

ASSESSMENT OF NEED AND REVIEW OF SERVICES FOR CHILDREN AND FAMILIES AFFECTED BY PARENTAL SUBSTANCE MISUSE

An independent report for
Edinburgh Alcohol and Drug Partnership

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TABLE OF CONTENTS

ACKNOWLEDGEMENTS	2
TABLE OF CONTENTS	3
1. INTRODUCTION	5
1.1 AIM, OBJECTIVES AND BACKGROUND	5
1.2 SCOPE	6
2. METHODS	8
2.1 METHODS USED IN THE STUDY	8
2.2 STAKEHOLDERS ENGAGED IN THE PROCESS	9
2.3 LIMITATIONS OF THE STUDY	9
3. FINDINGS AND DISCUSSION: ASSESSMENT OF NEED/PREVALENCE	11
3.1 AREA-WIDE FIGURES IN DETAIL	12
3.2 SERVICE-LEVEL DATA	14
3.2.1 <i>Specialist services</i>	14
3.2.2 <i>Primary care</i>	15
3.2.3 <i>Maternity services</i>	16
3.3 IMPROVING DATA COLLECTION IN THIS FIELD	17
3.3.1 <i>Multiple difficulties with clearly defining CAPSM</i>	17
3.3.2 <i>Difficulties with reliably and appropriately identifying who fits into any given definition</i>	19
3.3.3 <i>Multiple difficulties with recording and reporting such identification</i>	19
3.3.4 <i>Risks of negatively affecting outcomes for the family</i>	20
3.3.5 <i>The way forward</i>	20
4. FINDINGS AND DISCUSSION: SERVICE AVAILABILITY AND GAPS	22
4.1 HOW TO CATEGORISE SERVICES	22
4.2 SERVICE INFORMATION	25
4.2.1 <i>Information about parenting services</i>	25
4.2.2 <i>Information about Targeted and specialist family support services</i>	26
4.2.3 <i>Information about services for children and young people</i>	26
4.3 RANGE & AVAILABILITY OF SERVICES FOR PARENTS & PRE-SCHOOL CHILDREN	27
4.3.1 <i>Universal, lower threshold services for parents</i>	27
4.3.2 <i>Targeted services for vulnerable parents</i>	30
4.3.3 <i>Specialist services for parents with substance misuse issues</i>	30
4.3.4 <i>Self-help services</i>	31
4.3.5 <i>specific support for Fathers</i>	32
4.3.6 <i>Services for minorities</i>	33
4.3.7 <i>Other gaps/actions</i>	34
4.4 RANGE & AVAILABILITY OF SERVICES FOR SCHOOL-AGED CHILDREN	36
4.4.1 <i>Range and capacity of services versus need</i>	37
4.5 FUTURE COMMISSIONING	40
5. FINDINGS AND DISCUSSION: SERVICE EFFECTIVENESS AND ACCESSIBILITY	41
5.1 TYPES OF HARM & MECHANISMS FOR REDUCING HARM	42
5.2 IMPROVING PARENTING & FAMILY FUNCTIONING	43
5.2.1 <i>How services currently identify parenting support needs</i>	44
5.2.2 <i>Making parenting support conversations the norm</i>	47
5.2.3 <i>capacity building and Support for staff</i>	49
5.2.4 <i>Conversations about parenting support in adult treatment services</i>	51

5.3	SUPPORT FOR CHILDREN AND YOUNG PEOPLE.....	54
5.3.1	<i>Supporting children where their parents are known to services.....</i>	54
5.3.2	<i>Supporting children where their parents are not in services</i>	56
5.4	INTER-DISCIPLINARY WORKING	58
5.5	MODELS OF WORKING AND OUTCOME EVALUATION	59
5.5.1	<i>Parent and family oriented services</i>	59
5.5.2	<i>Children and young people’s services</i>	61
5.5.3	<i>Improving service descriptions and outcome evaluation</i>	62
5.6	IMPROVING ACCESSIBILITY OF UNIVERSAL SERVICES FOR SUBSTANCE MISUSERS	63
6.	OVERALL CONCLUSIONS &RECOMMENDATIONS.....	67
6.1	LEVELS OF NEED &DATA COLLECTION.....	67
6.2	CAPTURING AND CLARIFYING SERVICE PROVISION.....	68
6.3	SERVICE COMMISSIONING, CONSOLIDATION AND CO-ORDINATION.....	69
6.4	IDENTIFYING, ENGAGING AND SUPPORTING PARENTS IN NEED.....	70
6.5	THE ROLE OF ADULT TREATMENT/SUPPORT/SELF-HELP SERVICES	70
6.6	IDENTIFYING, ENGAGING AND SUPPORTING CHILDREN AND YOUNG PEOPLE.....	71
6.7	DEVELOPMENT OF MODELS OF PRACTICE & ASSOCIATED CAPACITY BUILDING	72
6.8	INTERDISCIPLINARY WORKING	73
6.9	OUTCOME-BASED MONITORING, EVALUATION, RESEARCH AND DISSEMINATION	73
6.10	CHAMPIONING CULTURE CHANGE IN UNIVERSAL SERVICES	74
	APPENDIX A: ESTIMATING THE NUMBER OF CHILDREN AFFECTED BY PARENTAL ALCOHOL MISUSE	75
	APPENDIX B: GEOGRAPHIC REMITS OF SERVICES.....	76
	APPENDIX C: OPTION 2 PROJECT INFORMATION	80
	APPENDIX D: SUMMARY OF THE STARS INTERVENTION PROGRAMME	81
	APPENDIX E: BARNARDOS HOPSCOTCH.....	83

1. INTRODUCTION

1.1 AIM, OBJECTIVES AND BACKGROUND

The aim of this needs assessment was to “inform implementation of priority 2 of the Edinburgh Alcohol & Drug Partnership (EADP) Children, Young People and Families Action plan which states:

“The impact of parental alcohol and drug use on children and young people is reduced”

It also relates to the following intermediate outcome from EADP Alcohol and Drug Strategy A Framework for Partnership Action 2011-2014:

“Children will be less affected by parental alcohol and drug use and will be able to have the best start in life, be able to make and sustain relationships, and be ready to succeed.”

The 6 specific objectives of this needs assessment were:

1. Identify, on a neighbourhood basis, the prevalence of problematic parental alcohol and drug use and numbers of children (under the age of 16) affected including if possible a separate breakdown for alcohol and drugs.
2. Map existing services to support CAPSM in Edinburgh including:
 - A detailed picture of specialist service provision on a neighbourhood by neighbourhood basis.
 - Detailed breakdown of service usage by CAPSM and parents reporting having dependent children where available.
 - Detailed profile of services provided, barriers to access, duration of engagement, referrals, follow up, capacity etc.
3. Provide an overview of models of service delivery and good practice for identifying and supporting children affected by parental substance misuse elsewhere in Scotland and the UK including analysis of their effectiveness and whether they might work in Edinburgh.
4. Explore children’s and parents’ perceptions of an effective support service for families affected by parental substance misuse.
5. Carry out a gap analysis to compare the existing range and capacity of services on a neighbourhood basis versus local need, priorities and stakeholder’s views, as well as key statutory requirements and current guidance.
6. Make recommendations regarding priorities and models for CAPSM services in Edinburgh in particular how EADP partners would develop effective services to address CAPSM problems.

Create Consultancy Ltd., an independent agency specialising in substance misuse and health improvement, based in Glasgow, Scotland, tendered for the contract to carry out this needs assessment in March 2012 and was successful. The needs assessment was carried out between March and July 2012 and was commissioned and funded by Edinburgh Alcohol and Drug Partnership and procured by the City of Edinburgh Council.

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1.2 SCOPE

This piece of work sought to assess the need for and review current provision of services seeking to reduce the harm arising from parental drug and alcohol misuse. The initial scope of the work limited the focus to specialist support services for children or parents¹ and drug/alcohol treatment services for adults. The difficulties in limiting this work were apparent from the start however in that the list of stakeholders for the project included many organisations and services (e.g. parenting support groups; carers' services; maternity services) which did not fit this tight definition.

In exploring the topic with services and strategic stakeholders in initial interviews, it quickly became apparent that a much broader range of services were relevant to the strategic aim of reducing harm caused by parental substance misuse. Families affected by parental substance misuse range from those which are functioning relatively well but where there may be emotional harm, to the most vulnerable families in our community where physical, social and emotional needs are profound. In between are families with multiple challenges relating to health, imprisonment, bereavement, housing, criminal justice, emotional wellbeing, employment, education, finances/benefits, parenting and even daily living. Across this spectrum, all public services from the most universal to the most specialised in all of these areas will regularly be working with families affected by parental substance misuse.

It is important to note that this needs assessment is not about child protection. It is not about making sure children are 'alright', it is about reducing the impact of parental substance misuse on children so that they are more than 'alright' – confident, contributing, successful and responsible². The impact of parental substance misuse includes a whole range of effects which are much more subtle than those which would give rise to child protection action. These impacts may not prevent a child from being 'alright', but they may nonetheless have a detrimental impact on the child achieving more ambitious goals in terms of wellbeing and contentment.

With this in mind, it was particularly difficult to pick and choose which stakeholders and services were most relevant and important to include within the available time and resources. Having started with a list of stakeholders from the commissioning group, we expanded this as much as was possible in the timeframe. This resulting report is therefore based on:

- Interviews with services working with substance misusing adults and services specifically for children, parents or families affected by parental substance misuse (CPFAPSM) or where a high proportion of service users fall into this group.
- Stakeholder interviews with senior individuals who could provide a strategic overview and personal insight into current provision for CPFAPSM including contacts for broad statutory/voluntary services such as maternity services, health visiting, school nursing, parenting services, early years, and so on.

¹ The word 'parent' is used throughout this report to refer to anyone acting in a parenting role.

² Successful learners, Confident Individuals, Effective Contributors and Responsible Citizens are the four capacities which Curriculum for Excellence aims to achieve for Scotland's Children.

<http://www.educationscotland.gov.uk/thecurriculum/whatiscurriculumforexcellence/thepurposeofthecurriculum/index.asp> (Accessed 12th July 2012).

- Telephone interviews and focus groups with parents with a history of substance misuse.
- A range of interviews, desk-based research and meetings investigating models of provision and services outside of Edinburgh including case study development, and discussions with national stakeholders e.g. Al-Anon; Scottish Government etc.

We believe that the thought process which led us to expand the needs assessment to include wider stakeholders from a range of universal services leads us to an initial finding of this work. To fulfil the its aim of reducing the harm caused by parental substance misuse, the Edinburgh Alcohol and Drug Partnership needs to think beyond commissioned services, acting in addition to champion the improvement of all services in Edinburgh to rise to the challenge posed in seeking to reduce harm from parental substance misuse. This is discussed further in Chapter 5 below.

The full methods used and an outline of some of the limitations of the work are outlined in Chapter 2 below.

2. METHODS

- This study consisted of a mixed method approach including analysis of prevalence data, semi-structured interviews, service meetings and discussion groups with staff and service users.
- The approaches used were designed to capture as far as possible clear data and to explore how services could be improved in terms of availability, accessibility and effectiveness to reduce harm caused by parental substance misuse in Edinburgh City.
- There are a number of limitations to the study given the timescales, data and resources available. In particular, it was not possible to consult directly with young people. Such consultation should in future be planned over a longer timescale.

2.1 METHODS USED IN THE STUDY

The methods used are summarised in the following table.

Table 1: Summary of Methods

Method	Details	
Stage 1: Establish Context and Prevalence	<ul style="list-style-type: none"> • Meetings with steering group. • Extensive web searches and email/telephone follow-up to source strategic literature – national and local. • 6 interviews/meetings and web searching to source area-wide prevalence data. 	
Stage 2: Models of service delivery and best practice	<ul style="list-style-type: none"> • Web searches to identify grey & other literature outlining models of good practice in the delivery of services to reduce the harm from parental substance misuse. • Also identified via discussion during Strand 3 interviews. • 5 case studies written up – including web searching and interviews with organisations/services illustrating aspects of best practice. 	
Stage 3: Service Mapping, Description and Usage	<ul style="list-style-type: none"> • Service mapping template developed. • Interview schedule included in template to cover strategic questions. 	42 strategic or service telephone interviews (15-90 mins) with 39 individuals 4 face to face meetings (60-90 mins) with 6 service staff. 2e-mail responses received from staff.
Stage 4: Engagement of Service Users	<ul style="list-style-type: none"> • Flyers developed for recruiting parents from drug services; parents from alcohol services and young people. • Flyers distributed to a wide range of relevant organisations. • Schedules of consultation topics and questions developed separately for parents and young people. • Follow up calls made to services to explore challenges of recruiting service users. 	1 group discussion with 7 parents with history of drug misuse. 1 group discussion with 4 fathers. 7 telephone interviews with parents with history of drug/alcohol use.
Stage 5: Analysis	<ul style="list-style-type: none"> • Review of strategic documents and good practice literature. • Tallying of quantitative data. • Thematic analysis of qualitative data and reflection on ways forward. • Review of additional documentation including assessment forms etc. 	
Stage 6: Report	Report drafted and re-drafted July-December 2012. Final report submitted January 2013.	

2.2 STAKEHOLDERS ENGAGED IN THE PROCESS

The following table shows the different service stakeholders who were involved in this project. Each section is presented in alphabetical order.

Table 2: Stakeholders involved in the research.

Prevalence Contacts	National & Models of Practice Contacts
ISD	Aberlour
NHS Health Information Unit	Al-Anon (UK and Scottish contacts)
NHS Midwifery	Barnardos Scotland
NHS Public Health	Kids Company (London)
Primary Care Enhanced Services	Option 2 (Wales)
Social Work SWIFT	Scottish Government Parenting Strategy Unit
	SMART Recovery UK
	STARS National Initiative
	What About Me? East Renfrewshire
Statutory Sector Services	Voluntary Sector Services
BumpStart	Aberlour Outreach
CAMHS	Broomhouse Young Carers Support Project
Child and Family Centres	Broomhouse Youth Befriending
Early Years	Broomhouse Youth Counselling
Edinburgh Access Practice	Castle Project
GIRFEC Strategic Team	CHAI Fathers Group
Health Visiting	Children 1st
HM Prison Service	Circle – FABI Project
Lothian and Borders Police	Circle – Harbour Project
NHS Midwifery	Edinburgh and Lothian Council on Alcohol
NHS Substance Misuse Directorate	Edinburgh Young Carers
Parenting Services Strategic Team	Families Outside
PrePare	Health Opportunities Team
School Nursing	Integrated Community Support Service (CAIR)
Schools Additional Support for Learning	Muirhouse Young Carers
Social Work Children and Families	NEDAC
Social Work Drug and Alcohol Services	Sunflower Garden
Stepping Stones	The Restalrig Project
Youth Offending Service	Turning Point
Youth Services Strategic Contact	

2.3 LIMITATIONS OF THE STUDY

There are a number of limitations which should be taken into account when reading this report. These are outlined below.

- The findings of this report are based on the fieldwork and methods described above. It cannot be assumed that the views of the participants in interviews are representative of all similar stakeholders.

- There are a number of gaps in the fieldwork, notably, we did not interview staff from all relevant universal services including housing and the benefits agency. We were also unable to speak with frontline staff in many services. Although many managers did inform staff of the opportunity to participate, only a few got in touch for interview or provided feedback.
- The views of those interviewed and surveyed are taken and reported in good faith and are their own, not necessarily those of Create Consultancy Ltd. or Edinburgh Alcohol and Drug Partnership. Informant interviews were recorded electronically in addition to extensive notes being taken during the interview/meeting.
- The views of practitioners and service users reported here are only of those who were involved in the study. It does not take account of the views of service providers who were not interviewed or service users who did not want to be involved in the needs assessment. It is likely that there are many substance misusing parents who are not currently in contact with services and their views are not included. It may be that those parents face even greater barriers to access than those who did participate in this piece of work.
- Of those service users who did provide their contact details initially in order for us to contact them to discuss taking part in the needs assessment, we were unable to conduct interviews with 8 parents and with any of the 3 young people. This was due to a variety of reasons including phone numbers not working, no answer to calls or a lack of response to telephone messages.
- We were therefore unsuccessful in our efforts to consult with young people affected by parental substance misuse at all. We offered a range of ways to get their views including supporting staff working with them to explore the consultation questions on our behalf, recognising the importance of having an existing relationship if discussing such sensitive issues. Having been unsuccessful in this regard, we explored with services why they felt this had been the case and their responses (some shown below) illustrate the difficulties of singling out a group for consultation.

“The youths are reluctant to speak to an unknown person...Create suggested setting up a focus group lead by our worker but we couldn’t get enough people to do this. I find that those who are young carers because of drug and alcohol misuse...do not want to be identified as a young carer [for this reason]...They will be scared that they might get into trouble, or taken away by social work or really just don’t want to talk about it.”

“With my caseload at the moment there is quite a few new ones who I’m still getting to know...Also most of mine are young men who also seem more reluctant to speak to other people about their experiences...I think this also shows that young people receiving support require it for a sustained period of time rather than a time limited input in order to get to know them more and for them to feel comfortable to speak about their experiences.”

We agree that effective consultation with vulnerable young people would require additional time, support and possibly resources for the researchers and staff working with the targeted young people and their organisations to ensure that the time and skills are in place to do this kind of consultation.

Future needs assessments or similar research which requires consultation with young people should be planned over a much longer timescale and with adequate time and resources to do consultation with individuals or groups according to their need, in collaboration with project staff.

3. FINDINGS AND DISCUSSION: ASSESSMENT OF NEED/PREVALENCE

- It is impossible to definitively count the numbers of children, parents and families in Edinburgh affected by parental substance misuse due to difficulties and risks relating to definition, identification and recording.
- Children can be affected by all levels of parental substance misuse, which is widespread. Such harm is not perfectly correlated with levels or types of substance misuse.
- In 2009/10, there were approximately 5,300 adult problem drug users and 21,000 adult dependent alcohol users in Edinburgh City.
- Using Scottish Government criteria, it can be very roughly estimated that approximately 7,000 children in Edinburgh City live with parents with at least some level of problematic alcohol use. It is important to note that the criteria used are wide and many of these children will be at very low risk.
- A minimum estimate of children affected by a problem drug using parent or carer is 2,173. This is based on figures from treatment and other services and relates to parents with opioid or benzodiazepine problems only.
- In 20011/12, GP practices reported 1,449 children as living with an adult with a diagnosis of drug dependence. This figure relates only to children of adults with the diagnosis who are registered with one of the 91% of GP practices which participate in the reporting scheme.
- Approximately 55 children are born in Edinburgh every year with Foetal Alcohol Spectrum Disorder (FASD) giving a total of approximately 1,000 children under 18 in Edinburgh living with the disorder at any given time. An additional 100 children may be suffering from Foetal Alcohol Syndrome at any given time.
- Based on the services available, service usage data and these estimates of prevalence, there must be high levels of unmet need. In the vast majority of cases this is because individuals and families have not been identified, do not know about, cannot or choose not to access the services reviewed here, rather than that there are waiting lists for these services.
- While there are some aspects of relevant data collection which should be improved, in general the focus of energies needs to be in equipping staff and services to better serve and support children, parents and families affected by parental substance misuse, rather than trying to count something that is not necessarily going to change outcomes per say.
- NHS Lothian should lead further work to support accurate identification of alcohol consumption levels in pregnancy and appropriate responses to the levels identified to reduce the risk of FASD including adaptations to TRAK and research work.
- Adult treatment and counselling services (including alcohol counselling services and primary care services providing treatment for alcohol or drug use) should record and report the number of adults receiving treatment for substance misuse who have children living with them all or part of the time in line with SMR25 requirements. Further arrangements will be required for people with primary alcohol problems until this data is reported through the SMR 25.

- **Social work services should consider what aspects of data recording would be beneficial to children and families, and if/how SWIFT can and should be adapted to facilitate such data collection, taking realistic account of the constraints outlined here and the overall finding that the focus should be on providing support rather than counting prevalence.**
- **Successful data recording in all settings is likely to require an element of culture change and staff support/training.**

3.1 AREA-WIDE FIGURES IN DETAIL

- It is estimated that in 2009/10, there were 5,300 problem drug users in Edinburgh City, of whom 3,900 were male and 1,400 were female. The 95% confidence interval is 4,900-5,900 people³. This figure is based on a definition including any misuse of opiates or benzodiazepines rather than any other substances. It cannot be assumed however that children of parents included in this estimate are in need of any specific support. At the very lowest level of concern, such parental misuse could be seen as an unhealthy example to children, whereas at the extreme the problems accompanying such use would necessitate statutory procedures to protect children.
- Of new patients entering drug treatment services in 2010/11 in Edinburgh City reported to ISD⁴:
 - 41% (465 clients) reported either living with their own or others' children, or having dependent children elsewhere or both (down from 45% in the previous year, and the same as the national figure for 2010/11).
 - 15% of clients (167/1143) were living with their own or others' children.
 - Up to 265 children were recorded as living with parents/carers who entered treatment that year for drug problems in Edinburgh City. If more than one client is living with a child and newly in treatment, and more than one client reports that child, the child will be double counted. This figure would then be an overestimate. However, this is self-reported data which may therefore also be under-reported.
 - 3% of clients (38/1143) reported that they or their partner was pregnant. This may include double counting if both mother and partner were newly in treatment that year and reported the same pregnancy.
- A very rough estimate of the number of problem drug users living with children or whose own children live elsewhere is 2,173 (41% of 5,300) in Edinburgh City. This assumes that those in treatment and not in treatment are equally likely to be living with children. Many will be living with or parents to more than one child, so 2,173 should be seen as a minimum figure of the number of children affected by problem drug use by parents/carers.
- In 2011/12, GP practices in Lothian as a whole reported 1,449 children registered with a GP practice living with an adult with a diagnosis of drug dependence. This is based on figures

³http://www.drugmisuse.isdscotland.org/publications/local/prevalencetables2009_10.xls.

