

REDUCING HARM TO CHILDREN AND FAMILIES AFFECTED BY PARENTAL SUBSTANCE MISUSE: ASSESSMENT OF NEED AND SERVICES IN MIDLOTHIAN AND EAST LoTHIAN

An independent report for
Midlothian and East Lothian Drug and Alcohol Partnership

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1. INTRODUCTION

1.1 AIM AND OBJECTIVES

The aim of this needs assessment was to inform Priority 3 of the MELDAP Delivery Plan 2012-2015:

‘We will reduce the harm to children affected by parental substance misuse’¹.

The specific objectives of this needs assessment were:

1. To identify the prevalence of problematic parental alcohol and drug use and numbers of children (under the age of 16) affected
2. To map existing service delivery to support children (under 16) affected by parental alcohol and drug use and the link with adult services
3. To evaluate whether existing arrangements for service delivery are appropriate to address the problems identified
4. To explore service users perceptions of an effective support service, in particular how best to intervene early in families affected by parental substance misuse
5. To review the impact on children of domestic violence and its link to alcohol misuse in particular
6. To provide an overview of models of service delivery for identifying and supporting children affected by parental substance misuse elsewhere in Scotland and the UK
7. To make recommendations regarding priorities and models of service delivery to support children affected by parental substance misuse and effective joint working arrangements between these and adult addiction services.

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 November 2012 and was successful. The needs assessment field work was carried out between December 2012 and May 2013 and was commissioned and funded by Midlothian and East Lothian Drug and Alcohol Partnership (MELDAP).

For further information about how MELDAP will take forward actions relating to this report, please contact: John Thayers of MELDAP, jthayers@eastlothian.gov.uk.

For further information about the findings and views expressed in this report, please contact Dr. Niamh Fitzgerald, niamh@createconsultancy.com.

1.2 INTRODUCTION TO RELEVANT RESEARCH

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 and can occur prior to birth, through childhood and affect individuals well into adulthood. Types of harm includes:

- Secrecy, denial, distorted realities
- Attachment, separation and loss
- Family functioning, conflict and breakdown
- Fear, violence (especially relating to alcohol problems) and abuse

- Role reversal, confusion and caring responsibilities
- Physical, social and emotional neglect.
- No clear boundaries, lack of routine, inappropriate supervision
- Educational disruption. ^{2, 3, 4, 5, 6, 7, 8, 9}

Lower levels of substance misuse may have more subtle impact but be detrimental to a greater number of children – and their potential to be Safe, Healthy, Active, Nurtured, Achieving, Respected, Responsible and Included (the GIRFEC ‘SHANARRI’ indicators).¹⁰

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.

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 responsible. The impact of parental substance misuse includes a whole range of effects, which are much more subtle than those that 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.

The challenge for services cannot be underestimated – many parents with substance misuse problems will never access formal treatment and the harm arising from their problems is often hidden.

This is particularly true in more affluent areas such as Midlothian and East Lothian, where alcohol use is higher than the Scottish average, but related hospital admissions and (prior to recent capacity increases) service usage (measured by PSURs) are low.¹¹ For drugs, treatment uptake is low in East Lothian, though a good uptake figure (50%) still means that half the families affected may not be accessing treatment.

In terms of meeting needs, the literature is clear that:

- Interventions with children of drug and alcohol using parents come too late, once matters have reached a child protection, rather than a family support or child ‘in need’ level. ^{12, 13, 14}
- Children need safe times and spaces where they feel comfortable discussing their experiences to enable them to access support. ¹⁵
- Parents need to be able to recognise when they need help and where to get it. ¹⁶
- Services need to be accessible, acceptable and effective, and should focus on meaningful, measurable outcomes. ^{17, 18}
- Universal, targeted and specialist services, and adult and children’s services, have a part to play and need to work closely together to better understand each other’s agendas and priorities. ^{19, 20, 21}
- Services should take a ‘whole family’ approach in the context of a holistic approach to recovery from substance misuse problems. ^{22, 23, 24}

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. What constitutes impact on children and young people cannot be easily quantified or defined 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)**
- **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 sufficiently 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. Potentially, the most effective way to achieve this is through a national population-level approach to reducing economic and health inequalities²⁵. It is also clear that the most effective means of reducing substance-related harm are not those measures directed at individual people or families but population-based policies that tackle price, availability and marketing, particularly in relation to alcohol²⁶. **The recommendations in this report should be considered in this broader context of whole population approaches.**

This report discusses how services can and do support a goal of improving parenting, how services support children directly to enhance resilience and coping strategies and how these harm reduction goals could be better achieved in future. It also considers wider services that 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.

1.3 SCOPE

This needs assessment sought to assess the need for and describe current provision of services seeking to reduce the harm arising from parental drug and alcohol misuse. A very broad range of services are relevant to the strategic aim of reducing harm caused by parental substance misuse. 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.

With this in mind, it is difficult to pick and choose which stakeholders and services were most relevant and important to include in the research 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 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 including contacts for broad statutory/voluntary services such as education, general practice, youth services, health visiting and so on.
- Telephone, individual interviews, group interviews and consultation with service users conducted both by the authors and in some cases by service staff.
- Previous work exploring models of services available elsewhere in Scotland and the UK and the research and other literature on best practice in this field.

The challenge of reducing harm in this field requires consideration not just of commissioned services but also of how the full range of statutory and voluntary services across the board respond to and support vulnerable parents and families prior to substance misuse, parenting or child welfare issues reaching crisis point.

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

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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 in identifying and reducing the harm caused by parental substance misuse in Midlothian and East Lothian.
- There are a number of limitations to the study given the timescales, data and resources available including a relatively small level of consultation with service users and lack of data relating to smaller local services.

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: Initiation, Stocktake, Models of Good Practice	<ul style="list-style-type: none"> • Sourcing, checking and analysing data to generate prevalence estimates from ISD, NHS Lothian Maternity Services and NHS Lothian Primary Care Services. • Desk-based review of previous work exploring models of good practice. 	
Stage 2: Engagement of Staff in Services	<ul style="list-style-type: none"> • Snowball sampling of relevant staff starting with list provided by MELDAP. • Interview schedules for universal and specialist staff developed. • All interviews and group discussions were electronically recorded and approximately 50% transcribed. 	48 staff interviewed as follows: 2 group interviews (both face to face) 5 paired interviews (4 face to face) 21 individual interviews (7 face to face) Interviews lasted about 60 minutes on average both online and face to face.
Stage 3: Engagement of Service Users	<ul style="list-style-type: none"> • Information for parents and for young people were developed separately and shared with services who were encouraged to suggest adaptations where needed. • Schedules of consultation topics and questions developed separately for parents and young people. 	24 parents and 8 young people involved as follows. 1 group discussion with 15 parents. 1 group discussion with 3 parents and 1 young person 1 group discussion with 5 parents 1 individual interview with a young person All above were face to face. 1 individual telephone interview with a parent 6 young people from 1 project completed a short questionnaire supported by staff.
Stage 4: Analysis, Write Up and Dissemination	<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. 	

2.2 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 smaller local services.
- 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 MELDAP. Informant interviews were recorded electronically in addition to extensive notes being taken during the interview/meeting. Most recordings were transcribed verbatim to facilitate timely analysis.
- 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 and their children who are not currently in contact with any services and their views are specifically missing. It may be that those parents and young people face even greater barriers to accessing support than those who did participate in this piece of work.

We feel that the service user consultation that was done has been valuable, however it would have been better had more people (particularly young people) been involved. Service users can sometimes prefer to speak with a trusted worker, however, that it is not conducive to the kind of feedback needed in an independent evaluation where feedback about the service they are accessing is also sought. More time and resources would be required to conduct a dedicated piece of work consulting service users on this topic which involved building trust with vulnerable young people and parents over multiple face to face contacts.

3. NEED AND PREVALENCE DATA: FINDINGS & DISCUSSION

- There are multiple difficulties with reporting an accurate picture of the numbers of children and families affected by parental substance misuse. These difficulties relate to issues of definition, identification and recording.
- Using Scottish Government criteria, it can be very roughly estimated that in the order of 1,500 children in Midlothian and in the order of 1,800 children in East Lothian 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 (see Appendix A).
- A minimum estimate of children affected by a problem drug using parent or carer is 709 across the two areas combined. This is based on figures from treatment and other services and relates to parents with opioid or benzodiazepine problems only.
- An estimate of the number of infants, children and young people up to the age of 18 living with FASD (foetal alcohol spectrum disorder) at any given time is 180 for Midlothian and 190 for East Lothian.
- Though the actual figures will never be known, we can say with a high degree of certainty that there are at least hundreds of families across MEL who are affected by parental substance use where the children, and in many cases also the parents, are not receiving any specific help from services. Fear about statutory action to remove children was the prime motivation behind maintaining such secrecy.
- The focus of action to reduce harm to children affected by parental substance misuse (CAPSM) must therefore focus on convincing such children and families that help is available and worth accessing.
- Services may be able to report more detailed data on children affected if asked to do so in future, however this would need to be clearly defined and for a clear purpose. 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 se.
- Some specific suggestions for improved data collection are discussed in relation to maternity services, treatment and recovery services, and education.

3.1 AREA-WIDE FIGURES IN DETAIL

3.1.1 DRUGS

- It is estimated that in 2009/10, there were 570 problem drug users in Midlothian, of whom 400 were male and 170 were female. The 95% confidence interval is 490 – 700 people²⁷.

²⁷ http://www.drugmisuse.isdscotland.org/publications/local/prevalencetables2009_10.xls. [Accessed 22nd November 2013]

- For East Lothian, the same estimate is 810 problem drug users, with 510 males and 290 females. The 95% confidence interval is 670 – 1,000 people.
- These figures are 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 Midlothian in 2010/11 reported to ISD²⁸:
 - 52% (63 of 122 clients) reported either living with their own or others' children, or having dependent children elsewhere or both (down from 57% in the previous year, and higher than the national figure (41%) for 2010/11).
 - 18% of clients (22/122) were living with their own children.
 - Up to 48 children were recorded as living with parents/carers who entered treatment that year for drug problems in Midlothian. 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.
- Of new patients entering drug treatment services in East Lothian in 2010/11 reported to ISD²⁸:
 - 51% (72 of 141 clients) reported either living with their own or others' children, or having dependent children elsewhere or both (down from 55% in the previous year, and higher than the national figure (41%) for 2010/11).
 - 20% of clients (28/141) were living with their own children.
 - Up to 36 children were recorded as living with parents/carers who entered treatment that year for drug problems in East Lothian. 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.
- A very rough estimate of the number of problem drug users living with children or whose own children live elsewhere is 296 (52% of 570) in Midlothian and 413 (51% of 810) in East Lothian. This assumes that all those in treatment and problem drug users not in treatment are equally likely to be living with children. Many will be living with or parents to more than one child, so 709 should be seen as an estimate of the minimum number of children affected by problem drug use by parents/carers across the two areas.
- In 2012/13, GP practices in Midlothian reported 210 children registered with a GP practice living with an adult with a diagnosis of drug dependence. This is based on figures reported under the Child Health and Wellbeing Enhanced Services Contract from 12 of 13 practices²⁹.

²⁸ 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.

- In 2012/13, GP practices in East Lothian reported 166 children registered with a GP practice living with an adult with a diagnosis of drug dependence. This is based on figures reported under the Child Health and Wellbeing Enhanced Services Contract from 15 of 16 practices.

3.1.2 ALCOHOL

- 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.
- Most recent Scottish Government figures (2012) state that analysis of the Scottish Health Surveys (SHeS) 2008-10 provides estimates 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 MEL.
- Taking a previous Scottish Government (2008) estimate as a starting point, it can be estimated that in the order of 1,500 children in Midlothian and in the order of 1,800 children in East Lothian live with parents with at least some level of 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 2003³⁰. 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. The basis for this estimate is outlined in Appendix A.
- Estimates of foetal alcohol spectrum disorder (FASD) (Scottish Government, 2012) suggest that in one in every 100 live births, the baby is affected by FASD and in one in every 1,000 births by Foetal Alcohol Syndrome. This would mean that approximately 10 children are born in Midlothian³¹ and 11 in East Lothian³² every year with FASD.
- An estimate of the number of infants, children and young people up to the age of 18 living with FASD at any given time is therefore 180 for Midlothian and 190 for East Lothian.

3.1.3 MATERNITY SERVICES DATA

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. Due to some changes in the system, 6 months of data for Midlothian and East Lothian from September 2012 to February 2013 are reported here.

²⁹ Data provided by NHS Lothian specifically for this needs assessment.

³⁰ A more detailed outline of the basis for this estimate is available in Appendix A.

³¹ <http://www.gro-scotland.gov.uk/files2/stats/council-area-data-sheets/midlothian-factsheet.pdf>

³² <http://www.gro-scotland.gov.uk/files2/stats/council-area-data-sheets/east-lothian-factsheet.pdf>

- Of the 1,104 records for September 2012 to February 2013, nine women or 0.82% reported drinking alcohol while pregnant. This varied from one unit up to eight units per day
- 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 class³³ 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).
- 31 women or 2.8% reported using any street drugs, gas or glue within the last year. Of these 31, six women or 0.5% of the total reported that they currently use any street drugs, gas or glue. This figure is also at odds with survey data such as that from the Scottish Crime Survey for 2010/11 in which 7% of women aged 16-44 reported having used drugs in the last year.³⁴

3.1.4 SPECIALIST SERVICES

- The tables below show the complexity of assessing how many children and families are currently receiving support. Some of these figures may be made up by children in contact with more than one service who have been double-counted. Other children known to be affected by parental substance misuse who are under statutory measures or receiving support from youth agencies (e.g. Place 2 Be, CLD etc.) are also not included. Similarly parents being supported by early years services are not included.
- Despite these limitations, when taken along with the prevalence estimates above, the 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 level of 'untapped need' was commented on by a number of participants:

"I remember a risk management case conference about a particular guy. Turns out the guy has two brothers who are both drug users who have never been in treatment in any of local services – and they have children. We know there are a large number of people out there who are doing that."

"There are children affected by parental alcohol use that no service will ever see. Some will recover."

Addiction services reported that many people coming into the service with alcohol problems were older with grown up children, and that there were other indications that alcohol use might be particularly hidden.

³³ Ford (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>

³⁴ Scottish Crime Survey 2010/11. <http://www.scotland.gov.uk/Publications/2012/03/2775/20>

“Speaking to our patients who are drug dependent, when they start talking about their growing up, these are guys in their twenties, women in their twenties, and they talk about history of family addiction and it tends to be alcohol. So there have been families growing up with alcohol, its played a big factor in that family but the parents weren’t known to us so certainly [a gap] must be there.”

- The data presented here is incomplete as it relates only to those services that both engaged with the research and who were able to provide relevant figures including specific CAPSM estimates or counts at the time.

