families get the support they need to lead a normal life, in what can be very difficult circumstances. It also means that Swanswell can offer practical and emotional support at core group meetings and case conferences. In some cases, support has also been offered in the family court.*

*“Working closely with other services ensures kinship carers and their families get the most appropriate support with the right people involved, with the carer’s permission. This also means that the kinship carer has access to other important support services such as domestic abuse services, home safety checks and access to mental health carer groups.*

*“What is clear is that kinship carers can be important to the substance misuser on their recovery journey, so it’s vital that more areas recognise this by offering similar help and support through services such as Swanswell’s Carer Support Service.’*

To find out more about Swanswell and the Carer Support Service in Barnsley, visit

[www.swanswell.org](http://www.swanswell.org).

## The availability of support services

Only a minority of drug agencies make any provision for the children of their clients, and only a handful made deliberate attempts to meet their needs<sup>62</sup>.

*“Due to funding [cuts]...services are fragmented, the experiences needed for case work and the knowledge of what to do and how to do it are not there”*

– focus group

**Why is it important?** Effective intervention, partnership work, the engagement of the family and all other aspects of work with parental substance users and their children have one simple element in common – the actual existence of services to work with them in the first place. There is of course the looming shadow of cuts in both the statutory sector and for voluntary services, but this is not the only issue at hand: services specifically for children affected by parental substance use have always operated on an inconsistent basis anyway.

Most focus group participants were aware of specific parenting programmes available in the local area (for example Webster Stratton or the Solihull approach) and stated that they referred clients on to them. But the question of how extensively these parenting programmes are taken up by substance users has no clear answer and would benefit from further research. Some practitioners mentioned substance using parents’ reluctance to attend ‘generic’ courses due to the fear of stigma, even where services were quite readily available; others believed that parenting skills are the central issue, more so than the substance use itself, and there is a clear value to be added by increasing the attendance of substance-using parents at such courses, as well as at more ‘specialist’ programmes for families experiencing difficulties or vulnerabilities, such as Mellow Parenting, Safe Landings and Strengthening Families<sup>63</sup>.

### Cuts

*“Cuts or no cuts, one thing we can’t afford is to put children at risk”* – focus group

As discussed previously, there were concerns that support below crisis level is lacking. Further to this, practitioners were also worried that funding cuts are exacerbating this problem: “we’re already oversubscribed, but cuts mean we’re able to take fewer referrals”. This can force thresholds up and in effect widen the gap which exists between no support at all, and support geared towards very serious cases and events: if money is short all round, then services meeting the highest level of need get the most funds; [there are] reduced services below ‘severe’ thresholds”. So despite political

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<sup>62</sup> Advisory Council on the Misuse of Drugs (2003) *Hidden Harm: Responding to the needs of children of problem drug users*

<sup>63</sup> Examples from London Borough of Islington (2011) *Parenting Programme Guide: Information for Islington mothers, fathers, carers and agencies*

focus on early intervention, there is a risk that in concentrating funds in the hands of services focused on the most serious problems – vital though this work obviously is – the wider concerns of early intervention are being overlooked.

Practitioners in different areas were concerned about funding cuts, which “often run in the opposite direction from what commissioners say they want”. A different worker noted that “the message is ‘we want early intervention’ but managers have just got rid of frontline early intervention workers”. This inconsistency was the cause of much frustration and pessimism amongst the practitioners. Others complained that “decommissioning is leading to the loss of experienced and capable staff”, which is particularly important given the crucial role of professional relationships in effective partnership work, which take time to build and nurture and cannot be easily or immediately recreated.

On top of this, there were reports of whole services being decommissioned, including those aimed specifically at children affected by parental substance use. Social care is already notable for high staff turnover, and this exacerbates the situation: the social worker vacancy rate in 2010 was found to be 11.3% compared with 0.4% for teachers, 0.5% for nurses and 1% for midwives<sup>64</sup>; and Department for Education figures show that 1 in 11 social workers leave their post each year<sup>65</sup>. This is not just a point about people losing jobs, though: as one focus group member explained, “turnover of staff is high and this affects the quality of service provided – this leads to mistakes which affect the children”.