⁴ ISD figures provided for the purposes of this needs assessment. NB: All of these figures relate only to clients *newly* in treatment, not the bulk of clients in ongoing treatment.

reported under the Child Health and Wellbeing Enhanced Services Contract from 91% of practices.

- The recent Scottish Health Survey 2010 found that an estimated 49% of men and 38% of women in Scotland exceeded the daily and/or weekly limit and these are likely to be under-estimates (Scottish Government, 2010). At the lowest level of concern, this may represent an unhealthy example to children, and contributes to a cultural tolerance of alcohol use at levels that are risky to health.
- Estimates of greater levels of problem with alcohol are almost impossible to make, due to the difficulties of defining what constitutes a problem. It is not possible to say that a particular level of alcohol affects parenting and/or results in harm to children. It is more helpful to view alcohol consumption on a continuum where any consumption carries some risk, and the greater the consumption, the greater the risk, to health and other aspects of life including parenting and childcare.
- The adjusted prevalence estimate from the Scottish Alcohol Needs Assessment (Drummond et al., 2009⁵) suggests that 5% of the population over 16 are dependent on alcohol. This suggests that around 21,000 adults in Edinburgh City were dependent on alcohol in 2011 (GRO, 2012). As with drug use, at the extreme, the alcohol usage may require statutory measures to protect children.
- Most recent Scottish Government figures (2012) states that analysis from the Scottish Health Surveys (SHes) 2008-10 shows that current estimates suggest that between 36,000 and 51,000 children nationally are living with parents (or guardians) whose alcohol use is potentially problematic. No basis is given for how this calculation was made, so it is not possible to calculate an estimate on the same basis for Edinburgh.
- Taking a previous Scottish Government (2008) estimate as a starting point, it can be estimated that approximately 7,000 children in Edinburgh live with parents who have problematic alcohol use. This was based on the number of adults self-reporting problems including 'feeling as though I should cut down my drinking' and 'feeling guilty about my drinking', in the Scottish Health Survey from 2003⁶ (see Appendix A). As with most estimates of this kind, this cannot necessarily be taken as indicator of child harm or even risk, but perhaps at the very least indicates potential exposure to unhealthy patterns of alcohol use.
- There is no available data that measures the number of family members in Edinburgh affected by an individual's substance use. Al-Anon suggest that for every individual in recovery from alcohol problems an average of 5-6 others are affected negatively by their problem. This could include partners, children, parents, friends and so on and although no basis is given for the figure, it does not seem outrageously high. This would give a figure of 105,000-126,000 adults and children who may need support services to cope with issues arising from alcohol dependence.

⁵ Drummond, C., Deluca, P., Oyefeso, A., Rome, A., Scrafton, S., Rice, P. (2009) Scottish Alcohol Needs Assessment. Institute of Psychiatry, King's College London: London

⁶ A more detailed outline of the basis for this estimate is available in Appendix A.

- Estimates of foetal alcohol spectrum disorder (FASD) (Scottish Government, 2012) suggest that in 1 in every 100 live births, the baby is affected by FASD and in 1 in every 1,000 births by Foetal Alcohol Syndrome. This would mean that approximately 55 children are born in Edinburgh every year with FASD (GRO, 2011).

3.2 SERVICE-LEVEL DATA

3.2.1 SPECIALIST SERVICES

- A maximum of 121 families were reported as receiving support from a specialist support service for families affected by parental substance misuse in the last year. A small number of others will have received parenting education through a specific programme such as Mellow Parenting etc.
- A maximum of 419 children affected by parental substance misuse were reported as being in services included in this needs assessment. Some of this figure may be made up by children in contact with more than one service who have been double-counted. Other children affected by parental substance misuse who are in contact with generic youth health or counselling services (e.g. The Junction/Place2Be) have not been included.
- Although only one adult treatment service provided specific figures, they reported that between 52 and 70% of their service users were parents.
- These figures suggest that the vast majority of parents, children and young people affected by parental substance misuse are not currently in contact with specialist services. It is impossible to know how many are receiving other kinds of support.
- The data presented here is incomplete as it relates only to those services who engaged with the research and who were able to provide relevant figures at the time.

Table 3: Parent or Family Focused Service Data

Parent/Family-focused Support	Year	Overall Number using service	Service users who are parents	Service users who have substance misuse issues	Children using service affected by parental substance misuse	Families affected by parental substance misuse
CHAI Fathers	2012 (current)	19	19	50% (estimate)		
Circle Harbour	2011-2012		112	112	154 children	78 families
Aberlour Outreach		127	43	43	84	43
PrePare	2011-2012	53 pregnant women		53		

Table 4: Child-focused Service Data

Service:	Year	Overall numbers using service.	No of children APSM accessing service.
Edinburgh Young Carers	2011-2012	155 young carers	33
Muirhouse Young Carers	May 2012	43 young carers	3
Broomhouse Young Carers		38 young people in a year	15
Broomhouse Youth befriending		20 young people in a year	18
Broomhouse Youth counselling		40 young people in a year	17
Health Opportunities Team		In contact with 340 over 6 month period	
Castle Project 1:1 Service			20
Circle Harbour	2011-12		154
Aberlour Outreach			84
Sunflower Garden	2011 - 2012		75
Max number of children in services:			419

3.2.2 PRIMARY CARE

There are two contracts which can provide data in primary care.

1) The Child Health and Wellbeing Scottish Enhanced Services contract: If practices opt into this contract, they are required to provide data relating to various child protection issues, have a named child protection contact, have an appropriate risk assessment system, regular practice meetings and follow up action relating to child protection. The following data under this contract relates to the year ending 31st March 2012 across NHS Lothian.

- 126 of 139 practices provided data. Of these, 11 did not provide data and 3 had not signed up to the contract.
- 1,449 children were living in a household with an adult with a diagnosis of drug dependence.
- 1,037 children were reported as being on the child protection register.
- 2,027 newly registered children assessed as being at risk were offered face to face consultations and of these 1,533 consultations were completed.

2) The Drug Misuse National Enhanced Services Contract. There is theoretically the possibility of collecting information in relation to children living with drug users who are being treated under this contract, however it requires further thought about what is needed and how it could be collected in a useful and standardised form.

- There are currently two 'read codes' that are relevant and could be extracted or 'counted' via the Enhanced Services Contract Reporting Options (ESCRO) system. These are:
 - 13WZ. No children living with patient/Family circumstance NOS
 - 13IX. Child / children lives with patient/ Child lives with parent
- Practices are not currently required to collect this data and it may/may not be included on the screens used by GPs in Edinburgh.
- It may be possible to include these codes as part of a future update, however as the practices are likely not to have had to submit this data before, the quality of information

recorded under those codes might be inconsistent or very poor. This would mean additional work to make the data useful.

“If [this data] is to be collected on a regular basis going forward, it will be essential for some work to be done to ensure the quality of the information recorded is up to standard. This is unlikely to be a straightforward piece of work.”

3.2.3 MATERNITY SERVICES

The TRAK system records data collected by midwives in consultation with pregnant women at various points in pregnancy but primarily at the ‘booking appointment’ which is usually around 12 weeks of pregnancy. The system has changed recently to include questions relating to drinking both before and during pregnancy. The following data is available:

- Of the 11,067 records for 2011 for NHS Lothian (not Edinburgh City specific), approximately 260 pregnant women, or 2.3%, reported drinking alcohol while pregnant. This varied from less than one unit to over 40 units weekly.
- This figure is at odds with survey data suggesting that about 25% of women drink while pregnant (but is similar to what is reported to midwives in other parts of Scotland). Such data indicates that drinking alcohol while pregnant increases with income and social class⁷ and is more prevalent in rural areas.
- This data has to be manually counted as the field which asks about the number of units consumed weekly (both before and during pregnancy) allows the entry of free text (rather than being a drop down list). Thus there were 412 different answers entered into this box (e.g. ‘0-2’, ‘many’, ‘zero’, ‘35-40’ etc.).
- 510 women or 4.6% answered positively to the question ‘Are you currently, or have you ever used street drugs, gases or glues?’ This figure is also at odds with survey data such as that from the Scottish Crime Survey for 2010/11 in which 32% of women aged 16-44 reported having ever used drugs.⁸
- The question about drug use is unhelpful in identifying whether use is current or previous, and which substance is involved. The questions are not nested, so if a woman answers yes, new questions do not appear, rather all questions are visible at all times (unlike in other sections of the TRAK system).

TRAK is a system that is devised by an external software provider who has been paid to develop specific screens for Edinburgh based on the Scottish Women’s Handheld Maternity Record. If further changes were requested to how the questions on alcohol or drugs appear, these changes would need to be paid for. The cost would need to be weighed up against the possibility that the data being obtained is inaccurate anyway owing to other unknown factors, as appears to be the case from comparing the TRAK data with general survey data.

⁷Ford (2008). Understanding of the use of alcohol in pregnancy amongst women in Scotland: First year update. Scottish Government. <http://www.scotland.gov.uk/Resource/Doc/175356/0066306.pdf>

⁸Scottish Crime Survey 2010/11. <http://www.scotland.gov.uk/Publications/2012/03/2775/19>

Despite this caveat, a change to the alcohol response options to include a drop down list to assist with decisions on how to respond to women who do admit alcohol use, and to encourage more honest reporting would be valuable. This is important when the levels of foetal alcohol spectrum disorder and the low rates of referral of pregnant women for further discussion/support/counselling around alcohol issues are considered.

The point of the drug use question needs to be thought through, it is not sensible to ask about previous use together with current use.

NHS Lothian should lead further work to support accurate identification of alcohol consumption levels in pregnancy and appropriate responses to the levels identified to reduce the risk of Foetal Alcohol Spectrum Disorder.

- **The response options for questions on alcohol consumption in TRAK should be changed to closed (e.g. drop-down) categories (such as 0-2 etc.) linked to the alcohol brief intervention care pathway in antenatal settings⁹.**
- **Additional support or training for midwives would benefit from observational work on how existing questions on alcohol are being presented to women at booking.**
- **Further consideration should be given to the usefulness and purpose of the question on drug use in the TRAK system including consideration of whether questions about cannabis use are best covered with other (illegal) drugs or with questions about tobacco smoking in pregnancy.**

3.3 IMPROVING DATA COLLECTION IN THIS FIELD

Measuring or even estimating the numbers of children, parents and families affected by parental substance misuse is fraught with difficulty. These difficulties can be summarised as follows:

- Multiple difficulties with clearly defining what counts as a child or family affected by parental substance misuse.
- Difficulties with reliably and appropriately identifying who fits into any given definition.
- Multiple difficulties with recording and reporting such identification.
- Risks of negatively affecting outcomes for the family due to further stigma, labelling or damaging the working relationship by alienating parents.

All of the above issues are discussed further below.

3.3.1 MULTIPLE DIFFICULTIES WITH CLEARLY DEFINING CAPSM

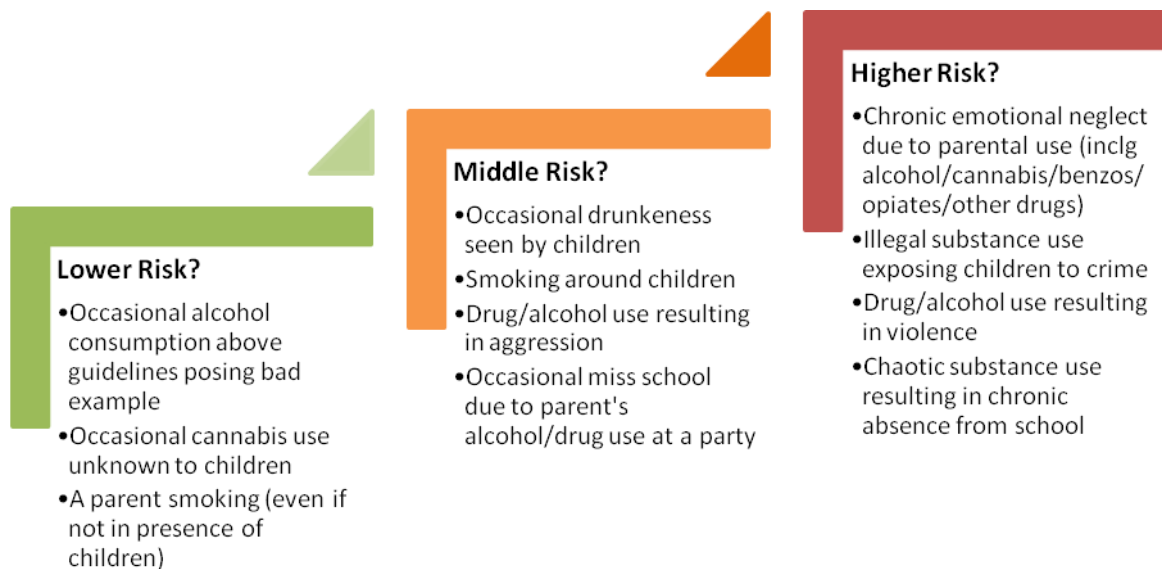
Firstly to be able to measure or count something, one needs to be clear on what exactly it is that you want to count. Within this area, there are multiple challenges of definition including:

1. What constitutes parental substance misuse; when does use become misuse?

⁹NHS Health Scotland (2010). Antenatal Care Pathway for Alcohol Brief Interventions:
http://www.healthscotland.com/uploads/documents/12105-ABI_1_AntenatalCarePathway.pdf

2. What constitutes being 'affected' by parental substance misuse or what constitutes 'harm' due to parental substance misuse?
3. Which parents or people with a parenting role are included – those who live with children some of the time/all of the time/their partners/those who do not live with children/those caring for other's children etc?
4. What age children are included – up to 16, up to 18?

These challenges are not new. They have arisen in previous needs assessments and in national publications. Fundamental to this difficulty is the recognition that it cannot be automatically assumed at any particular level of substance use that harm to children is inevitable. All parents who use substances legally or illegally, do so on a continuum of risk of harm to their children. Some examples of risks from various levels of consumption are illustrated in the diagram below.



The placement of behaviours on the above continuum is massively subjective and could be subject to endless argument about the relative risks and dangers of different behaviours. Any number of different professionals would have differing views on whether physical or emotional neglect was more worrying, whether infrequent heavy use was better or worse for children than frequent lower level misuse. This is because it is not the exact level of substance use that dictates the quality of parenting, and there are a whole range of other factors which may protect children or put them further at risk of harm from parental substance use.

“There are a number of difficulties with deciding the threshold for defining this. If a parent smokes, are the children affected by substance misuse?”

Prevalence Contact

It is unreasonable to expect most universal and targeted services (social work, health visiting, youth services, schools) to collect or report data on 'the number of children/families affected by parental substance misuse' who use their service. This is because it is ill-defined, and arguably impossible to define holistically or in such a way that can be measured.

3.3.2 DIFFICULTIES WITH RELIABLY AND APPROPRIATELY IDENTIFYING WHO FITS INTO ANY GIVEN DEFINITION.

Even if the concept of CAPSM could be defined, counting it would rely on parents admitting such usage, and while many may do so, that tends to happen over time as they build up a relationship with individual workers. Whether a parent is using substances to a degree that is affecting their parenting, is not something that many workers could appropriately ask about during assessment, or to which they could expect to get a truthful answer.

“I would imagine that there are quite a few of our mums and dads who have been using cannabis but unless they tell us or the midwives know that then we wouldn’t necessarily find that out.”

“With alcohol use it is often hidden, unless it was something that was brought to our attention or obvious on visiting the home.”

3.3.3 MULTIPLE DIFFICULTIES WITH RECORDING AND REPORTING SUCH IDENTIFICATION.

Many services are not working with electronic case files and the electronic systems that do exist do not currently have well-defined fields relating to this issue due to the problems described above. Some of the difficulties with existing electronic systems are described in the box overleaf relating to the SWIFT system in social work and the TRAK system in maternity services.

Where files are largely on paper, or based on electronic ‘free-text’ case notes, counting those parents who disclose substance misuse, would currently require a laborious audit. This would involve going through individual case files to trawl for information indicating such an issue and would be highly subjective. We do not therefore feel that this would yield sufficiently reliable information to justify the resources.

Some Data Collection Challenges

- Participants described difficulties getting staff to record data and in ensuring that the data recorded is of sufficient quality. For example: open ended input fields are completed very differently by different staff which makes analysis difficult and time-consuming. There is

[We have had a] huge battle to change the culture to accept the need for performance management and good data quality – and electronic recording – [staff] don’t always see the immediate benefit of putting information in. But I think we have won that battle now.

- These systems are developed and owned by large national or international organisations who provide them to hundreds of organisations for local use. For TRAK, the NHS has had to pay for new screens to allow for additional data analysis. For SWIFT, there is some flexibility to make local changes but not major ones. This means that it is not straightforward to adjust the systems to facilitate better data collection, notwithstanding the challenges of clearly defining the questions to be asked.

3.3.4 RISKS OF NEGATIVELY AFFECTING OUTCOMES FOR THE FAMILY

Before attempting to collect such data, it is important to ask what benefit it will bring to service users and their families. The process of deciding or formally assessing that someone has a substance misuse problem that is affecting their parenting, may not in itself be a necessary step for the resolution of the problem, and it could even be detrimental to the chances of helping the family.

"[In this particular case the problem] could easily have been described as a substance misuse problem, but the Mum was very resistant to calling it that. She described [her alcohol use] as her way of coping...she framed the difficulty as low mood [not substance use]."

"The concept can be quite socio economically loaded as well. We are very good at labelling people we work with."

The fact is that any service working with adults will be working with a significant number whose substance misuse will make their task of effective parenting more challenging, and any service working with young people will be working with a significant number whose healthy physical, social and emotional development will sometimes be challenged by parental substance use.

"The problem with the whole concept is that its so pervasive is that virtually every child that we work with is going to be affected by it."

3.3.5 THE WAY FORWARD

Recommendation 1: While there are some aspects of relevant data collection which should be improved, in general the focus of energies needs to be on equipping staff and services to better serve and support children, parents and families affected by parental substance misuse, rather than trying to count something that is not necessarily going to change outcomes per say.

Despite the difficulties outlined above, data collection in this field could be improved in services providing treatment for substance misuse to adults.

A useful concept that may be more measurable is the number of adults receiving treatment for substance misuse who have children living with them (even if not their own children) all or part of the time. This information could be gathered at least annually from each service user and collated for report to the EADP. Currently this is only gathered for new patients in drug treatment services, it is not required by ISD for alcohol treatment or from patients in ongoing treatment.

There is generally a lack of data relating to alcohol as well as a general sense that the impact of alcohol use on children can go unnoticed, and so it would be valuable if counselling services for alcohol use also gathered this information annually.

This would allow services for supporting parents to be planned on the basis of the numbers of people with a parenting role who have a recognised substance misuse problem who are already in treatment and who can be offered and may benefit from parenting support.

Adult treatment and counselling services (including alcohol counselling services and primary care services providing treatment for alcohol or drug use) should record and report the number of adults receiving treatment for substance misuse who have children living with them all or part of

the time in line with SMR25 requirements. Further arrangements will be required for people with primary alcohol problems until this data is reported through the SMR25.

Due to the difficulties outlined above, no clear conclusions could be drawn about useful ways to improve data collection in social work services.

Social work services should consider what aspects of data recording would be beneficial to children and families, and if/how SWIFT can and should be adapted to facilitate such data collection, taking realistic account of the constraints outlined here and the overall finding that the focus should be on providing support rather than counting prevalence.

In order to clearly identify the numbers of children affected by parental substance misuse who require a service through the Local Authority an audit would be required. This would involve going through individual case files to trawl for information indicating such an issue and would be highly subjective. We do not therefore feel that this would yield sufficiently reliable information to justify the resources.

Recommendations on data collection in maternity services are discussed in Section 3.2.3 above.

Successful data recording in all settings is likely to require an element of culture change and staff support/training.

4. FINDINGS AND DISCUSSION: SERVICE AVAILABILITY AND GAPS

- There are a wide range of services working in Edinburgh to reduce the harm to CAPSM including a number of examples of good practice.
- There is no straightforward way to categorise services for children, parents and families affected by parental substance misuse (PSM) because of overlap between target group, age and eligibility across many services. The GIRFEC model in Edinburgh is a useful model for describing children's services. Many organisations and staff relevant to CAPSM provide services at more than one GIRFEC level.
- The number and diversity of services relevant to reducing the harm to CAPSM makes it difficult for practitioners and families to keep well informed as to what support is available and what is best for them.
- There is a need for much greater clarity and awareness among practitioners and service users about what services can support parents, families, children and young people affected by PSM to support appropriate referrals and uptake of services.
- There is a need to consolidate and co-ordinate services providing universal, lower-threshold and targeted support to parents, specialist CAPSM family support, targeted support for children and young people including young carer services, and specialist support for children and young people affected by parental substance misuse. This should ensure consistent, city-wide provision for those most in need and will require co-operation across the City of Edinburgh Council and with partner agencies and funders.
- There is currently a need for co-ordination and increased capacity particularly in direct support for young children, in direct one to one support for young people and targeted support for vulnerable parents.
- If services across the board improve their effectiveness at identifying, referring and engaging children, parents and families in need of support, there is likely to be an increase in the number of families needing support from specialist family support services as well as those receiving support within universal services.
- There are further areas for development of services in relation to self-help support, children with FASD, fathers, those who are homeless, equality groups, parents who are older than the remit of 'young parents' services, residential treatment for mothers with children and less-chaotic substance using pregnant women.

4.1 HOW TO CATEGORISE SERVICES

As outlined in Section 1.2, any service which works with children, parents or families affected by parental substance misuse has the potential to reduce the harm arising from that substance use. In describing the services which are available to parents and children, it is necessary to categorise these in some way in order to help with understanding and the readability of this report. Such categorisation is not, and cannot be done neatly however, as services operate on a spectrum in terms of the eligibility of children and families for support based on the age of the children. There is much overlap across the different age groups. Some work only with children or young people, some

only with adults and some with both. In addition, services operate on a continuum from those which are completely universal e.g. school, to those which are highly specialist e.g. Circle Harbour Project. Some work with families with no particular vulnerability, some with a particular issue which may include substance misuse but also with others, and some projects are open to both. Across all these variables, any combination is possible.

