



Safeguarding Children of Parents with Substance Misuse Problems and other Vulnerabilities

A Strengthening Complex Families Approach

A REPORT FROM THE ESSEX HIDDEN HARM STEERING GROUP TO
ESSEX SAFEGUARDING BOARDS FOR CHILDREN AND ADULTS

Commissioned by



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CONTENTS

FOREWORD	2
EXECUTIVE SUMMARY	4
1. INTRODUCTION	10
2. POLICY CONTEXT	14
3. PROBLEM ANALYSIS	25
4. ESSEX NEEDS ANALYSIS	42
5. WHAT WORKS	65
6. DELIVERY	76
7. RECOMMENDATIONS	90
LIST OF ANNEXES	99

DEFINITIONS

For the purposes of this report, the following definitions for terms have been used:

Parental Vulnerability	A problem that impacts on an adult's ability to parent, in particular substance misuse, mental health problems, domestic abuse and offending behaviour
Complex Families	Where a number of parental vulnerabilities exist with one or both parents in a family. The children do not have to also display problems for this term to apply
Children Looked After	Children and young people who are, or have spent time, in the care of the local authority
Substance Misuse	The problematic use of alcohol and/or illegal or prescribed drugs

FOREWORD

Families that have one or more parents with vulnerabilities or problems such as alcohol misuse, drug misuse, mental health problems, domestic abuse or criminal involvement are shown to have poor outcomes for the children as well as the adults. These problems are often overlapping creating complex families that present a challenge for services to deal with effectively. These complex families can cost public services between £250,000 and £350,000 a year to deal with.

Government policy and evidence of effective programmes support a move towards giving greater priority to vulnerable families, and adopting an approach to build their resilience through whole family assessments, whole family care plans and intensive whole family interventions.

If we can see these families coming (by identifying them through services or data) and know that they are not likely to do well in our normal service responses (by acknowledging the evidence of poor outcomes, difficulties in intervening effectively and the resultant high costs to public services), then we have a duty to do something different with them in future. We can intervene early rather than wait for a crisis to happen.

Adults who are parents and have more than one vulnerability is the norm for adult and children's social care rather than the exception. The prevalence estimates we have generated show that these issues should not be considered to be a "hidden harm" or a specialist issue – these families form the bulk of those who regularly attend key agencies and should be considered a core issue and be afforded greater priority. A more tailored response is needed from adult services for parents with multiple vulnerabilities as evidence shows that these parents are likely to drop out of standard support services or be hard to engage.

Strategically we should concentrate our resources where it will have the biggest impact, especially during a time of public sector spending cuts.

*"Be there, do
the right
thing, help
and follow
through.
That's what
helps"*

Young Person,
Essex



This means identifying and targeting high cost families with programmes that have been shown to work and save money.

The current set up of services encourages the fragmentation of families into individual members (adults and children) with numbers of individual problems dealt with separately, in spite of research demonstrating how linked these problems are and that parent's affect the whole family's outcomes not just those of the individual.

Intergenerational transmission, where many of these parental vulnerabilities mean that their children are significantly more likely to experience similar problems, typified by local case studies we were told about showing 2nd and 3rd generation drug misusers and children in care, demonstrates the need to adopt a “never too late to intervene” principle to ensure that services do not give up on families or pre-judge their ability to improve.

The evidence shows that you can have success and change the lives of vulnerable families by proactively engaging them, building their resilience, reducing their risk factors and strengthening the family to cope by themselves in the long term.

There appears to be an opportunity for a “Win-Win” situation. By developing and building capacity for whole family interventions with families with complex needs, the evidence suggests that it can be better for the outcomes of the children and the adults in that family, whilst also serving to reduce the cost burden on social and health care, and even improving staff recruitment and retention.

In short, now is the right time to look again at families with complex needs and use the evidence and policy direction to change our approach for the better.

EXECUTIVE SUMMARY

Introduction

Following issues raised in the Joint Area Review, by the National Treatment Agency and in Serious Case Reviews, the Essex Drug and Alcohol Partnership and the Safeguarding Children Unit in Essex County Council have been looking to improve the response to children and families where there are substance misusing parents through better joint working and whole family approaches.