Concern was expressed that cuts lead services to be more “inward-looking”; that is, uncertainty over a service’s organisational health and future can overshadow and diminish concentration on the welfare of the child as a singular priority, and on partnership work as vital in securing positive outcomes. This means “services can hold onto clients and not refer them on”. There were also concerns about volunteers: they “are valuable but have less longevity and commitments, and shouldn’t be covering positions that were previously paid”; “you can’t offer continuity with a volunteer”.

But voluntary sector services – and not just in the drugs, alcohol and family support sector – are currently subject to the perfect storm of reduced funding and increased workload, and as a result they may be unable to meet rising demand in an effective way. One focus group attendee believed a “sort of outsourcing” was going on, with oversubscribed statutory services referring on to support in the voluntary sector; “but with cuts to both, where is the support going to be?” A young people’s drug worker also noted that they had developed a secondary role of *de facto* early intervention service with potential or actual young parents on their caseload. Nevertheless, cuts are a reality of the present economic and political climate and practitioners did recognise the opportunity they might bring to refocus a service’s priorities on the most important aspects of its work.

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<sup>64</sup> Community Care magazine investigation, August 2010

<sup>65</sup> Department for Education (2012) *The Local Authority Children’s Social Care Services Workforce report*, December 2011, England

### Key points:

- Funding cuts can harm partnership work firstly, and most obviously, by taking away services which were previously available; but they can also harm it through the loss of experienced staff and by causing a move towards more inward-looking, and less collaborative, working practices, as a response to worries over organisational health and increased workloads in times of increased need and oversubscription.
- Declining availability of support services, particularly those working below thresholds of crisis, is a direct threat to the chances of successful early intervention with children in need.

## The context of reform

### Safeguarding is an afterthought in the NHS reforms<sup>66</sup>.

**Why is it important?** In 2011-12, there were 10,218 applications for care applications to Cafcass (the Children and Family Court Advisory and Support Service)<sup>67</sup>, and a total of just over 67,000 looked-after children<sup>68</sup>; in 2010-11, 615,000 children were referred to social care by individuals with concerns about their welfare, and 382,400 were assessed as being 'in need'<sup>69</sup>. The Government has identified 120,000 'troubled families' as in need of intensive support. But the number of children affected by parental substance use is far beyond these figures – the most recent and reliable estimate, which is now a decade old, estimates there to be 250-350,000. The National Treatment Agency estimates that there are 120,000 children with a parent currently in drug treatment<sup>70</sup>. The lack of specific focus on these children's distinct needs is therefore in need of redress and we must reiterate their importance.

As well as a lack of service provision in the first place and cuts to those which do exist, the seismic changes being undertaken in the public sector – particularly the health service – may also hinder progress in safeguarding children. Eileen Munro specifically recognised this when following up her original set of child protection recommendations: 'it is vital that the Government gives a clear message about the priority of safeguarding vulnerable children and young people so that their needs are not obscured or overlooked in the midst of unprecedented change'.<sup>71</sup>

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<sup>66</sup> Royal College of Paediatrics and Child Health (2012) *Safeguarding in 2012: Views from the frontline*

<sup>67</sup> Cafcass (2012) *Cafcass Annual Report and Accounts 2011-12*

<sup>68</sup> Department for Education (2012) *Children looked after in England (including adoption and care leavers): statistical release*

<sup>69</sup> Department for Education (2011) *Characteristics of children in need in England, 2010-11: statistical release*

<sup>70</sup> National Treatment Agency (2009) *Moves to provide greater protection for children living with drug addicts* (media release)

<sup>71</sup> Professor Eileen Munro (2012) *Progress report: moving towards a child centred system*

Yet substance use only merits a single mention in the revised *Working Together to Safeguard Children* guidance, noting that healthcare professionals – including drug and alcohol treatment workers – are in a ‘unique position’ to identify children and families with safeguarding issues. In the extensive lists of organisations which have statutory duties to safeguard children, which must be included in Local Children and Safeguarding Boards and which have key duties identified by the Children’s Acts of 1989 and 2004, drug and alcohol services are conspicuous by their absence, whilst the British Transport Police, the Probation service, prisons and the armed forces all merit specific mentions. In a submission to the Department for Education, Adfam argued that parental substance use must be given greater prominence in statutory guidance and that, through managers and Local Safeguarding Children Boards, this emphasis must be matched by local protocols, training initiatives, professional supervision and frontline practice<sup>72</sup>.