In terms of the Children's Services Delivery Model, part of the Getting it Right for Every Child in Edinburgh agenda, a staged model of intervention is described which starts with early identification and intervention. It is not possible (nor intended) that this model be used to 'classify' services as a 'Stage 1' service or as an 'early identification' service. While universal services tend to operate at the lower levels of the model, and more specialist services further up, most have a role in providing services at more than one level. The model therefore categorises the type of intervention, rather than the service which provides that intervention. It does not therefore make sense for us to attempt to group the services included in this needs assessment using the Children's Services Delivery Model stages.

Instead, we have chosen to describe services in three groups as shown in Table 5 overleaf. Within each category, services are listed starting approximately with more universal services and finishing with services specialising in support to parents and children affected by substance misuse. In some cases services are included where they are for vulnerable parents or children but where the vulnerability is not specifically due to substance misuse but this is the exception.

It is essential to note that this list is by no means comprehensive but is intended to provide a snapshot of the range of organisations and services that are relevant to this needs assessment. Undoubtedly some organisations or services will have been omitted due to the enormity of the range of relevant services but we do not anticipate that our conclusions would be vastly different as a result.

We have interviewed representatives of most, though not all, of the organisations or services listed, however service providers have not signed off on these specific descriptions. Sometimes services did not engage with our attempts to contact them or in other cases the service was identified as relevant late in the work and it was not possible to interview them.

Table 5: Categorising Services

		Services mainly for parents and/or children where children are the following age:					
		Pre-Birth	Pre-School	Primary	Secondary	Adult Mainly	
Universal ↕	Targeted	NHS Maternity/Midwifery Service					
			Nurseries/Early Years				
			Parent & Toddler Groups				
			CHAI Father's Group*				
			Rhyme Time Groups				
			Parenting Education				
			Health Visiting Teams				
			BumpStart*				
			Stepping Stones*				
			Family Nurse Partnership				
Specialist ↕	Specialist	Child & Family Centres*					
		Social Work Children & Families					
		Support for Prisoners & Families					
						Al-Anon	
						Families Anonymous	
		Circle Harbour					
		Aberlour Outreach					
		PrePare					
		Services for School-Aged Children/Young People:					
		Universal ↕	Targeted ↕			Schools	
				Youth Services			
				Additional Support for Learning			
				CAMHS			
				Bfriends Edinburgh*			
				Youth Offending Service			
				Edinburgh/Broomhouse*/Muirhouse* Young Carers			
				ICSS			
						Health Opportunities Team*	
						Castle 1:1*	
Specialist ↕	Specialist	Aberlour Outreach					
		Circle Harbour					
		Sunflower Garden					
NB: This is not intended as an exhaustive directory of all services.							
*Not city wide.							

4.2 SERVICE INFORMATION

The number and diversity of services relevant to reducing the harm to CAPSM makes it difficult for everyone to keep well informed as to what support is available and what is best for them and their service users. This is unhelpful for generating appropriate referrals and uptake of services.

This project spent a considerable amount of time getting to know the many and various services available in Edinburgh that are relevant to CAPSM. It is not straightforward to describe and present such services comprehensively. Nowhere are such services presented in a continuum from universal to targeted to specialist services with clear guidance for staff and parents as to what might be helpful at different stages. However, staff working on the frontline need to be able to find out exactly what is available for their service users quickly and easily. There is a need for much clearer information for parents and staff about when, where and how they can access services as discussed below.

“What we struggle with is staying on top of what the services are, you tend to develop a specific knowledge with one family but how do you keep a good up to date knowledge of what’s around? That would be really helpful.”

Overall, the information available about services for CAPSM was poor, and difficult to access and understand unless, and in some cases even if, you were already an insider in the field.

Recommendation 2: There is a need for much greater clarity and awareness among practitioners and service users about what services can support parents, families, children and young people affected by PSM to support appropriate referrals and uptake of services.

Edinburgh ADP should consider how to compile and maintain up to date, detailed directories of services and supports specifically for parents, families, children and young people affected by parental substance misuse.

The number and presentation of such directories should be appropriate to the target groups but should include clear guidance on thresholds for access, distinguishing features of similar services and ways of working. Consideration should include the potential to commission an external Edinburgh based organisation to take on this task.

4.2.1 INFORMATION ABOUT PARENTING SERVICES.

There is no easy way for any parent to find out about universal and low-threshold services that are available in their area including parent and toddler groups etc. Many find out only through word of mouth and this disadvantages more vulnerable parents such as those affected by substance misuse who may not have sufficient peer support from other parents to find out in this way.

“Just more of them and more awareness of them. They could put posters in Doctors, libraries, schools, papers”

Father of 1 pre-school, 2 primary school and 2 secondary school aged children

“There wasn’t a lot of advertising, not a lot of people know about [universal pre-school support group]. It needs to be advertised in different areas...It was in [location] and that closed down so I just assumed that there was no more [support group] but it moved to [another location] and it was me who had to go down and ask if [the group] was still going.

So, my daughter missed a year of that because there was no advertising when they moved location that it was still up and running. Nobody told us the times and places”

Mother of 1 pre-school, and 2 primary school-aged children

Children and Families (at City of Edinburgh Council) should map current provision in terms of universal parenting support groups or services. This should include exploring how best to provide information on and promote universal and targeted parenting support services as part of future developments to better co-ordinate parenting support across Edinburgh.

A map of provision, similar to the online map provided for youth work services in Edinburgh City, may be helpful for some parents and would support staff with signposting. There is also a need to co-ordinate how such services are organised and promoted in local areas and to ensure that such services are accessible to more vulnerable parents. This is discussed further in the next chapter.

4.2.2 INFORMATION ABOUT TARGETED AND SPECIALIST FAMILY SUPPORT SERVICES.

There is a perception among frontline staff that it is too difficult to know what is available and some specialist services reported that they were not getting referrals early enough. While there are only a small number of organisations or teams providing such support, we could find little guidance for staff on how to choose which would be more appropriate for different parents or families. For example, there is a leaflet describing Aberlour, Circle and Sunflower Garden as specialist services, but it simply describes the three agencies, rather than guiding on how to select between them.

“Far too many small teams and projects for service users and services like ours to keep on top of what is available. Need something that is more joined up.”

“I think we have a good knowledge of services that is out there which is key to getting the appropriate referral. Referring to the right place at the right time for the client.

“[We need to do more] raising awareness of the service with referrers - getting out there and selling the service. People, referrers not always sure if the service is still running due to funding changes/difficulties...[We] need to improve on getting out and delivering inputs and presentations to potential referrers, getting the service known.

The difficulties presented above are compounded by a lack of integration and co-ordinated effort across the range of services designed to support parenting. In particular, the work of the parenting support team at City of Edinburgh Council in organising parent education programmes both for universal delivery and for vulnerable groups, is not well known in general by those involved in supporting parents with substance misuse issues. The need for integration is discussed further below.

4.2.3 INFORMATION ABOUT SERVICES FOR CHILDREN AND YOUNG PEOPLE

Similarly to services for parents above, there is a need to provide clearer information for staff, particularly staff in universal services, about what services are available to children and young people affected by parental substance misuse. Current service provision is somewhat piecemeal and is not clearly described or listed anywhere.

Further recommendations relating to co-ordination and integration of services (rather than service information) are discussed below.

4.3 RANGE & AVAILABILITY OF SERVICES FOR PARENTS & PRE-SCHOOL CHILDREN

The table overleaf describes some of the range of services directed at parents, or prospective parents, and where applicable pre-school children. Services that are primarily aimed at children or young people (rather than for or with their parents) are listed in Section 4.4. Some are listed in both.

Taking this list of services, support for parents can be roughly divided into that provided by services which are more or less **universally** available, services which are **targeted** at groups with a particular vulnerability, and those which could be considered **specialist** services specifically for work with children, parents and families affected by parental substance misuse. As a whole across Edinburgh City, there are a good range of services available, but there are some gaps and overlaps, and a general lack of co-ordination due to the number and variety of providers.

4.3.1 UNIVERSAL, LOWER THRESHOLD SERVICES FOR PARENTS

These are currently provided by a wide range of providers across the city including many community and church groups, and peer-led groups all of which provide time or space for parents to come together and get peer support. They include parent and toddler groups, rhyme time, baby massage, PEEP (Parents Early Education Partnership) groups etc. The nature and number of these kinds of groups and providers and their broad target group is such that it is beyond the scope of this work to map them or to comment on specific geographical gaps. It is worth noting however, that current funding pressures may lead to an even greater need for these kinds of participant-led or community-led (rather than state-organised) groups to be supported and flourish.

It was agreed by participants in this research, the GIRFEC philosophy and the research literature, that keeping families in universal services where possible is beneficial for parents and children and so it is important to include these services in this report. In addition, specialist services working with vulnerable families spoke of the importance of supporting them back into universal services. For these reasons, the range and availability of simple parenting support groups like baby massage or parent and toddler is important for reducing harm to CAPSM.

For all of these kinds of universal services, there may be difficulties in terms of how accessible they are to more vulnerable parents. This is discussed further in Section 5.6.

It is apparent that there is a paucity of support available for parents after the point when their children start school, despite this being identified as a time when parents still need support. There are currently lots of open, universal groups for parents of babies or toddlers but much less for parents of older children.

“There should be more support for homework and stuff, I really struggle and he does. There isn’t one homework group in his school” (Female, mother of 1 primary school age child and 1 secondary school age child)

There are a number of organisations which are well-placed to help parents of school-age children fulfilling a similar peer support function as parent and toddler groups during the early years. A similar range of options would be valuable including drop-ins, parenting education, social and semi-social events. Schools and parent councils would be well placed to do this, in that they could facilitate social support for parents of children of the same age groups through events and informal

opportunities to meet as part of their interaction with schools. Community organisations could also play an important role. While there is a 'Family Learning' initiative available through Community Learning and Development that may fulfil this role in part, this was not mentioned by parents or staff in this study and the initiative has not been specifically considered.

Some funding would be beneficial to promote more activity in this field but the focus should be on stimulating bottom up activity rather than commissioning services. Particular efforts would need to be made to ensure that more vulnerable parents felt comfortable and supported to attend such events. These kinds of efforts are discussed in the next chapter. The full recommendation relating to this is presented here, and repeated in Section 5.6.

Children and Families (at City of Edinburgh Council) in partnership with other providers, should identify existing organisations and groups which are already or which have the potential to facilitate peer support for parents (especially of school age children) and arrange for them to be supported to do so in ways that are as accessible as possible for all parents in order to expand accessible provision in this area.

This could include community-led groups, NHS-led groups, peer-led groups, schools, churches, parent councils and employers and may involve providing guidance such as suggested ways of working, having someone visit and support groups directly, or providing training.

In addition to services specifically focusing on parenting, there is a need for universal services that work with children and young people e.g. early years, health visiting, education and youth services to be better able to understand substance misuse issues and work with such parents effectively where appropriate. This is discussed further in Section 5.2 below.

Table 6. Services for Parents and Children or for Parents only.

	Service	Service Description	Target Group
Universal ↔	NHS Maternity/Midwifery Service	Universal clinical service to care for mothers and babies during pregnancy and immediate post-natal period. Provide antenatal education.	All pregnant women and their babies. New mums and babies up to first few weeks old. Fathers at antenatal ed.
	Nurseries/ Early Years	Universal services providing childcare and/or early years education.	6 wks to 5 years and various age ranges within that. 3-5 years common.
	Parent & Toddler Groups	Ad-hoc community based informal peer support for adults and play groups for their accompanying child/children in various venues led by various organisations across the city.	Parents/carers with children of pre-school age.
	CHAI Father's Group	Community based activity-focused support group. Some one to one work with fathers.	For vulnerable fathers and their children pre-school or primary aged.
	Rhyme Time Groups	Library based group singing, rhyme and story sessions.	Parents/carers with pre-school children.
	Parenting Education	Education programmes to improve parenting e.g. building literacy, numeracy and play skills; improve parent-child relations etc.	Any parents of children under 5 (e.g. PEEP). Vulnerable parents (e.g. Mellow Parenting; Incredible Years)
Targeted ↔	Health Visiting Teams/GPs	Universal NHS service for children and families. Home visiting to identify needs, provide support or signpost. Clinical medical services.	Everyone for GPs. All parents with children for health visiting. Intensive support to vulnerable parents/families.
	BumpStart	Targeted service providing simple or intensive one to one support with social issues e.g. housing, benefits, emotions, orientation, language etc. Also topic specific education cafés.	Mainly work with vulnerable young pregnant women and v. new Mums. Less work with Dads.
	Stepping Stones	Targeted service providing group work, one to one and home visits.	Vulnerable young parents (<25) of children (<3). Less work with Dads.
	Family Nurse Partnership	Intensive, nurse-led home visiting programme.	During pregnancy and continuing until the child is two years old w women <19.
	Child & Family Centres	Childcare, parenting support, group work, one to one/home based work to	Vulnerable parents and children (pre-birth to <8) mainly where there is a risk of child protection concerns.
Specialist ↔	SW Children & Families	Assessment, family support, referral, liaison with other agencies: home-based, 1:1 family work.	Any children in need or at risk, and their families.
	Support for Prisoners & Families	Range inclg Willow (group & 1:1 work for women), Families Affected by Imprisonment (FABI – home based and direct support to families), and Families Outside (telephone and direct support).	Willow: Women over 18 in criminal justice system FABI: Families & Prisoners Families Outside: Families & Prisoners
	Al-Anon	Self-help group and one to one peer support using 12 step model.	Anyone (aged 12+) affected by someone else's drinking.
	Families Anonymous	Self-help group peer support using 12 step model.	Family members affected by someone else's drug use.
	Circle Harbour	Family support – parenting, appointments, liaison with other agencies. 1:1 with adults or child.	Any family affected by parental substance use with a child <18.
	Aberlour Outreach	One to one work – parenting, appointments, liaison with other agencies.	Substance misusing parents and their children aged 0-16 (not in pregnancy).
	PrePare	Clinical antenatal care; social support – housing, benefits etc; specialist SM treatment. Mainly 1:1	Relatively chaotic substance misusing pregnant women.

NB: This list is not intended as an exhaustive directory of all services.

4.3.2 TARGETED SERVICES FOR VULNERABLE PARENTS

There are a number of teams and services which provide support to parents who fall within specific target groups unrelated to substance misuse per se e.g. young parents etc. These include BumpStart, the Family Nurse Partnership, Stepping Stones etc. All of these have slightly different access criteria, funders and geographic constraints. For example, BumpStart and Stepping Stones both provide services to young parents in the North, the former working mainly in pregnancy and with very new Mums and the latter with young parents of under 3s. This means that a vulnerable young parent receiving support from BumpStart may then get support from Stepping Stones as their child gets older. This is not ideal as it involves a new staff-service user relationship and trust being built up for one to one work and a more integrated approach would be better.

It was reported that BumpStart in particular are experiencing demand for their services from beyond their commissioned geographic remit. As well as being a positive reflection on the service, the demand from midwives for it to be available more widely perhaps reflects the partnership nature of the BumpStart service as a joint initiative involving staff from NHS, council and voluntary sector organisations. This means that although it is a targeted service, it is very well embedded into universal provision. This partnership approach may offer some learning for how to increase early referrals for specialist CAPSM family support services.

Provision of support to pregnant women who are less chaotic but nonetheless misusing substances was highlighted by a number of participants as a gap. Any future expansion or commissioning of targeted services should ensure that the ability to provide early intervention in these cases is included in the service specification.

NHS Lothian, City of Edinburgh Council and other partners should jointly consider what targeted services are needed by vulnerable parents (not those with more serious substance misuse problems who could access specialist family support), and specifically commission these in areas of need.

- **In particular there is a need to consider how to provide services such as those provided by BumpStart and Stepping Stones in the North in a coherent and co-ordinated way, and to expand such provision to other areas such as Craigmillar, Sighthill, Westerhailes, Tollcross, Gilmerton and Liberton.**
- **Consideration needs to be given to gaps in provision for targeted support to vulnerable parents who are older than the remit of 'young parents' services.**
- **These services need to be supported and training provided to ensure that they can appropriately identify and address lower/less chaotic levels of substance misuse in pregnancy that would not be appropriate referrals for the PrePare project.**

4.3.3 SPECIALIST SERVICES FOR PARENTS WITH SUBSTANCE MISUSE ISSUES

There are two main services providing specialist support for families affected by parental substance misuse: Aberlour Outreach and Circle Harbour project. Both operate on a city-wide basis (though Aberlour's service base is in the East), and describe offering a similar range of services funded by various organisations. While the services may be working with different families and slightly different age ranges of children, it does not appear to be an efficient use of resources to have two

such similar projects. Currently there is duplication of effort in terms of management, development of practice and protocols, marketing the service to potential referrers and service users, staff training and so on. It would make more sense to have one service offering specialist support to families city wide, operating from local service bases as needed.

Ideally such a service would work in a partnership, integrated way with universal provision like schools and early years, not only in terms of where they provide services to parents, but also to increase expertise and capacity within universal services to pick up on and support less chaotic parents with their parenting. This is discussed further in Section 5.4.

Funders of specialist CAPSM family support services should work towards open commissioning of one city-wide co-ordinated specialist support service for parents affected by their own substance misuse and their families.

4.3.4 SELF-HELP SERVICES

In addition to statutory and voluntary sector organisations, it is important to consider the contribution to reducing harm due to parental substance misuse that could be played by the self-help sector. There are at least eight meetings of Al-Anon every week in Edinburgh¹⁰. According to Al-Anon:

Al-Anon family groups hold regular meetings where members share their own experience of living with alcoholism. Al-Anon does not offer advice or counselling, but members give each other understanding, strength and hope.

Al-Anon groups are non-restrictive – that is open to anyone affected by someone else’s drinking. Al-Ateen groups operate on a similar basis for 12-17 year olds, however there are currently no Al-Ateen groups meeting in Edinburgh. The absence of Al-Ateen groups was reported to be because of difficulties getting Disclosure Scotland checks in place for facilitators of meetings, though it is unclear exactly where this difficulty lies. Al-Anon report that in the absence of an Al-Ateen group, those 12 years old and upwards are welcome at Al-Anon meetings and that sometimes, young people could be accompanied to a meeting by a teacher or other adult. It is unclear whether any young people are currently getting support from Al-Anon meetings in Edinburgh, or what disclosure checks then become required for the Al-Anon meeting facilitator.

A key strength of the self-help sector is the ability of people to access completely anonymous help without any fear of exposure. This is particularly important in the alcohol field, as there are so many individuals not in contact with formal treatment. However, this needs to be balanced by a need to take reasonable steps to protect the children of those misusing alcohol. This applies to the approach to groups such as the AA (in terms of procedures for protecting children of alcohol misusers who are attending the groups) and also to how Al-Anon/Al-Ateen protect young people accessing support through them (both through child protection procedures and arrangements for Disclosure checks).

Given the level of unmet need in relation to child and family support, it is important that opportunities for support from the self-help sector are maximised. With this in mind, the concerns about child protection highlighted should be addressed pragmatically and quickly. This should then

¹⁰ Al Anon website search for meetings: <http://www.al-anonuk.org.uk/meetings/>

enable action to be taken to promote the availability of self-help groups for young people as an important option for support for those who do not object to the 'spiritual' aspects of these groups.

EADP should engage with AI-Anon to explore every avenue available to maximise the availability and awareness of self-help groups for young people and others affected by parental alcohol misuse including solving the issue of Disclosure checks and child protection.

SMART Recovery UK are currently collaborating with a substance misuse family support organisation to develop a model of self-help groups for family members using their secular, cognitive-behavioural therapy based approach. Smart Recovery would welcome support with the development of this model including a Scottish location to pilot it. This model is not aimed at young people currently.

EADP should engage with SMART Recovery UK to consider how they can tap into any future developments of secular family self-help including exploring the potential for groups for young people in the future.

4.3.5 SPECIFIC SUPPORT FOR FATHERS

A number of participants highlighted the need to reach out to fathers and fathers to be and that current services are not as good as they could be at doing so. Firstly, participants reported that current services are not always described in ways which make it seem as though men are welcome. Universal services are sometimes referred to as 'mother and toddler' groups, or some services run 'pregnancy' cafés. These terms were flagged up to us as unlikely to encourage men to attend.

"Its always geared for the mothers"

FatherA of 1 primary school-aged child

"so I'm a single dad and there's nothing for single dads..."

FatherB of 1 primary school-aged child

More than one service described their efforts to engage fathers as something that they had only recently started to work on, or on which they planned to more in the future. It was clear that services were not always sure how best to reach out to fathers and that in some cases more staff would be needed to do so.

"We are well equipped to work with fathers, but we don't have the capacity. We need more staff to provide support to Dads. Even in the areas where we already work we could do a lot more for Dads if we had capacity."

"We are in the process of setting up antenatal classes for young Dads because we have noticed it is a gap. A lot of services in the area are called pregnancy café or mums' clubs which they (Dads) themselves have recognised that they find difficult to access just because of the nature of the group and they want something for themselves."

There are multiple sources of information and support on how to involve fathers in early years' services available online as well as training courses which can be bought in (see Fatherhood Institute; Saunders et al., 2006; Children in Wales¹¹). For those services which are already identifying

¹¹www.fatherhoodinstitute.org;
www.derby.ac.uk/files/fathers_in_early_years.pdf

and effectively working with children and families affected by substance misuse, it would be beneficial for them to consider how well they are involving and meeting the needs of fathers and what their learning and service development needs are by consulting some of the available literature.

Targeted and specialist support services should consider how well they involve and meet the needs of fathers. Children and Families should look to bring representatives of different services together for some training and an event to discuss how to improve the level and quality of father's involvement in services.

Children and Families should develop a short briefing and reflective checklist should be developed for all services to encourage them to consider how their service could be more accessible to fathers including changing the name of services where necessary.

