

Parental
substance use:
through the eyes
of the worker



Adfam

Families, drugs and alcohol

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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.

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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 UK¹, 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, and at least 120,000 children are living with a parent currently engaged in treatment²; and there could be five times as many children affected by parental alcohol misuse as drugs³.

Though harm to children is not inevitable⁴, 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 attainment⁵. In 2007-09 22% of Serious Case Reviews mentioned parental drug use, and 22% parental alcohol use⁶.

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.

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

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

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

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

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

6 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 rather than 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 defined lines of accountability, and made clear the different roles and responsibilities of different local agencies working in partnership to safeguard children.

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 judgement' 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

Practitioners' arguments: summary of findings

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 for helping to build mutual understanding of roles and responsibilities. Multi-agency training courses focused on embedding local protocols, and which include the use of live, anonymised case studies to show the levels at which different services would intervene in the same case, are particularly useful.

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 the kinds of effective early intervention which can prevent the consequences of parental addiction being visited upon children.

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 to secure positive outcomes, 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 due to increased workloads in times of 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

- 1 With the dissolution of the National Treatment Agency in April 2013, **clarify leadership** of safeguarding in drug and alcohol treatment services.
- 2 **Publish data** on the number of people in treatment with childcare responsibilities, including the extent of under-reporting of this information by treatment services.
- 3 **Re-emphasise parental substance use** in priority policy areas where it is of crucial importance, including **troubled families** and **early intervention**.
- 4 Make the role and accountabilities of drug and alcohol treatment services in safeguarding a clear part of statutory safeguarding guidance.
- 5 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

- 1 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.
- 2 There should be arrangements for **compulsory pre-qualification training** on parental substance use.

Service providers and managers

- 1 Implement **management and supervision processes** which have an explicit and standing place for parental substance use issues.
- 2 Ensure effective **referral chains** with local family support services so that anyone looking after children – particularly grandparents – has access to appropriate support.
- 3 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

- 1 Identify parental substance use as a local priority and provide strategic leadership in implementing effective practice.
- 2 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.
- 3 Subject **decisions on cuts** to the scrutiny of other local services to reflect the impact on partnership work that the decision may have.
- 4 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.

Local Safeguarding Children's Boards

- 1 Include a representative from local **drug and alcohol treatment agencies.**
- 2 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.
- 3 Provide **multi-agency training** on parental substance use and monitor its uptake and effectiveness.

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