Table 2: Specialist Services Providing Support to Parents and Families including Young People

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
Midlothian						
Children and Families Family Support Service	Managers estimate: 12 families per worker, 15.5 workers (family support and social work assistants) = 186 families. 60% affected by PSM = 112 families. This mainly includes families receiving ‘Stage 2’ support. This does not include families receiving Stage 3 support from Children and Families Social Work.					112 families getting support.
Family Support (C1st)	2012 1.5 WTE workers	18 families full service. 6 families brief intervention.	6 Dads 15 Mums Full service.	100%	17 males 10 females. 26 children (including some of the above) received group support.	24 families getting support. <i>This does not include families going through assessment/screening group.</i>
Hawthorn Children & Family Centre	Current point in time (2013)	72 families	All	29 parents	14 children	
MYPAS – Young People’s Service	April 2012- March 2013	37 young people	2	37	15 (not including the children of the 2 young people)	15
East Lothian						
Adult SM Social Worker	Current point in time (2013)	45 adults.	30 are parents.			
ADAPT	Current point in time (2013)				~20 children.	12 families
Throughcare and Aftercare Nurse	Current point in time 2013	7 adults, 3 children		3 are parents with substance misuse issues	Unknown	3 families
Olivebank Children & Family Centre	<i>No data specific to CAPSM kept.</i>					

Table 3: Specialist Services Providing Support Primarily Oriented to Children and Young People

Service:	Year	Overall numbers using service.	No of children APSM accessing service.
Midlothian			
Young Carers	Current point in time.	37 young people.	11 affected by PSM in some way; 5 or 6 PSM is main factor.
MYPAS	April 2012- end March 2013	37 young people	2 are parents. 15 are APSM.
East Lothian			
Young Carers			
Integration Team	6 months Sept 2012 to Feb 2013	15 young people including siblings from 10 families (during six month period).	12 children APSM (including siblings) from 7 families.
Bfriends			
Throughcare and Aftercare Nurse	Current point in time Sept 2013	10 including 3 aged under 18.	All 3 under 18s are APSM

3.2 DATA COLLECTION CHALLENGES

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.
- A need to be clear about the purpose of identifying children in this way – and to balance that against the possibility of risks to them or their family of doing so.

“No-one has asked us for this information in the past. In the past we have kept these statistics [on CAPSM] and we were sending them to the local authority and no-one was doing anything with them. We keep them for ourselves now because we want to show the work that we’re doing and the complexity of the work.”

All of the above issues are discussed further below.

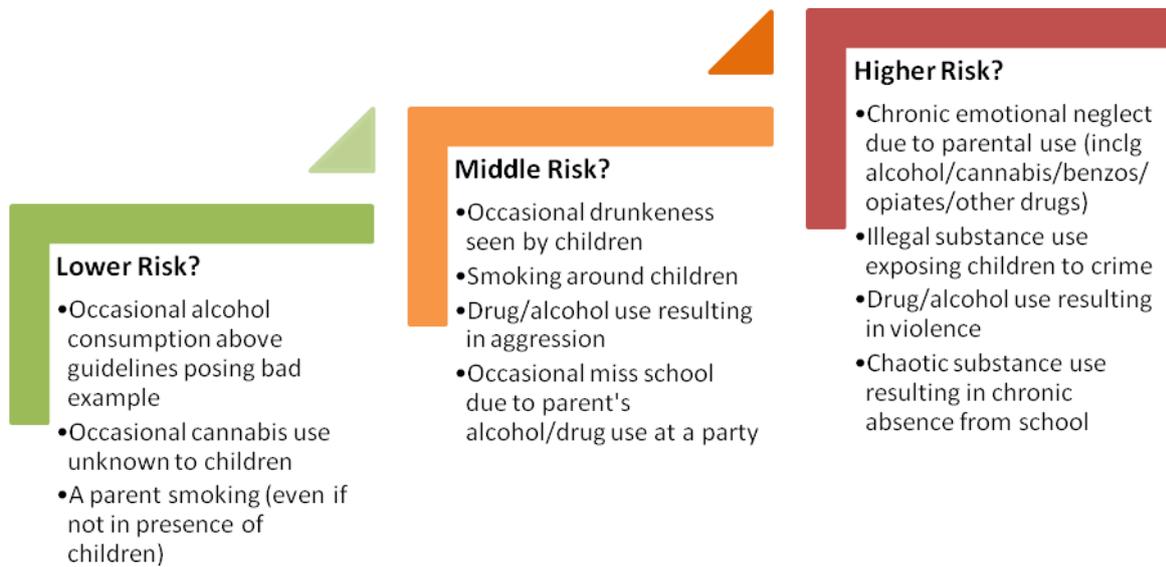
3.2.1 MULTIPLE DIFFICULTIES WITH CLEARLY DEFINING CAPSM

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?
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 highly subjective and could be subject to endless argument about the relative risks and dangers of different behaviours. 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.

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

Even if the concept of CAPSM could be defined, counting numbers 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.

“Can I also just say it kind of goes back to that point of what is normal? Because the youngster nowadays actually feel it’s normal to have a wee joint, right? Whereas it’s not, it’s normal in society but it’s not acceptable.”

“If somebody’s in denial as a professor or GP because they’ve got a lot to lose...lots of people will not deny it because they’ve nothing to lose, no job, no income etc. But they [the affluent clients in my previous post] were manipulating the situation, they were hiding, but the same impact was on these children.”

3.2.3 MULTIPLE DIFFICULTIES WITH RECORDING AND REPORTING SUCH IDENTIFICATION.

Many smaller 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. 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.

There are a range of issues to be considered in relation to how electronic recording can be improved. These are discussed below using two systems as examples. Similar issues arise with other systems.

- The SEEMiS system used by 28 of the 32 education departments in Scotland including both Mid- and East Lothian includes an ‘Additional Support Needs’ (ASN) module. This includes an option to indicate that a pupil has a range of ASN using a ‘pick list’, including if looked after/accommodated or if a young carer, and ‘substance misuse’ however there is no option to indicate that a pupil is affected by parental substance misuse
- Although many young people APSM may be young carers, many would not identify as such and their experiences and needs are likely to be very different from those young people caring for a sibling or parent for another reason. A recording of parental substance misuse could arguably be sufficient to determine that a child has additional support needs as defined in law.
- Systems such as SEEMiS and TRAK (in maternity services) are developed and owned by large national or international organisations, who provide them for use by many local organisations. This means that it is not straightforward to adjust the systems to facilitate better data collection, notwithstanding the challenges of clearly defining what is meant by such a designation.
- TRAK is devised by an external software provider who has been paid to develop specific screens for NHS Lothian 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.
- SEEMiS is updated and developed annually in accordance with the priorities of the local authorities which use it and also responds to Scottish Government data requirements. It was noted that the option of ‘young carers’ was added following the inclusion of the term in the National Pupils Census. In this case, the term was clearly defined and guidance provided by the Scottish Government so that the term would be used consistently across Scotland. If CAPSM was to be included as a category, a national approach would avoid the risk of different

authorities using a variety of definitions. The need for guidance and awareness-raising in relation to when and how the category should be used if introduced into SEEMiS was also noted.

3.2.4 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. It could even be detrimental to the chances of helping the family.

“There is no identifier for CAPSM in SEEMiS... We have never been asked to keep records on how many children are affected by parental substance misuse or who are the children affected by this. We would need to see what would be the purpose of identifying these children.”

Education practitioner

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. Likewise, 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.

3.3 THE WAY FORWARD

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

3.3.1 FUTURE DATA FROM TREATMENT AND RECOVERY SERVICES

Despite the difficulties outlined above, a useful concept that may be 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 MELDAP. 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. Therefore it would be valuable if other alcohol services (e.g. lower threshold treatment or counselling services) 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.

Recommendation 1a: 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.

3.3.2 FUTURE DATA FROM MATERNITY SERVICES

It would be valuable to introduce a change to the alcohol response options in TRAK to include a drop down list to assist with decisions on how to respond to women who do admit alcohol use. This could also encourage more honest reporting, which 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. Some improvements to TRAK have been made since we (the authors) previously considered this issue, however further work would be valuable as recommended below.

Recommendation 1b: NHS Lothian should lead further work to prevent and support accurate identification of alcohol consumption levels in pregnancy and to implement appropriate responses to the levels 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 linked to the alcohol brief intervention care pathway in antenatal settings³⁵.**
- **Additional support or training for midwives would benefit from observational research on how existing questions on alcohol are being presented to women at booking. [This research is currently being designed with a view to sourcing suitable grant funding.]**
- **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.**

3.3.3 FUTURE DATA FROM OTHER SERVICES

It is more complex to record clear information about who is affected by parental substance misuse in social work and education settings and so we recommend further consideration of this.

Recommendation 1c: Social work and education services should jointly consider what aspects of data recording would be beneficial to children and families, and if/how their systems 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 establishing exact prevalence.

³⁵ NHS Health Scotland (2010). Antenatal Care Pathway for Alcohol Brief Interventions: http://www.healthscotland.com/uploads/documents/12119-ABI_1_AntenatalCarePathway.pdf

Recommendation 1d: MELDAP should consider whether it is feasible and beneficial to require commissioned services to record and report service usage by children/parents/families affected by parental substance misuse.

4. SERVICES FOR FAMILIES, PARENTS AND YOUNG CHILDREN: FINDINGS AND DISCUSSION

- There is no straightforward way to categorise services because of overlap between target group, age and eligibility across many services. Rather than categorisation, a model is presented that suggests that a continuum of services is needed to support vulnerable or at risk parents both prior to and at the early stages of any problem with substance misuse and for those recovering from substance use problems.
- The suggested continuum ranges from universal prevention and support, to early targeted and re-integration services, to later and crisis-level intervention. It must be recognised that any such model will be imperfect in how it depicts the wide range of services relevant to this field, however it is helpful in considering potential gaps.
- There are a wide range of services working with families, parents and young children in Midlothian and East Lothian to reduce the harm caused by parental substance misuse. The number, fragmentation and diversity of services relevant to reducing the harm to CAPSM makes it difficult for practitioners and families to make best use of them.
- Overall, the information available about service availability, remits and referral pathways 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 or area. This is exacerbated by the use of confusing names and titles for jobs and service and compounded by a sense of complexity in relation to the range of systems in place for judging what a family needs and making referrals. There is a need to develop clear service pathways and an up to date service directory.
- Both parental substance misuse, and difficulties or struggles with parenting itself, are difficult for parents to admit, as they carry a high sense of stigma and guilt. Both issues can exacerbate each other or conversely resolving either issue may help to resolve the other.
- Universal and community services which have regular contact with children and parents are best placed to identify those parents (or prospective parents) who are vulnerable to stress, mental health problems, or other issues which may predispose them to substance misuse. Such services need to be accessible, build trust and be able to offer universal, accessible and acceptable forms of support with parenting or other issues either directly or by referral.
- A strategic and proactive approach is needed offering and providing parent support prior to any crisis point. This must not rely on parents revealing problems as this is unlikely to happen in many cases. Accessible, consistent, simple guidance describing the core principles of effective parenting for staff and parents is required. Recovery and treatment services need to consider their role in supporting parents as part of a strengths-based, whole-person recovery focus.
- All statutory services need to consider how they work with adults to make them more accessible and responsive to the needs of substance misusing parents. This will require strong leadership from senior staff and an openness to culture change.
- A co-ordinated commissioning approach should consider specific gaps in the development of services in particular: 'Level 2' services providing targeted support for vulnerable families and re-integration of recovering service users; support for parents of school-aged children; some specialist services; as well as capacity issues in some current services.

4.1 UNDERSTANDING AND DESCRIBING SERVICES

As outlined in Section 1.3, 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 that 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. This chapter focuses on services which are primarily oriented at parents or at families, and the next chapter focuses on services which are primarily oriented at children and young people.

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, the age of the children and the type of service. Services should operate on a continuum from those which are completely universal e.g. school, to those which are highly specialist e.g. specialist support teams for families affected by parental substance misuse. 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.

There is a need for a continuum of services to support vulnerable or at risk parents both prior to and at the early stages of any problem with substance misuse, and for those recovering from substance use problems. This requires creative thinking about services beyond those which have a specific remit in relation to CAPSM or substance misuse more generally and has a distinct purpose that is separate from but fits well with the staged approach of Getting it Right for Every Child (GIRFEC).

The table below lists services primarily oriented towards parents and/or families on a continuum from universal to specialist services in each area. Some services could clearly be listed in more than one place on this continuum but the important point is that ideally the continuum would fulfil the following functions:

1. **Level 1 'Universal' services:** These services include large statutory and small community-led services such as NHS, education, CLD and local/voluntary groups/initiatives. Together these have regular contact with children and parents and are therefore best placed to prevent problems with substance misuse arising by identifying those parents (or prospective parents) who are vulnerable to stress, mental health problems or other issues which may predispose them to substance misuse. Early identification of struggling parents should allow for steps to be taken to offer support either by the universal service, or by signposting/referring parents and families to other support (e.g. from another universal service or from targeted support by level 2 services). For this stage to work effectively it is vital that universal services are accessible and acceptable to more vulnerable and stigmatised families.
2. **Level 2 'Targeted' services** are more focused services which have a specific remit e.g. for vulnerable families with a certain issue or for parents who would benefit from a service tailored to their specific needs. This stage of services is ideally positioned for interventions to prevent deterioration in a family's circumstances; to provide slightly more intensive support to reduce stress and problems and enhance parents and families own coping. This stage must work effectively in order to reduce the numbers of families requiring intensive level 3 services, due to crises and statutory child protection measures. This stage also has a vital role in transitioning those previously supported at level 3 back into level 1 services. So

many community or service-user led services specifically focusing on recovery and re-integration would fit into this stage.

3. **Level 3: Specialist Services:** Relatively intensive services with a specific remit for supporting families seriously affected by parental substance misuse where there are complex issues; crises or statutory child protection proceedings. This includes voluntary sector and social work based family support teams; also children and families social workers and could also be considered to include treatment services for substance misuse which are focused on stabilisation.

“I think the great thing about the universality of services is that if everybody is actually using them, so that’s your first tier approach to GIRFEC. Then you’ve got your second tier, so then those who are delivering those first tier services can actually maybe earmark those who need extra support. So what you’re then doing is making a continual assessment of the parents and actually could we earmark it and offer extra support. So what we’ve got established; prevention, early intervention before we get to Stage 3.”