4.3.6 SERVICES FOR MINORITIES

There was a sense that services were not being accessed by many ethnic minorities, with the exception of BumpStart who specifically mentioned providing language support to their clients. One participant (not from BumpStart) said:

"Ethnic minorities don't access [our] service...Language is often a big barrier. We find that some ethnic minorities keep themselves to themselves a little more and its harder for them to access services".

It was not within the scope of this work to review the availability of all parenting support services, or those specifically targeted at equality groups, however it would seem that there is limited specialist support for parents with substance misuse issues who come from equality groups. The development of specialist services is not seen to be the solution to this, but as recommended for fathers above, efforts should be made to ensure that all services are adapted to meet the needs of equality groups in line with the Equality Act 2010.

A pragmatic approach should be taken by commissioners and service managers to review how well services are currently meeting the needs of equality groups using Equality and Rights Impact Assessment Tools, and Rapid Impact Checklists should be completed for new services/service changes¹². Support and guidance should be provided to services to ensure a consistent approach and to make it a meaningful and productive exercise.

- This should include consideration of the needs of substance using women who may also be homeless and whether they have sufficient access to health visiting services e.g. through the Access Practice.

www.childreninwales.org.uk/areasofwork/parenting/workwithfathers/fathersandearlyyears/index.html

All accessed 8th July 2012.

¹² Equality Impact Assessment Tool: <http://www.scotland.gov.uk/Publications/2005/02/20687/52426>

Rapid Impact Checklist: <http://www.scotland.gov.uk/Publications/2005/02/20687/52425>,

[Both accessed 10th July 2012.]

4.3.7 OTHER GAPS/ACTIONS

There were a number of other areas of potential need raised by one or two participants which merit further consideration, but on which a definitive view could not be taken at this time.

The issue of **residential treatment which could be attended by mothers with their children** was raised by some participants.

“It’s at the drug rehab with a family unit within it and it’s too easy to split a family up...if they keep the family unit together then whole families are in recovery then, rather than just the parent”

Father of 1 secondary school-aged child

There is no such treatment currently available in Edinburgh City, although it is possible for some to be funded to attend such treatment in England. The needs of mothers with older children were particularly highlighted as being poorly served by this arrangement. Others noted that the few options available for substance misusing women who give birth, noting that 50% of babies are separated from these women at birth. The solution to this may not necessarily be the provision of a local service, as some people may benefit from residential treatment giving them the opportunity to get away from negative influences which may exist locally. In addition, the access route to getting funding for such treatment is unclear and needs to be considered.

“If we can find a way of doing a short residential rehab, we can look at not having to separate, not having to use the care system, not having to use link workers and foster to carers but to save that...Not separating mother and baby because we are disrupting attachment, disrupting relationships which makes it more difficult for rehabilitation to take place, particularly for young mums. We know that when teenage mums for example are separated from their children at birth the likelihood is that they will not be able to rehabilitate back because of their age and status, disempowerment.”

The EADP should bring together relevant stakeholders (including Children and Families and Health and Social Care within the City of Edinburgh Council) in the treatment of women drug and alcohol users to jointly consider the need for residential treatment for mothers with children, with a view to developing models of delivery and routes of access to provision that are most likely to be both effective and cost-effective.

There are currently no services oriented towards identifying and supporting children with Foetal Alcohol Spectrum Disorder (FASD). Prevention of this condition is obviously vital and is discussed in Section 3.2.3. It is not clear what such services could usefully do, as the identification of FASD is extremely difficult, and once identified, there are few treatments specific to the condition, which could not be provided symptomatically even without diagnosis. Nonetheless, a focus on awareness raising of possible symptoms and ways to respond by universal staff could be valuable in preventing such children from being judged simply as troublesome or difficult. An online education course is being developed nationally by NHS Education for Scotland on this issue and may supplement/complement the training already available on this issue through PrePare.

“It would be useful to know where children with FASD are being picked up... If a child is needing extra support e.g. in the early years or visiting teacher service. If we are identifying them early - is there a tracking system to put the support in at earliest possible stage?”

There was a disparity of views on whether additional capacity was needed within child and family centres (C&F Centres). Some universal staff (who were very positive about what C&F Centres offered) reported that they had difficulty getting a place at C&F centres for some of their families, whom they then supported themselves. Others felt that it was important to keep families within universal services where possible and that universal staff could be better supported to work with such families rather than pushing those who might not need it into specialist services.

“Child and family centres: they are excellent. Their work and involvement with families can be so so beneficial because they work with the parents as well as offering the children play facilities, nursery facilities, peer interaction....The benefits for families and how that affects their parenting is great. But the pressures on C+F centres are huge but with cutbacks centres have been closed...it often can be difficult – its got to be quite a 'high tariff' case for C&F centres to get support...Some are successful and others are not offered a place because the service cannot accommodate them. They might be offered outreach instead or if child is of an age when perhaps a playgroup would be deemed appropriate for the child - but that doesn't help parents with parenting.”

It appears that there is a gap in terms of expertise within universal and non-specialist services in relation to how to identify, respond to and meet the needs of these parents. It is important that capacity is built within universal services to offer specialist support as in our view there will always be parents who would benefit from support from their nursery or school, for example, rather than having to access a specialist project.

There is a need to consider how specialist knowledge and expertise can be made more available through universal services and vice versa. There may be particular gaps prior to children starting at nursery school or school.

Children and Families need to consider whether the needs of children affected by parental substance misuse are best served by focusing future investment on increasing capacity in child and family centres for those who most need it or on providing support, competence-building and time for universal staff to take the lead in working effectively with more such families. A balanced approach is likely to be best. This is also discussed in Section 5.2.3.

The way forward will likely include greater links between specialist staff and universal services (including co-location of staff¹³) as a point of reference and source of support and capacity building for universal staff in addition to any expansion of capacity which may prove to be appropriate.

Crisis intervention was not part of the remit of this needs assessment, however, it is worth noting that in Edinburgh there is no intensive support project similar to the Welsh ‘Option 2’ project which is primarily focused at crisis point for families, to enable children to safely stay with their parents. Full details on Option 2 are provided in Appendix C.

¹³ In referring to ‘co-location’, we mean co-location of individual staff so that they are working directly alongside other professionals, rather than co-location of services. Services sharing a building is not necessarily the solution, which could be simpler e.g. staff being able to work at adjacent desks from time to time.

4.4 RANGE & AVAILABILITY OF SERVICES FOR SCHOOL-AGED CHILDREN

The table below describes some of the range of services available for children of primary and secondary school age, again starting with universal services and moving towards more specialist services. Virtually all of these have some contact with parents, and some will do specific work directly to parents, but generally to a lesser extent than projects listed elsewhere.

Table 7: Services Provided Directly to Children or Young People

	Service	Service Description	Target Group
Universal	Schools	Universal education service during term time. Holiday clubs provide limited cover outside of term-time.	All children 5-16
	Youth Services	Universal informal community education. Huge range of projects providing a wide variety of services and support.	All children of primary and secondary school age – varies by project.
	Additional Support for Learning	Mainstream school based education support, or specialist schools	Children and young people with additional needs, including emotional, social and behavioural problems.
↙	CAMHS	Mental health assessment and diagnosis; clinical and psychosocial interventions.	All children 0-18 with significant concerns re. mental health/wellbeing
	Bfriends Edinburgh	Children 1 st project offering volunteer befrienders to build self-confidence and self-esteem.	Vulnerable children & young people aged 5-16 (with specific difficulties). In particular, those living in designated areas of disadvantage; those from black and ethnic minorities; those referred through pupil support groups.
Targeted	Integrated Community Support Service	Multi-agency service that delivers a range of high intensity programmes.	Young people aged 11-16 within the Children's Hearing system.
	Youth Offending Service	Multidisciplinary team providing one to one, family and parenting support (Teen Triple P).	Children/young people 8-17 years involved in criminal/antisocial behaviour and their families.
	Children 1st Family Support Team	Individual, group or family work.	Children (</=12) affected by social, emotional or behavioural difficulties at risk of exclusion and their families.
	↙	Edinburgh/Broomhouse/Muirhouse Young Carers	Meetings, activities, peer support and in some cases one to one counselling and befriending.
Health Opportunities Team		One to one counselling support programme delivered over 10-12 weeks.	13-25 year olds including those affected by parental alcohol use.
Specialist	Castle Project YP One to One	One to one counselling support.	12-18 year olds affected by parental drug use.
	Circle Harbour	Family support – parenting, appointments, liaison with other agencies. One to one with adults or child.	Families with at least one child aged 0-8.
	Sunflower Garden	Group work, one to one work and befriending.	5-14 year olds affected by parental drug and alcohol use.

NB: This list is not intended as an exhaustive directory of all services.

4.4.1 RANGE AND CAPACITY OF SERVICES VERSUS NEED

The prevalence data and service usage data indicate that there is insufficient capacity within specialist services for children and young people affected by parental substance misuse (PSM), given that there may be up to 10,000 such children in Edinburgh City and only a few hundred are currently accessing specialist support. The automatic solution to this does not necessarily mean that more services are needed, but that focus is needed on how to better identify those young people who may need support and then make best and full use of the services already available, given that few have waiting lists. Such children affected by PSM currently have the following options:

1. Their family may be referred to a specialist family support service e.g. Harbour. The child or young person could then receive one to one support from staff who specialise in working with children and families affected by PSM.
2. They may get a place in Sunflower Garden, which offers a unique child-focused service for PSM, if they are aged 5-14 and subject to capacity.
3. They can access a young carers' service, if there is one operating locally, but capacity is limited and they may or may not have specific expertise on PSM issues.
4. They may access a befriending service, but coverage appears to be patchy and the service is not specialist in working with CAPSM.
5. They may access one to one counselling or support. This is available through generic health services such as The Junction, or through a very small number of specialist workers such as in HOT or the Castle project.
6. They may access support through universal services which they already attend e.g. early years services, schools or youth services, but again there is little expertise in these services specific to PSM.

There is currently insufficient capacity within the first five of the above services, and insufficient expertise on CAPSM in most of the last four. There is also no one place with clear information on all of these options as noted in Section 4.2.

Young carers' services have very limited capacity and while they have some specialist expertise around caring responsibilities, they are not specialist services for young people affected by substance misuse. There needs to be greater clarity about what the remit and functions of young carers' groups are in relation to this issue and appropriate training and support then provided to staff.

Young carers' services staff feel that training specific for young (rather than adult) carers should be made available on the following topics: first aid for young carers, eating on a budget, moving and handling and potentially naloxone training (if there was an ethically sound way to do this). Training for staff needs to be carefully developed so as to consider how best to balance the need to support the young person with the responsibilities that they want to take on but not collude with a situation in which their responsibilities are causing them harm.

There are currently three young carers' services in the City, serving slightly different areas and age groups. This will naturally lead to some duplication of effort in terms of management time, training, and development of policies and practice. Such an approach also does not lend itself to a sharing of

experience and expertise between young carers staff members who are very experienced and skilled in working with CAPSM and those who are newer or have less confidence or skills in this area. We are recommending that a single service be available across the city, however this should not mean on the ground that any existing service disappears, with the loss of local links and expertise that would bring. The three existing services could jointly bid for any future contract, or the successful bidder could be required to protect existing frontline posts (e.g. under TUPE regulations).

We recommend consolidating and formalising young carers' services by commissioning a consistent city-wide service. The specification for the service should make clear what the role and remit of the service is in relation to CAPSM and how they should link in with other universal and specialist services.

Development work is needed to explore and clarify the role and remit of young carers staff in relation to CAPSM, including balancing the need to provide support with any child protection concerns. Such work should define a model of working in this field, and training should then be developed and offered to young carers staff to enable them to better support CAPSM.

Although young carers' services have a role to play, there is little specific specialist support available for young people who are sufficiently competent and wish to access support in relation to their parent's substance misuse *independently of their parents*.

"There's not much concentration put on the kids... all the focus is put on the parent with their drugs issues and stuff".

Father of 1 secondary school-aged child.

This is a particular gap for children affected by parental alcohol use where many may not be in recovery, or may be recovering independently of treatment services, or with the support of self-help groups. Similar issues arise in families where the parents do not see their drinking or drug use as a problem and/or where there are no child protection concerns. Children in such families are much less likely to receive any specialist support. Such children often only come to terms with their parent's drinking/drug use and their experiences much later in adulthood, if at all.

In Edinburgh there is currently no service exactly equivalent to the STARS projects (see case study on opposite page) which was set up and branded as a specialist service for children/young people affected by parental substance misuse. While there are existing services which work with young people on this issue (such as the Health Opportunities Team, the Junction or the Castle project), they are not specifically services for this issue. Such branding is probably an important part of the picture for highlighting and normalising this issue with potential referrers and for the provision of the full range of support options for young people. The STARS projects were successful in identifying and supporting young people (mainly 10-12 year olds) through links with schools, even where parents were not in any form of treatment, and from families who were not previously known to services.

As noted in the previous needs assessment of young people's drug and alcohol services, which focused on young people who were themselves misusing substances, there is a general lack of capacity for one to one support for young people. This is also true of one to one support for young people affected by parental substance misuse as there are very few opportunities for one to one support and only a very small number of these are specialists in CAPSM e.g. Harbour, Aberlour (where families are getting support) or Castle. These are not normally accessed by children from families unknown to services.

Case Study: The Childrens Society: STARS Initiative & STARS Birmingham Project

The overall aim of the STARS initiative is to promote the rights and needs of children, young people and families affected by the substance misuses of a parent/carer. The work of STARS has been going on for over a decade and was originally delivered through a range of projects that sprung up organically in local areas including Nottingham and Birmingham. These projects have now ended and the emphasis has shifted away from specific projects to a focus on supporting and training all staff who come into contact with these children. The STARS National Initiative continues to provide training and support to wider staff groups on this issue on a consultancy basis across England¹. This case study focuses on the work that was done by STARS Birmingham.

The STARS project in Birmingham was a school-based stand-alone service for children and young people affected by parental substance misuse between the ages of 3-18 years old. Children aged over 13 could access the project without parental knowledge or consent, provided they were judged to be competent. Staff worked towards seeking to engage parents, and worked closely with the referring agency, but would respect the wishes of a competent teenager if they did not want their parents to know. For under 13s parental consent was sought. Of particular note is that most of the children in contact with STARS were in families where parents were not in treatment.

Referrals could come from anyone including young people, but schools were the main referrer and self-referrals were very low. Over more than a decade, STARS Birmingham built up excellent relationships with schools; spending time meeting staff and running twilight training sessions around the issue of parental substance misuse. By the end, STARS were starting to develop resources to help teachers identify children in need and work with them.

The aim of the project was to provide children with appropriate knowledge and skills to enable them to develop coping strategies. Direct therapeutic work was carried out to draw out children and young people's feelings and wishes regarding their lives. Project workers used an "all-about-me" worksheet which records achievements, life map and wishes. The project also did some work with interested parents through an in-house informal parenting programme.

The project aimed to use short-term solution focused interventions of 6-8 sessions although the length of time in contact with the service varied. An initial risk assessment was followed by a full assessment and then case work. The intervention plan/model that was applied to all children and young people in the service is outlined below.

The STARS Intervention Model (see Appendix D) was designed to help, support and guide STARS staff supporting children and young people affected by parental substance misuse. The issues to be addressed have been highlighted/identified as common themes for this group of children and young people. The model recognises that children and young people often come to the service having lived with parental substance misuse for months if not years and have developed protective factors, which lead to resilience. It is important therefore to focus on strengths (i.e. the ability to cope with often difficult and stressful situations) as well as risks.

For further information on the STARS Initiative, please contact:

Joanna Manning, Joanna.Manning@childrensociety.org.uk

The one to one support provided by the Castle project worker is not that worker's main role (which is education in schools) but her links to schools and to the adult substance misuse service mean that she is well placed to receive referrals including for early intervention as well as through treatment services. The support provided by the Health Opportunities team is via a 10-12 week structured programme rather than being open-ended and its aims are not specific to CAPSM rather than alcohol persay. HOT and Castle are mainly available in the East. There is a need to consolidate and co-ordinate specialist one to one support for older young people and improve links across the board.

If specialist youth work posts are developed to focus on substance misuse as recommended in the young people's needs assessment, these practitioners could also be trained to support CAPSM. However, the role and models of working for specialist workers in universal settings, including how children would be referred to or identified by them needs further development (see below) prior to such training being provided.

EADP should identify ways to increase capacity for one to one support for young people affected by parental substance use to give young people a range of support options:

- **Providing greater capacity in one to one support services and ensuring competence in such services on how to work with CAPSM.**
- **Providing greater capacity in youth work to support CAPSM through the specialist substance misuse youth workers recommended in YP Needs Assessment.**
- **Expanding capacity for the provision of individualised specialist CAPSM support to children of primary school age and ensuring that a consistent service is provided across the city. We also recommend that such a service do more to develop links with staff and children in universal services (schools and youth settings) to increase referrals and support for children even where their families are not previously known to services.**
- **Investing in specific specialist CAPSM one to one support across the city for teenagers, that works in partnership with adult treatment services and universal services (such as schools and youth projects). Such a partnership should focus on maintaining interest and awareness in this issue and developing relationships within and with both treatment and universal services to generate appropriate referrals of young people whose parents are in as well as those not in treatment.**

4.5 FUTURE COMMISSIONING

The following recommendations summarises the findings of this chapter in relation to service commissioning, consolidation and co-ordination.

Recommendation 3: There is a need to consolidate and co-ordinate services providing universal, lower-threshold and targeted support to parents, specialist CAPSM family support, targeted support for children and young people including young carer services, and specialist support for children and young people affected by parental substance misuse. This should ensure consistent, city-wide provision for those most in need and will require co-operation across the City of Edinburgh Council and with partner agencies and funders.

5. FINDINGS AND DISCUSSION: SERVICE EFFECTIVENESS AND ACCESSIBILITY

- There are a number of mechanisms which facilitate the goal of reducing the negative impact of parental drug and alcohol use on children and young people including (1) improving parenting and family functioning, (2) improving wider child and family circumstances and (3) improving children's resilience/coping ability.
- Support to reduce harm via all of these mechanisms (as well as services to support reductions in substance misuse or abstinence and recovery) should be available to families where there is harm due to parental substance misuse, whatever the level.
- There is an unhelpful stigma associated with the need for parenting support in general. This means that parents are reluctant to ask for support and staff are reluctant to ask parents about parenting support needs.
- Children and Families (at City of Edinburgh Council) need to take a strategic approach to ensuring that the whole range of services in contact with parents, universal and otherwise, can proactively improve access to parenting support at all levels, prior to any crisis point, and not just when substance misuse or parenting support needs have been disclosed as this is unlikely to happen in many cases.
- Midwives, health visitors and primary care staff, early years and school staff who regularly work with parents; and all staff working with clients in substance misuse treatment services should be able to supportively raise the issue of, raise awareness of, provide support and/or facilitate access to support for effective parenting. The mechanism and specifics of what is needed to achieve this are discussed further in this Chapter.
- Adult treatment and support services (including Tier 2, primary care and self-help groups) should focus on facilitating parents and children to access support in addition to and separate from any work relating to formal child protection. They should discuss parenting in a supportive way on an ongoing basis including specific structured conversations at least annually with all service users in substance misuse treatment who are parents or living with children. This should be considered part of a holistic approach to supporting recovery.
- Treatment and Recovery Services should further explore and develop best practice guidance in how to engage parents in recognising the potential need for and in offering suitable support options to children and young people. Self-help groups need to consider their role in this too.
- Universal services working with children and young people need to continually reflect on how they can do better at creating safe times and spaces where young people in difficult family situations feel comfortable disclosing and discussing their experiences with others to enable them to access support and to come to terms with and move on from those difficulties.
- There is a need for a co-ordinated programme of development of models of practice and associated capacity building for harm reduction in CAPSM. This needs to be specific to a number of different staff groups and to relate to conversations with both parents and young people. It will involve development of models of working, writing associated competency guidance and developing learning opportunities to build competency and will require effort by City of Edinburgh Council, NHS Lothian and partner organisations.

- **Careful planning is needed to ensure that staff from across and within the full range of services that work with children and parents, including universal services such as early years, education and health, social work children and families teams, specialist CAPSM services and adult treatment and support services, have more opportunities to work together and alongside one another similar to approaches such as 'Link-Up' in Angus.**
- **Commissioners, funders and services across Edinburgh should work towards a more consistent and co-ordinated approach to outcome-based monitoring and evaluation and clearer descriptions of models of working/practice in services. In addition, the rollout of actions and initiatives recommended in this report should be thoroughly researched and reported.**
- **There is a need for members of the EADP Executive to consider how it can act as a champion for culture change within large statutory services that work with adults to make them more accessible and responsive to the needs of substance misusing parents. In addition, such services, including City of Edinburgh Council and NHS Lothian, need to consider the accessibility of all their services to vulnerable groups in the context of this issue.**

5.1 TYPES OF HARM & MECHANISMS FOR REDUCING HARM

The overarching focus of this work was to inform the goal of reducing the (negative) impact of parental drug and alcohol use on children and young people. Reducing this impact requires an understanding of the potential impact or harm due to parental substance misuse. This has been documented widely in recent years in both research and strategic literature¹⁴ and at the severe end key harms can arise from issues surrounding:

- Secrecy, denial, distorted realities
- Attachment, separation and loss
- Family functioning, conflict and breakdown
- Fear, violence and abuse
- Role reversal, confusion and caring responsibilities
- Physical, social and emotional neglect.

What constitutes impact on children and young people cannot be easily quantified or defined however, as outlined in Chapter 2 above, and the impact of lower levels of substance misuse may be more subtle but still detrimental to the achievement of the potential of a greater number of children.