Similarly, the Royal College of Nursing’s *Safeguarding Children and Young People: roles and competences for health care staff* states that workers should ‘understand that certain factors may be associated with child maltreatment...such as drug and alcohol abuse’. Parental substance use must receive a much greater prominence in practice than these fleeting mentions in policy.

Of course, mentioning parental substance use in guidance and policy does not in itself result in good practice: it must be accompanied by the requisite changes in frontline practice which improve the identification of, work with and outcomes for the children affected. However, there remains a role for clear leadership by the relevant Government departments and professional bodies which will help to embed this effective practice.

### Key points:

- The number of children affected by parental substance use compares favourably – if we can use such a term – with groups who receive much greater emphasis in policy and practice, such as ‘troubled families’ and children in care.
- We cannot continue to discuss popular Governmental themes like troubled families, early intervention and safeguarding without emphasising the immediate relevance of parental substance use to all of these agendas.
- Though local, frontline action will always be the primary determinant of outcomes for children and families, parental substance use must be more prominent in national and local guidance in order that the importance of the issue is properly translated into practice.

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<sup>72</sup> Adfam (2012) *Consultation response: revised safeguarding statutory guidance*

## Conclusions

Of course, parental substance use is not the cause of all safeguarding concerns, and where it does exist, it does not inevitably result in harm to children. However, as this report has shown, the numbers of people involved and the effects that they suffer are significant enough to merit a great deal of attention.

There is not one single coping stone upon which the success of a local child protection system succeeds or fails. It is a much more complex web involving Government strategies, the design of local systems, leadership of local authorities, the management of support services and the actions, experiences and feelings of practitioners on the front line. There is no doubt that assessing the overall effectiveness of our country's responses to parental substance use requires extremely broad and complex research, at the end of which we may find no simple answers. However, this report has identified a number of key starting points from which effective local work could flow.

## Progress

Adfam's findings suggest that there has indeed been progress in some key areas, including the recognition of parental responsibilities in substance use treatment and the acceptance of safeguarding as 'everyone's business' in professional circles. But any progress which is identified must be monitored in an ongoing and long-term way.

*Hidden Harm's* own three-year review highlighted short-term funding approaches as a key barrier to improvement and clearly expressed concern that services or initiatives formed on the back of *Hidden Harm's* learning would not still be there in years to come; these concerns were echoed by one Parental Substance Use Coordinator Adfam spoke to in this research, who feared for the future of their post in times of cutbacks. We need to take another look and ensure that what progress is identified is not allowed to recede, and that *Hidden Harm's* legacy is not short-lived. It's not just about *getting* parental substance use on the agenda: it's about *keeping* it there. This is why the buy-in of senior management and the development of organisational cultures which prioritise parental substance use are so vital.

## Opportunities for improvement

**Data and research:** It will always be possible to find well-designed, well-run services and examples of good practice. It will also be possible to highlight mistakes when something goes wrong. But what is lacking is a truly representative view of how parental substance use is tackled across the country, and it is not clear who would take on this work as an ongoing responsibility. Much of the evidence presented here is anecdotal and based on relatively small numbers of professionals, and we need something which shows more conclusively the state of play.

**Leadership:** With the dissolution of the National Treatment Agency and the implementation of the recommendations of the Munro Review – including the creation of Chief Social Worker posts – there

could be uncertainty over who would take forward the points addressed in this work. The College of Social Work and the British Association of Social Workers will also have a role, as do organisations providing large numbers of treatment services. With an issue that touches so many different professionals, it is not the job of one person or organisation alone to ensure that responses to parental substance use are effective – but successful partnership also requires good leadership.

**Supporting the workforce:** Parental substance use should be a consideration for anyone who comes into contact with children and families – not just drug treatment staff, and not just social workers. This does not mean that every teacher, nurse or Sure Start worker must become an overnight expert in a specialist area of practice – rather that they see themselves as involved in, not separate from, these issues.