Table 4: Services Aimed Primarily at Parents and/or Families

Service	East Lothian	Midlothian	
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/Schools	Universal services providing childcare and/or early years education. Children aged: 6 wks to 5 years and various age ranges within that in some ests. 3-5 years entitled to a place. Includes wraparound services where available. Primary and secondary schools.	
	Parent & Toddler Groups/Courses	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. Also baby massage – patchy coverage.	
	Book Start Groups	Library based group singing, rhyme and story sessions. Parents/carers with pre-school children.	
Specialist	Parenting Education	Education programmes to improve parenting e.g. literacy, numeracy and play skills; parent-child relations etc. Incredible Years; Raising Children with Confidence; Escape	Any parents of children under 5 (e.g. PEEP). Vulnerable parents (e.g. Mellow Parenting; Incredible Years)
	Health Visiting Teams/GPs	Universal NHS service for children and families. Clinical medical services. Everyone for GPs. All parents with children for health visiting. Intensive support to vulnerable parents/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.
	Community-led Parenting/Childcare Support	First Step Community Project: Supportive centre-based, outreach activities - funded nursery, parenting & group-based support. Parents, grandparents and children aged 1-4. Musselburgh only. Also Home Start .	SureStart Midlothian: Supportive centre-based, outreach services in 6 locations for parents of children in early years (0+). Groups, parenting, complementary therapies, counselling, baby massage etc.
	CLD-led Support	Targeted work in East Lothian with groups of vulnerable parents in partnership with health visitors, Olivebank and social work. e.g. group-based support for vulnerable families in Dunbar – mainly where children are 0-3yrs. Community groups in Pennypit.	Joint working CLD-MYPAS – streetwork, community development work and related groupwork e.g. graffiti art – to build trust.
	Targeted Statutory Child &	Olivebank: covers areas of high deprivation in East. Childcare, Parenting and family	Hawthorn: Targeted support for families mainly where statutory proceedings are in

4. Services for Families, Parents and Young Children: Findings and Discussion

Family Centres	support, reduced ratios. Children aged 2-4 and parents.	place. Children pre-birth to 5. Childcare, parenting, family support etc.
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. Family support workers (via integration team in East Lothian; and in children and families Midlothian	
Treatment and Recovery Services	NHS Substance Misuse; Self-Help/Fellowships (AA, NA, SMART); Voluntary Sector (MELD; ELCA). Support adults with substance misuse problems (including alcohol); Child protection responsibilities, but services are not aimed at CAPSM. Includes a variety of one to one, groupwork and recovery-oriented programmes.	
Al-Anon/Families Anonymous	Self-help group and one to one peer support using 12 step model. Anyone (aged 12+) affected by someone else's drinking/drug use.	
Specialist CAPSM Family Support	Children 1st: Young Families Outreach (not specific to substance misuse), ADAPT: families with children pre-birth to age 11.	Children 1st: Family Support Team.

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

It is essential to note that this table 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 many of the organisations or services listed, however service providers have not signed off on these specific descriptions.

Many of the services listed outlined constraints on capacity including waiting lists and/or greater demand than could currently be fully met (e.g. EL Young Carers, Olivebank, ADAPT, Hawthorn, Midlothian SureStart, Children 1st family services in both EL and ML etc.). This was expected to worsen as local authorities funding positions continue to deteriorate. These economic pressures were already filtering through to cuts in services in organisations included in this study e.g. Children 1st East Lothian. At the same time, the needs of families are expected to become greater as welfare reform put additional strain on parents.

4.2 SERVICE INFORMATION

The populations covered by MELDAP are relatively small and this was felt to aid staff in knowing the staff involved in services, what services were available and their remit. Notwithstanding this, the number and variety of services relevant to reducing the harm to CAPSM makes it difficult to quickly assimilate a clear picture of what support is available and what is best for particular service users.

While many staff felt that they knew who was who, few people had an adequate understanding of services at all levels in the above continuum for both parents and children, and many acknowledged that it is difficult to maintain a clear picture of what is available for whom and when. Teams and workers have (sometimes overly corporate) inaccessible titles, can have different titles but similar roles or, in some cases, the same title but very different roles. This is very confusing and leads to something of a lottery about what support a family might get.

Nowhere are services presented in line with the above continuum (from universal to targeted to specialist services) with clear guidance for staff and parents as to what might be helpful at different

stages and what the particular remits and criteria are for accessing each service. This is unhelpful for generating appropriate referrals and uptake of services. 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 therefore a need for much clearer, up to date, accessible information for parents and staff about when, where and how they can access services as discussed below.

“There’s the broader bit about just knowing what supports are there more generally I think. I’m not actually clear in East Lothian what we’ve got to be perfectly honest with you and I should do”.

“We do feel that...we need more information about what supports are available – there are lots of changes over the years.” (Midlothian practitioner)

Overall, the information available about service availability, remits and referral pathways 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 or area. This is compounded by a sense of complexity in relation to the range of systems in place for judging what a family needs and making referrals. This was alleviated to a certain extent in Midlothian through the existence of the Midlothian Substance Misuse Screening Group because it was used by practitioners from a wide range of statutory and voluntary sector services both for referral into the group and in receiving referrals from it.

Strategic Recommendation 2: There is a need for much greater clarity and a clear service pathway from universal, to targeted, to specialist support for parents, families and children affected by PSM to support appropriate referrals, monitor gaps, facilitate recovery and re-integration and inform service users of their options.

Recommendation 2a: MELDAP, in collaboration with multiagency partners from the statutory and voluntary sector, should consider how to compile and maintain a clear service directory including up to date, details of services and support for parents, families, children and young people affected by parental substance misuse at all levels.

The presentation of such information 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, locally-based organisation to conduct comprehensive mapping of services in each locality at a deeper level than could be conducted for this needs assessment and maintain the information on an ongoing basis.

4.3 LEVEL 1: UNIVERSAL SERVICES - EARLY INTERVENTION WITH PARENTS/FAMILIES

As outlined above, these services include large statutory and small community-led services such as NHS, education, CLD and local/voluntary groups/initiatives. Together these have regular contact with children and parents and are therefore best placed to prevent problems with substance misuse arising by identifying those parents (or prospective parents) who are vulnerable to stress, mental health problems or other issues which may predispose them to substance misuse. To adequately fulfil this role, such services need to be able to be accessible to such parents, have sufficient contact with them to build trust, and to offer universal, accessible and acceptable forms of support.

Conceptualising the role of universal services in relation to CAPSM requires an acceptance that all substance misusing parents need support with parenting, 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. For some it happens through their own experiences and contact with other parents, friends or family. Others learn through antenatal parenting classes, or through community groups such as the parent & child groups or 'rhyme time' and the myriad of other social opportunities for parents which are available. Others will read books or attend local seminars or classes about various childcare topics or about parenting in general.

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 all contributed to an overriding sense of stigma associated with a parent 'admitting' that they are struggling, unhappy or need help with their parenting role.

"We can't say we've had a really bad day and I slipped up once or something because we know that it will go straight back to social work. So you can't really, after you've had a social worker, you can't really speak to anybody, at least I can't anyway."

It could be argued that while the impact of substance misuse on parenting is often discussed, the impact of parenting stress on substance use, and its potential to increase substance use is at least of equal importance. 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.

"I've always been a single parent. I've never had a partner there. And that's hard work. And sometimes I think a lot of people blame that on the substance misuse, but it's not. It's because it's really hard."

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."¹⁰

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.

The need for action to enhance access to appropriate parenting support has been discussed in detail elsewhere¹¹. A key factor is that both enquiring about and asking for help with parenting support is

¹⁰ Mitchell, F and Burgess, C (2009). A research review on working with families affected by parental substance misuse. <http://withscotland.org/resources/working-with-families-affected-by-parental-substance-misuse-a-literature-review> [Accessed 22nd November 2013]

experienced as difficult, and parents with substance misuse issues who are struggling therefore experience a double-stigma. As a result, most substance use by parents is hidden from services:

“I did find that I was in tears one day...because one of the midwives was very surprised to hear that I had an older son and even more surprised to hear that I was looking after him. And it really got to me, you know, the stigma that people tar everyone with the same brush, everyone who has a problem.”

“We should be able to speak the truth without getting the bairns taken off us. I hide a lot of things because I’m scared in case the bairn is taken off me.”

“You want to be honest but then again you can’t because you’re getting penalised for it. Punished for it.”

The issues involved can be summarised as follows:

- There is a need to consider how all parents, prior to any crisis point, can be supported to access appropriate parenting support. This could be through family/peers/community or more formal provision.
- Parenting support is surrounded in jargon and acronyms that are many and varied (Solihull; attachment; PEEP etc.). Like parents, universal staff 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 that are understandable and accessible to non-specialists in this field (teachers etc.) outside of early years staff. These core principles should be seen as a value statement agreed by all partners, informed by evidence, in collaboration with parents, as to what is important for the long-term wellbeing of children.

“Health, education, social work, I think they all talk about positive parenting. I think that’s broadly universal”....Interviewer: “Do people know what that means though?”.... “I would totally agree with you. Every role that everybody, professionally, there is differences in their language and their jargon.”

“It’s about standardisation. It’s about making sure people are delivering core information at core times...yes you’re autonomous, but you still have to be able to deliver at certain points in this child’s life.”

“It’s about the language they use. It’s also about what the parents interpret is actually being said to them so there’s that two way gap.”

- The issue of varying approaches has been recognised in East Lothian:

“Well what we decided as a multi agency team in East Lothian, at some point, and we’re now regrouping to do that again, especially with the Early Years collaborative and stuff like that. it’s looking at, you know, what different styles and approaches are being used and, you know, is that enough, because we do want to be giving the same message across the piece. So for example all the public health teams were trained in Solihull approach so that everyone

¹¹ Fitzgerald, N., Heywood, S. and Johnston, L., (2012). Assessment of need and review of services for children, parents and families affected by parental substance misuse in Edinburgh City.

was getting the same message no matter where they went and there was some kind of standard.”

- Services and staff need to be supported with appropriate training and guidance on how to ask about parenting support needs and where support can be offered. The design of a short structured conversation (mirroring the stages of an alcohol brief intervention) would be helpful in making the task appear manageable.
- A change in culture across services is required to make proactive identifying and offering support for parents something that is done proactively – by all universal services – health, schools, CLD, early years etc. The presence of substance misuse does not mean that only a specialist service can support a family but there was a sense that other services might not readily recognise what they can offer.

“Certainly pre-school, nursery, that sort of thing, that are not necessarily seeing it on a regular basis, they would more sort of expect that there’s other specialist services that would support the family around that. Whereas in actual fact they could be dealing a lot with the parenting or, you know, other issues around about that anyway. There’s a little bit of, I think a little bit of a fear of I don’t know what I’m doing here.”

- Parents need to feel comfortable before they will disclose problems or ask for help. It is therefore important that they are able to access lower-threshold services with which they can build a relationship to a point where they feel comfortable talking about either their substance misuse or parenting issues.
- Conversations about parenting support are already being carried out by some staff, especially in the early years, however, such conversations are much less likely to happen as children get to school-age and older. Yet when children are of school-age, the headteacher is normally the named person for a child, and the school may be the only service in regular contact with the family. Schools therefore need to be better supported, set-up and empowered for early intervention.
- This may best be achieved by considering how to pool budgets across teams/services as this is very relevant to other agendas including increasing co-operation between parents and schools generally and reducing inequalities.
- There is a need for co-ordination of parenting support across the board to avoid duplication and reduce confusion about what is available where.

“There are lots of organisations who do parenting work but is it the right parenting work? Families could get confused at who’s doing what. So you might have adult services working with the parent on some specific role but they might veer into parenting advice. You might be a health visitor who will give guidance as a parent, you may have Children First coming in saying we will do a specific Mellow Parenting, Triple P piece of work with you, and you may have somebody else, Children & Families worker...there’s lots of people potentially involved. So I think there is a number of organisations out there who support the family or individuals within the family. Are they joined up? No. I would say that’s the problem.”

Strategic Recommendation 3: Midlothian and East Lothian councils, in conjunction with NHS and third sector partners need to take a strategic approach to parenting support and access to such

support. This will require co-ordination and clarification of service provision in line with a developed care pathway. They should also ensure that all services in contact with parents of children of all ages (including schools) 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.

Recommendation 3a: Midlothian and East Lothian Councils, 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 and used across all services enquiring and educating about parenting.

4.4 ADULT TREATMENT AND RECOVERY SERVICES - FACILITATING PARENTING SUPPORT

Supporting parenting skills is very much in keeping with the recovery focus which Scottish treatment services are seeking to deliver. Aside from the benefit to children, supporting parents in their parenting role through problem-solving, behaviour management, enabling peer support and family support and building confidence offers another helpful tool for building recovery capital.

Parents who misuse substances often struggle with feelings of guilt around how their substance misuse affects their children and this can fuel ongoing substance use or relapse. When a parent begins to recover from substance use family dynamics can be complicated when a child, who was previously the main carer for his/her family, suddenly loses that responsibility if the adult involved begins to resume the parenting role. Although substance use may be reduced when a person starts their recovery journey, it takes time to address underlying issues and for parents these will often include needs relating to their role with their children. The circular links between substance misuse and parenting stresses are clear as described here by one worker.

“There was an intense range of support working with the client. It was recognised that the client was really struggling with getting her daughter to bed and with her daughter’s behaviour generally throughout the day. She was taking more diazepam when she was going out. She wouldn’t be embarrassed at what people thought about her children when she had taken the diazepam.”

It would therefore make sense for treatment services to take on a proactive role in relation to identifying parenting support needs and offering basic support and/or signposting to others who can. The involvement of recovery champions and developments such as the national ‘Circle of Care’ proof of concept project suggest further opportunities to involve family and community members in supporting parents in recovery¹². The importance of focusing on families’ natural support networks (a key feature of Circle of Care) was noted in the current study:

“But also looking at widening out families natural support network because none of us would say that social work was part of a support network. Whoever is in their family or their friends...the whole thing about resilience and children having a trusted adult.”

“That’s where the community does become important, looking at the wider circle of support and looking at who else can support you.”

¹² Fitzgerald, N. and Heywood S. (2013). “If I didn’t have that Circle, I don’t think I would have made it.” Evaluation of the National Circle of Care Proof of Concept Phase. In draft.

The delivery of recovery oriented services and systems of care appears to be patchy currently as noted above and recently¹³. MELD were the only service to make the link between the CAPSM agenda and the work they are doing on recovery in this research.

“We’ve recognised that there are gaps in relation to services, particularly those that would be increasingly viewed as being about sustainable recovery. Historically we’ve worked with clients at the chaotic end of the scale, then they might be stabilised and there’s not necessarily supports there to sustain stability. Over the last two years we’ve been trying to pilot and develop moving on services.”

“[Our service for recovery] has broken down barriers about [the service users’] perceptions of who they are. It equalises the power imbalance. They come here cap in hand. ‘I can’t control what’s going on in my life’ and now they are taking back control.”

As noted above, there is also a need for clarity and consistency about the language that should be used in conversations about parenting and the need for this was also clear from descriptions of conversations with substance users. Our sense is that these still tend to be more focused on identification of risk (see first quote below), are not always as proactive as they might be (as in second and third quotes below) and are less likely to focus on the provision of encouragement and support (as in the fourth quote).

“We challenge their ability to parent. If they say things like they always use in another room – what happens to your child while you’re doing that? What if there’s an emergency or crisis?”

“I could probably be better at more routinely asking about that. I would obviously ask more if I picked up on it.”

“We don’t proactively screen for that but often would be getting information about that.”