A steering group was established to focus on these issues and produce a report to: (i) raise awareness; (ii) develop a better understanding among services of the issues and improve practice; and (iii) build a case for changing the approach to families affected by these issues.

A decision was taken to include the issues of parental mental health, domestic abuse and offending behaviour, in addition to that of drugs and alcohol, due to the overlapping nature of these issues.

A report has been developed by assessing local need, interviewing key interested parties across partnership agencies in Essex, listening to young people and parents affected directly by these issues, and by reviewing the available evidence of the impact on families and of what works in terms of effective interventions. The findings and a series of recommendations have been set out for consideration by the Essex Safeguarding Boards for Adults and Children.

Policy Context

The new Government has committed to helping families with multiple problems. Nationally, there has been a raft of policies over the last decade placing greater emphasis on the importance of the family, including Think Family, the Drug Strategy, the Youth Alcohol Action Plan and Working Together to Safeguard Children guidance.

“Families with drug and alcohol problems need support to rebuild their lives and their family, to get things back on track – things like help with housing, food and better relationships and getting into services”

Substance
Misusing Parent,
Essex



“Services should talk to each other more”

Young Person,
Essex

In Essex, there are commitments to ensure that all children thrive, that parents are supported, and that families affected by substance misuse receive more integrated help. These commitments must be considered against the backdrop of rising demand for services and reducing levels of resource, which creates the need both nationally and locally to improve outcomes and drive efficiencies.

Problem Analysis

A number of factors for parents impact on their ability to parent well and impact negatively on their children in terms of both immediate safety and longer-term outcomes, including if a child is taken into care. Most prominent amongst these vulnerabilities for parents are drug misuse, alcohol misuse, mental health problems, domestic abuse and offending. These vulnerabilities are often linked, overlapping and mutually reinforcing. Families with multiple vulnerabilities present challenges for services, cost the local authority and health services significant amounts of money to respond to, and are difficult for staff to work with effectively across social care and partner agencies.

Local Needs Analysis

Essex has a population of approximately 262,000 children aged 0-15 years. Using the latest methodology for generating estimates of children of substance misusing parents¹, Essex has an estimated:

- 73,000 (28%) children living with a binge drinking parent, of which:
 - 57,000 (22%) live with a hazardous drinker
 - 11,000 (4.2%) live with a problem drinker with concurrent mental health problems
- 7,300 (2.8%) living with a dependent drug user, of which:
 - 6,000 (2.3%) children live where the only adult uses drugs
 - 6,800 (2.6%) live with a drug user with concurrent mental health problems

¹ Manning et al (2010)

In addition, other estimates that we have generated or been given show that Essex may have:

- 3,200 (2%) families with multiple vulnerabilities² - including mental health problems, drug misuse, alcohol misuse, offending and domestic abuse
- There are an estimated 3,486³ crack and or heroin users in Essex and it is estimated that around 1,603 (46%) of these will be parents
- 58% of current court cases for the Permanency Teams were known to have at least one substance misusing parent
- 67% of Adoption service cases involved parental substance misuse
- 50% of children attending CAMHS had at least one parent with a mental health problem who either was or had been in contact with adult mental health services, and 25% had a parent with a substance misuse problem
- Of the 1,465 children looked after in Essex, we conservatively estimate that at least 492 (33%) have a substance misusing parent, 527 (36%) have parents involved in domestic abuse, 211 (14%) have alcohol misusing parents, 421 (29%) have at least one parent with a mental health problem, and 386 (26%) have a parent involved in offending

“Services should be a lot more honest with families and offer practical support. Social services involvement shouldn’t be threatening or a punishment, this actually stops parents going to treatment or services for help, making things worse”

Substance Misusing Parent, Essex

Headlines from treatment data in Essex show that parents engage for less than half the average treatment duration for non-parents. There is an even greater difference for female parents who, on average, engage in treatment for only 37% of the average duration for non-parents. Local treatment data also shows that over 50% of non-parents will complete treatment in a planned way, compared to only 15% of non-parents.

² “Think Family” (Social Exclusion Task Force)

³ Problem Drug User Estimates based on Glasgow Research



When looking at a sample of cases of Children Looked After (CLA) in Essex, we found that the majority (83%) of cases had one or more parental vulnerabilities identified, and 40% had two or more vulnerabilities. 69% of CLA had at least one other looked-after sibling.