The workforce is our greatest asset in tackling the impact of parental substance use, but workers cannot be left simply to fend for themselves. The slimming down of statutory guidance and an increased emphasis on professional judgment need to be backed up with new systems of professional support which are more fit for purpose. We cannot identify safeguarding as a national priority only for the number of expert practitioners to fall and for the support structures for those still in place to disintegrate.

This requires ongoing training and managerial supervision which addresses parental substance use directly, including for staff in universal services.

**Direct services for children:** Again, as identified by *Hidden Harm's* own review, an increased recognition of parental substance use did not necessarily lead to a growth in services to support the children themselves: services supporting the parents, or trying to keep the family together, were more likely. This is similar to an argument Adfam has put forward for some time: that involving families in substance users' treatment is not the same as supporting families in their own right<sup>73</sup>.

We cannot assume that work with parents will automatically be reflected in better outcomes for their children, and there should be dedicated services to meet their needs; but this service provision remains inconsistent. Despite the clear, strong role of the voluntary sector, protecting and supporting the children of substance users should not just be something left to small charitable organisations operating in a challenging funding environment. It needs more emphasis from national and local Government.

## Challenges

**Localism:** As is evident from this report, not every local area tackles issues of parental substance use in the same way. This discrepancy will continue, and may well increase over time as different local approaches are implemented.

However, this report also shows that there are different routes to success, and it is not necessary for each local system to be designed identically in order to protect and support children affected by

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<sup>73</sup> See, for example, Adfam (2010) *Adfam's manifesto for families: 5 key challenges for supporting families affected by drug and alcohol use*

parental substance use. There will be opportunities for different areas to innovate, learn from each other and implement 'what works' according to local need; but there are also risks that as different areas implement their own responses, it may take time for both 'success' and 'failure' to manifest.

**Managing change:** The process of change in itself can present risks as well as opportunities, even if the long-term outlook improves. We may lose whole services, inspirational leaders, knowledgeable and experienced staff and the professional relationships which underpin effective work. Responsibilities will shift, accountabilities may change and new services and providers will spring up.

In the future, this may result in more effective practice as new ways of working are embedded over time. But as one worker remarked, in the current state of service upheaval "things will get worse before they get better". If this is the case, it may be difficult to ascertain whether things really are about to improve, or if they will regress further.

## Calls to action

### Government

- **Clarify leadership** of safeguarding in treatment services when the National Treatment Agency is dissolved in April 2013.
- **Publish data** on the number of people in treatment with childcare responsibilities, including the extent of under-reporting of this information by treatment services.
- Re-emphasise parental substance use in priority policy areas where it is of crucial importance, including the **Troubled Families** programme and **early intervention** schemes
- Make the role and accountabilities of drug and alcohol treatment services in safeguarding a clear part of **statutory safeguarding guidance**.
- Commission **Hidden Harm: 10 years on** from the Advisory Council on the Misuse of Drugs, or other qualified body. A decade after its publication, the learning and statistics from Hidden Harm are still used as the most robust available, and its figures have not been extensively built on or revised.

### Professional bodies

- The **College of Social Work**, the **British Association of Social Workers** and the **Chief Social Workers**, when appointed, must emphasise knowledge of parental substance use as a key element of effective practice and continuous professional development.
- There should be arrangements for **compulsory pre-qualification training** on parental substance use.

### Service providers and managers

- Implement **management and supervision processes** which have an explicit and standing place for parental substance use issues.
- Ensure effective **referral chains** exist within local family support services so that anyone looking after children – particularly grandparents – has access to appropriate support.
- Make arrangements for partnership work across organisational boundaries more explicit, by introducing more **co-located services, joint visits to families, job shadowing, induction meetings** and regular **practitioners' forums**.

### Local authorities

- Ensure that **services working below crisis levels** with children and families are still available locally, and that evidence is gathered to support its continued provision.
- Subject **decisions on cuts** to the input of other local services to reflect the impact on partnership work that the decision may have.
- If funding and/or services are cut, **convene systems-level 'exit interviews'** to ensure that local practitioners are aware of any change in responsibilities and service design.
- Identify parental substance use as a local priority and provide **strategic leadership** in implementing effective practice.