The effectiveness of services to reduce harm to children and young people due to parental substance misuse depends on their ability to influence a number of mechanisms including:

- Improving parenting
- Improving other personal or life circumstances (e.g. housing, poverty, employment)

¹⁴ For example: Mitchell, F and Burgess, C (2009). A research review on working with families affected by parental substance misuse. <http://www.sccpn.stir.ac.uk/documents/MitchellBurgess2009PSMResearchReview.pdf>
Scottish Government (2012). Getting Our Priorities Right Consultation paper. See <http://www.scotland.gov.uk/Resource/0039/00396490.pdf>.

- Improving children's resilience/coping
- Reducing or stopping the substance misuse, recovery.

Any one of these mechanisms may reduce harm by itself, or more than one mechanism may be needed to reduce harm. For example, in some cases, interventions to reduce or stop substance misuse may be all that a family need to reduce harm to children. In others, reducing substance use alone may not result in improved outcomes for children, if general life circumstances or parenting are still poor. Conversely outcomes may be improved by improving parenting, or children's coping strategies, even with ongoing substance misuse.

Support to reduce harm via all mechanisms (improving parenting, personal or life circumstances, children's resilience/coping, recovery) should be available to families where there is harm due to parental substance misuse, whatever the level.

This chapter discusses how current services support a goal of improving parenting, and how services support children directly to enhance resilience and coping strategies and how these goals could be better achieved in future. It also considers wider services which have a role in improving the broader circumstances of families affected by parental substance use, and in particular, the need for those services to be more accessible to parents with substance use problems.

5.2 IMPROVING PARENTING & FAMILY FUNCTIONING

All substance misusing parents need support with parenting. This should come as no great surprise, because actually, all parents need support with parenting. This does not mean that they need formal parenting education, but all parents benefit from learning about parenting, thinking about parenting, and considering what parenting strategies and approaches work best for them and their families. Most of this learning, thinking and consideration happens informally, sometimes without parents even realising.

"We are very much trying to normalise parenting support and not have it as something that comes in only in a crisis."

Everyone learns about parenting initially through their own childhood experiences and how they and any siblings were parented (whether by their biological parents, others or the state). Adults learn about parenting through contacts with other parents, both before and after they become parents themselves. For some, this will happen through existing friends and family members. Some will make contact with parents and learn through services such as antenatal parenting classes, or through community groups such as the parent & child groups or 'rhyme time' and myriad of other social opportunities for parents which are available. Some parents will read books or attend local seminars or classes about various childcare topics or about parenting in general.

All of this informal support helps parents with the task of taking on a completely new, often scary, complex and demanding role. These informal networks allow them to find out what is 'normal' or not 'normal' for their baby and others, observe, discuss or learn about ways in which others deal with challenges and stresses, build confidence in their parenting ability and ultimately enjoy their parenting role more. Despite the normality of this learning process, the individual nature of parenting, the vilification of 'bad parents' in society generally, and a pervasive fear of state intervention among some sectors, have contributed to an overriding sense of stigma associated with a parent 'admitting' that they are struggling, unhappy or need help with their parenting role.

“if I say the wrong thing these people, they are going to take my kids off me...so people have constantly got that fear in their head when they’re talking to the services and stuff.

Father of 1 secondary school aged child

Normal challenges and stresses associated with different stages of parenting (pregnancy, newborn, toddlers, early years, primary school, teenage years etc.) can both result in, and be worsened by increasing levels of substance misuse. Unfortunately, few services are proactive about helping parents to access support, unless a crisis point is reached. As a result, if parents are not linked into such informal networks already, and do not know about or are unable to use more formal support services it will likely be difficult for them to access support when they need it.

“I don’t think parents take full advantage of what is out there. I mean there can always be more but I don’t think there’s any point in having more. I think it about spreading awareness for adults to know what services are there and what they can use. So, a wee bit more advertising would help”

Father of 1 pre-school, 2 primary school, and 2 secondary school aged children

“From my own experiences of the services...everything’s temporary and it’s only for short periods of time...when you start to engage with a service you go in there with a set of problems. At the end of it you’re back in the same situation with the same problems”

Father of 1 secondary school aged child

If appropriate support with parenting, informal or otherwise, is available to all parents, early problems could be resolved thus potentially preventing either an increase in the substance misuse, greater harm to children through ineffective parenting, or both.

Recommendation 4: Children and Families (at City of Edinburgh Council) need to take a strategic approach to ensuring that the whole range of services in contact with parents, universal and otherwise, can proactively improve access to parenting support at all levels, prior to any crisis point, and not just when substance misuse or parenting support needs have been disclosed as this is unlikely to happen in many cases.

5.2.1 HOW SERVICES CURRENTLY IDENTIFY PARENTING SUPPORT NEEDS

We found that there are a number of barriers currently to ensuring that parents who misuse substances at all levels are supported with parenting:

- There is a stigma and fear associated with asking for parenting support.
- Most substance misuse by parents is hidden from services.
- Many parents may not recognise by themselves when they could benefit from help.
- Professionals are perhaps better at focusing on child protection than on early identification of parenting support needs.

The ways in which parents with varying degrees of substance misuse issues may currently be identified and supported with parenting breaks down as follows:

For parents with less severe substance misuse problems, for example of a nature that can be addressed by a brief intervention or by the person taking action of their own accord, the substance

misuse is unlikely to be disclosed to services, perhaps ever, or at least until such time as the parent needs and wishes to get help in addressing their usage. Unless there were concerns about children for another reason, or parents asked for help with parenting, professionals would be unlikely to ask about whether parents needed support. This is largely due to a sense that there is a stigma associated with asking parents about parenting and that parents would be likely to take offence.

“Needs some finesse to do it (ask about parenting needs). Everybody thinks they do okay. They are doing their best.” Treatment participant.

If parents were to seek help for this level of substance misuse, the most appropriate sources of help would be universal services such as primary care professionals or online/informal sources of advice. Such professionals were felt to be unlikely to discuss parenting support needs for lower levels of substance use, despite a clear sense that even low or controlled levels of substance use could be impacting on parenting.

*“Definitely some of our parents are smoking a lot of cannabis. It has to have a detrimental effect on parenting...”*Treatment participant.

“Making people aware of the little things that really do matter. We get some parents saying that they smoke cannabis ‘but I only do it at night time when the kids are in bed’ and its about pulling that out and saying okay how do you know that...you’re compos mentis if your child tries to wake you up during the night.” Treatment participant.

In addition, the pressures and responsibilities of parenting itself, without adequate support, could lead to an increase in the level of substance misuse and greater impact on children.

“The parents themselves haven’t done well at school. [when their children are] at primary school age they manage, but when school work becomes more challenging...the parents find it very difficult to support their children at that stage.” Treatment participant

For parents with moderate substance misuse problems, however defined, it is worth remembering that the level of problem does not necessarily correlate with the impact on children. It was acknowledged that the majority of these parents will be hidden to services, particularly where they are misusing alcohol or cannabis.

“Out there alcohol blows drugs out of the water”

“If parent acknowledged this is a problem - it would be down to them to think they have a problem...with IV drug use - it can't be hidden as much but a lot of alcohol and cannabis misuse is hidden.”

“Its hard to identify lower levels of alcohol misuse”

Substance use at this level will definitely make effective parenting more difficult, and while it cannot be assumed that children are in need or at risk, it is likely that parenting is not optimal.

“In terms of the children of people on methadone [they] may not have [child protection] problems as such but [parenting] is not as good as it could be.” Treatment participant

For parents with severe substance misuse problems, it cannot be assumed that drug dependency automatically means that children are at risk, but it undoubtedly poses an additional challenge in what some would say is the already challenging role of being a parent. The associated stigma and

potential impact on lifestyle can also make it more difficult to access universal services (see Section 5.6).

Parents with moderate to severe substance misuse problems who are in contact with treatment services will currently be asked about what children they have. There was an overriding sense from descriptions and examples of assessment processes for such adults that the focus of questions for parents is on ensuring the welfare of children, with less focus on helping parents to understand what constitutes effective parenting. Although this is of concern, it is worth highlighting the extent to which treatment agencies have improved their focus on child protection issues in recent years.

“From the very beginning, we identify service users who have children. At referral stage, they are asked if there is any social work involvement. We don't ask if they are a parent but if they have any responsibilities to children for instance partner's children and wider family. At the next stage of assessment, we quite thoroughly go through two full pages on children and family involvement; children's names, what school they go to, where do they live during week, any other carers, social work involvement and if so why, are they on child protection register, do children know parent has substance misuse problem. This ensures we have a good amount of baseline info in case we need to make a call to social work directorate.”

[We developed a] children's screening form...came up with 4 pages of interrogating you about any contact with children at all - We've been doing that for 7/8 years now: 'Do you have people to help? Where are your strengths and weaknesses? Would you want referred on?'

“We obviously only go with what they tell us, until such times that suspicions arise for us.”

It should not be forgotten that there is another group of parents, who do not have a current substance misuse problem, but who may be in recovery. They may or may not have received treatment, support from a self-help organisation or support with parenting in the past, but they could be considered more vulnerable to future problems in the event of a partial or full relapse. Some may still be in contact with specialist services, but others may not and so the role of universal services becomes vital.

The primary focus of treatment services in assessments with parents is on child protection and less on parenting support. This is clearly illustrated by the answers received to questions about what guides their intervention with parents. All responded that they follow child protection guidelines and most also mentioned the GIRFEC framework. Few talked about models of intervention where child protection was not an issue, or long prior to any risk of it becoming an issue. The focus and language is often, though not exclusively, on 'management of risks' rather than on supporting effective parenting.

“Before, we panicked when it was child protection. Now we are much better at putting in a multi-agency package for amber risks.”

“We use the orange book and GIRFEC.”

Adult services reported asking detailed questions about children and home circumstances, but they did not routinely discuss or offer parenting support, unless parents raised an issue or they became concerned about the welfare of a child i.e. a child protection issue. This meant that parenting

support was only discussed and accessed at a late stage in terms of family problems often at a crisis point.

“Drug and alcohol agencies are not good at identifying who are parents and who are not. Even if they do, they are not good at identifying when people might benefit from family support. They are good at identifying when things are not good enough and become child protection and refer to social work...but its too late.”

“it didn’t matter because I was so chaotic. But if they had worked with me through that I would probably have my bairn now”

Mother of 1 primary and 1 secondary school aged child

This was also reflected in the low level of early referrals reported by specialist family support services.

“We would like the referrals much earlier so we could do more pro-active, preventative work earlier on.” Family support participant.

The lack of early intervention is highlighted as a major gap in the literature.

“Children and families may remain invisible to services until a point at which circumstances have reached a crisis point. Interventions with children of drug and alcohol using parents come too late, that is once matters have reached a child protection, rather than a family support of child ‘in need’ level (Nagle and Watson, 2008).

Kearney et al., (2000), found the focus was often on children at risk rather than in need, with limited overall family welfare. Allowing time and space to assist parents to deal with issues in their lives can appear incompatible with meeting the immediate needs of children.”¹⁵

While the research literature is clear on the need for early intervention, the guidance available is generally focused on early intervention when child protection concerns have been raised, rather than intervention with families as normal even in the absence of acute or chronic concern.

5.2.2 MAKING PARENTING SUPPORT CONVERSATIONS THE NORM

Large proportions of the population are drinking alcohol and using substances at levels that may impact on parenting but which are hidden from services. In order to provide parenting support to these groups, it is necessary to empower all parents to explore and identify what support they may need. This requires a culture change in terms of how parenting support is conceptualised and conversations about parenting support are carried out.

“In first few weeks and few months we would screen mothers for post natal depression - and that tool may alert that there are parenting issues but not aware of anything with questions targeted on parenting... It might help to have a questionnaire to identify parenting support needs.” Primary care participant.

¹⁵Mitchell, F and Burgess, C (2009).A research review on working with families affected by parental substance misuse. <http://www.sccpn.stir.ac.uk/documents/MitchellBurgess2009PSMRResearchReview.pdf>

Discussing effective parenting is important, as it can be an issue where ‘you don’t know what you don’t know’. Without informal parent support networks, and particularly if their own experiences of parenting were poor, many vulnerable parents may not ever have thought about what it means to be a good parent or they may have an unrealistically idealised view of parenting and children.

Following such a discussion, some parents may be able to improve parenting without further support, may recognise as parenting problems issues that they previously thought of as normal or inevitable, or may want additional support.

Midwives, health visitors and primary care staff, early years and school staff, who regularly work with parents; and all staff working with clients in substance misuse treatment services should be able to supportively raise the issue of, raise awareness of, provide support and/or facilitate access to support for effective parenting.

This section discusses the mechanisms of these conversations in more detail and related capacity building issues are discussed in the next section.

This could be done as part of a ‘Help for Parents & Carers’ or ‘Parenting Support’ discussion – a kind of ‘brief intervention’ for parenting. Similar to the alcohol brief intervention initiative (also focused on encouraging frontline staff to discuss a sensitive issue), this discussion could be seen to involve stages including raising the issue, raising awareness and signposting if needed.

City of Edinburgh Council, in collaboration with NHS Lothian, should lead on the development of ‘parenting support’ conversations to reflect the most appropriate, acceptable and effective way to cover the necessary issues in different settings.

In order to reduce the stigma associated with needing or seeking support with parenting, it is vital that *raising the issue* with parents become the norm. However it is not as simple as asking ‘do you need any support with parenting?’ We like the sound of the approach suggested in the following quote.

“It’s about the language – it needs to be part of what we are constantly offering – a regular thing. Ask ‘what do you think is good parenting? How do you get on with the kids?’. If it’s not a regular thing, if people are not thinking about it, they won’t do it.”

The focus of raising the issue could also be around ‘where do you get support with parenting?’ rather than ‘do you need support?’ as it should be seen as the norm that all parents need support (from someone or somewhere). Another suggestion for parents of older children was to raise the issue from the point of view of ‘everybody wants to help their kids’.

The second aspect suggested for these conversations, *raising awareness*, could simply raise some issues seen as the broad principles of effective parenting (attachment, boundaries, consistency, routine etc.) and help parents to recognise in very simple ways how children can react when this is lacking. This is particularly important for more vulnerable parents or those with more severe substance misuse problems, (whether this is known to services or not), where the evidence suggests they are slow to recognise the impact of their substance misuse on their children. Like parents, staff too may struggle to articulate key messages about effective parenting without some support. There is therefore a need to source or develop clear messages about these broad principles, perhaps in the form of a leaflet or tip-sheet. This kind of information already exists in some formats used by proprietary parenting education programmes e.g. Triple P.

City of Edinburgh Council, in collaboration with NHS Lothian, should develop accessible, consistent, simple guidance describing the core principles of effective parenting for staff and parents to enable a common language and understanding to be developed.

The third aspect of a 'brief parenting intervention' would be *signposting*. Of course, not all parents need to get support from specialist services, but consideration of where they are able to find support is important. This applies whether from peers, family, community groups, parenting education etc. or any specialist support for parents experiencing greater challenges. The development of a clear directory of services for parenting support and the improvement of the range and accessibility of community/peer-led support for parents are important here.

Although most will not need it, it stands to reason that if more conversations about parenting support are happening, more parents will seek formal support than currently do, and there is a risk that supports currently available will be swamped by parents who are less vulnerable. There is a need to protect capacity in such services for those parents who need them most by careful and appropriate signposting by frontline practitioners and place allocation by service providers.

All parents could be made more aware of the range of supports available to them, and how they can access them. Consideration needs to be given to how any support or promotional materials for parents can be produced in formats which are accessible to all, with a particular focus on accessibility for more vulnerable parents including those with low literacy levels. Online and mobile media should be considered along with traditional leaflets and posters. Other work through community venues such as libraries etc. which is already being carried out by parenting staff in Edinburgh may also be effective in reaching those who are not otherwise in contact with services, though this should be investigated further.

Changing Routine Practice

Lessons from research into the implementation of innovations in healthcare, as well as from the rollout of the alcohol brief intervention initiative would suggest that a range of supports would be needed over a long period to make these parenting conversations part of routine practice.

With appropriate support, the parenting support team at City of Edinburgh Council, should develop a strategic medium to long-term plan to make discussions of parenting part of routine practice, taking into account learning from implementation science¹⁶. This will require action from and partnership working across and outwith the Council.

5.2.3 CAPACITY BUILDING AND SUPPORT FOR STAFF

Conversations about parenting support are already being carried out by some staff, especially in the early years, however, it is clear from both the service user consultation and the comments of some practitioners that such conversations are much less likely to happen as children get to school-age and older.

In addition, the focus and effectiveness of such conversations will be influenced by how the practitioner presents the issue, their understanding of some basic principles of effective parenting

¹⁶Damshroder LJ et al. (2009). Fostering implementation of health services research findings into practice: a consolidated framework for advancing implementation science. *Implementation Science* 2009; 4:50.

and their ability to discuss and signpost people to the full range of parenting support options however informal or formal as appropriate to their needs.

While midwives and health visitors will already have a high level of knowledge in relation to some aspects of parenting, evidence would suggest that any change in practice will require continuous strategic effort and advocacy. Clear guidance will also still be important.

In other settings, such as schools, delivery of these conversations will require significant investment in time and effort to ensure relevant staff understand, and are able and motivated to have these conversations. This may best be achieved by considering how to pool budgets across teams/services as this is very relevant to the other agendas including increasing co-operation between parents and schools generally, reducing inequalities, and Edinburgh's parenting strategy. Others such as early years staff and community workers will also require support.

City of Edinburgh Council, NHS Lothian and partners should consider how best to support staff from different settings to initiate and conduct parenting support conversations with all parents including those known to have or who disclose substance misuse problems and to provide appropriate guidance and learning opportunities.

Across all services, particular support is likely to be needed in relation to conducting these conversations with parents who are known to have, or who disclose substance misuse issues, and in tackling the associated stigma of substance misuse. It is vital that staff in universal services can understand, empathise and work effectively with such parents in ways that do not make parents feel excluded or judged. Some respondents noted that there is a range of training already available,

"I am really keen that people have a basic understanding of drugs and alcohol and the effects that it will have on a parent and how a parent might present under the influence of different drugs. So if they were dropping off a child into the child care facility, we should know what to be looking for and how do we support these parents and what effect does it have on the child. There is lots of training out there."

It is our view that such training focuses mainly on awareness raising, and not on what practitioners should actually do differently. It is also not usually tailored to the various different staff groups or specifically focused on what changes in practice are necessary to reduce stigma and increase support. Also, there is a sense that many staff groups are not accessing the training that is already there as training for staff on working with children and families affected by parental substance misuse was mentioned as necessary by managers of a wide range of staff groups. These included Child and Adolescent Mental Health Services, Child and Family Centres, Children and Families Social Work, Early Years and Youth Services.

"Gap for specific issue but they do deal with it on a daily basis, and learn from other professionals, but not specific training – don't think any would have done much except child protection training."

"There is still a great need for training in substance misuse for Children and Family Centres... In terms of training nursery workers, social workers and early years workers need to look at the more problematic issues of substance misuse and that training is greatly needed in Edinburgh...What happens when you hide substance misuse; what to look out for; how addiction behaviour impacts on parenting behaviour; all that needs to be tied up in more training."

“I think for a lot of health visiting colleagues, its probably no different to colleagues in education etc. The problem is where parents are not admitting it but it is impacting on their parenting: identification of lower level issues. If it is identified - do people know how to respond? I think they might be concerned about opening a can of worms. What supports are available for them to direct the parents to? Are there support services out there for that?”

In developing such training, thought should also be given to what aspects of specialist services including family support and parenting education could be delivered effectively (and potentially cost-effectively) to a greater number of parents should adequate support be provided to staff in universal services such as early years. Such services could conceivably work effectively with parents who are recovering well from a substance misuse problem and ready to move away from needing specialist support or with parents with less severe substance misuse issues.

This process would require collaboration between senior practitioners in specialist and universal services to develop a model of working, an associated competency framework and a plan for transforming services and practices including training. This is therefore a 3 pronged approach – what should they be doing differently, what do they need to know and be able to do to implement that, and what educational approaches can give them that knowledge and skills? As well as training, this effort will be assisted by developing strong links between these staff and those working in adult treatment/support services. This is discussed further in detail in Section 5.4 below.

City of Edinburgh Children and Families Services and NHS Lothian need to develop models of working and associated training and learning for staff in universal services such as early years, health, youth services and education to enable them to better understand, work with and provide or facilitate access to appropriate support to parents in recovery or those with less severe substance misuse problems, including in pregnancy, reducing the need for such parents to be referred to specialist services (including child and family centres).

This is one of a number of related findings relating to capacity building which are summarised in Recommendation 7 below.

5.2.4 CONVERSATIONS ABOUT PARENTING SUPPORT IN ADULT TREATMENT SERVICES

Supporting parenting skills is very much in keeping with the recovery focus which Scottish treatment services are seeking to deliver. Parents who misuse substances struggle with feelings of guilt around how their substance misuse affects their children, and recovery can be complicated when a child who was previously the main carer for his/her family, suddenly loses that responsibility.

“If people can manage to get clean and sober, just help with parenting skills because you have to learn it all from the beginning”

Mother of 1 primary and 1 secondary school aged child

Recovery-focused work acknowledges the whole person and so inputs to support parenting should be seen not only as a way to reduce harm to children but also as a key aspect of helping the adult to recover. This is acknowledged by work done in one service:

“We never see the individual’s children. We don’t do direct parenting support although there was a specific group that we used to do on parenting skills and the reason we had to pull it

out of the main framework of groups was because not everybody we work with is a parent. We now offer parenting skills as a 1:1 resource.”

As noted above, current discussions with parents in substance misuse services focus on management of risk. While this is obviously hugely important, the language and culture of risk management is quite different to what would be expected where early intervention to support parenting is the goal. We would argue that risk management and parenting support conversations do not sit well together in that if parents feel practitioners are focused on risks, they are less likely to discuss aspects where they are struggling to cope or finding it difficult. This is borne out by the secrecy and lack of co-operation that professionals sometimes report from parents in trying to support children.

We would suggest that holistic assessment tools similar to the ‘My World Triangle’ tool should be used with adults in the Recovery Hubs and returned to at regular intervals throughout an individual’s recovery journey. Recovery is about a person’s whole life, and so assessment should be holistic. If this is achieved, then discussion of parenting ability, support, capacity, skills, feelings, should then follow as part of the normal recovery process.