Four of the five districts of highest deprivation in Essex⁴ (Tendring, Harlow, Basildon and Colchester) are also among the five districts with the highest number of open child protection cases.

There is a rising trend across Essex in the demand for child protection services, numbers of children going into care, adults seeking drug treatment and adult safeguarding referrals.

Our interview programme revealed that there are identified gaps in service provision for complex families, direct support for children of parents with substance misuse, mental health problems, offending and domestic abuse issues. However, this data was not habitually recorded nor brought together across the partnership for the purposes of needs analysis, identifying high risk families or informing commissioning.

What Works

There is a growing evidence base to support the efficacy of whole family interventions that demonstrate improved outcomes for vulnerable and complex families and provide evidence of cost savings or cost avoidance for public services. These have been shown to be effective for families with parental substance misuse, domestic abuse and mental health problems. These programmes include Westminster Family Recovery Project, Family Intervention Projects, Strengthening Families Programme, Option 2, M-PACT and Family Drug and Alcohol Courts.

⁴ IDACI in 2007

Delivery Options

Using the evidence of what works and the local needs analysis, we have developed a set of principles and characteristics of effective programmes that should underpin any future service development, joint working protocols and training. We have also outlined three delivery models to take this work forward:

1. A multi-agency joint working protocol
2. A programme of training, support and co-location
3. Adopting an evidence-based programme

Recommendations

We have generated a series of recommendations for the partnership in Essex to consider. We believe that Essex should:

Identify

- Conduct an exercise to identify the top 400-600 complex families that cost Essex services the most money to deal with
- Pool training resources by bringing together budgets, expertise, venues and overlapping issues (e.g. parental drugs, alcohol, mental health, domestic abuse) into a single set of training programmes to: (i) help identifying agencies to spot signs and engage complex families; and (ii) develop whole family working practices across key agencies
- Pool communications resources to ensure that key messages about working with complex families go to all staff across agencies in a joined up way, spreading evidence of what works
- Commissioning priority should be given for parents with vulnerabilities and complex families, with commissioners actively ensuring an appropriate response from service providers



Intervene

- Improve inter-agency working through developing and implementing a specific protocol to drive improved joint working for complex families. Key agencies need to sign up, setting out expectations and commitments from each agency in line with evidence of what works
- Consider adopting an evidence based programme to deal with complex families more effectively
- Bridge the gap between adult and children's services by joining up the safeguarding functions and championing a multi-agency approach to complex families, in line with evidence based programmes
- Consider whether the current use of money for drug testing and substance misuse experts in child care proceedings could be more effectively used to fund specialist drugs worker input co-located with children's social care to joint work these cases

Prevent

- Address the current gap in support after a child goes into care when parents have vulnerabilities, by ensuring appropriate family strengthening support and parenting skills for the parents and specific support for the children who may experience long term problems
- Establish self support groups for parents (esp. mothers) going through these issues

1. INTRODUCTION

SUMMARY

Following issues raised in the Joint Area Review, by the National Treatment Agency and in Serious Case Reviews, the Essex Drug and Alcohol Partnership and the Safeguarding Children Unit in Essex County Council have been looking to improve the response to children and families where there are substance misusing parents through better joint working and whole family approaches.

A steering group was established to focus on these issues and produce a report to: (i) raise awareness; (ii) develop a better understanding among services of the issues and improve practice; and (iii) build a case for changing the approach to families affected by these issues.

A decision was taken to include the issues of parental mental health, domestic abuse and offending behaviour, in addition to that of drugs and alcohol, due to the overlapping nature of these issues.

A report has been developed by assessing local need, interviewing key interested parties across partnership agencies in Essex, listening to young people and parents affected directly by these issues, and by reviewing the available evidence of the impact on families and of what works in terms of effective interventions. The findings and a series of recommendations have been set out for consideration by the Essex Safeguarding Boards for Adults and Children.