“We always say to them, how are things at home? How are you managing the children? Are your children going to bed at night? Any problems? There’s great little clubs about, there’s people that can come and help you...”

The language around parenting enquiries is very important in encouraging trust so that a parent can ask for support and is quite different to the language and culture of risk identification/management. 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 experience from parents in trying to support children that was reported earlier. Some comments indicate some doubt amongst treatment providers about the boundaries of their role in relation to this issue.

“We’re not funded to deliver parenting support.”

There needs to be a shift in culture in treatment services so that conversations about and access to parenting support become more normal. Holistic assessment tools similar to the ‘My World

¹³ Scottish Drug Strategy Delivery Commission (2013). Independent Expert Review of Opioid Replacement Therapies in Scotland.

Triangle' tool (from GIRFEC) may offer one way to include discussion of parenting confidence, ability, support, capacity, skills, feelings as a follow on from a broader recovery conversation. Such conversations about parenting support could also be supported by node-link mapping and ecomaps that are a feature of strengths-based, recovery oriented approaches to care such as the 'Treatment Process Model'.¹⁴ The establishment of clear common principles of effective parenting (as discussed above) would greatly aid with consistency and accessibility of language around parenting across all services and would support workers in substance misuse services in having these discussions.

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 the next chapter about providing direct support to children and young people.

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. This was particularly apparent where services were co-located e.g. ADAPT in East Lothian with social work; or Children 1st Family Support team co-located with NHS substance misuse services. 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.

Undoubtedly, there are workers who 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.

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. This is discussed further in Chapter 6 below.

Recommendation 3b: All adult treatment and support services (including Tier 2, primary care and self-help groups) should consider how they can support parents (through encouragement/guidance/signposting etc.) as part of a strengths-based, whole-person recovery focus. This should be done in addition to and separate from any work relating to formal child protection. Parenting should be discussed on an ongoing basis as a normal part of treatment, and specific structured conversations should take place 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.

4.5 TACKLING STIGMA AND INCREASING ACCESSIBILITY OF SERVICES

It was universally agreed that it is important 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

¹⁴ Best D. (2011). Treatment Process Model Staff Manual for NHS Lanarkshire.
<http://www.lanarkshireadp.org/Professionals/SupportforProfessionals/Documents/TPM%20Staff%20Manual.pdf>

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 as well as parenting groups and so on.

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.

“It was a wee group that met up, but yet again after I had an addiction and I would excuse myself for not going because I thought there’s nobody else there that’s a single parent and I always felt like the odd one out.”

“Why do people not access services? 1. They feel that child protection measures may come in. 2. It’s an admission of guilt that they’re not a good parent. 3. They’re stigmatised. That’s a whole list.”

Recovering substance using parents require specific support to access many services, and this support is not always available. Others, who may be at a very early stage of substance misuse or experiencing stress or problems with parenting, may not be aware of what is available, or feel comfortable accessing it.

If parents with substance misuse histories are to be better supported into community groups (such as parent and toddler groups, rhyme time, and where they are developed, social support groups for parents of older children and teenagers) such community-based groups need to proactively promote the idea that everyone is welcome regardless of background. The development of recovery-focused initiatives and services generally and initiatives such as the national Circle of Care proof of concept model offer examples of work that should eventually help to break down current stigma, though the recovery agenda generally has not yet progressed sufficiently to make a real impact in all areas¹⁵. It was mentioned rarely in this work outside of treatment services, yet the ambition of the recovery movement involves transformation of societal attitudes towards substance misuse much more broadly.

Unfortunately, many services and initiatives are still perceived as being ‘not for people like me’ despite the success of self-help groups such as Alcoholics Anonymous and other recovery communities in welcoming everyone. Recovery champions and movements have a lot of potential in changing attitudes and perceptions of the general public, as well as building the confidence of service users so that they are not afraid to use community services. This is particularly important in relation to small towns and communities where people’s personal histories are well-known.

“A lot of towns that we work in are pretty small – so someone’s individual circumstances are pretty well known. It’s not to say that when they go they are being treated differently but they are reluctant to engage. Some will come across prejudice and discrimination – from the people accessing the group – clients would experience that.”

“If you lived in East Linton area and you’re a substance user going to that mother and toddler group...there are massive barriers – self-esteem – confidence etc. so you feel disempowered

¹⁵ Scottish Drug Strategy Delivery Commission (2013). Independent Expert Review of Opioid Replacement Therapies in Scotland.

about how others feel about you. Your history and offending, antisocial behaviour etc. are very well known to the community. The person may recognise the changes that they themselves have made, but others may not."

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 may need only simple support to become more open. Others may need time to reflect on and change attitudes or prejudices. Some key principles for moving forward have been discussed elsewhere.¹⁶

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.

It was clear that such stigma was not only experienced by service users, but has also been observed in the attitudes of staff. One participant described the variable attitudes of GPs towards substance users:

"I think the reality is that [drug users] are viewed as a nuisance by the majority of GPs and I don't know how easy it is to change that and how much GPs would want to change it. I'm quite shocked dealing with... GPs who I would say don't have a positive outlook on dealing with substance misuse... There's maybe feeling of well people have brought this on themselves, that perhaps they don't see it as a medical problem as more a lifestyle choice that has gone wrong. And I think have probably been affected by other people with substance misuse issues who they feel have manipulated them in the past."

We are by no means the first to discuss and recommend action to enable better access to services for drug users. Indeed, in November 2010, the RSA argued for a 'progressive universalism' which while available for all, offers most support for those who need it most¹⁷. This was also discussed in detail in the 2010 'Melting the Iceberg' report by the national Independent Enquiry group¹⁸. There is also a whole body of work which discusses inequalities sensitive practice which will be informative in moving forward¹⁹.

"Drug users should be treated like any other recipients of public services. They have not forfeited their rights to effective support and they may need it more than the average person if they are to achieve their full potential."²⁰

Strategic Recommendation 4: There is a need for large statutory services (including General Practice) to audit and improve how they work with adults and young people to make them more accessible and responsive to the needs of substance misusing parents and those affected. From a

¹⁶ Fitzgerald, N., Heywood, S. and Johnston, L., (2012). Assessment of need and review of services for children, parents and families affected by parental substance misuse in Edinburgh City.

¹⁷ Daddow R. and Broome, S., 2010. Whole Person recovery: A user-centred systems approach to problem drug use. RSA.

¹⁸ Independent Enquiry into Scotland's Drug and Alcohol Problem (2010). Melting the Iceberg of Scotland's drug and alcohol problem: report of the Independent Enquiry.

¹⁹ www.equalitiesinhealth.org has guidance and examples of ISP projects. Also worth looking on the Glasgow Centre for Population Health website: www.gcph.co.uk has a number of useful publications on this topic.

²⁰ RSA, 2007. Drugs – facing facts. The report of the RSA Commission on Illegal Drugs, Communities and Public Policy.

prevention perspective, there is a need to consider how all universal and statutory services take an inequalities-sensitive approach to meeting people's needs. This will require strong leadership from senior staff and an openness to culture change.

4.6 GAPS IN SERVICES FOR PARENTS AND/OR FAMILIES

4.6.1 LEVEL 2 SERVICES – NOT HIGH TARIFF, NOT UNIVERSAL

These services are perhaps best described as services for parents and families with some kind of vulnerability but who are not in crisis or do not have problems that could merit statutory child protection action as outlined in Section 4.1 above. The capacity of many of the statutory services working with families in difficulty is limited and largely taken up with higher tariff or crisis cases. Participants in this needs assessment were clear that this 'middle' group were the parents and families where the greatest gaps in service exist both in East Lothian and Midlothian.

"The ones that don't reach the threshold [for child protection], that don't reach that point of required intervention, they get put on an unallocated list until sad to say it escalates up and there is a deterioration in the substance misuse then children and families and statutory services will pick it up...these families would have a degree of need but...limited resources, lack of social workers, family support workers, you prioritise the priorities."

"It's almost like, it's the old story of you have to have a crisis and then you get the help. But you can't get the help before the crisis."

The work of the Midlothian Multi-Agency Screening Group was felt to have helped in having something to offer some of these families in need. In addition, it was felt that social work services would like to be able to offer more to families at a Stage 2 level of need, at least in part so that workers had a balance of working at the 'heavy hard core' as well as at earlier intervention.

The gap noted was not only in providing support to families early, but also in relation to there being suitable supports available to transition vulnerable families from specialist back into universal services.

"What is available from that middle core, if you like going back into universal service, what is that transition? What is that link?"

"We need special groups for a short duration, only for people who definitely require them... to assist people to move into community groups in their own local setting."

Specific gaps were noted in relation to services and outreach support for vulnerable families with young children as noted here, and in relation to families with school-aged children (see next section).

- Olivebank services are not currently available to families of children under two years old, though such a development is being discussed as it was a recognised gap. In addition, there is no equivalent service to Olivebank in the West of the authority.
- Children 1st provide a Young Families Outreach service in East Lothian for families who are vulnerable and under stress and have children aged zero to five years. Funding for this service had just been reduced at the time of this research being conducted.

- In Midlothian, Hawthorn services are generally taken up with high tariff cases and are only available in one geographic location. The need for a 'Hawthorn-type' service in Mayfield was noted as a gap, as was a need for a bigger outreach service to work with *'what should be better in the home rather than coming here'*.
- The work of Midlothian SureStart fills an important gap in services across six locations though the level of service is greater in some areas while others are part-time and capacity is a problem. *"Our waiting list is huge. If we had more family support workers that were able to go out and support, there's so much more we could do."*

It is notable that these services are not specific to substance misusing parents but could work with families affected by a wide range of vulnerabilities.

The evidence reported by staff in some of these services suggests that they are very well placed to identify and support the hidden population of parents who are using substances at worrying levels but not at levels that would merit child protection action. What is striking about the reports from staff in these services was that parents trusted them enough to regularly reveal the levels of their drinking and other drug use, to the point where it was clear that there would be a degree of impact on children. The following quotes are about parents' reported alcohol use as described by staff:

"It's seen as social. When I had discussions with those women it wasn't made an issue or a problem..."

"It's large amounts of alcohol. It's not like a couple of wee drinks that you go out for..."

"Monday they've got the skinned knees. There have been consequences over the weekend."

"They talk about the situations they find themselves in, they've passed out or they don't know where they've been..."

"The children are there when they're drinking. They say they're not but they are..."

Other drug use was also disclosed:

"We also have solvent rushes as well, and prescribed drugs. There's an awful lot. They talk. They're pretty open, but there's quite a lot of swapping prescription drugs, a bit of negotiating and topping up the methadone with some other."

We feel therefore that these staff have a vital role to play in reducing harm to CAPSM in vulnerable families. They are already seeking to address these issues, however training that might help them to play this role more effectively is discussed in Chapter 6.

4.6.2 SUPPORT FOR PARENTS OF SCHOOL-AGE CHILDREN

It was also apparent that there is little 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.

"I have families coming back time and again because they go to nursery and maybe a year down the line...I've had families with kids at primary school and they come back to us because they don't know where else to go or they can't access..."

“When the children go onto school and that’s when the parents find it difficult to cope with homework and that if they’ve got literacy problems...and homework clubs are closing.”

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 could 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.

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 and services as discussed above.

One service user noted specifically that she had been ‘*made to attend*’ the Incredible Years parenting programme by her social worker who felt she needed support with disciplining her daughter. She attended the programme though she felt it wasn’t useful as it was aimed at mothers of younger children and her daughter was 12/13. Many respondents mentioned the Escape programme as more targeted at parenting support for parents of older children, however the service users with whom we spoke had not heard of it or been offered it. They were very interested in attending but on investigation, it was unclear whether additional funding would be required to enable such parents to access an Escape course specifically for them.

4.6.3 SPECIALIST SERVICES FOR PARENTS WITH SUBSTANCE MISUSE ISSUES

The specialist services for parents with substance misuse issues are provided by Children 1st and ADAPT.

- Children 1st provide a specialist family support team in Midlothian although there was a sense that they could not promote the service to a large extent as they would be unable to cope with a much larger number of referrals.
- ADAPT provides a service in East Lothian which has an upper age limit for children of 11. It is also possible that the Young Families Outreach service also in East Lothian meets some of this need.
- There is a need for specialist services to have a remit to increase expertise and capacity within universal services to pick up on and support less chaotic parents with their parenting.
- There is no specialist midwifery service for women who have substance use problems in pregnancy. This kind of service is available through PrePare which serves Edinburgh City but it is a City of Edinburgh Council initiative, which means it is not available to women in Midlothian and East Lothian.
- For families or parents with the most complex needs e.g. co-morbid substance use and mental health problems, there can still be difficulties in getting suitable co-ordinated support and there was a sense that such families are sometimes passed from service to service.

4.6.4 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 is one Al-Anon meeting in Haddington each week, though none in Midlothian²¹. 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 Midlothian or East Lothian.

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/Families Anonymous/Al-Ateen protect young people accessing support through them (both through child protection procedures and arrangements for membership of the Protecting Vulnerable Groups (PVG) scheme where necessary).

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 issues about child protection highlighted should be addressed pragmatically and quickly. This should then 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.

4.6.5 SERVICES FOR MINORITIES

There was a sense that services were not being accessed by many ethnic minorities, which would reflect the broader population of the areas however the small numbers could potentially mean that those minorities are more vulnerable to social isolation. The development of specialist services is not seen to be the solution to this, but efforts should be made to ensure that all services are adapted to meet the needs of equality groups with protected characteristics covered by the Equality Act 2010.

4.6.6 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. There is no such treatment currently available in Lothian,

²¹ Al Anon website search for meetings: <http://www.al-anonuk.org.uk/meetings/>

although a previous needs assessment in Edinburgh City has recommended that provision in this area be looked at.

“Like if I had a partner I could say, I’m going to detox, look after the kids. I’m going to take myself off somewhere.”

“The only places are down in England and they are talking about at least 12 weeks and that’s an awful lot of time to go without seeing my children.”

- Concern was raised that out of hours social work in East Lothian is currently provided through an Edinburgh-based service and so the geography may place East Lothian at a disadvantage in the event of simultaneous crises happening in two areas, if one is for example in the South of East Lothian and the other crisis much nearer. There was also a sense that families needs are just as great outside of office hours and this was a gap:

“You want to keep the baby with mum at all costs so long as the risk is manageable. But if she doesn’t know how to bath him, she doesn’t know how to settle him at night, you know and its getting somebody out there those hours, you know, 7, 8 o’clock at night to show her. To be a mentoring type person. And yes, I suppose just a bit of company and that.”

- Crisis intervention was not part of the remit of this needs assessment, however, it is worth noting that 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 have been published previously.²²

4.6.7 RECOMMENDATIONS ARISING FROM IDENTIFIED SERVICE GAPS

Strategic Recommendation 5: There is a need for commissioners from across the public sector and other funders to come together to jointly consider gaps in services and how best to fill gaps in services for example through the use of pooled budgets or joint commissioning. This is particularly important to address specific gaps in relation to supporting vulnerable (or Level 2) families. An important consideration in future commissioning is ensuring that the remit of services is clearly described, and that further fragmentation of services in this field does not result.