Where parents are receiving support with substance misuse, an important part of the parenting conversation would be to ensure that they are also made aware of and encouraged to facilitate access to support for their children. This is discussed further in Section 5.3.1 below about providing direct support to children and young people.

Recommendation 5: All adult treatment and support services (including Tier 2, primary care and self-help groups) should focus on facilitating parents and children to access support in addition to and separate from any work relating to formal child protection. They should discuss parenting in a supportive way on an ongoing basis including specific structured conversations (as described in Section 5.2.2.) at least annually with all service users in substance misuse treatment who are parents or living with children as part of a holistic approach to supporting recovery.

This will be most likely to happen through a combination of a greater focus on parenting in conversations with service users, earlier referrals, more in-house expertise and closer co-operation with children’s services.

This development may benefit from broader efforts to make assessments in adult services more holistic, e.g. using a My World Triangle approach with adults, and it is felt that this has synergy with the concept of recovery-focused services generally.

We recognise that services have come a long way in improving child protection procedures and that many already work well with specialist providers of parenting support for substance misusing parents. As with other staff groups however, there is a need for treatment services to be more aware of the wide range of parenting support and child support services that are available, not just these specialists.

There needs to be a shift in culture in treatment services too so that conversations about and access to parenting support become more normal. Part of this may be getting across to substance misusing parents that practitioners may actually be more worried about the children of a parent who says they do not need any support, than that of a parent who can recognise where they are struggling and access the necessary help. This may encourage more openness from parents.

Undoubtedly, there will be workers who feel that they are already having these kinds of conversations in very supportive ways, and we welcome that. We would like to see more of it and happening regularly e.g. at least annually, with all service users who are in treatment including those who are in treatment in primary care, or community services.

"I think one of the best things we do is educate service users to know that it's a really important step, it actually supports them as well, it's not just about the children but of course foremost it's about the children but it's about making sure they feel good at being a parent, that they know how to access support if they are struggling. It about making them realise we are not here to criticise, we here to help and support the needs of them and the child. Highlighting that their practices can be harmful to children because sometimes they can be completely oblivious because it is their culture/lifestyle and all they have ever known. They don't see it as a big problem and wonder why professionals tell them to stop. We are good at clarifying why we talk about these things."

The literature is clear that the divide between adult and children's services is unhelpful in changing culture to focus more on parents, children and families, not just individual clients, and that closer integration and joint working would be helpful in this regard. Our work indicates that there is still a significant level of discomfort in adult treatment services with movement towards this change in emphasis:

"We don't provide services for children because we are an adult service really, so how far do you go, do you have to be everything to everybody? There are, I am saying adequate, but I don't know if they are adequate, there are children's services in the area and I would rather my workers worked in partnership with people who have been trained in working with children and with children's issues and have the experience and the network and contacts round about them to get the support for the children and the family that they require.. Rather than trying to be everything."

"Working with children is not within our remit as an adult treatment provider. It starts muddying the waters."

"I spoke with the operations manager a few weeks ago and they had discussions at head office about providing services for children and families and they said very clearly no that [named treatment provider] were not going to provide any services for children. They looked into it and realised there was a whole minefield."

Despite this reluctance, some workers within adult treatment services acknowledged that there is a level of need in relation to working with families as a whole and with young people but that staff would need a greater level of support and training to meet that need. Training is currently focused on child protection, rather than on how to work with families. The following quotes contradict some of the above resistance.

"That's very much a gap [training in family support]. That whole families thing. When we work with service users, we have often worked with generations and we have seen the lack of progress - no changes, 3 generations are presenting the same problem...A family intervention where there is time invested into that...the dividends that would come from that would be great."

“I think its because it is not a main part of the job working with families. I think working with parents, most of us have been on the child protection and advanced child protection training so we are very aware of our responsibilities and how that operates for our on specific responsibilities. But actual family based stuff, you get a lot of service users coming in who have issues with their parents, their children as a family as a whole because the substance misuse has really torn the family apart and I don't think we are trained. Probably because we don't have mum, dad, brother, sister there at one time.”

We agree that more training and support is needed to build the expertise of addiction workers on how to take a family focused approach to work, however, we would not wish to see them becoming providers of direct support to families, children or with parenting persay.

5.3 SUPPORT FOR CHILDREN AND YOUNG PEOPLE

While it is clear that there are large numbers of children and young people (locally, nationally and UK wide) affected by parental substance misuse who are in need of support, there was almost universal acknowledgement of how difficult it is to identify and engage them. These difficulties vary depending on whether their parents are in treatment of some kind or not.

All services reported that children and young people were often reluctant to disclose parental substance misuse unless they had a good enough relationship with an adult to feel sufficiently comfortable to do so. This reluctance is based on a wide range of fears for children and young people including:

- Fear of feeling different, judged, labelled.
- Fear of loss of anonymity – the ability to just be ‘normal’ outside of the home – if for example school staff find out.
- Fear of statutory intervention, being taken into care.
- Sense of shame, guilt, letting a parent down, getting a parent into trouble by disclosing.

This was illustrated by one parent from his own experiences as the child of a substance using parent:

“I was scared to be honest because they people in front of me, social workers and all of that, they had the power to take me away from my family. So I wasn't going to tell them how I really felt or what was happening, what was going on inside my head. Just for the fear that I would say the wrong thing and make things worse”

Father of 1 secondary school aged child

Recommendation 6: Universal services working with children and young people need to continually reflect on how they can do better at creating safe times and spaces where young people in difficult family situations feel comfortable disclosing and discussing their experiences with others to enable them to access support and to come to terms with and move on from those difficulties.

5.3.1 SUPPORTING CHILDREN WHERE THEIR PARENTS ARE KNOWN TO SERVICES

Treatment services, including primary care services, Tier 2 counselling services and self-help groups, as well as other services such as mental health services, where parental substance misuse may be

known or disclosed, have a responsibility to build parental awareness that their children may benefit from support. Whilst this is a sensitive and sometimes difficult area, where the needs of children may not be acknowledged by parents, the responsibility of such service providers for the wellbeing of children cannot be ignored.

Treatment and Recovery Services should further explore and develop best practice guidance in how to engage parents in recognising the potential need for and in offering suitable support options to children and young people.

There is a need to consider the ethical problem of whether and how children should/could be offered support, if parents do not acknowledge the potential for harm, or if they insist that children are unaware or unaffected by their problems. There is a conflict here between ensuring confidentiality for parents and exploring children's need for support.

Some parents in treatment reported positive experiences of workers engaging their children in support:

"[The worker] goes to my oldest school once a week and takes her for an hour and work with her just to get things off her chest"

Father of 1 pre-school, 2 primary and 2 secondary school aged children

This ethical dilemma also applies to the role of other members, facilitators or sponsors when parents are attending self-help groups. Clearly anonymity and a peer-support rather than 'advice giving' philosophy is central to the success of such groups, however that should not preclude efforts to safeguard the wellbeing of the children of group members, over and above any child protection procedures.

Representatives of self-help groups operating in Edinburgh should consider how they can work with partner organisations to ensure that such children are being identified and offered support.

The young person's worker in the Castle (adult drug treatment) project in Edinburgh, provides one to one support to young people, and receives referrals through the education work being conducted in schools as well as directly from the project. Despite reservations about young people accessing support from an adult project, we do see an advantage to having staff with a remit to support young adults (e.g. teenagers) co-located with adult services. Such staff would not necessarily need to be employed by the adult treatment agency and the contact with young people should happen in their own communities or youth services and not in the adult service base.

There is currently insufficient capacity within one to one support services specifically for young people affected by parental substance misuse to meet need. Locating staff with a remit to support young people, at least partly within adult services, is in line with earlier recommendations about interdisciplinary working. If done along with guidance/training for addiction workers on conversations on parenting and child support, this could mean that more young people are given the opportunity to receive specialist one to one support.

Staff providing specialist one to one support specifically for children and young people affected by parental substance misuse should have very strong links with adult treatment services, including

some co-location¹⁷, although the support provided to young people should be done in the community (not in the adult service base). Close links are also needed with universal services.

There is a particular opportunity to support some young people (whose parents may or may not be in treatment), by the development of capacity via the self-help community. This was discussed Section 4.3.4 above.

5.3.2 SUPPORTING CHILDREN WHERE THEIR PARENTS ARE NOT IN SERVICES

“....it seems fair to suggest that as adults we have not yet created an environment that encourages children to talk openly to us about things that really bother them.....when we don't listen to children it is not only that we fail to take on board information, feelings or experiences that the child wishes to communicate, but also that our lack of attention impacts on that child's sense of self-worth, their ability to trust, their sense of safety, their connection to themselves and their connection to reality, and leaves children more vulnerable to abuse and neglect”¹⁸

As suggested by this quote, and by the prevalence figures presented in Chapter 3, services working with children are currently failing to identify many who are living with parental substance misuse at a variety of levels.

There are examples nationally of projects, such as STARS (see case study on page 39) that have been successful in identifying and supporting young people, even where parents were not in any form of treatment, and from families who were not previously known to services. It appears that they did so by developing relationships and reputation in schools over a long period of time, by being visible and consistent and also by providing training and support to teachers so that both staff and children felt comfortable accessing the service. There is no equivalent service in Edinburgh currently.

Some of the aspects identified in this review as helping and hindering with this identification effort are as follows:

- The development of one to one counselling services such as Place 2 Be within schools could offer a safe place for young people to disclose parental substance misuse. However it is worth noting that even with the STARS projects noted above, most of the caseloads came from referrals generated through building staff awareness rather than through self-referral.
- The demise of the role of the school nurse as a consistent and well-known face within schools due to other work pressures removes one avenue that could have been used to support these children and young people. School nurses are highly trained but their role in this work was relatively limited in the past.
- Staff do not currently feel comfortable raising the issue of parental substance misuse either with parents (e.g. in early years as well as schools), or with children and young people (e.g. in schools)

¹⁷ In referring to 'co-location', we mean co-location of individual staff so that they are working directly alongside other professionals, rather than co-location of services. Services sharing a building is not necessarily the solution, which could be simpler e.g. staff being able to work at adjacent desks from time to time.

¹⁸Robinson, 2008.Children – Not Seen and Not Heard. *New Directions in the Study of Alcohol Group Journal*. p14-15

and youth services). There is little or no support or guidance for them in how best to do this and what conversations to have with parents or young people should they have suspicions or knowledge that this is an issue. Unless it becomes more normal that this is talked about however, the stigma surrounding disclosing it will remain.

This was highlighted by parents as an issue.

“You get shunned from teachers and stuff if you are a drug addict because they don’t understand”

Mother of 1 primary and 1 secondary school aged child.

The need for development work and training relating to supporting parents in universal services has been noted earlier (Section 5.2)

In many respects the findings here reflect not a local gap but a general gap in literature on models of practice in discussing this issue in universal services. We were unable to find in published or grey literature or in speaking with practitioners any current guidance on what conversations a youth worker or guidance teacher for example should be having with young people who may be experiencing difficulties with parental substance misuse. There was a similar gap in relation to a more general conversation focusing on child support with any aspect of parenting difficulty. It would be useful to be able to support staff to raise the issue of parenting and explore young people’s understanding of what is normal, what informal supports might help, and what is available for them if they want more specific, peer or structured support.

Children and Families at City of Edinburgh Council should develop models of practice on how staff in universal services (including youth services and education) seek to identify, talk to, provide support to or facilitate access to support for children and young people affected by parental substance misuse.

This finding can be summarised along with previous ones relating to development of models of working and capacity building into a single recommendation:

Recommendation 7: There is a need for a co-ordinated programme of development of models of practice and associated capacity building for harm reduction in CAPSM. This needs to be specific to a number of different staff groups and to relate to conversations with both parents and young people. It will involve development of models of working, writing associated competency guidance and developing learning opportunities to build competency and will require effort by City of Edinburgh Council, NHS Lothian and partner organisations.

One of the key aspects preventing disclosure (as noted above) is fear on the part of children and young people of what will happen to their family. This could possibly be helped if schools were better supported to openly discuss parental substance misuse as part of health and wellbeing education including what supports are available for parents and children. Social services may have a supporting role to play here, working in partnership with schools to emphasise that services want to keep children with their parents while improving things for them, dispelling the notion that children will be instantly removed whatever the difficulty, and emphasising how important it is that children and parents seek help – signposting to what help is available etc.

5.4 INTER-DISCIPLINARY WORKING

Greater collaboration and co-ordination between adult oriented and child-oriented services, is recommended by the literature.

“Taylor and Kroll (2004) argue that the potential for cross-over posts needs to be developed, where drug or alcohol specialists are attached to family centres or children and family teams or where family centre workers are placed in drug and alcohol settings. They suggest that this type of response helps to break down interprofessional barriers, provide specialist consultation and intervention and contribute to a more rounded response to people’s problems. Nagle and Watson (2008) argue that the placement of a health visitor and child social worker within an adult treatment service and their work on raising the profile of ‘hidden harm’ to children, modelling effective practice and partnership working has shifted the culture of treatment services, children’s social care and universal health services in a number of positive ways. They see treatment services as moving towards focusing on family rather than individuals only”¹⁹

We are aware that a family support worker is now working with one of the Recovery Hubs in Edinburgh and that there is also a young person’s worker within the Castle project. Such links should be evaluated, developed and built on. The Hub example may work well, it will be interesting to see how many clients are ready to get family support at the initial assessment stage, but at least they will know the service exists. The Castle project example is one where adult drug services are provided by the project, but a young person’s worker also offers education inputs and one to one counselling for young people. We welcome these kinds of collaboration, although care should be taken to avoid exposing young people to other substance misusing adults and further normalisation of substance use e.g. by meeting and engaging with young people in community venues.

Co-operation between adult and child services can be facilitated through other means as suggested in the literature:

“Murphy and Ould (2000) suggest it is important for practitioners and managers to have positive contact with staff from the ‘other system’. This could be achieved through mutual ‘shadowing’, attending team meetings or by having inter-team meetings, or by establishing a special interest group or practitioner exchange forum.

Kroll and Taylor (2008) propose the formation of family focused practitioner discussion forums as part of a model of good practice. Joint training events offer an opportunity to bring different practitioners together to explore the other system and the cross-over between the two systems. Involving staff from both agencies as participants and facilitators in the training can help to ensure it balances the perspectives and needs of the two systems (Murphy and Oulds, 2000).

Green et al (2008) suggest that additional resources may be needed to allow time and space for practitioners to foster trust between professional groups and agencies, by attending each other’s team meetings for example.”⁹

¹⁹In Mitchell, F and Burgess, C (2009, p61).A research review on working with families affected by parental substance misuse. <http://www.sccpn.stir.ac.uk/documents/MitchellBurgess2009PSMResearchReview.pdf>

Joint working between professionals working with children and adults across both universal and specialist services at all levels from leadership to frontline practitioners was a key part of the Link-Up approach to supporting CAPSM taken by the Angus Learning Partnership.²⁰ As part of this initiative, professionals that had not traditionally worked together, for example practitioners in substance misuse services and teachers met and focused on a shared agenda.

They found a number of benefits from bringing together the full range of professionals including:

- *“Increased consistency amongst practitioners in adult services in identifying CAPSM and asking questions about parenting.*
- *Practitioners in universal services had a greater awareness of parental substance misuse.*
- *Services are now more family focused and better co-ordinated, taking account of the needs of adults and children.”*

However, they also cautioned that:

- *There is a need to pay attention to the quality of collaboration between professionals within the same agencies (e.g. GPs and health visitors) as well as inter-agency collaboration.”*

As found in the Link Up project, improved collaboration is therefore not only about enhancing the ability of treatment services to pick up on parenting support issues. It is, as noted in Section 5.2.3 above, also about increasing the ability of universal services to understand and work constructively with parents and families with substance misuse problems.

Recommendation 8: Careful planning is needed to ensure that staff from across and within the full range of services that work with children and parents, including universal services such as early years, education and health, social work children and families teams, specialist CAPSM services and adult treatment and support services, have more opportunities to work together and alongside one another similar to approaches such as ‘Link Up’ in Angus.

As suggested in the literature, shadowing, joint team meetings, part-time co-location and so on should be considered to facilitate a genuine chance for staff to see and understand the practice and priorities of other professionals.

5.5 MODELS OF WORKING AND OUTCOME EVALUATION

5.5.1 PARENT AND FAMILY ORIENTED SERVICES

It has been acknowledged recently that there is very little clear evidence on what models of working or intervention are most effective in supporting families affected by parental substance misuse. The literature and evidence is largely focused on working with children at risk, rather than children in need. The most recent review of evidence on parental alcohol misuse concluded²¹:

²⁰ Kosonen, M, (2011). Angus Learning Partnership for children affected by parental substance misuse (CAPSM). A summary report.

²¹ Adamson & Templeton (2012). Silent Voices. Supporting children and young people affected by parental alcohol misuse. Office of the Children’s Commissioner (England).

“There is evidence of a range of ways that children, parents and families seem to benefit from services and interventions. However there is a need to consider the potential longer-term benefits of such support, to include comparison with control groups and to assess cost-effectiveness.”

Perhaps because of, or in addition to the lack of evidence, services in Edinburgh are not currently able to articulate clearly what model or approach they are using, if any. Although the Solihull parenting approach was mentioned by some participants, it was clear that in general, practice is specific to individual workers, their professional experience and views about what works. This was best described by one participant in this needs assessment as follows:

“Various workers come with their own toolkit. We have people who will create their own format or framework. Some will rely on Positive Parenting materials and workbooks. For some families and workers this provides a good structure. Get these for all age ranges and all problem areas. People are varied in experience and know themselves what works.”

Thus it is possible that the effectiveness or ineffectiveness of services can be attributed to individual workers and their ways of working, personal characteristics etc., rather than to any particular model. This was also noted by Adamson and Templeton.¹¹

“It is unclear whether the potential benefits of services are driven by a particular model or intervention or if it is the characteristics of the support, and the relationships between children, families and workers which guide change.”

One of the issues that further complicates the picture, is that there is no consistency in the ways in which services define, agree, measure and report on the outcomes of their service for the families involved. (This applied across the board, not just to family support services – and will be discussed below in relation to children and young people). Wellbeing measures such as the SHANARRI indicators (‘safe, healthy, achieving, nurtured, active, respected, responsible, included’) were mentioned along with a range of in-house evaluation forms, a confidence scale and a ‘distance travelled’ model. It is impossible for commissioners to explore whether one worker or one service was having more success than another, and why that might be. In addition, there was little sense that services were exploring outcomes between workers, to get a sense of whether one worker was having better outcomes than another and why that might be.

Of course, care would need to be taken with such data to avoid knee-jerk reactions, as workers and services will be working with different families, but nonetheless a tighter approach to outcome-based evaluation in commissioning and monitoring services would contribute to answering some of the questions that are outstanding in the literature. The discussions with participants indicated that some family support services were clearly putting a lot of effort into monitoring and evaluating to meet the needs of various funders and some were fairly happy with their current practice. The following quotes are both from family support services:

“Outcomes are collated quarterly with the staff by looking at our indicators that go with each of the outcomes that are set for the organisation. These are influenced by self-reporting from parents and young people, if age appropriate, by feedback from other professionals and family members and if actual changes have taken place, e.g. that we have supported the parent to access drug or alcohol services, if more appropriate housing has been secured or if benefits have been reviewed etc. We also on a yearly basis ask for evaluations from parents,

children and young people and professionals to help us measure our impact... We use specifically developed evaluation forms (different for parents, children and professionals)."

"I think we do it quite well. Our organisation has an evaluation officer that we can use... We collect a lot of evaluation data."

Some participants felt that evaluation practice could be streamlined or would welcome a more joined-up approach across different services:

"Knowing what all other projects are doing so we can compare outcome measures, would like to compare with other services so would like to see services working along with the same review/evaluation tools."

"There was talk about doing a standardised tool which would be great so we could all read from it and that would be interesting to use in place of our own or in conjunction with our own."

It is clear that this is an area of continuing development for projects and services:

"We do have a team meeting where we look at our overall evaluation, do we need to change our methods while we are changing the paper work for one area of the project, is it worth doing it for all of the project?"

5.5.2 CHILDREN AND YOUNG PEOPLE'S SERVICES

The findings here very much mirror those reported for parent and family services above. The literature and models of working more widely are not particularly clear in what should be done in providing specialist support to children and young people affected by parental substance misuse. There is no clear evidence on what model of working is most effective and services both within and outwith Edinburgh were working with a wide range of tools and approaches. The approach used seemed to depend on the type and origins of the service and of the specific staff involved and it was therefore difficult to get a clear picture of what is being done.

In terms of outcomes frameworks, the picture was also similar to that described earlier. Some projects mentioned using STARS tools for measuring outcomes, based on the SHANARRI indicators, whereas others used a range of in-house tools. More widely, Barnardos Scotland are known to have done a lot of work developing an outcomes framework used in projects such as Hopscotch (see Appendix E). While it would be helpful to develop a more consistent language and framework around good practice and outcomes measurement, it is worth noting that there are competing agendas. For example, in CAMHS, there is national work going on around outcomes measurement based on the CORE tool. In addition, some services have already invested a lot of time in developing their own tools.

"We know that we want to develop a much better picture of who the children and young people are that we have coming to use and what the issues are. We are actively looking at that. Developing systems so that we don't have this rush at the end of the year to evaluate and gather info. Looking across the ADP and the range of services that are available – whether there is some measurement of evaluation across services because some children are common to different services."

“We use YP Core with young people for emotional health and we use Teen Star again for emotional health. This also has an alcohol measure for young people and for family and resilience. We use FEEL which is an internally created measure and we get feedback from the young people and referrers. When I put my report together we look at shifts in emotional health so have they gone up or down by how many points and that can link into different resilience factors. You can break it down to say we have increased confidence by this many points, we have increased coping strategies by this many points. That is outcome focused.”