BACKGROUND

This report has resulted from an identified need for a focussed piece of work to improve the safeguarding response in Essex to children of substance misusing parents in response to a number of issues:

- The outcome and recommendations of the Joint Area Review
- Serious Case Review (SCR) recommendations
- The need to develop more effective safeguarding working arrangements across drug and alcohol services and children's social care driven by the National Treatment Agency for Substance Misuse (NTA) both nationally and regionally



- The Essex Drug and Alcohol Partnership's (EDAP) vision for developing and delivering on more effective "Think Family" service provision and their System Change Pilot
- The Essex priority to ensure more effective engagement with parents and families in general
- The need to identify cost saving opportunities in public services

Hidden Harm Steering Group

This project is overseen by the Hidden Harm Steering Group, which consists of: Ben Hughes and Sally Hills from the Essex Drug and Alcohol Partnership; Tamsyn Basson from the Children's Safeguarding Unit in Essex County Council; Mike Gogarty, Director of Public Health; and Belinda Beukes from the Leaving and Aftercare team. Currently the steering group is extending its membership to include representation from Adult Safeguarding and Safeguarding within the NHS in Essex.

The aim of this first phase of the project is to develop a report from the Hidden Harm Steering Group to the Essex Safeguarding Boards for Adults and Children regarding the safeguarding response to children of substance misusing parents (also known as Hidden Harm). However, during this work, it became clear that this also presented an opportunity to look at other related parental vulnerabilities such as mental health problems, offending behaviour and domestic abuse, where the evidence shows substantial cross over in terms of impact on ability to parent, negative impact on children's outcomes and safety, and the presence of multiple vulnerabilities in complex families leading to long-term poor outcomes for the whole family.

This brings the responsibility to not only look at safeguarding children but also how to best support parents and strengthen families where parents have vulnerabilities which impact on themselves, their children, the family as a whole, and the wider community resulting in high costs to public services. The findings from the first phase of this work was reported back to partners at a conference on 14 October 2010.

The project aims to:

- i. **Raise awareness** of the issues and develop a better shared understanding of the impact of parental vulnerability on children and families, of what works, and promote the key messages for communication and training
- ii. **Change practice** at the frontline through embedding good practice into policy and establishing the basis for joint working protocols
- iii. **Build a business case for change** in the way that services identify the needs of parents with vulnerabilities and the responses they give in strengthening the family, providing a basis for re-design and re-prioritisation

The desired outcomes of this work are to:

- Strengthen and build resilience in complex families
- Improve children's and parents' outcomes from complex families
- Drive efficiencies and improvements to the safeguarding response that these families receive to keep children safe
- Avoid future costs to society

The second phase of actions in this project will disseminate the key messages and findings from the report widely and develop the protocols required to deliver improvements to practice.

The funding for this project comes from the National Pooled Treatment Budget (through the National Treatment Agency), a Department of Health grant allocated to Drug and Alcohol Action Partnerships annually. The project was approved and commissioned through both Adult and Young People's Joint Commissioning Groups of EDAP (now a single Integrated Substance Misuse Commissioning Group), and a business case went to the contracts board and was approved.



METHODOLOGY

During this project, we have undertaken a variety of approaches to develop this report, including:

- Reviewing relevant literature, policies, protocols from other local areas and national policy
- Reviewing evidence of which approaches and programmes have demonstrated effectiveness (i.e. what works)
- Listening to key stakeholders at senior manager, team manager and frontline practitioner level across the partnership
- Listening to young people and parents affected by these issues in Essex. Relevant quotes from these discussions have been used in the margins of this report
- Conducting a survey with practitioners and created snapshot data
- Undertaking a needs analysis using local data to generate estimates of prevalence across Essex

More detail about our methodology is set out in Annex 14.



Project Team

The project team is led by Matthew Scott, with support from Dr Tim Legrand and Simon Legrand. Matthew has specialised in drug and alcohol work for 15 years, making a significant contribution in Government policy and as a frontline practitioner, service manager, and commissioner. He has also worked in wider children's and youth services. Tim is a social policy research specialist, with expertise in the transfer of policies and best-practice from/to overseas, he combines a strong background in qualitative and quantitative research methodology with experience in social welfare and drug and alcohol policy. Simon has worked extensively across drug prevention, early intervention and treatment services, from frontline practitioner work to service management, service development and specialist substance misuse and mental health consultancy.

2. POLICY CONTEXT

SUMMARY

The new Government has committed to helping families with multiple problems. Nationally, there has been a raft of policies over the last decade placing greater emphasis on the importance of the family, including 'Think Family', the Drug Strategy, the Youth Alcohol Action Plan and Working Together to Safeguard Children guidance.