### Local Safeguarding Children's Boards

- Include a representative from local **drug and alcohol treatment agencies**.
- Use their position to **improve the recognition** of parental substance use issues across the whole range of local services coming into contact with children, families and drug and alcohol users.
- Provide **multi-agency training** on parental substance use and monitor its uptake and effectiveness.

# Appendix I – focus group case studies

These fictional, representative case studies were used in focus groups to facilitate discussion between practitioners.

## Case study 1

Service user: Imran, 32

Partner: Jennifer, 30

Children: David and Misha, 3 and 5

You are working with Imran to address his heroin problem. He has said that Jennifer drinks frequently but is not in contact with services.

## Case study 2

Service user: Abby, 20

Partner: James, 23, is in prison.

Children: 18 month old baby, Jada.

Abby has a history of offending and antisocial behaviour, and has been referred to you through criminal justice channels. Since the birth she has been using stimulants (cocaine and amphetamines). Abby's parents frequently provide childcare for Jada.

## Case study 3

Service user: Tom, 40

Children: Danielle 12, from a previous relationship.

Tom is on a take-home substitute prescription.

Danielle lives with her mother nearby, but there are no formal contact arrangements in place and they have been estranged for 7 years. However as Tom's treatment has progressed, he has been trying to rebuild his relationship with Danielle – they have been back in touch and she has visited his house on several occasions.

# Appendix II – the online survey

## Section I: Parental substance use: awareness and priority

### 1. What questions do you ask your service users about their parental status?

- Whether they have children
- Whether they are living with children
- Whether they have contact with children

Other (please specify)

### 2. Are you aware of a named 'Hidden Harm' or parental substance use lead in your:

	Yes	No
Organisation?	<input type="checkbox"/>	<input type="checkbox"/>
Local area?	<input type="checkbox"/>	<input type="checkbox"/>

If yes, how useful do you find them?

### 3. Are you aware of named 'Hidden Harm' or parental substance use leads in your local schools?

- Yes
- No
- Some of them

Please give any additional thoughts.

### 4. Is there a service provided specially to meet the needs of children affected by parental substance use in your local area?

- Yes, specifically for children affected by parental substance use
- Yes, as part of another service (e.g. young carers)

No

If not, where are children affected by parental substance use referred to?

**5. Do you use any specific parenting programmes in your work?**

Yes, in my own practice

No, but they are available within my organisation

No, but I refer client on to services elsewhere

No, and I do not refer clients on to services elsewhere

If yes, which programme(s) are available? (e.g. Webster Stratton, Mellow Parenting, Strengthening Families etc)

**6. What, if anything, is needed to improve practitioners' awareness of parental substance use issues in your local area?**

**Section II: Partnership working**

**1. If you have concerns for a child, which agencies do you contact?**

**2. What are your experiences of information sharing with other local agencies?**

**3. How would you describe the relationship between drug/alcohol treatment services and social services in your local area?**

Very negative

Negative

Neither negative nor positive

Positive

Very positive

Please explain your answer.

**4. How would you rate the relationship between drug/alcohol services and children and family support services in your local area?**

- Very negative
- Negative
- Neither negative nor positive
- Positive
- Very positive

Please explain your answer.

**5. Have you made a referral to children's social care in the last:**

- 3 months?
- 6 months?
- 9 months?
- 12 months?
- Never
- n/a (I work for children's social care)

What was your experience of the referral process?

**6. What, if anything, do you think is needed to improve partnership work between all agencies in your area? This can include health services, criminal justice services and others, as well as children and family services and social care.**

**Section III: Workforce development**

**1. Have you accessed training specifically on the impact of parental substance use on children?**

- No
- Yes, in my organisation
- Yes, multi-agency
- Yes, other

How useful did you find this?

**2. Are parental substance use issues raised in your managerial supervision?**

- Never
- Rarely
- Sometimes
- Often
- Always

**3. How would you describe the importance of the following factors in effective local responses to parental substance use?**

	Unimportant	Slightly important	Important	Very important	Critical
Protocols/guidance					
Managerial support/supervision					
Effective training					
Partnership with other services					
Personal judgment					
Relationships with families themselves					
Relationships with other professionals					

Are there any other factors you think are important? Please explain.