“We don’t use a formal tool for setting goals. We are looking at a number of different goal setting tools that will help to measure outcomes better. One that is being looked at for CAMHS nationally is called CORE.

“We have 4/5 outcomes and we have devised questionnaires. We have a questionnaire for families, professionals and for schools.”

Many staff in services working with children and young people felt that they would really welcome support with evaluation and measuring impact.

“We have lots of outcomes to measure and its difficult.”

“I would love support with this.”

“It would be quite good to get support to help us to measure impact. We would like someone to help us look at that and show us what would be the best way of doing that. We have not done it before so it would be good to speak to someone who knows more about it than we do to come along and say this is how we have done it or suggests ways that you could do it. I think that could be useful.”

5.5.3 IMPROVING SERVICE DESCRIPTIONS AND OUTCOME EVALUATION

Better, more consistent outcome monitoring and evaluation is essential for informing future commissioning decisions and developing the most effective practice in this field. There is also a need to more clearly describe and capture what it is that services and individual workers actually do so that one can know what is actually being evaluated. Without these two actions, there is a risk that what helps children and families is not identified and shared, and could be lost such as when a worker moves post, and that resources and effort are wasted on practices that are less effective.

In order to encourage and enable learning about what works, specialist and targeted services working with vulnerable families (or parents/children/young people) should be supported to clearly define and describe how they work and what guides that work including assumptions, processes, interventions, theories and so on.

A series of documents recently published by the Institute for Research and Innovation in Social Sciences provide excellent guidance on taking an outcomes-focused approach to work with parents and children²². Our key conclusions from our study of these documents are:

²² Access the full series at: <http://www.iriss.org.uk/project/leading-outcomes>

- The process for work with children and families, as well as the pace and order of discussions needs to be individualised but this does not negate the need for an assets/resilience based outcomes-focused approach.
- Identifying outcomes can be very different from a traditional service-led approach and centres even more than usual around the conversation between the practitioner and the person receiving services.
- There is a difference between outcomes identified for measuring and monitoring the work of an organisation and person or family specific outcomes used in frontline work. While outcomes rightly should be chosen specifically for each families or children, such outcomes should still be able to feed into a consistent and comparable framework across an organisation or system. This will likely require additional work around defining and categorising outcomes at different levels.
- The process for identifying outcomes starts with the ‘outcomes conversation’ which should start with listening to the person’s story – rather than a question and answer style – with a focus on recognising the client as an expert as well as the worker.
- This has parallels with the concept of patient-centred consultation in healthcare, where much work has been done to breakdown the specific skills and techniques necessary to communicate effectively with people and understand their issues and problems from their point of view²³. It is likely that a similar forensic analysis of the ‘outcomes conversation’ would be beneficial here, and has not yet been done.
- Whatever outcomes framework is used, a range of visual tools to aid discussion with families are important. ‘Stars’ tools, which are in use by some organisations in Edinburgh already, are seen as good practice, providing the right outcomes are included.

Furthermore, as many of the initiatives and changes proposed in this report as a whole are innovative, a clear plan for research, evaluation and dissemination, as robust as is feasible, should be developed at an early stage. The implementation of this plan should then inform future actions, contribute to the overall body of evidence in this field and share learning with other areas.

Recommendation 9: Commissioners, funders and services across Edinburgh should work towards a more consistent and co-ordinated approach to outcome-based monitoring and evaluation and clearer descriptions of models of working/practice in services. In addition, the rollout of actions and initiatives recommended in this report should be thoroughly researched and reported.

5.6 IMPROVING ACCESSIBILITY OF UNIVERSAL SERVICES FOR SUBSTANCE MISUSERS

It was universally agreed that it is important for recovery, that recovering users have access to non-using peer groups and can identify themselves in ways that do not relate to substance use e.g. as a mum/dad, not as a drug user. It is also a principle of GIRFEC to keep children and families within universal services where possible – as it is generally recognised that they do best when they can be adequately supported in universal contexts. Thirdly, in order to improve outcomes for children, parents and families, it is necessary that substance misusers can effectively access universal services that help with housing, benefits, employment and so on.

²³Silverman, Kurtz, Draper (2005). Skills for Communicating with Patients, 2nd Edition. Radcliffe Publishing.

The overarching barrier to achieving all of this is the stigma and collective disadvantage experienced by substance users that results in them feeling uncomfortable or unable to access universal services.

“There’s embarrassment around it (addiction)... You just isolate yourself and you’re not interested in services or nothing”

Father of 2 adult children

Substance using parents require specific support to access many services, and this support is not always available.

In the context of this work there are three groups of services which need to work hard to increase their accessibility to parents and children affected by parental substance misuse. These are:

- Universal parenting services such as parent and toddler groups, rhyme time, and where they are developed, social support groups for parents of older children and teenagers.
- Universal statutory services such as Jobcentre Plus and telephone advice providers from the Department for Work and Pensions; Housing; the Identity service and so on.
- Universal statutory services working with children especially early years, schools and youth services as discussed in Section 5.2.3 above.

Community-based/Peer-led Services

If parents with substance misuse histories are to be better supported into community groups, such community based groups need to proactively promote the idea that everyone is welcome regardless of background. Many such groups may be perceived as being ‘not for people like me’ however the success of self-help groups such as Alcoholics Anonymous and other recovery communities in welcoming everyone, may offer models from which to learn.

“Where there are groups that are facilitated by parents or a voluntary organisation, someone that our parents don’t know, it makes them nervous. They feel different, they worry about being judged. If their child was misbehaving, they may not respond as the group expects –they might shout at the child. Many workers would not know how to intervene with that parent, and if they did intervene, they might not be ready for the parent’s reaction. The parent might get defensive and angry.”

There is a need for these kinds of groups to be better able to set up the group and manage the behaviour in a way that will make people feel okay. Some simple support may be all that is needed by some groups to become more open. Others may need time to reflect on and change attitudes or prejudices. Some key principles could be:

- Acceptance and welcoming of all parents regardless of background etc. etc.
- It is probably not necessary to seek to identify or assess which parents within a group have (or have had) substance misuse issues, if the focus is on what help or support any/all parents need to make them feel welcome.
- Simple gestures are likely to be important: welcoming new faces, taking names and phone numbers, introducing people to the rest of the group, having someone available to meet with parents before they attend and accompanying them to the groups, calling to see how people are

if they miss a group or to remind them before a session and see if they need any help with attending.

- Tolerance of non-attendance and awareness of potential chaos in the lives of others, and ability to manage individual and group behaviours.
- Communicating the welcoming/accepting philosophy to all who attend the group so that every attendee is clear on their role and responsibility in making others feel welcome, safe and accepted.

Many more universal parent support services are operating in isolation (ad-hoc community groups) from wider or indeed more specialist parent support initiatives. A more joined up approach as recommended in Chapter 4 will help to move this forward. In addition, as noted in discussing the availability of services in Section 4.3.1 there is a need for more such services particularly for parents of school-age children. The recommendation presented there is repeated here.

Children and Families (at City of Edinburgh Council) in partnership with other providers, should identify existing organisations and groups which are already or which have the potential to facilitate peer support for parents (especially of school age children) and arrange for them to be supported to do so in ways that are as accessible as possible for all parents in order to expand accessible provision in this area.

This could include community-led groups, NHS-led groups, peer-led groups, schools, churches, parent councils and employers and may involve providing guidance such as suggested ways of working, having someone visit and support groups directly, or providing training.

Universal Social Services & Agencies

Over the course of this work we were told of many examples of where services were not set up to support individuals in recovery from substance misuse to access the benefits and help that could improve their circumstances and those of their children.

Staff reported that the effectiveness of the response often depends on who happens to answer the phone or be on the desk. This is not good enough. There is a need for these large services to do better in terms of ensuring that the already stark inequalities experienced by substance misusers are not worsened by barriers to accessing, understanding and liaising with such essential services. For example, staff reported that parents may be supported because children go to school, but that there is a big gap over the school holidays. While there are holiday programmes, they reported limited availability and no mechanism to facilitate or prioritise access for more vulnerable families or to cater specifically for them.

These inequalities are well-documented, but worth revisiting briefly here in the words of participants:

“There is a need for something for vulnerable children in the holidays. [For the boy that we’re talking about] home life is not great so summer must feel like forever for him.”

“If you have lived in an area and developed a drug problem there. It is very difficult for you to recover living across the hall from your drug dealer who is keen to get you back on it...There is just not enough housing, and drug users are not a popular group to be prioritising.”

“A typical mum coming here will have anxiety, depression, post-natal depression, a couple of kids under 5 and drug-dependence. She has not got the skills to manage finances, routine, keep the house clean etc. A lot of services have disappeared...or you have to be at risk of losing tenancy to access them....”

“The institutionalisation of people - folk coming out of prison don't have daily living skills to manage independent life –they can't cook, don't know how to shop, budget etc.”

Quotes from Parents:

“People went to the antenatal classes with their partners. I was a single parent and it was a bit shit. They didn't really support me. I was made feel a bit of an outcast... there wasn't any particular support for single parents. Maybe they could have ran separate classes for single parents in antenatal groups”

“I didn't like meeting people at groups because I kept getting panic attacks and didn't like meeting other people. If I knew my worker for ages and she wanted to take me along, I probably would have went”

“I think you are scared to access them because they might look down their nose at you”

It was beyond the remit of this work to review directly how these services contribute to reducing the harm to children affected by parental substance misuse but it is clear that they do have a role to play, and that there is room for improvement. There is a whole body of work which discusses inequalities sensitive practice which will be informative in moving forward²⁴.

Recommendation 10: There is a need for the EADP to consider how it can act as a champion for culture change within large statutory services that work with adults to make them more accessible and responsive to the needs of substance misusing parents. In addition, such services, including City of Edinburgh Council and NHS Lothian need to consider how all their services are sensitive to the needs of and accessible to vulnerable groups in the context of this issue.

²⁴ www.equalitiesinhealth.org

6. OVERALL CONCLUSIONS & RECOMMENDATIONS

There are a number of mechanisms which facilitate the goal of reducing the negative impact of parental drug and alcohol use on children and young people including (1) improving parenting and family functioning, (2) Improving wider child and family circumstances and (3) Improving children's resilience/coping ability. [5.1]

Support to reduce harm via all of these mechanisms (as well as services to support reductions in substance misuse or abstinence and recovery) should be available to families where there is harm due to parental substance misuse, whatever the level. [5.1]

6.1 LEVELS OF NEED & DATA COLLECTION

It is impossible to definitively count the numbers of children, parents and families in Edinburgh affected by parental substance misuse due to difficulties and risks relating to definition, identification and recording. [3.3]

- Children can be affected by all levels of parental substance misuse, which is widespread. Such harm is not perfectly correlated with levels or types of substance use. [3.3.1]
- Using Scottish Government criteria, it can be very roughly estimated that approximately 7,000 children in Edinburgh City live with parents with at least some level of problematic alcohol use. It is important to note that the criteria used are wide and many of these children will be at very low risk. [3.1]
- A minimum estimate of the number of children affected by parental problem drug use is 2,173. This is based on figures from treatment and other services and relates to opioid or benzodiazepine problems only. [3.1]
- Approximately 55 children are born in Edinburgh every year with Foetal Alcohol Spectrum Disorder (FASD) giving a total of approximately 1,000 children under 18 in Edinburgh living with the disorder at any given time. An additional 100 children may be suffering from Foetal Alcohol Syndrome at any given time. [3.1]
- When compared with the levels of alcohol consumption in pregnancy reported in surveys, the data collected by maternity services suggests that most women are not disclosing alcohol consumption in pregnancy to midwives at the booking appointment thus missing the opportunity to deliver potentially effective interventions. [3.2.3]
- Based on the services available, service usage data and these estimates of prevalence, there must be high levels of unmet need. In the vast majority of cases this is because individuals and families have not been identified, do not know about, cannot or choose not to access the services reviewed here, rather than that there are waiting lists for these services.

Recommendation 1: While there are some aspects of relevant data collection which should be improved, in general the focus of energies needs to be on equipping staff and services to better serve and support children, parents and families affected by parental substance misuse, rather than trying to count something that is not necessarily going to change outcomes per say. [3.3.5]

- **NHS Lothian should lead further work to support accurate identification of alcohol consumption levels in pregnancy and appropriate responses to the levels identified to reduce the risk of FASD including adaptations to TRAK and research work. [3.2.3]**
- **Adult treatment and counselling services (including alcohol counselling services and primary care services providing treatment for alcohol or drug use) should record and report the number of adults receiving treatment for substance misuse who have children living with them all or part of the time in line with SMR25 requirements. Further arrangements will be required for people with primary alcohol problems until this data is reported through the SMR25. [3.3.5]**
- **Social work services should consider what aspects of data recording would be beneficial to children and families, and if/how SWIFT can and should be adapted to facilitate such data collection, taking realistic account of the constraints discussed in Chapter 2 of this report and the overall finding that the focus should be on providing support rather than counting prevalence. [3.3.5]**
- In order to clearly identify the numbers of children affected by parental substance misuse who require a service through the Local Authority an audit would be required. This would involve going through individual case files to trawl for information indicating such an issue and would be highly subjective. We do not therefore feel that this would yield sufficiently reliable information to justify the resources. [3.3.5]
- Successful data recording in all settings is likely to require an element of culture change and staff support/training, which could be done as part of other recommended capacity building efforts (see below). [3.3.5]

6.2 CAPTURING AND CLARIFYING SERVICE PROVISION

There are a wide range of services working in Edinburgh to reduce the harm to CAPSM. The number and diversity of such services makes it difficult for practitioners and families to keep well informed as to what support is available. [4.2] In particular, the parenting support provision within City of Edinburgh Council is not as well-known as could be expected among staff working with substance misusing parents. [4.2.2]

Recommendation 2: There is a need for much greater clarity and awareness among practitioners and service users about what services can support parents, families, young people and children affected by PSM to support appropriate referrals and uptake of services. [4.2]

- **Edinburgh ADP should consider how to compile and maintain up to date, detailed directories of services and supports specifically for parents, families, children and young people affected by parental substance misuse. [4.2]**
- **Children and Families (at City of Edinburgh Council) should map current provision in terms of universal parenting support groups or services. This should include exploring how best to provide information on and promote universal and targeted parenting support services as part of future developments to better co-ordinate parenting support across Edinburgh. [4.2.1]**

6.3 SERVICE COMMISSIONING, CONSOLIDATION AND CO-ORDINATION

There is no straightforward way to categorise services in this field because of overlap between target group, age and other eligibility criteria. [4.1] Within some broad types of services, there are a number of different providers offering similar but different interventions with the same goals. While the services themselves may be doing good work, the set-up is unhelpful, inconsistent and inefficient in cases. [4.3], [4.4]

Recommendation 3: There is a need to consolidate and co-ordinate services providing universal, lower-threshold [4.3.1] and targeted [4.3.2] support to parents, specialist CAPSM family support [4.3.3], targeted support for children and young people including young carer services [4.4.1], and specialist support for children and young people affected by parental substance misuse [4.4.1]. This should ensure consistent, city-wide provision for those most in need and will require co-operation across the City of Edinburgh Council and with partner agencies and funders.

- There is currently a need for co-ordination and increased capacity in direct support for children and young people to give a range of support options. [4.4.1] This includes consolidation and co-ordination of young carers services across the city, increased capacity in one to one counselling/support, youth work and specialist CAPSM support for younger children, development of specialist CAPSM services for teenagers and increased self-help group capacity for young people affected by PSM. [4.4.1], [4.3.4].
- Commissioners and service managers should take a pragmatic approach to reviewing how well services are meeting the needs of equality groups using Equality Impact Assessment [4.3.6].
- This research suggests that there are further areas for development of services in relation to children with FASD [4.3.7], fathers [4.3.5], those who are homeless [4.3.6], equality groups [4.3.6], parents who are older than the remit of 'young parents' services [4.3.2], and less-chaotic substance using pregnant women [4.3.2].
- The EADP should bring together relevant stakeholders (including Children and Families and Health and Social Care within the City of Edinburgh Council) in the treatment of women drug and alcohol users to jointly consider the need for residential treatment for mothers with children. [4.3.7]
- NHS Lothian, City of Edinburgh Council and other partners should jointly consider what targeted services are needed by vulnerable parents (not those with more serious substance misuse problems who could access specialist family support), and specifically commission these in areas of need. There is a need to consider co-ordinating and expanding service provision (such as that provided by BumpStart and Stepping Stones) to areas not currently served. [4.3.2]
- Funders of current specialist CAPSM family support services should work towards open commissioning of one city-wide co-ordinated specialist support service for parents affected by their own substance misuse and their families. [4.3.3]
- Children and Families need to consider whether the needs of children affected by parental substance misuse are best served by focusing future investment on increasing capacity in child and family centres for those who most need it or on providing support, competence-

building and time for universal staff to take the lead in working effectively with more such families. A balanced approach is likely to be best. [4.3.7], [5.2.3]

6.4 IDENTIFYING, ENGAGING AND SUPPORTING PARENTS IN NEED

There is an unhelpful stigma associated with the need for parenting support in general which needs to be reduced. This means that parents are reluctant to ask for support and staff are reluctant to ask parents about parenting support needs. [5.2], [5.2.1]

All substance misusing parents need support with parenting. This should come as no great surprise, because actually, all parents need support with parenting. [5.2] Most of this learning, thinking and consideration happens informally, sometimes without parents even realising, but more vulnerable parents may not be able to easily access support from the same family, community and peer-led sources that others do. The literature suggests that early intervention is a key gap. [5.2.1]

“Children and families may remain invisible to services until a point at which circumstances have reached a crisis point. Interventions with children of drug and alcohol using parents come too late, that is once matters have reached a child protection, rather than a family support or child ‘in need’ level.”²⁵

Recommendation 4: There needs to be a strategic focus in Edinburgh City on how a whole range of services in contact with parents, universal and otherwise, can proactively improve access to parenting support at all levels, not just when substance misuse or parenting support needs have been disclosed as this is unlikely to happen in many cases. [5.2]

- **Children and Families (at City of Edinburgh Council) in partnership with other providers, should identify existing organisations and groups which are already or which have the potential to facilitate peer support for parents (especially of school age children) and arrange for them to be supported to do so in ways that are as accessible as possible for all parents in order to expand accessible provision in this area. [4.3.1], [5.6]**
- **Midwives, health visitors and primary care staff, early years and school staff who regularly work with parents; and all staff working with parents in substance misuse treatment services should be able to supportively raise the issue of, raise awareness of and signpost to additional support for effective parenting. The suggested content of such conversations is discussed further in this report. [5.2.2]**
- **With appropriate support, the parenting support team at City of Edinburgh Council, should develop a strategic medium to long-term plan to make discussions of parenting part of routine practice, taking into account learning from implementation science²⁶. This will require action from and partnership working across and outwith the Council. [5.2.2]**

6.5 THE ROLE OF ADULT TREATMENT/SUPPORT/SELF-HELP SERVICES

²⁵ Nagle and Watson, 2008 quoted in Mitchell, F and Burgess, C (2009). A research review on working with families affected by parental substance misuse <http://www.sccpn.stir.ac.uk/documents/MitchellBurgess2009PSMResearchReview.pdf>

²⁶ Damshroder LJ et al. (2009). Fostering implementation of health services research findings into practice: a consolidated framework for advancing implementation science. *Implementation Science* 2009; 4:50.

The literature is clear that the divide between adult and children's services is unhelpful in changing culture to focus more on parents, children and families, not just individual clients, and that closer integration and joint working would be helpful. Our work indicates that there is still a significant level of uncertainty in adult treatment services about movement towards this change in emphasis. [5.2.4]

More training and support is needed (as described below) to build the expertise of addiction workers on how to take a family focused approach to work, however, they do not need to become providers of direct support to families or children or with parenting. [5.2.4]

Recommendation 5: All adult treatment and support services (including Tier 2, primary care and self-help groups) should focus on facilitating parents and children to access support in addition to and separate from any work relating to formal child protection. They should discuss parenting in a supportive way on an ongoing basis including specific structured conversations [5.2.2] at least annually with all service users in substance misuse treatment who are parents or living with children as part of a holistic approach to supporting recovery. [5.2.4]

This will be most likely to happen through a combination of a greater focus on this in conversations with service users, earlier referrals to specialist family support, more in-house expertise and closer co-operation with children's services. [5.2.4]

- **Treatment and Recovery Services should further explore and develop best practice guidance in how to engage parents in recognising the potential need for and in offering suitable support options to children and young people. [5.2.4]**
- **Representatives of adult self-help groups operating in Edinburgh should consider how they can work with partner organisations to ensure that such children are being identified and offered support. [5.2.4]**

6.6 IDENTIFYING, ENGAGING AND SUPPORTING CHILDREN AND YOUNG PEOPLE

While it is clear that there are large numbers of children and young people (locally, nationally and UK wide) affected by parental substance misuse who are in need of support, there was almost universal acknowledgement of how difficult it is to identify and engage them. These difficulties vary depending on whether their parents are in treatment of some kind or not. [5.3]

Recommendation 6: Universal services working with children and young people need to continually reflect on how they can do better at creating safe times and spaces where those in difficult family situations feel comfortable discussing their experiences with others, to enable them to access support, come to terms with and move on from those difficulties. Other services can also help to support more of those in need. [5.3]

- **As part of their health and wellbeing curriculum, Edinburgh schools should acknowledge and openly discuss parental alcohol and drug misuse, where supports are available for parents and children, explaining the focus on keeping children with their families where possible, and emphasising how important it is that children and parents seek help. [5.3.2]**
- **EADP should engage with self-help groups (Al-Anon and SMART Recovery) to explore their role in supporting children and young people affected by parental substance misuse. [4.3.4]**

- **Staff providing specialist one to one support specifically for children and young people affected by parental substance misuse should have very strong links with adult treatment services, including some co-location²⁷, although the support provided to young people should be done in the community (not in the adult service base). Close links are also needed with universal services. [5.3.1]**
- There is a need to develop models of practice (see Section 6.7 below) on how staff seek to identify, talk to, provide support to or facilitate access to support for children and young people affected by parental substance misuse. [5.3.2]

6.7 DEVELOPMENT OF MODELS OF PRACTICE & ASSOCIATED CAPACITY BUILDING

The value of further training on CAPSM was noted by managers of a range of staff groups including child and adolescent mental health services (CAMHS), health visitors, child and family centres, and children and families social work. Capacity building endeavours should not be restricted to training but should also consider on the job learning and interdisciplinary working as outlined below. Some of the more specialist services did not feel they needed further training, but would still need to be part of developments relating to consistent models of practice. [5.3.2]

Recommendation 7: There is a need for a co-ordinated programme of development of models of practice and associated capacity building for harm reduction in CAPSM. This needs to be specific to a number of different staff groups and to relate to conversations with both parents and young people. It will involve development of models of working, writing associated competency guidance and developing learning opportunities to build competency and will require effort by City of Edinburgh Council, NHS Lothian and partner organisations. [5.2.3], [5.3.2].