In Essex, there are commitments to ensure that all children thrive, that parents are supported, and that families affected by substance misuse receive more integrated help. These commitments must be considered against the backdrop of rising demand for services and reducing levels of resource, which creates the need both nationally and locally to improve outcomes and drive efficiencies.

NATIONAL POLICY

The new Government's programme⁵ commits to "investigating a new approach to helping families with multiple problems". They have expressed an intention to focus on 50,000 'high need' families, equating to the 400 – 600 highest need families in each local authority.

This fits with other priorities expressed by the new Government to strip away the obstacles that stop disadvantaged children from succeeding, to make improvements to safeguarding children at risk, and to improve the cost effectiveness of children's services. The Government sees the key challenges to be how best to build on existing work (such as family intervention projects, family pathfinders, family recovery project etc.), whilst improving access to specialist help, improving staff skills, linking families to other local services and to voluntary and community services, and taking a more sustainable approach to funding.

In addition, the Government asked Professor Eileen Munro to make recommendations about how to reform frontline social work practice and strengthen the profession, focusing on improving social work practice in

⁵ "The Coalition: our programme for government" (HM Government, 2010)



assessing and helping children, young people and their families. The problems identified by Professor Munro in her first report⁶ include:

- Professionals too focused on complying with rules and regulations and so spending less time assessing children's needs
- A target-driven culture meaning social workers are unable to exercise their professional judgement
- Serious case reviews concentrating only on errors when things have gone wrong, rather than looking at good practice and continually reflecting on what could be done better
- Professionals becoming demoralised over time as organisations fail to recognise the emotional impact of the work they do and the support they need

Whole Family Approaches

These commitments indicate that the issues and approaches highlighted in the 'Think Family' work are still highly relevant and will continue to shape the future agenda. The Government's '*Families at Risk review*'⁷ set out plans to support families experiencing the most entrenched problems – including substance misuse and poor mental health – to reduce the impact that this has on their children.

The five elements outlined in '*Reaching Out: Think Family*' are:

- **Families at the centre**, requiring family centred services and systems to be put in place incorporating the principles of participation and empowerment
- **Integrated frontline delivery**, encompassing multi agency team working, lead professional role and cross sector/age specific services' understanding and cooperation
- **Integrated processes** supported by training, development of holistic assessment and agreed protocols around information sharing

⁶ September 2010

⁷ Think Family: Improving the Life Chances of Families at Risk (Cabinet Office, 2008)

- **Integrated strategy:** that focuses on vulnerable families and draws upon joint commissioning
- **Interagency governance,** driven by the 'Think Family' principles

In practice, this means that relevant services need to work together to:

- **Identify families at risk of poor outcomes** and provide support at the earliest opportunity
- **Meet the full range of needs** within each family they are supporting or working with
- **Develop services which can respond effectively** to the most challenging families
- **Strengthen the ability of family members** to provide care and support to each other

Safeguarding Guidance

'*Working together to safeguard children*' guidance states, "it is important that arrangements are in place to enable children's social care and substance misuse (including alcohol) service referrals to be made in relevant cases. Where children may be suffering significant harm because of their own substance misuse, or where parental substance misuse may be causing such harm, referrals need to be made in accordance with Local Safeguarding Children's Board procedures. Where children are not suffering significant harm, referral arrangements also need to be in place to enable children's broader needs to be assessed and responded to."⁸

Drug Strategy – Protecting Families

The Government's drug strategy⁹ includes a number of specific actions relating to families and substance misusing parents, including that 'all drug-misusing parents with treatment need are to have ready access to treatment and all problem drug user parents whose children are at risk

⁸ '*Working together to safeguard children's guide to inter-agency working to safeguard and promote the welfare of children*' (Department for Education, March 2010)

⁹ '*Drugs: protecting families and communities*' (Home Office, 2008)



are to have prompt access to treatment, with assessments taking account of family needs'. It then moves the agenda on further to include encouraging local areas to give priority to:

- Supporting the children of drug misusers
- Intervention with families at risk of suffering harms
- Increasing the availability of personalised treatment services, with better support to help people complete treatment and re-establish their lives, implementing the 'Think Family' approach

Recent advice from Government regarding the direction of future drug strategy¹⁰ indicates that families are still at the centre of government drug and alcohol policy and that there will be greater emphasis on local decision-making. In drug treatment, the focus will be on sustained recovery, moving from process to outcomes, and ensuring tailored support for individuals. There is an emphasis on the role of families and carers in enabling access to treatment for individuals with problematic drug and alcohol issues, improving treatment journeys and outcomes, promoting sustainable recovery and reducing re-offending.