**4. Overall, how confident do you feel in the following areas when working with parental substance users?**

	Very pessimistic	Pessimistic	Neither pessimistic nor confident	Confident	Very confident
Keeping the family together					
Securing a good outcome for the family					
Your ability to deal with the case					
The level of managerial					

<b>support</b>					
<b>Responses from other services</b>					

Please explain your answers.

**5. How confident are you about the overall response to children affected by parental substance use in your local area?**

- Very pessimistic
- Pessimistic
- Neither pessimistic nor confident
- Confident
- Very confident

Please explain your answer.

**6. What, if anything, is needed to improve the knowledge and confidence of the workforce in relation to parental substance use?**

# Appendix III

## Local leadership and parental substance use: the coordinator's view

Adfam spoke to a local authority-employed Parental Substance Use Coordinator who split their time between bases within children's social care, the local hospital (with the pre-birth team) and a day per week with local drug and alcohol services. The Coordinator also undertakes bi-weekly 'surgery-style' meetings with drug workers in treatment agencies. The post is jointly funded by adult drug services and children's social services.

### Rationale: why a Coordinator?

The Coordinator believed "there has been a growing awareness of parental substance use issues in recent years" – for example being frequently referenced in Serious Case Reviews and being linked to mental illness and domestic violence – but accompanied by the recognition that it's a relatively specialist area of practice, and "frontline social workers can't be experts in absolutely everything they come across". The Coordinator's post was introduced, then, to recognise not only the prevalence of substance use issues in a social worker's caseload, but also their lack of experience and need for guidance in dealing with the specific issues it presents. There were also "issues around communication" between adult treatment agencies and children's services which the Coordinator's post was designed to bridge, and "concerns about over-optimism" with substance using parents - "but we've sorted them now".

Treatment services needed a "shift in attitude...[there was a] tendency to ask the basic questions about children that you have to ask, tick the box and move on". In line with previous research and practitioners in the focus groups, the Coordinator had a sense that "treatment services...worry about their relationship with the client" and this is a barrier to sharing information with other professionals. This had also been improved, but it was noted that "sometimes [treatment workers] feel it's OK to tell me, but not social services", suggesting some level of suspicion remained. Also, without a coordinated approach and protocol, "different teams and workers are all approaching [cases] in different ways, and are influenced by their own experiences, views and sometimes prejudices". Part of the Coordinator's job, then, centres on "attitude and culture" amongst practitioners.

### Indicators of success

Mirroring practitioners' views commonly expressed throughout focus groups and surveys, the Coordinator thought that "the relationship base...having someone there who people know and recognise, and see now and again" was one of the most conducive factors to effective working, especially information sharing: "you're more willing to tell them things". The Coordinator identified "being accessible to as many people as possible" as a key feature of their work; this was also praised

by frontline workers, who frequently mentioned the value that the post adds to the overall local response to children affected by parental substance use.

The Coordinator also set up and chairs a bi-monthly forum of 'children's champions' from each local treatment services. As well as emphasising a safeguarding focus, these meetings are also meant to "improve treatment services' knowledge of support services for families before you get to safeguarding level", again chiming with the frontline practitioners' views on the importance of workers having a full local picture of service provision, including low-level support.

The Coordinator noted that "communication has improved, though it took quite a long time", and that "children's services are getting more information than ever before". However, there could be an over-reliance on the Coordinator as an individual "funnel" for information rather than services speaking directly to each other, which would be preferable.

Work during pregnancy was especially effective in the Coordinator's local area due to an 'all under one roof' support model with a substance use worker, specialist midwife and representative from children's services all available at one clinic. It was also beneficial to record information on the central children's social care system after each meeting.

'Early intervention' often means accessing support before problems become serious; it often also means intervening early in the life of the child, when they can be very vulnerable and not in regular contact with any kind of professional services. To this end, the Coordinator had set up a service for substance-using mothers with childcare facilities, which served multiple aims of engaging the parents in a service they felt confident and supported in attending; where there was an element of peer support between the mothers, who could communicate openly; and which also provided a way to access children below statutory school age and engage them with children's services and local family support programmes. "The most vulnerable children are often under the radar so you need to get to them early", the Coordinator explained.