Recommendation 5a: In addition to service commissioning, consideration needs to be given to how universal staff can be supported in terms of remit, resources and expertise to be able to work with some Level 2 families.

Recommendation 5b: The two local councils 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.

²² Fitzgerald, Heywood, Johnston (2013). Assessment of need and review of services for children, parents and families affected by parental substance misuse in Edinburgh City.

Recommendation 5c: There is a need to consider how to expand the resources available for recovery by mobilising family and community members to offer support to vulnerable parents. There should be increasing opportunities to do this through the development of recovery oriented systems of care and through a focus on building individual's social networks.

Recommendation 5d: The councils should consider making more information on the Escape programme or similar suitable programme available to parents in recovery who have older children and should make a course available and accessible specifically for this group where appropriate.

Recommendation 5e: There is a need for co-ordination of specialist family support in the context of a clear service pathway as discussed above to clarify where parents and families at different ages, stages and needs can be supported.

Recommendation 5f: MELDAP should engage with Al-Anon to explore ways 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 PVG checks and child protection where necessary.

Recommendation 5g: 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 changes²³. Support and guidance should be provided to services to ensure a consistent approach and to make it a meaningful and productive exercise.

²³ 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 22nd November 2013]

5. SERVICES FOR YOUNG PEOPLE: FINDINGS AND DISCUSSION

- **No youth-oriented service in either Midlothian or East Lothian has a specific and publicised remit for supporting young people affected by parental substance misuse (APSM). Young carers comes closest in terms of the service provided but it is acknowledged that many young people APSM would not identify themselves as needing a young carers service. Other agencies support young people APSM but do not have an explicit remit or public profile in doing so.**
- **There is a need for a pathway of support to be developed and publicised widely that integrates with the care pathway recommended earlier for parents and families with young children.**
- **For the many young people currently living with parental substance misuse, there is no obvious place to go to get help and the issue is often hidden. Young people felt that there was a need for greater efforts to raise awareness of this issue with other young people and staff across services, including where and what kind of help is available.**
- **Universal services need to continually reflect on how they can better encourage and support disclosure of parental substance use by young people (and parents).**
- **There is a sense that services for young people are focused around specific labels such as 'LAAC' (looked after or accommodated), 'young carer', or 'ASN' (additional support needs), and that the needs of children APSM overlap with and are distinct from these labels. Professionals and groups concerned by each issue/label make the case for specific services and attention however it is clear that it is not possible or desirable to have whole systems of services for each individual issue.**
- **There is a need for creative thinking about how holistic services can support young people with multiple, distinct and overlapping issues and how a truly individualised approach can be taken. This may require fundamental changes to how all services are delivered including the role and remit of education services. GIRFEC implementation is a move in this direction but it is a long way from a solution. Services for vulnerable young people are far more fragmented than is sensible for areas the size of Midlothian and East Lothian and they would be more effective, accessible and efficient to deliver and use if they were more co-ordinated.**
- **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.**
- **Further consideration needs to be given to how the needs of children affected by foetal alcohol exposure can be identified and met. MELDAP should work with partners to raise awareness of FASD through nationally available resources.**

5.1 RANGE & AVAILABILITY OF SERVICES FOR SCHOOL-AGED CHILDREN

The table overleaf describes some of the range of services which are relevant to supporting children of primary and secondary school age, who are affected by parental substance misuse. As before, the table starts with universal services and moves on towards more targeted 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 in the previous chapter.

Table 5: Services Provided Directly to Children or Young People

	Service	East Lothian	Midlothian
Universal →	Schools	Universal education service during term time. Holiday clubs provide limited cover outside of term-time. All children 5-16 Includes some specific school projects e.g. young carers (check transcript)	
	CLD/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 – some services are more targeted. Detached youth work in Midlothian in partnership with MYPAS.	
Targeted →	Additional Support for Learning	Mainstream school- or hub-based education support. Children and young people with additional needs, including emotional, social and behavioural problems. Young carers may be identified in this way.	
	Child/youth counselling – non-targeted	Place 2 Be in primary schools.	
	Targeted youth services	Bfriends: Children 1 st project offering volunteer befrienders to build self-confidence. 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. and self-esteem. Recharge (Tranent) drop in nights, trip programmes and detached youth work, one to one support, issue based group work and youth participation	MYPAS: Targeted at yp who are themselves involved in substance use (or with sexual health needs). Offers counselling; issue-based groupwork; school education; informal work, drop in service and one to one support.
Specialist	Family Support	Integration Team Children 1st: Young Families Outreach (not specific to substance misuse), ADAPT: families with children pre-birth to age 11.	Children 1st: Family Support Team.
	Young Carers	Meetings, activities, peer support and in some cases one to one counselling and befriending. (not specific to substance use). East Lothian Young Carers	Children 1st Midlothian Young Carers
<i>NB: This list is not intended as an exhaustive directory of services and necessarily omits smaller local services.</i>			

5.2 GAPS IN SERVICES FOR SCHOOL-AGED CHILDREN

A key finding of this mapping process is that there are currently no youth- or child-oriented services within Midlothian or East Lothian that have a specific and publicised remit for supporting young people affected by parental substance misuse.

Young carers comes closest in terms of the service provided but it is acknowledged that many young people affected by parental substance misuse would not identify themselves as needing a young carers service.

“As a [young carers] service, we want to be positive...They’re proud of their caring role. It’s harder for children affected by parental substance misuse to identify themselves as young carers. It’s much easier to recognise caring if there is a physical disability. Mental health issues, domestic abuse and substance misuse are much more stigmatised.”

Other agencies support young people affected by parental substance misuse but do not have an explicit remit or well-publicised profile in doing so and it is difficult for services and service users to know what is available from whom or when. There is a fragmentation of services for young people with various individual workers and teams of two or three people working on different youth issues in both the voluntary and statutory sectors. This also contributes to the sense that it is ‘difficult to know what is out there’. [It is also likely to be relatively inefficient and lead to some duplication of effort as will be discussed below.] Specific gaps in terms of specialist CAPSM support were identified in relation to both younger and older children. For older children there were conflicting views as to the best way to fill these gaps:

“The gap in the market would almost be a different service outwith the school that didn’t need parental consent, that young people can just go to.”

“If other agencies were to be based in and around schools, I think that could be hugely beneficial in terms of the confidence of kids to take forward issues. But it could also have a huge effect on the culture of the schools.”

For younger children the absence of services offering play or art therapy or something similar to that offered by Sunflower Garden in Edinburgh was noted.

“On a personal basis, I am aware of the work of Simpson House with younger children affected by parental substance misuse. Sunflower Garden. There is not anything equivalent to that here.”

“What the art therapy tends to be better for is for our age group which are slightly younger. So your age 12 to say 14 year olds who may struggle with expressing themselves.”

Other gaps were also noted:

- Services which could support young people affected by domestic abuse were noted as a gap by one Midlothian practitioner. One to one support for 6 -14 year olds affected by domestic abuse available through Children 1st Midlothian, but there is actually no such specialist support available specifically for CAPSM.
- In relation to children involved in the hearings system, it was felt that more could be done to ensure the child’s voice is sought out and supported:

“We go to a children’s hearing and the parent could have a lawyer and an advocacy worker and the other parent could have their father and you think where is the child in all this? If you sat and taped the conversation you would struggle to hear the child’s voice.”

Strategic Recommendation 6: There is a need for a pathway of support for young people affected by parental substance misuse to be developed and publicised widely as part of wider efforts to encourage young people to feel comfortable coming forward with this issue. This needs to integrate with the pathway for parents, families and young children recommended above.

5.3 HOW TO IDENTIFY AND SUPPORT YOUNG PEOPLE

5.3.1 IDENTIFYING AND SUPPORTING CHILDREN

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. Supporting children whose parents are in treatment is discussed in the next section.

The literature on this issue is clear that as a society we have work to do in ensuring children feel that they can trust adults enough to reveal their issues and difficulties.

“...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”²⁴

As suggested by this quote, and by the prevalence figures presented earlier in this report, services working with children are currently failing to identify many who are living with parental substance misuse at a variety of levels. Young people do not feel comfortable disclosing their use due to fear, stigma, mistrust, guilt and many other strong motivators against asking for help.

“By the time they get to secondary stage, they know there’s going to be consequences if they disclose you know? More often than not we get parents saying ‘if you tell, that will be it, you’ll get taken away’. The amount of times you hear that. Especially with the oldest child. They carry a huge burden.” Mother

“[My daughter] still says it, now she’s 14 and she still says it now. I’m not going to tell [social work] anything because if I do my Dad says I’ll be put in a home.” Mother

“I think school’s do as much as they can but with the best will in the world, you know, its only if a child wants to disclose are they really going to.” Practitioner

“Its really underreported and that’s understandable. Youth workers can perhaps encourage that kind of dialogue within a youth club setting.” Practitioner

“If you were going to open up to someone about your family life and what’s going on at home, you don’t want your friends to know or even any teachers. So even if you’re in the middle of class and you get called out of class, kids start to talk.” Young Person

Raising awareness of CAPSM more widely was considered crucial especially by young people consulted in this study – to inform people about the issue and where support is available.

²⁴Robinson, 2008. Children – Not Seen and Not Heard. New Directions in the Study of Alcohol Group Journal. p14-15

"In guidance and PSE classes we just got taught about what not to do, like ourselves individually. We never really talked about family issues or anything like that." Young Person

"If it was talked about to the class in general then it would help to teach the fortunate people who are lucky enough not to have a parent in that situation. It would maybe make them understand how maybe one of their classmates will be feeling if they're in that situation."

Parent

"I think tapping into PSE would be useful...for young people to see that they're not alone...and the help that is in place." Practitioner

Raising the profile of this issue generally would help young people to feel less isolated, have the potential to reduce the sense of stigma about this issue and encourage people to self-disclose and seek help. An initiative relating to young carers provides an interesting case study of how this might be done and what issues might arise as a result.

Children 1st/Secondary School Young Carers Initiative

This year, we've been doing a project with Children 1st on Young Carers which focuses on raising awareness of young carer issues. It has made a really good, positive start. Some of the issues have been 'what is a young carer?'; 'who would be identified as a young carer?' etc. It has included work done with young people via Personal and Social Education classes delivered by Children 1st, who worked alongside the guidance teacher. They also delivered in-service sessions with learning assistants and guidance staff to raise awareness with key staff. Lessons were developed, Children 1st delivered one PSE lesson which was supported by prior and follow-up work. The idea was to build up towards improving disclosures and referrals to the young carers service. Young people have a place where they can self-refer - a confidential drop-off box where they can ask to speak to someone. The person from Children 1st checks the box. Guidance staff are aware. We also have a young carers' notice board that everyone can see. Young carers have access to supports through this project, and they can also ask questions during the lessons on post it notes. So it has been a positive start.

There are a few young people who have come forward but they don't want to be recorded as young carers on SEEMIS (which includes an option to record that a young person is a young carer under the additional support needs section). This is a difficulty, as normally if someone identifies as a young carer it would be recorded.

We also have a problem we're coming up against when young people come forward but they say they don't want their parents to be involved. We can't give any guarantees to children.

The difficulty that when a young person has self-identified as being a young carer, how does that get recorded? And what about the young people who have self-identified but don't want it recorded? A policy is being drawn up by the council to work out how to deal with this issue but I can imagine similar issues would arise for children affected by parental substance misuse.

A second, similar piece of work, also between Children 1st (Supporting Children and Families project) is described in the second case study below.

Children 1st/Domestic Abuse and Gender Education in Secondary Schools

A Supporting Children and Families practitioner from Children 1st described similar work relating to domestic abuse and gender issues which involved the delivery of bespoke education over three 50 minute sessions as well as the availability of one to one therapeutic support. Following each session workers remain behind in a room for 30 minutes where children are free to come on their own or in pairs to speak with the workers confidentially. The workers also leave a post-box behind in the class for questions or comments. The children know that if they raised anything that is a child protection issue that the head teacher would have to be informed.

“When I started this and going around and speaking to other services, particularly those who do similar visits at the start of secondary school and they said “Nobody will come forward, nobody will come forward. We always wait and nobody comes forward.” Well in our first two schools 20% of the children came forward.”

These case studies highlight that young people can be encouraged to come forward to reveal difficult issues but this was not reported in relation to parental substance misuse. The fears of what will happen when people come forward often relate to misunderstandings about the circumstances in which families will be ‘split up’ and children taken into care. It was noted by a number of practitioners in this study that there is a need to dispel these myths about social work action.

“A lot of people just don’t understand what social work do. It’s a grey area. You can’t really have a definition or a set list of what we do. People don’t quite know what the social work department are there for and what we do.”

“People can be scared their children are going to be removed. If they’re in that situation, even if they’re hearing that we don’t want to do that, they’re not taking it in or believing it because they’re stressed...it’s very difficult to reassure people, to try to explain that to them.”

“Perceptions of social work have changed. They try as far as possible to keep children within the family unit...We need to highlight the benefits of engaging with social work. They will try to put some support in there to help your recovery.”

While children and young people can be offered no certainty about what will happen to them if they disclose, it would be helpful to develop case studies illustrating stories of others (preferably real) who have come forward and in what circumstances information has been passed on or not, and to whom. As part of efforts to raise awareness, young people should also be informed that if they wish to remain totally anonymous that they can make use of services such as ChildLine that can offer support in cases where others who know the child would be required to take formal action.

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.

More general conversations focusing on child support with any aspect of parenting difficulty (parental mental health, parental illness, marital problems) may also be more common if suitable guidance was made available to universal services. 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. This relates back to the discussion of having clear principles of what effective parenting in Section 4.3 above. Educating young people about effective parenting could also help young people to recognise when their own circumstances are, in fact, not 'normal' and encourage them to seek help.

Taking the time to build positive trusting relationships with young people was seen by participants in this study to be the key to facilitating earlier disclosure. This is done through other work, for example, with groups of young people, which in itself may or may not make a difference but which is important for providing time and space for trust to grow. It was noted by more than one practitioner that 'issues tend to emerge over time' when working with young people. These reports came from services which were working with young people on other issues related to PSM.

"Once we get in and get a relationship it's much easier for them to come to us and tell us what's going on – they trust us."

"We'll put our group work programme on. Part of that will be looking at drugs and alcohol but not all...there will be a social aspect to it, there will also maybe be an activity aspect to it as well. And if we get the group right we usually get 2 or 3 young people who will then go on to receive individual support."

"We'll ask about parental substance use at the initial assessment but if it doesn't come up in the initial assessment, it should come up further down the line...We assess in terms of family relationships, we'll do a sort of family tree. Some young people don't tend to, they don't want to disclose it early doors as well. So it will actually come up further down the line."

Strategic Recommendation 7: 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.

Recommendation 7a: As part of their health and wellbeing curriculum, 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.

Recommendation 7b: There is a need to develop models of practice 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.