Government guidance¹¹ has been produced with the National Treatment Agency, which recommends that drug and alcohol services should:

- Have effective joint working with parenting and family services which may be best supported by establishing a Single Point of Contact within each local treatment system to act as the main lead and contact for families services
- Utilise the knowledge and expertise of family service professionals in order to assess the potential impact of service user's substance misuse on their children's health and development to assist in a holistic approach

¹⁰ '2010 Drug Strategy Consultation Paper' (Home Office, August 2010)

¹¹ Joint Guidance on Development of Local Protocols between Drug and Alcohol Treatment Services and Local Safeguarding and Family Services (2009)

- When requested, substance misuse services should provide information to family services (or a lead professional from children’s social care) regarding the nature of parent’s substance misuse and treatment services being accessed

This guidance also recommends that Parenting and Family Services should:

- Routinely record whether a parent has substance misuse problems on family case records and for data collection to aid service planning
- Consider whether the parents’ condition or their need to attend treatment sessions may be leading to heavy caring responsibilities falling on children within the family. Ensure support offered to the family as a whole, including adult social care where appropriate, is sufficient to ensure that children are properly protected and do not have to take on levels of caring responsibility which are too much for them
- Family services workers should consider undertaking Government and NTA approved substance misuse training on substance misuse, screening and referral protocols¹²

The Government’s National Carers Strategy¹³ draws attention to the vulnerability of children who are young carers in families affected by substance misuse, and states the importance of better prevention and whole family working across the different agencies involved.

Parenting and Family Support

Recent guidance on parenting and family support¹⁴ illustrates an approach with a graduated model that highlights the need for joined up, multi-agency approaches for the whole family – especially complex families:

¹² Joint Guidance on Development of Local Protocols between Drug and Alcohol Treatment Services and Local Safeguarding and Family Services (2009)

¹³ Carers at the heart of 21st century families and communities (Department of Health, 2008)

¹⁴ Parenting and Family Support: Guidance for local Authorities in England (March 2010)



“My step-dad was a proper headcase and mum was on and on at him to try smack. She used to go out and anyone that looked at her he would go mental and smash them up, that’s what it was like... Now I’m a heroin user but I’m getting it together”