### Worker skills

The Coordinator was circumspect about experience on the frontline being a necessary indicator of success: "being experienced is great but it depends on how you use it – are you open to new possibilities or do you feel jaded because you've seen things go wrong before?" There was also a call for realistic expectations of social work, and that practitioners need to recognise that "we don't always end up keeping families together, but sometimes we do – workers need to keep an open mind". Still, the Coordinator was adamant that "prejudice [from workers] actively reduces the chances of success for families – you can't write them off immediately".

"Parenting is one of the biggest things in any parent's life: if you're not looking at that, you're missing a huge part of the picture." The Coordinator thought that "[treatment workers] need to feel more comfortable talking about *parenting*, not just 'safeguarding'. You can't ignore it – it helps to get [drug workers] into children's centres and so on".

The Coordinator identified an honest, challenging relationship between worker and parent as an essential part of effective work: "make it clear what you expect from them and why, and give clear timescales for change". Workers also need to "be honest about what they think the risks are for the

children: parental substance users want the best for their children as much as any parent does, and understanding the impact that they're having can help them make changes that wouldn't be seen otherwise". A good relationship with the worker can give the parents a new perspective on how their behaviour and lifestyle is impacting their children, even if – as is common<sup>74</sup> – they underplay their children's knowledge of substance use. Another important point was that workers "saying they have a duty to report something or break confidentiality doesn't help parents understand *why* they are doing it".

### **Supervision, management and training**

The Coordinator, who delivers training on behalf of the Local Safeguarding Children's Board, stated that "you can throw as much parental substance use training as you want [at frontline workers] but they'll forget if it's not embedded into daily practice".

Ongoing professional development was also an issue: "managers themselves need to come onto [parental substance use] training – it's not true that you get to manager level and automatically know everything you need to". Managers also "need to ask the right questions of the workers and not make it a tickbox issue". But "with services overstretched and caseloads too high, supervision becomes more and more cursory".

Again, more conceptions of the term 'early intervention' come up – in this case, 'early' means as soon as the parent comes into contact with services. At this point the Coordinator can meet with new referrals from the beginning to break down any fear of services, give them clear expectations of change and engage them with a social worker. As well as services "being involved, monitoring and supporting from early on", it's also the case that parental substance users need to "know what will be seen as evidence that they want to make it work" and that "social work assessment begins from the minute they're pregnant, which they often don't realise". Being involved from the offset also means that with no evidence of change, social workers can act quickly when the child is born.

### **The future**

The Coordinator mirrored the thoughts of frontline workers in the focus groups with concern over funding cuts: "resources will come up again and again...when you're trying to improve responses [to parental substance use] and money's being taken off you all the time, 'challenging' isn't the word – it's *impossible* at times". Funding cuts also meant "services for harmful and hazardous drinkers are decreasing, and alcohol [services] were never well funded anyway". On top of this, the Coordinator stated that their role was currently under review and not safe from budget cuts.

The Coordinator stated that "a massive amount of the contact I have from social workers is about binge-drinking parents", often accompanied by issues of domestic violence and arrests with the children present: this again spoke to the need for alcohol support below levels of dependency. But as well as services which help stop substance use problems from becoming 'serious', there also need

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<sup>74</sup> Barlow & Barnard (2003) *Discovering Parental Drug Dependence: Silence and Disclosure*, Children and Society 17:1

to be services for alcohol problems which *never will* turn into dependency: “a lot of these parents will never be ‘dependent’, but they’ll always have problems”, as the Coordinator put it.

The Coordinator also felt that “more specialist services for working directly with the children” would be beneficial, and that “you don’t want to just tell children that their parents use drugs – many of them are already keeping it a secret – but support them appropriately”. The approach of the Family Drug and Alcohol Court was also examined for indicators of good practice that might be mirrored in other areas – “clear timescales, regular review, letting people know what’s expected of them, therapists on call...you can try to replicate this as best you can by having good communication”.

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