There are examples nationally of specialist CAPSM projects, such as STARS (see Appendix B) 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 a 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 or referring to the service.

Although no such service exists in Midlothian or East Lothian, we are reluctant to recommend that one be commissioned in an area of this size. There is a sense that services for young people are focused around specific labels such as 'LAAC' (looked after or accommodated), 'young carer', or 'ASN' (additional support needs), and that the needs of children APSM can both overlap with and be distinct from these labels. Professionals and groups concerned by each issue/label make the case for specific services and attention however it is clear that it is not possible or desirable to have specific services for each individual issue.

"What we seem to be working to is an agenda of boxing children, demanding rights, if these children can jump through that loophole, that threshold."

In areas the size of Midlothian and East Lothian it is particularly important not to attempt to have a 'service for every issue', not just for resource reasons, but also because the size of the area does not lend itself to young people being able to access such services without others knowing. Most importantly however, one issue services are less desirable because each of these issues does not exist in isolation. There was also evidence to suggest that not all young people affected by a particular issue may want support from a specialist service:

"[Our colleague] has been raising awareness of young carers' issues in schools, but there is a gap. Young carers are identifying themselves in schools and they're not accessing our [young carers] service."

The case studies above highlight very similar pieces of work being conducted (possibly in different secondary schools) which have overlaps. It does not make sense for these practitioners to be operating as separate initiatives. It would be much more sensible for schools to have a single link point for support on these issues and for each school to have one system for reporting issues in confidence, not separate ones for every service. Individual staff within a specialist health service for young people should have specific specialisms but it is not necessary that they all operate as separate teams.

One advantage of specialist services is that even by their existence they play a role in highlighting the specific issue that they address, but it does not feel right to play into a culture where you need a label/'diagnosis' to have your needs recognised/supported. Clever branding of holistic services around vulnerability, including a wide range of issues, and careful awareness raising of each issue in an integrated way would be a more helpful and realistic response.

There is a need for creative thinking about how holistic services can support young people with multiple, distinct and overlapping issues and vulnerabilities and how a truly individualised approach can be taken. This may require fundamental changes to how all services are delivered and to some extent raises expectations about the role and remit of education and youth services more generally.

Education services in particular are overwhelmed to a point where truly holistic approaches to young people are not supported by current systems or contractual obligations. The response to this cannot simply be to ask schools to do more, but to work towards a shift in focus that comes with full support for staff and accompanied by reductions in other expectations. GIRFEC implementation is a move in this direction but it is a long way from a solution to these issues of school's capacity and identity, which impede them from taking on a more holistic approach.

“We aren’t going to get to the level of service that we need for kids...its easy to say great if teachers are universal, and they need to be skilled up, but I know some fantastic teachers who kids love and who are brilliant people and they are struggling because of the demands of that job. The constraints, the form filling, the whole new curriculum and structural reviews in schools which have seen a diminishment in the number of say guidance staff. Its crippling them.”

Strategic Recommendation 8: There is a need to consolidate and co-ordinate services providing targeted support to young people on specific topics including young carers, domestic violence and other issues and vulnerabilities. Ideally all practitioners and teams with a remit to work directly with young people on a one to one basis, or to deliver external inputs on health and wellbeing in schools or informal settings, should work as part of one organisation, as a holistic youth health service.

Recommendation 8a: Within one service, practitioners should be trained to work holistically with young people to support them with any or multiple issues as needed, however individual practitioners should take a lead on different specialist topics. They can then act as a source of advice and support for colleagues on that issue.

Recommendation 8b: Each young person should have an identified link practitioner or key worker at the service, ideally who has expertise in whatever issue most concerns the young person. However a team approach should be taken to consider, with the young person (and their parents where involved) the best support package for any given young person who has more complex needs.

Recommendation 8c: The support offered could include counselling and more flexible one to one support but also broader group work to promote the service and build trust with vulnerable young people, and specific group work to offer peer and/or therapeutic support. The group work programme could be topic-specific or generic depending on demand and needs of young people. Age-specific groups are also likely to be needed.

Recommendation 8d: A planned approach should be taken across the team to consider clear messages and awareness raising in relation to each issue and to vulnerability in general. Such messages should be consistently promoted so that the visibility of services for each particular issue is not lost. At least one youth practitioner within both Midlothian and East Lothian should take on a specific CAPSM remit.

Recommendation 8e: A consistent and clear identity and point of contact should be established for the service, both in terms of website, social media, branding and contact details to make it easy for both young people and practitioners to know where to go. The service will also need to build excellent relationships with schools and treatment services over time to establish trust, support staff and generate appropriate referrals/self-referrals.

Recommendation 8f: This should ensure consistent area-wide provision (across both areas) for vulnerable young people regardless of the issue in question and will require co-operation across the two local authorities and with partner agencies and funders. An interim solution may be to bring together existing teams and practitioners under an umbrella youth health service where each practitioner retains their current employment with their existing organisation but they are

line managed through the new youth health service. Ideally if possible, just one service would operate across both Midlothian and East Lothian.

Recommendation 8g: This research suggests that there are further areas for development of services in relation to primary school-aged children affected by parental substance misuse. Commissioners need to use the above principles for supporting young people to consider who is best placed to offer this support to younger children.

5.3.2 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 children may benefit from support. The difficulties of this in terms of getting the balance between helping parents (and therefore children) and protecting children (but possibly at the expense of helping parents) are illustrated by an anecdote from one service.

“We recently had a mother of 2 children present to us who was struggling on the back of a relationship breakup. She was drinking 2 bottles of wine a night on her own when the kids had gone to bed. We had to discuss with her what if there was a crisis as there was a lack of other supports and she was trying to hide it. So we said we need to contact social work and if there are any concerns they would investigate. She didn’t return. She was looking for help with the alcohol stuff but she never came back.”

There is a need to consider the ethical problem of whether and how children should/could be offered support to come to terms with their own experiences of PSM, in cases where child protection issues have been resolved or did not arise. This is particularly difficult 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.

Services need to be more aware of what conversations they could be having with parents about lower levels of harm to children, which may be helped by the child getting support from a youth service. Parents in treatment should be made aware of the different services that are available to support their children and encouraged to pass on information to their children about it where possible even if they do not wish to access further support themselves.

This obligation to try to offer support to young people and children of parents misusing substances, above and below the threshold of child protection, 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. Such efforts require more than child protection procedures but a focus also on supporting children in need.

It is worth noting here that some young people respond to parental substance misuse without openly showing any adverse effects on behaviour or school performance. They may be exemplary pupils and so would not be picked up by mechanisms designed to respond to problems with

children's schooling or behaviour. One of the young people interviewed for this study spoke of his desire 'to be as anonymous as possible' throughout his schooling.

Strategic Recommendation 9: 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.

Recommendation 9a: MELDAP should engage with Al-Anon to explore ways 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 PVG checks and child protection where necessary.

Recommendation 9b: Representatives of adult self-help groups operating in Midlothian and East Lothian should consider how they can work with partner organisations to ensure that such children are being identified and offered support.

5.3.3 IDENTIFYING AND SUPPORTING CHILDREN AFFECTED BY FASD

There are currently no services oriented towards identifying and supporting children with Foetal Alcohol Spectrum Disorder (FASD). Identification of FASD is 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. It also has the potential to enable support to be provided to the parents so that siblings are not born with the condition.

An excellent and accessible online education course has been developed nationally by NHS Education for Scotland on this issue for staff working with children in any setting.²⁵ Furthermore, national groups including practitioners from health and social care are working on care pathway development for children with FASD or suspected FASD. It would be valuable for MELDAP to keep in touch with the work of these groups with a view to wide dissemination as appropriate.

Strategic Recommendation 10: Further consideration needs to be given to how foetal alcohol exposure can be prevented and how the needs of children affected can be identified and met. MELDAP should work with partners to raise awareness of FASD through nationally available resources.

²⁵ <http://www.knowledge.scot.nhs.uk/home/learning-and-cpd/learning-spaces/fasd.aspx>

6. CROSS-CUTTING ISSUES

- Training was seen as important for raising awareness, increasing knowledge, improving skills and addressing attitudinal change. This is an essential element of improving capacity in some organisations to be more aware of and focused on identifying and meeting the needs of CAPSM.
- Respondents felt that it would be useful if training was designed to meet the needs of particular groups and could include identifying signs of parental substance misuse and the roles of different agencies in supporting parents, families, children and young people.
- 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 relate to conversations with both parents and young people. An approach based on motivational interviewing is recommended for some early years services.
- Strong leadership will be needed to support and lead culture change on the range of issues raised in this report and so senior and service managers should also be targeted for education about CAPSM.
- There were examples of partnership working that were felt to be working well including the Midlothian Substance Misuse Screening Group, examples of co-location of services and working with the police.
- Some participants in both areas felt that co-operation could be closer and there was a particular issue highlighted in relation to information sharing with schools. 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 Scottish projects. Continued effort and planning is needed to support closer partnership working.
- Particular consideration should be given to the issue of information sharing with schools and there needs to be greater recognition in other services of the role of education staff as 'named person'.
- There are considerable difficulties with gathering any information on the effectiveness of services because such data is not routinely generated or collected.
- The development of a coherent approach to evaluation of the effectiveness of services using outcome-focused work is further hindered by the fragmented nature of services, confusing service names, failure to base approaches on theory or evidence, or to clearly articulate such a basis for approaches.
- Commissioners, funders and services across MEL 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 and underpinning theory/evidence.
- The actions taken as a result of this report ought to be robustly monitored and evaluated.

6.1 TRAINING

6.1.1 TRAINING FOR EARLY IDENTIFICATION

Training was seen as important for raising awareness, increasing knowledge, improving skills and addressing attitudinal change. This is an essential element of improving capacity in some organisations to be more aware of and focused on identifying and meeting the needs of CAPSM.

Respondents felt that it would be useful if training was designed to meet the needs of particular groups and could include identifying signs of parental substance misuse and the roles of different agencies in supporting parents, families, children and young people.

"I think it would be good to have training for our specific needs. It's something that we talk about quite a lot, that."

"I think it would be useful to have....a course or something... how you can go about addressing it rather than diving in with two feet. Look for the warning signs, how to support them, what do they need. That would be quite useful."

"It should include stages of what to do: if they are involved with agencies, if we've got concerns, do we still refer or pass on information?"

"You can be much more confident about referrals when you really know what you're doing"

It was generally felt that staff in frontline universal services and providers of mainstream support (e.g. pre-school staff, community-based staff, volunteers, teachers etc.) would benefit from training on parental substance misuse and that this might potentially support the identification of issues, reduction of stigma, and appropriate referrals for more targeted or specialist support. It would also ensure that all staff were at the same level of knowledge leading to a more consistent service.

"The emphasis is usually on guidance teachers, who get a fairly decent training ... but it's class teachers that miss out."

"Maybe working or liaising more with the schools, maybe some education for the teachers, although I'm sure they do receive some about earlier signs of noticing. I mean they're very good at noticing if parents turn up [under the influence] but maybe not all teachers are aware of that. Maybe some more education, or more awareness of what to look for."

"If young people were to feel comfortable then we would certainly have to embark on awareness raising amongst the part-time staff and indeed some of the full time staff as well. And also identify clear pathways of support."

"I still think there are lots of professionals out there that don't know what indicators to look for, how to look at the home environment and look for signals that, you know, potentially there is- ...Generally [the pupils are not] sitting there with a bottle of vodka in the class because the parent is chaotic and says I don't care. They will have an environment that's clean, it's tidy because maybe they're embarrassed and say oh everything's alright. And we know 90% of people in parental substance misuse minimise. So [professionals] need to get better [at knowing what to look for]."

There was a sense that people make distinctions between universal and specialist staff that are not always helpful and that it would be better to view supporting parents on a continuum rather than the role of one or another professional. Training was seen as important for making this case.

“I think there’s a little bit of a fear that that’s not their specialist area...that’s substance misuse, that’s somebody else that deals with that. So I think there’s a little bit, whether that’s confidence or knowledge of training, maybe if that was built on they would feel a wee bit more equipped to deal with some of that.”

Strategic Recommendation 11: 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 and delivering learning opportunities to build competency and will require effort by the local authorities, NHS Lothian and partner organisations.

Recommendation 11a: The areas for development and capacity building recommended are:

- **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. Models should include emphasis on educating young people about effective parenting more generally and what supports are available if they are worried about any aspect of their family life.**
- **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.**
- **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.**
- **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).**

6.1.2 MULTIDISCIPLINARY VERSUS BESPOKE TRAINING

Participants felt that multidisciplinary training had specific benefits.

“In terms of knowing what’s out there, I think multi-disciplinary training may be, that might be good”.

“More training events which were multidisciplinary events so people could get together and talk about their roles where there is an overlap and the importance of sharing relevant information.”

But others felt that training specific to their role was important including the following:

“More training on parental substance misuse and new research that comes out.”

“Actually really understanding what is involved in the life of somebody who has a substance misuse issue in terms of, not the practicalities, but what drugs are people taking and what are services doing for them, depending on the drug that that person’s dependent upon. ...the treatment side of it, the clinical side of what is being done because we go to meetings and we hear people saying they’re on this and they’re on that but we don’t maybe fully understand what it is and it’s not appropriate at that time to ask the question. That side of it. But also, so it’s very much understanding the clinical side of it.”

“It is important to focus on what are the effects of drug misuse, on their physical ability to care for a child, their cognitive ability, it’s about do they organise- it’s the management of their life. Because if that has an impact on their lives it automatically has an impact on the child.

“I would like to see training in relation to the new orange book – so training on that would be really good.”

Recommendation 11b: Consideration should be given to suitable opportunities for multi-disciplinary/multi-team development in relation to this issue however experience suggests that most of the training will need to be setting specific in order to be effective in changing practice.

The benefits of multidisciplinary training could be achieved through other means (see Section 6.2 below).

6.1.3 MOTIVATIONAL INTERVIEWING APPROACHES

Motivational interviewing is a collaborative conversation style for strengthening a person’s own motivation and commitment to change that is widely used to facilitate behaviour change around substance use. It has been extensively and rigorously evaluated in a range of settings, however little work has been done in this field.

In one UK study²⁶ motivational interviewing (MI) training (2 days) had a modest positive impact on evaluations of simulated practice, on some measures of attitudes to working with problem drinkers and in qualitative accounts of practice. Despite this, three months post-workshop, workers generally had not reached a skilful level of MI practice. The authors noted that the skill level that resulted in positive outcomes did not need to be as high as motivational interviewing, but for many participants it was relatively simple skills, such as using open questions or reflections that seemed to help improve relationships. A randomised controlled trial of MI in this setting is now underway. In the light of this evidence it is worth exploring whether MI training would support children and family social workers in Midlothian and East Lothian in a similar way.