The areas for development and capacity building are:

- Models of working for staff in universal services such as early years, health, youth services and education to enable them to better understand, work with and provide or facilitate access to appropriate support to parents in recovery or those with less severe substance misuse problems, including in pregnancy, reducing the need for such parents to access specialist services (including child and family centres). [5.2.3]
- Models of practice on how universal and targeted service staff working with young people should seek to identify, talk to, provide support to or facilitate access to support for children and young people affected by PSM. [5.3.2]
- Practice guidance on taking a family focused approach in adult treatment services including engaging parents in such services to recognise the potential need for their children to receive support and in offering suitable support options to their children directly and indirectly. [5.2.4]
- Models of practice to enable staff who work with young people (e.g. youth workers, guidance teachers) to raise the issue of parenting and explore young people's understanding

²⁷ In referring to 'co-location', we mean co-location of individual staff so that they are working directly alongside other professionals, rather than co-location of services. Services sharing a building is not necessarily the solution, which could be simpler e.g. staff being able to work at adjacent desks from time to time.

of what is normal, what informal supports might help, and what is available for them if they want more specific, peer or structured support. [5.3.2]

- Models of brief parenting support conversation to reflect the most appropriate, acceptable and effective way to cover the necessary issues in different settings in contact with parents supported by accessible, consistent, simple guidance describing the core principles of effective parenting. [5.2.2]
- Models of working will need to be specific to different staff groups so that they clearly outline what practice or change in practice is recommended (where needed). For example: clarifying and developing the role and remit of young carers staff in relation to CAPSM. [4.4.1]

6.8 INTERDISCIPLINARY WORKING

The research literature strongly advocates for a range of measures to facilitate staff from different groups and professions having more contact with each other and this was found to be beneficial in other projects such as the Link Up initiative²⁸ in Angus. [5.4]

Recommendation 8: Careful planning is needed to ensure that staff from across and within the full range of services that work with children and parents, including universal services such as early years, education and health, social work children and families teams, specialist CAPSM services, and adult treatment and support services, have more opportunities to work together and alongside one another similar to approaches such as 'Link Up' in Angus. [5.4]

- Shadowing, joint team meetings, part-time co-location and so on should be considered to facilitate a genuine chance for staff to see and understand the practice and priorities of other professionals. [5.4]

6.9 OUTCOME-BASED MONITORING, EVALUATION, RESEARCH AND DISSEMINATION

Services used a wide range of different approaches to outcome measurement, monitoring and evaluation. Perhaps because of, or in addition to the scarcity of robust evidence in this field, services in Edinburgh were generally unable to articulate clearly what model of working or specific theoretical approaches they were using, if any. [5.5]

Better, more consistent outcome monitoring and evaluation is essential for informing future commissioning decisions and developing the most effective practice in this field and services would welcome support with that. There is also a need to more clearly describe and capture what it is that services and individual workers actually do so that one can know what is actually being evaluated. Without these two actions, there is a risk that what helps children and families is not identified and shared and could be lost such as when a worker moves post, and that resources and effort are wasted on practices that are less effective. [5.5]

Recommendation 9: Commissioners, funders and services across Edinburgh should work towards a more consistent and co-ordinated approach to outcome-based monitoring and evaluation and

²⁸Kosonen, M, (2011). Angus Learning Partnership for children affected by parental substance misuse (CAPSM). A summary report.

clearer descriptions of models of working/practice in services. In addition, the rollout of actions and initiatives recommended in this report should be thoroughly researched and reported. [5.5.3]

- In order to encourage and enable learning about what works, specialist and targeted services working with vulnerable families, parents, children or young people should be supported to clearly define and describe how they work and what guides that work including assumptions, processes, interventions, theories etc. [5.5]
- In taking forward the initiatives and changes proposed here, a clear plan for research, evaluation, and dissemination, as robust as is feasible, should be developed at an early stage. The implementation of this plan should then inform future actions, contribute to the overall body of evidence in this field, and share learning with other areas. [5.5.3]

6.10 CHAMPIONING CULTURE CHANGE IN UNIVERSAL SERVICES

It was universally agreed that it is important for recovery, that recovering users have access to non-using peer groups and can identify themselves in ways that do not relate to substance use e.g. as a mum/dad, not as a drug user. [5.6]

Secondly, it is a principle of GIRFEC to keep children and families within universal services where possible – as it is generally recognised that they do best when they can be adequately supported in universal contexts. [5.6]

Thirdly, in order to improve outcomes for children, parents and families, it is necessary that substance misusers can effectively access universal services that help with housing, benefits, employment and so on. The overarching barriers to achieving all of this are the stigma and collective inequality experienced by substance users that result in them feeling uncomfortable or unable to access universal services. [5.6]

Recommendation 10: There is a need for the EADP to consider how it can act as a champion for culture change within large statutory services that work with adults to make them more accessible and responsive to the needs of substance misusing parents. In addition, such services, including City of Edinburgh Council and NHS Lothian need to consider how all their services are sensitive to the needs of and accessible to vulnerable groups in the context of this issue. [5.6]

APPENDIX A: ESTIMATING THE NUMBER OF CHILDREN AFFECTED BY PARENTAL ALCOHOL MISUSE

In 2003, the Scottish Government (Changing Scotland's Relationship with Alcohol: A Discussion Paper, 2008, (<http://www.scotland.gov.uk/Resource/Doc/227785/0061677.pdf> accessed 21/6/2012) estimated that 65,000 children in Scotland were living with parents with problematic alcohol use based on the number of people in the Scottish Health Survey who responded positively to two or more of the six alcohol problem questions that are included and figures from the General Register of Scotland (not referenced). The six statements were:

- *Felt the need to cut down on drinking*
- *Felt guilty about drinking*
- *Been criticised for drinking*
- *Had shakes due to drinking*
- *Had to drink to steady nerves*
- *Felt unable to stop drinking*

In the 2003 Scottish Health Survey, 9% of adults self-reported 2 or more of these problems. In 2010, that figure had risen to 12% of adults – so a crude calculation (ignoring any change in the birth-rate) would be that approximately 86,700 children nationally were affected by a parent with problematic alcohol use in 2010. As Edinburgh accounts for approximately 8% of Scotland's population of 0-15 year olds (<http://www.gro-scotland.gov.uk/files2/stats/council-area-data-sheets/edinburgh-city-factsheet.pdf>, accessed 21/6/2012), this gives a very rough estimate of 7,000 children in Edinburgh whose parents report problematic alcohol use.

APPENDIX B: GEOGRAPHIC REMITS OF SERVICES

The following table provides information on where each of the targeted and specialist services operate.

Name	Type	Postcode	Locality of service	Notes from interviews										
Parenting Education	Specialist programmes for vulnerable parents.	TBC		<p><u>Teen Triple P</u> – For parents and carers of 12- 16 year old children with behavioural and emotional problems of moderate severity 45 staff trained across the city and at least 2 practitioners are based in 5 neighbourhoods (North, South, West, Central and North West). Between now and June 2013, they are asking practitioners to deliver 2 programmes per year and aiming for 4 per year in each neighbourhood. Of the 45 practitioners, 20 will be trained in level 5 pathway programme which is a more intensive package which can be delivered individually or in a group. There will be a referral process into the pathway programme.</p> <p>A calendar of programmes is in the process of being compiled for the coming year. There is already one group planned for each neighbourhood between now and December. The central team have run 4 groups between January – August 2012 and their next one is planned for October 2012.</p> <p><u>Incredible Years</u> – For parents and carers of children 3 – 12 years. 15 practitioners who are involved in delivering the programme. We have a small number of other practitioners trained who are not at present available to deliver but may in the future. We ran 5 groups from April 2012 - June 2012. Our aim is to have a programme of delivery across the city available for the year ahead but this is still in progress. We aim to run one group in each neighbourhood per term (3 per year per neighbourhood)</p> <p><u>Mellow Parenting Information</u></p> <p>24 Practitioners in Edinburgh are trained in Mellow Parenting. 5 practitioners are based in the voluntary sector and 19 in Edinburgh's Children and Families department which includes Child and Family Centre staff, Social Workers, Education Nurseries and Visiting Teaching and Support Services.</p> <p>The voluntary sector practitioners are based in Leith, Muirhouse, and Wardieburn.</p> <p>The Children and Families practitioners are based in Leith, Craigmillar, Craigmoynton, Gilmerton, Murrayburn, and Stenhouse.</p> <p>12 practitioners have facilitated one or more Mellow Parenting groups.</p> <table border="0"> <tr> <td>North (Pilton)</td> <td>Sept- Dec 2010</td> </tr> <tr> <td>East (Craigmillar)</td> <td>March- June 2011</td> </tr> <tr> <td>North (Granton)</td> <td>Oct 2011-Feb 2012</td> </tr> <tr> <td>East (Craigmillar)</td> <td>Feb- June 2012</td> </tr> <tr> <td>North (Leith)</td> <td>Feb- June 2012</td> </tr> </table>	North (Pilton)	Sept- Dec 2010	East (Craigmillar)	March- June 2011	North (Granton)	Oct 2011-Feb 2012	East (Craigmillar)	Feb- June 2012	North (Leith)	Feb- June 2012
North (Pilton)	Sept- Dec 2010													
East (Craigmillar)	March- June 2011													
North (Granton)	Oct 2011-Feb 2012													
East (Craigmillar)	Feb- June 2012													
North (Leith)	Feb- June 2012													
Bumpstart	Universal	EH6 5JA EH4 4NL EH6 5JA	North (service base) North (Criagroynton HS) North (Dr. Bell The Junction)	Focus is on areas of high deocat. Greater Pilton (NW) and Leith (NE), the team has worked alot wider. No definites. Grey. So a lot of our families are mobile and might end up on South side but still come to cafe in Leith - but we do try to find appropriate situations in their own area. Because of health literacy work - could be a health literacy worker e.g. in westerhailes. I think this service was under re (contact RabByfield at council who manages them - CLD) view. I think possibly might be contracted back to North										

Stepping Stones	Targeted (young mothers)	EH5 1LY	North (service base)	Will go to homes in Greater Pilton, Muirhouse, Granton, Drylaw only. People come to the service base.
Family Nurse Partnership		TBC		
Child and Family Centres	Specialist	EH1 1QX	South (Cowgate Under 5's Centre)	
		EH16 4BR	East (Craigmillar Child and Family Centre)	
		EH4 4QP	North (Craigroyston Early Years Centre)	
		EH6 4HF		
		EH17 8PL	North (Fort Early Years Centre)	
		EH5 1LY	South (Gilmerton Child and Family Centre)	
		EH16 4DZ	North (Granton Child and Family Centre)	
		EH14 2SL	East (Greendykes Child and Family Centre)	
		EH14 2SL	South West (Hailesland Child and Family Centre)	
		EH6 5AY	East (Moffat Early Years Campus)	
			North (Pilrig Child and Family Centre)	

Circle: Harbour	Specialist	EH4 4EJ	North (Service base)	outreach, home and in community, schools. Based in Pilton but cover Edinburgh City. Cover all Edinb so potentially has links with all schools
Aberlour Outreach	Specialist	EH16 4NT for group work.	East (service base)	Outreach, in homes, community, libraries/children's centres.
Prepare	Specialist	EH11 3HS	West (service base)	All the work at Prepare is outreach and community based so wherever the woman is based.

Services Providing Direct Support to Children and Young People

Name	Type	Age	Postcode	Locality of service	Notes from interviews
Bfriends Edinburgh	Befriending service.	5-16	EH17 8RD	South (service base)	South Edinburgh, WesterHailes
Edinburgh Young Carers	Targeted (young carers)	5-25	EH7 5QY	North (service base)	Majority is done at the base but 1:1 work is mostly outreach
Muirhouse Young Carers	Targeted (young carers)	5-16	EH4 4TZ	North (Service base)	We do home visits but other than that children come to the service base
Broomhouse Young Carers Support & befriending Project	Targeted (young carers)	7-18	EH11 3RH	West (service base)	At service base
HOT	Specialist	13-25	EH16 4EA EH15 1NF EH16 4DP EH15 1ST EH164ND EH16 4BX EH16 4NT EH164DW EH15 3HZ EH15 1AU	East (service base) East (PortobelloHS) East (CastlebraeHS) East (Holyrod HS) East (Cafe K) East (Castle Project) East (Aberlour) East (Castleview) East (Bingham Comm Centre) East (Portobello Library)	school based work, outreach work, drop in at service base and link up with other youth groups and go on and do inputs there
Castle Project	Specialist	12-18	EH16 4BX EH16 5LJ EH16 4DP EH16 4PY EH16 4PY	East (service base) East (PrestonfieldPS) East (CastleviewPS) East (St Francis PS) East (NiddriemillPS)	in-school, children's house in Craigmillar/Portobello area, community, other projects

			EH21 8QZ	East (Newcraig PS)	
			EH7 6JA	North (St Ninnians PS)	
			EH15 1NB	East (St Johns PS)	
			EH16 4DP	East (Castlebrae HS)	
			EH15 1ST	East (Holyrood HS)	
			EH15 1NF	East (Portobello HS)	
			EH11 2QL	West (GeorgieMillHS)	
			EH16 4ND	East (Jack Kane Community Centre)	
			EH16 4DW	East (Castleview Community Centre)	
			EH16 4EA	East (HOT TEAM)	
Aberlour Outreach	Specialist		EH16 4NT for group work.	East (service base)	Outreach, in homes, community, libraries/children's centres.
Circle: Harbour	Specialist	<18	EH4 4EJ	North (Service base)	outreach, home and in community, schools. Based in Pilton but cover Edinburgh City. Cover all Edinb so potentially has links with all schools
Sunflower Garden	Specialist	5-14	EH2 3NS EH12 7HQ	South (service base)	Assessment is done in family home, home visits, 2 sites to work with kids and also use rooms in schools, local community centres. We also have a main site and children can come to us.

APPENDIX C: OPTION 2 PROJECT INFORMATION**Case Study: Option 2 Project**

Option 2 is a service that works with families in which parents have drug or alcohol problems and there are children at risk of harm. The service is focused on reducing the need for children to come into public care and is based in Cardiff and Vale of Glamorgan.

Option 2 respond at crisis point and work immediately with families; families are seen within 24 hours or referral. Services are delivered in the client's home. Therapists are on call 24 hours a day, 7 days a week. Families are given as much time as they need, when they need it. This accessibility is intended both to be helpful and to allow close monitoring of high risk situations. Services are concentrated over a 6 week period and designed to help the family resolve immediate crisis and make the changes needed to remain together. Each family receives a large amount of direct contact therefore therapists work with only one family at a time. Services are provided when and where the client wishes. At the end of the period of intervention the aim is that there will have been considerable improvement in family wellbeing and safety for children. Families have follow-up visits in the months following Option 2 to support the changes that have been made and identify any re-occurring problems.

Therapists work to accept and validate the clients feelings, identifying and reflecting on the positive aspects within the family. Subsequent weeks can be spent dealing with practical problems which may pose barriers to change. As the relationship continues, work turns to setting goals for the future. Goals are aimed at helping the family resolve current problems and to build a positive future. This stage draws on techniques used in Brief Solution Focused Therapy, and sets a limited number of achievable goals for clients to work towards. This stage may involve teaching and learning new skills required to reach these goals, for example, anger management and relaxation.

In the final stage of intervention, clients are encouraged to practice their new skills. Attention turns to identifying and linking the family to any other service or resources that may be required to maintain their progress. The therapist withdraws at this stage, however close monitoring occurs over the year. Families can receive booster sessions if there is a further crisis or a relapse in levels of substance use. Therapists use a Motivational Interviewing (MI) approach throughout their work. MI involves attempting to build a relationship with family members. Once a client is engaged, a variety of methods are used to explore and resolve ambivalence about behaviour change.

Option 2 is an adapted version of Homebuilders, an American model. Homebuilders provide an intense short term intervention to improve living conditions and allow children to remain at home. It may be appropriate for some services to follow the Option 2 model very closely however, it can be adapted or developed in new ways.

For further information about Option 2, please contact Donald Forrester,
Donald.Forrester@beds.ac.uk

APPENDIX D: SUMMARY OF THE STARS INTERVENTION PROGRAMME

Issues to be Addressed	Approach/ Model (suggested)	Objectives	Interventions/Resources (examples only)
Me and who I am	Person - centred	<ol style="list-style-type: none"> 1. Build therapeutic relationship 2. Understand session structure and confidentiality 3. Model effective relationships 	'All about Me' board game Generic board games Information sharing policy
Family	Person – centred	<ol style="list-style-type: none"> 1. Explore family structure 2. Identify significant relationships 	Genogram 24 hour chart Story telling
Feelings	Cognitive Behavioural	<ol style="list-style-type: none"> 1. Identify feelings 2. Understand all feelings are okay 3. Understand relationship between feelings, thoughts and behaviour 4. Changing thoughts 5. Changing body responses 6. Changing behavioural responses 	'Feeling good' board game "Up Facts to stop you feeling down" book The Huge bag of worries book Discussion Puppets Role-play Anger solutions board game Counselling Balls
Drugs/Alcohol	Educational	<ol style="list-style-type: none"> 1. Understand effects of drugs or alcohol 	Drug box Quiz Worksheets
Parental drug/alcohol misuse	Cognitive Behavioural	<ol style="list-style-type: none"> 1. Understand why parents misuse drugs or alcohol 2. Consider effect of parental drugs or alcohol misuse on children 3. Consider effects of parental drugs or alcohol misuse on me 4. Consider coping strategies for this 	Rory Resource pack "Journeys" – Adfam book Art work Role-play Puppets Story books Helping Hand
Staying Safe	Cognitive Behavioural	<ol style="list-style-type: none"> 1. Explore safety issues inside and outside the home 2. Assess risk to self or others 3. Explore support networks 4. Ensure child knows what to do in an emergency 	Helping Hand

Other issues (identified by child/parents/carer or significant other)	Person – centred	<ol style="list-style-type: none"> 1. Opportunity to explore other key issues 2. Identify other support needs 3. Signpost or refer on 	Issue Cards
Closing	Person-centred	<ol style="list-style-type: none"> 1. Fun activity 2. Recap on previous sessions/actions 3. Ensure child knows who to contact for support 4. Refer on/signpost to other services. 	Generic Games Closing Pack

APPENDIX E: BARNARDOS HOPSCOTCH

Barnardos Hopscotch

Barnardos Hopscotch aim to provide direct support to children and young people between 5 and 18 years old who has a parent that has alcohol and/or drug problems. Hopscotch also work with young people who are living with a non-using parent but has a parent who is involved in substance misuse, if the non-using parent is happy for the referral to be made. Hopscotch work directly with children to reduce risk, to develop protective factors and to promote resilience. The project is not exclusively for high tariff children and families however it tends to be the case that families with serious issues are referred into Hopscotch.

Referrals come from professionals as well as self-referrals. On receiving a referral, which includes consent from the family for it to have been made in the first instance, Hopscotch firstly arrange to meet with the referring agent and any other professional involved. This is to establish if Hopscotch is the most appropriate route of support for the child or young person. The family is not involved at this initial meeting

Having established that Hopscotch is the most appropriate service, Hopscotch accept the referral and undertake a 12 week resilience based assessment and covers all aspects of the young person's life; looking across the various domains of resilience and identifying strengths and weaknesses. Hopscotch would meet with the family and the child and determine the best way to proceed depending on the circumstances. Typically, introductions would be facilitated by the referring worker and would include the family and the child, usually together. A detailed explanation of Hopscotch and the service they provide is given at this stage. Consent is received from the parent to work with their child – sometimes at the Hopscotch base and sometimes at the child's school. Periodic contact is kept with parents during this assessment process. Hopscotch's client is the child and therefore do not directly work with the family. However, they do work as part of a care plan which fits in with other inputs to the family occurring simultaneously and being provided by other agencies.

As part of the assessment process the worker would meet with the key people involved in the child's life; this of course would include parents, other family members and key professionals (education, social work). This assessment phase covers six domains (education, secure base, social competencies, friendships, talents and interests, positive values). In the ongoing interventions specific outcomes would be identified and worked towards from six possible outcomes which are included in their outcomes framework:

- Improved mental health and well being;
- Reduced impact of parental substance misuse on children;
- Able to report safety concerns and complaints;
- Link with reliable and supportive role models;
- Development through new experiences and interests;
- Views and opinions voiced and acted on.

These outcomes underpin the work that Hopscotch does and are in line with the GIRFEC resilience matrix. Hopscotch identifies specific outcomes with the child or young person as they will be particularly relevant to the circumstances and experiences of the individual child.

At the conclusion of the assessment period Hopscotch host an assessment meeting at which they coordinate an action plan to support the child to achieve the identified outcomes derived from the assessment. Thereafter Hopscotch review on at least a 6 monthly basis the ongoing work with the child. In reviewing outcomes Hopscotch use outcome scaling to measure progress and identify outcome indicators to evidence positive changes.

For further information about Barnardos Hopscotch , please contact: Laura Falconer, laura.falconer@barnardos.org.uk.