²⁶ Forrester, D. et al., 2008. Child Risk and Parental Resistance: Can Motivational Interviewing Improve the Practice of Child and Family Social Workers in Working with Parental Alcohol Misuse? *British Journal of Social Work*, 38(7), pp.1302–1319

The Family Nurse Partnership intervention works with young first time parents from pregnancy until the child is 2 years old, shows a range of positive outcomes²⁷ and is also partly based on motivational approaches²⁸. A key factor in this study is that the whole ethos of the family nurse partnership approach and organisation is one based on positive motivational approaches.

Earlier (see Section 4.6.1) it was noted that services and outreach support for vulnerable families with young children were regularly hearing parents discuss levels of substance misuse that were of concern. While not giving rise to child protection issues in most cases, staff felt that they would welcome more support in how to address these issues sensitively without affecting relationships with parents. Training in motivational interviewing approaches may be helpful for these staff, however it is likely that relatively intensive training and support would be needed.

Recommendation 11c: In the early years services for vulnerable families, where substance misuse is disclosed by parents, an organisation-wide approach to working based on motivational interviewing should be considered. Staff should be offered motivational interviewing training, coaching, ongoing practice-based supervision and support from management to enable them to work in a motivational way with these parents. This will require funding and the impact of the change in practice should be properly evaluated and shared.

6.1.4 LIMITATIONS OF TRAINING

It was noted that are practical challenges in ensuring that staff can participate in training due to time and cost.

“When staff do attend training the vast majority of it is paid so there would be a cost implication if we were going to more specific training around drug use” (CLD)

It was also suggested that training alone would probably not be sufficient to support a sustained change in practice and that other measures would need to be implemented to ensure this.

“We can deliver as much training as we can to our workforce. My bit is about are we applying it to their jobs?”

In particular, the importance of organisational culture was raised. Training will need to address attitudes but this alone will not be sufficient to change culture

“First and foremost the training that’s required is the culture change within schools. And it is based upon, I go back to relationships being placed at the heart of everything...if you have that in place then it’s a case of you can take your issue to someone that you’re trusting, and then that person can actually at that point, right I’m going to find out what

²⁷ Macmillan, H.L. et al., 2009. Interventions to prevent child maltreatment and associated impairment. *Lancet*, 373(9659), pp.250–66

²⁸ Owen-Jones, E. et al., 2013. The effectiveness and cost-effectiveness of the Family Nurse Partnership home visiting programme for first time teenage mothers in England: a protocol for the Building Blocks randomised controlled trial. *BMC pediatrics*, 13(1), p.114

I need for you. So in other words they don't need to be experts in every system out there. The most important central point is that that communication and that dialogue can happen within a whole sense of trust."

"It's the difference between theory and cultural change that has to take place in some organisations. I don't think that can be underestimated. Certain people even with training won't change. You also meet people who might try their best. It does require considerable energy to get that culture change by various means"

Recommendation 11d: Change without education is unlikely, however the role of leaders within services in changing culture is important and so greater emphasis should also be placed on educating senior managers and service managers on the issues raised in this report. They are best placed to lead culture change, including finding solutions to practical constraints in providing learning opportunities for staff.

6.2 INTER-DISCIPLINARY AND PARTNERSHIP WORKING

Respondents largely respect and value the work of other teams and practitioners and particularly highlighted the example of the Midlothian multi-agency Substance Misuse Screening Group (SMSG) as an example of innovative good practice.

The Substance Misuse Screening Group was highlighted by many participants as a significant positive development in meeting the needs of families affected by parental substance misuse. It was felt to have a particular role in matching up such families with suitable support, especially where they fall under thresholds for social worker intervention.

"Agencies can refer any clients for discussion with the key agencies that sit on the steering group. Where information about anybody's knowledge can be shared to see whether there is a need for more formal processes."

"My background is in substance misuse, I've worked over 20 years in the public sector and it is unique in the authorities and various organisations that I've worked in that you can get the players around the table and you get an agreement of the remit of the group and its more prevention, early intervention, whereas we know in this field it tends to be medium or high tariff cases...so its pretty unique that way."

Participants felt that the SMSG could be further improved if all agencies referred all appropriate families to the group, and there were fewer direct referrals that bypassed the group. It was reported that Midlothian Young People's Advisory Service (MYPAS) were not able to participate in the SMSG, the reasons for this were unclear. It is important that services which can work directly with young people affected by parental substance misuse such as MYPAS are available at SMSG discussions when relevant so that they can outline what support they can offer young people as cases arise.

In both Midlothian and East Lothian, some practitioners felt that more could be done to improve partnership and inter-disciplinary working. For example in Midlothian, it was felt that there are many agencies with a role to play and that the picture of working together could be more cohesive.

“There are other agencies who provide family support...I suppose one of the dialogues we have had with [them] is that we have to actually work more cohesively together...we need to work more cohesively across the board with Family Support, Midlothian Sure Start, Children 1st so we’ve all got a role to play but it’s about how we deliver it.”

“[Co-ordinating] without duplicating things...resources are too scarce at the moment to be duplicating work.”

Similar concerns were raised in East Lothian:

“We’ve had one or two situations where a parent maybe has had a lot of agencies involved with them and my feeling is that there’s so many agencies involved we’re not sure what each other’s doing.”

More than one agency reported that they had good links and working relationships with the police, but in contrast particular issues were raised in both areas about how well information is shared especially with schools.

“I think it’s about information sharing as well because not all services who are maybe picking up information on families would contact the school. If I contacted the school they might be completely unaware that there’s been an issue. Schools are often the last to know I think.”

In most as yet undetected cases of parental substance misuse, the school head teacher will be the professional with ‘named person’ responsibility for the welfare of the child. They should be the one point of contact for all information about that child and their family which may be relevant to the welfare of the child. They need to have detailed information and awareness of family situations including parental substance misuse in order to judge what they and others need to know to support, protect and fully meet the needs of the child.

The observations in the above quote are borne out in this research through lengthy discussions with treatment services about who they would inform in the case of a parent seeking treatment and through discussions with school staff about what they find out when. School staff felt that they routinely did not have information or sufficiently detailed information about parental substance misuse to be able to help children.

“Information sharing can be frustrating. I feel that sometimes within education it is perhaps easier for us to share information with other services e.g. health but they have particular constraints in sharing information with us...Information only comes to us if it has become a big issue, a crisis for the young person...awareness of issues for the young person might be helpful.”

“If issues are dormant through primary school, [the information] doesn’t work its way through to secondary.”

“Even in the over 12 forum [multi-agency group which considers support for young people with difficulties at school] something might be said about ‘Mum’s own issues’ but no specifics given....adults using MELD services for example, they don’t want schools to know. We don’t know if parents of our children are accessing MELD.”

Treatment services are very aware of dilemmas around information sharing and the possibility that sharing information may put parents off attending treatment as noted in Section 5.2.2 above.

Despite initiatives like the Substance Misuse Screening Group, it seems that when parents enter treatment the question that is in practitioner’s minds about children is ‘are there child protection issues here, or not?’. This appears to be the focus of assessment and the question that underpins decisions about information sharing.

Treatment services therefore described that they would primarily share information with the parent’s GP, with the children’s health visitor if children were under 5 and would advise the social work department (but not share information with the school). Similarly if a school was concerned about a young person, they may contact the social work department (but would clearly not contact treatment services). In child protection cases therefore, if information is shared routinely in this way, it is likely that another practitioner, other than the head teacher, will be the named person for the child e.g. a children and families social worker. And as all agencies routinely check in with social work as issues arise, that named person would have a full and detailed picture of what is happening for the child.

The problem arises where children experience harm due to parental substance misuse which is not at ‘crisis’ point, is at a lower level, or is as yet undetermined. These children would be dealt with at Level 1 in GIRFEC, social work would not get involved, and the head teacher would continue to be the named person. In these circumstances it was acknowledged that ‘it might be possible that a school was providing support to a young person at the same time as a treatment service is supporting a parent, without anybody knowing that both was happening.’

We would argue that the question in the minds of all who are working with families APSM should not only be about child protection, but should be asking whether the children are likely to have had experiences or emotions to deal with that may benefit from support, even in the absence of child protection concerns. What difficulties might the stress and problems that this parent is experiencing have posed for their children and how can the children be helped with that?

Clearly there is a need for discretion and professionalism about how practitioners use information about parental substance use, but a fear that the information will be used inappropriately is not the only consideration. Sharing information with ‘schools’ clearly does not mean that everyone in the school will be told, and head teachers are well placed to make decisions about what guidance teachers and classroom teachers need to know to be able to understand and support young people.

“We all need to consider if we are getting that balance as to what we tell classroom teachers. There are issues that you don’t really feel you can share with classroom teachers.”

Clearly these are complex issues however the prevalence figures outlined in this study show that there are likely to be significant numbers of children and young people affected by parental substance misuse who are not currently being identified and supported. We feel there is currently a gap in relation to information sharing with head teachers as ‘named persons’ in non-child protection cases that is unhelpful in seeking to reduce harm to these children and young people. The reasons for, and solutions to, this situation need to be carefully considered by all agencies involved.

This problem is not unique to Midlothian and East Lothian. Greater collaboration and co-ordination between adult oriented and child-oriented services, is a key feature of the literature on reducing harm to children affected by parental substance misuse.

“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”²⁹

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).

²⁹ In Mitchell, F and Burgess, C (2009, p61). A research review on working with families affected by parental substance misuse. <http://withscotland.org/resources/working-with-families-affected-by-parental-substance-misuse-a-literature-review>

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

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.³⁰ As part of Link-Up, 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.

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. These kinds of initiatives were highlighted by participants in Midlothian and East Lothian as having the potential to have a positive impact.

“Shadowing workers and job swap for a day is very effective. We [treatment service] have done that in the past here where some workers here have gone with others e.g. health visitors, social workers etc. Very useful learning for everyone. Gives everyone an idea of what people's roles and responsibilities really are. Also been occasions where it's been mental health team. It has not happened for a wee while.”

“Again I think [teaching staff] are probably very good when they've got a child that is misbehaving but maybe thinking could this be because there's something going on in the house? Again, what you're saying, maybe us all shadowing each other. It doesn't necessarily need to be often. Maybe bi-annually, I don't know.”

“If other agencies were to be based in and around schools, I'm not talking about whole teams, but you know, representatives, so that there is basically a multi-agency team

³⁰Kosonen, M, (2011). Angus Learning Partnership for children affected by parental substance misuse (CAPSM). A summary report.

linked and working in a school, I think that that could be hugely effective in terms of the confidence of the kids to take forward issues. But also it would have, could have a huge effect on the culture of the school”.

There are already examples of co-location in both Midlothian (e.g. Midlothian Family Support Service co-located with NHS addiction services) and East Lothian (ADAPT co-located with social work and other third sector partners). This was generally felt to be helpful.

“Here the system works well even when there are loads of people working with the family because everyone is in the same building.”

Others warned that co-location should not be seen as a solution without greater integration.

“I think people get confused between co-location and integration. You can put people in a building but they don’t integrate...I think the integrated approach, people coming out of their silos, joining up and embracing the third sector...”

Strategic Recommendation 12: Continued effort and 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.

Recommendation 12a: 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.

Recommendation 12b: A short-life working group covering both Midlothian and East Lothian should be set up by MELDAP to consider the issue of information sharing between schools, health and treatment services to ensure that teachers have all the information necessary to take responsibility for child welfare in the role of ‘named person’.

6.3 MODELS OF WORKING AND OUTCOME EVALUATION

This review has primarily been a review of the range and availability of services to reduce harm to children affected by parental substance misuse, but where possible we have also attempted to make sensible comment on the effectiveness of those services based on available evidence. There are considerable difficulties with gathering any information on the effectiveness of services because such data is not routinely generated or collected.

There are certainly problems with a non-existent evidence base for some aspects of the services provided, however we feel the development of a coherent approach to evaluation of effectiveness is further hindered by the fragmented nature of services. The number of small teams and initiatives working within this field means that there are few opportunities to share the burden of thinking and development of outcome-focused monitoring and evaluation.

There is little consensus on how to measure outcomes from work, never mind how to attribute those outcomes to a particular project or agency. This is made worse by a generalised failure to consider research evidence in a rigorous approach to planning, articulating and monitoring what is actually being delivered by each service. The tendency for services to be given confusing brands or

titles, is also unhelpful and it makes it very hard to unpick and compare what is actually being delivered by one team compared with another.

“I think it’s sometimes that’s more the professional is comfortable with it, rather than it’s the right model.”

“There are people who are experienced saying ‘I’ll use my tried and tested knowledge and experience’. This is what you need to do...so people will not have the theory or not have a particular model but will say because this worked with other parents.”

This means that in practice:

- It is difficult to generate evidence to show whether the services that are being delivered are making a difference to children and families.
- If we knew they were making a difference, we would not be sure why or how, and it would be hard to replicate the service elsewhere.

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 children³¹. Our key conclusions from our study of these documents are:

- 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 view³². It is likely that a similar forensic analysis of the ‘outcomes conversation’ would be beneficial here, and has not yet been done.

³¹ Access the full series at: <http://www.iriss.org.uk/project/leading-outcomes>

³² Silverman, Kurtz, Draper (2005). Skills for Communicating with Patients, 2nd Edition. Radcliffe Publishing.

- 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 already, are seen as good practice, providing the right outcomes are included.

Strategic Recommendation 13: Commissioners, funders and services across MEL 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 and underpinning theory/evidence.

Recommendation 13a: 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, what guides that work including assumptions, processes, interventions, theories etc. and how they can monitor effectiveness using clear outcome measures.

Strategic Recommendation 14: 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.

7. CONCLUSIONS & RECOMMENDATIONS/EXECUTIVE SUMMARY

7.1 INTRODUCTION

The aim of this needs assessment was to inform Priority 3 of the MELDAP Delivery Plan 2012-2015:

'We will reduce the harm to children affected by parental substance misuse'.

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, can occur prior to birth, through childhood and affect individuals well into adulthood.

The challenge for services cannot be underestimated – many parents with substance misuse problems will never access formal treatment and the harm arising from their problems is often hidden.

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

This study discusses how services can and do support a goal of improving parenting, how services support children directly to enhance resilience and coping strategies and how these harm reduction goals could be better achieved in future. It also considers wider services that 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.

The recommendations in this report should be considered in this broader context of whole population approaches to reducing alcohol and drug related harm and an overarching focus on reducing economic and health inequalities.

7.2 METHODS

This study consisted of a mixed method approach including analysis of prevalence data, semi-structured interviews, meetings with teams of staff and discussion groups with staff and service users.

The approaches used were designed to capture clear data (where available) and to explore how services could be improved in terms of availability, accessibility and effectiveness in identifying and reducing the harm caused by parental substance misuse in Midlothian and East Lothian.

There are a number of limitations to the study given the timescales, data and resources available including a relatively small level of consultation with service users and lack of data relating to smaller local services.

7.3 NEED AND PREVALENCE

There are multiple difficulties with reporting an accurate picture of the numbers of children and families affected by parental substance misuse. These difficulties relate to issues of definition, identification and recording.

- Using Scottish Government criteria, it can be very roughly estimated that in the order of 1,500 children in Midlothian and in the order of 1,800 children in East Lothian 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 (see Appendix A).
- A minimum estimate of children affected by a problem drug using parent or carer is 709 across the two areas combined. This is based on figures from treatment and other services and relates to parents with opioid or benzodiazepine problems only.
- An estimate of the number of infants, children and young people up to the age of 18 living with FASD at any given time is 180 for Midlothian and 190 for East Lothian.

Though the actual figures will never be known, we can say with a high degree of certainty that there are at least hundreds of families across MEL who are affected by parental substance use where the children, and in many cases also the parents, are not receiving any specific help from services. The focus of action to reduce harm to CAPSM must therefore focus on convincing these children and families that help is available and worth accessing and ensuring that this is true.

Services may be able to report more detailed data on children affected if asked to do so in future, however this would need to be clearly defined and for a clear purpose.

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

- **Recommendation 1a: 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.**
- **Recommendation 1b: NHS Lothian should lead further work to prevent and support accurate identification of alcohol consumption levels in pregnancy and to implement appropriate responses to the levels identified to reduce the risk of Foetal Alcohol Spectrum Disorder.**
- **Recommendation 1c: Social work and education services should jointly consider what aspects of data recording would be beneficial to children and families, and if/how their systems 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 establishing exact prevalence.**

- **Recommendation 1d: MELDAP should consider whether it is feasible and beneficial to require commissioned services to record and report service usage by children/parents/families affected by parental substance misuse.**

7.4 SERVICES FOR FAMILIES, PARENTS AND YOUNG CHILDREN

There is no straightforward way to categorise such services because of overlap between target group, age and eligibility across many services. Rather than categorisation, a model is presented that suggests that a continuum of services is needed to support vulnerable or at risk parents both prior to and at the early stages of any problem with substance misuse and for those recovering from substance use problems.

The suggested continuum ranges from universal prevention and support, to early targeted and re-integration services, to later and crisis-level intervention. It must be recognised that any such model will be imperfect in how it depicts the wide range of services relevant to this field, however it is helpful in considering potential gaps.

There are a wide range of services working with families, parents and young children in Midlothian and East Lothian to reduce the harm caused by parental substance misuse although there are some gaps in capacity and availability. The number, fragmentation and diversity of services relevant to reducing the harm to CAPSM makes it difficult for practitioners and families to make best use of them.

Overall, the information available about service availability, remits and referral pathways 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 or area. This is exacerbated by the use of confusing names and titles for jobs and service and compounded by a sense of complexity in relation to the range of systems in place for judging what a family needs and making referrals.

Strategic Recommendation 2: There is a need for much greater clarity and a clear service pathway from universal, to targeted, to specialist support for parents, families and children affected by PSM to support appropriate referrals, monitor gaps, facilitate recovery and re-integration and inform service users of their options.

- **Recommendation 2a: MELDAP, in collaboration with multiagency partners from the statutory and voluntary sector, should consider how to compile and maintain a clear service directory including up to date, details of services and supports for parents, families, children and young people affected by parental substance misuse at all levels.**

Both parental substance misuse, and difficulties or struggles with parenting itself, are difficult for parents to admit, as they carry a high sense of stigma and guilt. Both issues can exacerbate each other or conversely resolving either issue may help to resolve the other.

Universal and community services which have regular contact with children and parents are best placed to identify those parents (or prospective parents) who are vulnerable to stress, mental health problems, or other issues which may predispose them to substance misuse.

Such services need to be accessible, build trust and be able to offer universal, accessible and acceptable forms of support with parenting or other issues either directly or by referral.

Strategic Recommendation 3: Midlothian and East Lothian councils, in conjunction with NHS and third sector partners need to take a strategic approach to parenting support and access to such support. This will require co-ordination and clarification of service provision in line with a developed care pathway. They should also ensure that all services in contact with parents of children of all ages (including schools) 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.

- **Recommendation 3a: Midlothian and East Lothian Councils, 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 and used across all services enquiring and educating about parenting.**
- **Recommendation 3b: All adult treatment and support services (including Tier 2, primary care and self-help groups) should consider how they can support parents (through encouragement, guidance, signposting etc.) as part of a strengths-based, whole-person recovery focus. This should be done in addition to and separate from any work relating to formal child protection. Parenting should be discussed on an ongoing basis as a normal part of treatment, and specific structured conversations should take place 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.**

Strategic Recommendation 4: There is a need for large statutory services (including General Practice) to audit and improve how they work with adults and young people to make them more accessible and responsive to the needs of substance misusing parents and those affected. From a prevention perspective, there is a need to consider how all universal and statutory services take an inequalities-sensitive approach to meeting people's needs. This will require strong leadership from senior staff and an openness to culture change.

Strategic Recommendation 5: There is a need for commissioners from across the public sector and other funders to come together to jointly consider gaps in services and how best to fill gaps in services for example through the use of pooled budgets or joint commissioning. This is particularly important to address specific gaps in relation to supporting vulnerable (or Level 2) families. An important consideration in future commissioning is ensuring that the remit of services is clearly described, and that further fragmentation of services in this field does not result.

- **Recommendation 5a: In addition to service commissioning, consideration needs to be given to how universal staff can be supported in terms of remit, resources and expertise to be able to work with some Level 2 families.**
- **Recommendation 5b: The two local councils 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.

- **Recommendation 5c:** There is a need to consider how to expand the resources available for recovery by mobilising family and community members to offer support to vulnerable parents. There should be increasing opportunities to do this through the development of recovery oriented systems of care and through a focus on building individual's social networks.
- **Recommendation 5d:** The councils should consider making more information on the Escape programme or similar suitable programme available to parents in recovery who have older children and should make a course available and accessible specifically for this group where appropriate.
- **Recommendation 5e:** There is a need for co-ordination of specialist family support in the context of a clear service pathway as discussed above to clarify where parents and families at different ages, stages and needs can be supported.
- **Recommendation 5f:** MELDAP should engage with Al-Anon to explore ways 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 PVG checks and child protection where necessary.
- **Recommendation 5g:** 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 changes³³. Support and guidance should be provided to services to ensure a consistent approach and to make it a meaningful and productive exercise.

7.5 SERVICES FOR YOUNG PEOPLE

No youth-oriented service in either Midlothian or East Lothian has a specific and publicised remit for supporting young people affected by parental substance misuse. Young carers comes closest in terms of the service provided but it is acknowledged that many young people affected by parental substance misuse would not identify themselves as needing a young carers service. Other agencies support these young people but do not have an explicit remit or public profile in doing so.

There is a sense that services for young people are focused around specific labels such as 'LAAC' (looked after or accommodated), 'young carer', or 'ASN' (additional support needs), and that the needs of children affected by parental substance misuse can both overlap with and be distinct from these labels. Professionals and groups concerned by each issue/label make the case for specific services and attention however it is clear that it is not possible or desirable to have whole systems of services for each individual issue. There is a fragmentation of services for young people with various

³³ 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 22nd November 2013]

individual workers and teams or two or three people working on different youth issues in both the voluntary and statutory sectors.

There is a need for creative thinking about how holistic services can support young people with multiple, distinct and overlapping issues and how a truly individualised approach can be taken. This may require fundamental changes to how all services are delivered including the role and remit of education services. GIRFEC implementation is a move in this direction but it is a long way from a solution.

For the many young people currently living with parental substance misuse, there is no obvious place to go to get help and the issue is often hidden. Young people felt that there was a need for greater efforts to raise awareness of this issue with other young people and staff across services, including where and what kind of help is available.

Strategic Recommendation 6: There is a need for a pathway of support for young people affected by parental substance misuse to be developed and publicised widely as part of wider efforts to encourage young people to feel comfortable coming forward with this issue. This needs to include universal, targeted and specialist services and integrate with the pathway for parents, families and young children recommended above.

Strategic Recommendation 7: 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 identify and support more of those in need.

- **Recommendation 7a: As part of their health and wellbeing curriculum, MEL 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.**
- **Recommendation 7b: There is a need to develop models of practice 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.**

Strategic Recommendation 8: There is a need to consolidate and co-ordinate services providing targeted support to young people on specific topics including young carers, domestic violence and other issues and vulnerabilities. Ideally all practitioners and teams with a remit to work directly with young people on a one to one basis, or to deliver external inputs on health and wellbeing issues in schools or informal settings, should work as part of one organisation, as a holistic youth health service.

- **Recommendation 8a: Within one service, practitioners should be trained to work holistically with young people to support them with any or multiple issues as needed, however individual practitioners should take a lead on different specialist topics. They can then act as a source of advice and support for colleagues on that issue.**

- **Recommendation 8b:** Each young person should have an identified link practitioner or key worker at the service, ideally who has expertise in whatever issue most concerns the young person. However a team approach should be taken to consider, with the young person (and their parents where involved) the best support package for any given young person who has more complex needs.
- **Recommendation 8c:** The support offered could include counselling and more flexible one to one support but also broader group work to promote the service and build trust with vulnerable young people, and specific group work to offer peer and/or therapeutic support. The group work programme could be topic-specific or generic depending on demand and needs of young people. Age-specific groups are also likely to be needed.
- **Recommendation 8d:** A planned approach should be taken across the team to consider clear messages and awareness raising in relation to each issue and to vulnerability in general. Such messages should be consistently promoted so that the visibility of services for each particular issue is not lost. At least one youth practitioner within both Midlothian and East Lothian should take on a specific CAPSM remit.
- **Recommendation 8e:** A consistent and clear identity and point of contact should be established for the service, both in terms of website, social media, branding and contact details to make it easy for both young people and practitioners to know where to go. The service will also need to build excellent relationships with schools and treatment services over time to establish trust, support staff and generate appropriate referrals/self-referrals.
- **Recommendation 8f:** This should ensure consistent area-wide provision (across both areas) for vulnerable young people regardless of the issue in question and will require co-operation across the two local authorities and with partner agencies and funders. An interim solution may be to bring together existing teams and practitioners under an umbrella youth health service where each practitioner retains their current employment with their existing organisation but they are line managed through the new youth health service. Ideally if possible, just one service would operate across both Midlothian and East Lothian.
- **Recommendation 8g:** This research suggests that there are further areas for development of services in relation to primary school-aged children affected by parental substance misuse. Commissioners need to use the above principles for supporting young people to consider who is best placed to offer this support for younger children.

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 children may benefit from support. The difficulties of this in terms of getting the balance between helping parents (and therefore children) and protecting children (but possibly at the expense of helping parents) are recognised.

Strategic Recommendation 9: 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.

- **Recommendation 9a: MELDAP should engage with Al-Anon to explore ways 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 PVG checks and child protection where necessary.**
- **Recommendation 9b: Representatives of adult self-help groups operating in Midlothian and East Lothian should consider how they can work with partner organisations to ensure that such children are being identified and offered support.**

Strategic Recommendation 10: Further consideration needs to be given to how foetal alcohol exposure can be prevented and how the needs of children affected by foetal alcohol exposure can be identified and met. MELDAP should work with partners to raise awareness of FASD through nationally available resources.

7.6 CROSS-CUTTING ISSUES

7.6.1 TRAINING

Training was seen as important for raising awareness, increasing knowledge, improving skills and addressing attitudinal change. This is an essential element of improving capacity in some organisations to be more aware of and focused on identifying and meeting the needs of CAPSM.

Respondents felt that it would be useful if training were designed to meet the needs of particular groups and could include identifying signs of parental substance misuse and the roles of different agencies in supporting parents, families, children and young people.

Strategic Recommendation 11: 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 and delivering learning opportunities to build competency and will require effort by the local authorities, NHS Lothian and partner organisations.

- **Recommendation 11a: The areas for development and capacity building recommended are:**
 - 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. Models should include emphasis on educating young people about effective parenting more generally and what supports are available if they are worried about any aspect of their family life.
 - 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.
 - 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.

- 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).
- **Recommendation 11b: Consideration should be given to suitable opportunities for multi-disciplinary/multi-team development in relation to this issue however experience suggests that most of the training will need to be setting specific in order to be effective in changing practice.**
- **Recommendation 11c: In early years services for vulnerable families where substance misuse is being disclosed by parents, an organisation-wide approach to working based on motivational interviewing should be considered. Staff should be offered motivational interviewing training, coaching, ongoing practice-based supervision and support from management to enable them to work in a motivational way with these parents. This will require funding and the impact of the change in practice should be properly evaluated and shared.**
- **Recommendation 11d: Change without education is unlikely, however the role of leaders within services in changing culture is important and so greater emphasis should also be placed on educating senior managers and service managers on the issues raised in this report. They are best placed to lead culture change, including finding solutions to practical constraints in providing learning opportunities for staff.**

7.6.2 INTER-DISCIPLINARY AND PARTNERSHIP WORKING

There were examples of partnership working that were felt to be functioning well including the Midlothian Substance Misuse Screening Group, examples of co-location of services and working with the police. However some participants in both areas felt that co-operation could be closer and there was a particular issue highlighted in relation to information sharing with schools. 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 initiative³⁴ in Angus

Strategic Recommendation 12: Continued effort and 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.

³⁴ Kosonen, M, (2011). Angus Learning Partnership for children affected by parental substance misuse (CAPSM). A summary report.

- **Recommendation 12a: 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.**
- **Recommendation 12b: A short-life working group covering both Midlothian and East Lothian should be set up by MELDAP to consider the issue of information sharing between schools, health and treatment services to ensure that teachers have all the information necessary to take responsibility for child welfare in the role of 'named person'.**

7.6.3 MODELS OF WORKING AND OUTCOME EVALUATION

There are considerable difficulties with gathering any information on the effectiveness of services because such data is not routinely generated or collected. The development of a coherent approach to evaluation of the effectiveness of services using outcome-focused work is further hindered by the fragmented nature of services, confusing service names, failure to base approaches on theory or evidence, or to clearly articulate such a basis for approaches.

Strategic Recommendation 13: Commissioners, funders and services across MEL 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 and underpinning theory/evidence.

- **Recommendation 13a: 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, what guides that work including assumptions, processes, interventions, theories etc. and how they can monitor effectiveness using clear outcome measures.**

Strategic Recommendation 14: 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.

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 21/06/2012) 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 Midlothian accounts for approximately 1.7% of Scotland's population of 0-15 year olds (<http://www.gro-scotland.gov.uk/files2/stats/council-area-data-sheets/midlothian-factsheet.pdf>, accessed 25/4/2013), this gives a very rough estimate of 1,474 children in Midlothian whose parents report problematic alcohol use.

As East Lothian accounts for approximately 2.07% of Scotland's population of 0-15 year olds (<http://www.gro-scotland.gov.uk/files2/stats/council-area-data-sheets/midlothian-factsheet.pdf>, accessed 25/4/2013), this gives a very rough estimate of 1,795 children in East Lothian whose parents report problematic alcohol use.

APPENDIX B: THE CHILDREN'S SOCIETY: STARS INITIATIVE & STARS BIRMINGHAM

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:

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