Young Person,
Essex

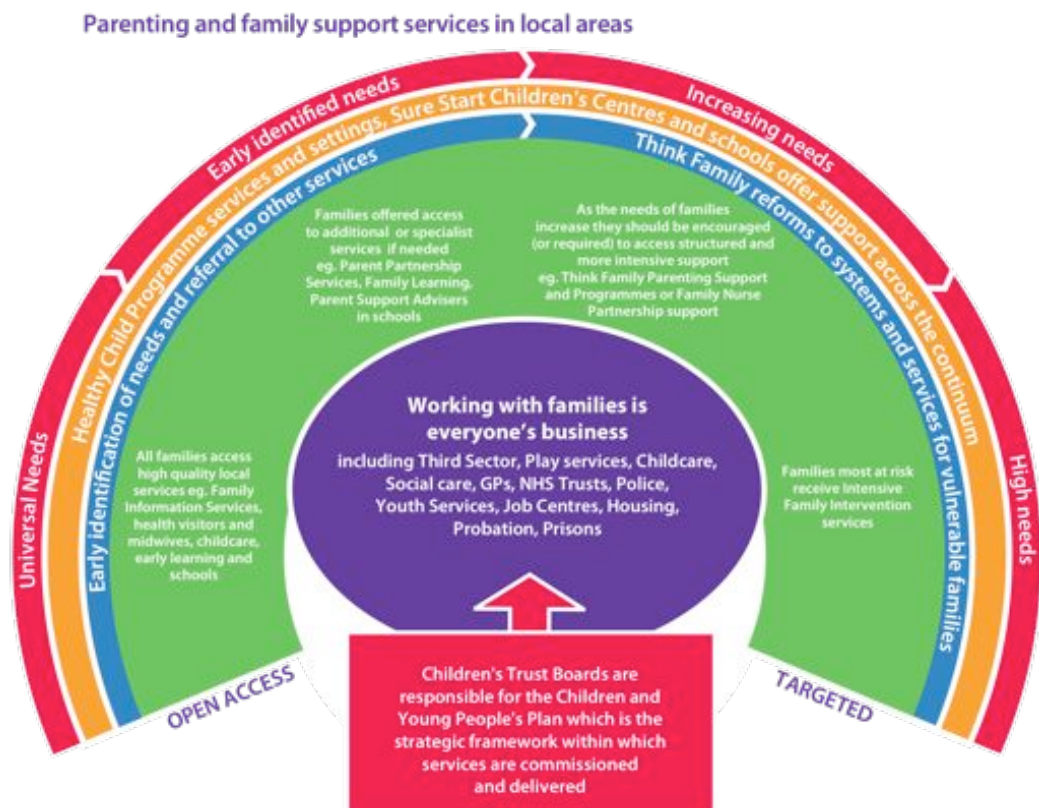


Figure 1. National Model for Parenting Support

Key Considerations drawn from Government Policy

- Parental substance misuse can and does cause serious harm to children of every age¹⁵
- Reducing harm should be the main aim of policy and practice¹⁶
- Services should make the needs of the child paramount, and work together (sharing information) to achieve better outcomes for the child¹⁷
- Co-ordinated and early intervention reduces risks to whole family¹⁸
- Harm to the child can be mitigated by adequate support and guidance to the affected parent¹⁹

A list of relevant Government policy documents in recent years is supplied in Annex 15.

¹⁵ Hidden Harm, 2003
¹⁶ Hidden Harm, 2003
¹⁷ Think Family, 2008; Hidden Harm, 2003
¹⁸ Think Family, 2008
¹⁹ Hidden Harm, 2003

British Association of Social Workers (BASW)

The BASW has recently issued a pocket guide for social workers on working with drugs and alcohol issues. The following points are made:

- “Social workers are in the front line of health and social care services. Alcohol and other drug use can play a significant role in the lives of people who use services”
- “Social workers should be able to intervene confidently and effectively where they encounter alcohol and drug problems”
- “In the past alcohol and drug problems have not been high enough on the social work agenda. However now it is recognised that core social work skills are ideally suited for work with people’s alcohol and drug use”²⁰

ESSEX POLICY

Essex County Council has a vision of ensuring that their customers remain at the heart of everything they do, in short “putting our customers first”. The Essex County Council Improvement Plan (2010) states that they “want Essex to be a place where children can thrive and grow up safely, free from harm and neglect”. The Improvement Plan aims to ensure high quality front-line practice in children’s social care, through:

- Building a range of services which support families and their children
- Effective multi-agency early intervention and prevention
- A high quality family support service
- A clear understanding of thresholds, risk and when to intervene
- Family support services and residential settings that keep children safe and achieve their potential

²⁰ British Association of Social Worker’s Pocket Guide on Drugs and Alcohol (September 2010)



Children and Young People's Plan

The Essex Children and Young People's Plan (CYPP)²¹ sets out Essex's commitment and approach to improving outcomes for children and young people in line with the Children's Act 2004. One priority is to provide effective support for parents, by "supporting parents and carers through parenting provision that will provide a range of parenting programmes and support services; developing systems and processes to monitor the outcomes and impacts of programmes and support provided; and reviewing services and building on current resources to develop a tapestry of graduated family support services".

The "Be Healthy" Implementation Group leads on this priority by developing services to help create resilience within families to cope with difficult situations. The aim is to increase the number of families accessing support through parenting programmes and other systems of support.

Tackling the Deficit

These aims must be considered against the current economic situation. A recently published emergency budget impact statement by Councillor Martin, Leader of Essex County Council, stated "we are in a time of great change for local government. Every department and organisation in the public sector is under pressure, and the emergency budget shows how determined the government is to tackle the huge national deficit. In the coming years we will also face multiple economic and social challenges, to which a transformed ECC will need to be able to respond. For example referrals to our children's services have increased".

Drug Treatment

The Essex Drug Treatment Plan (2010/11) sets out the aim to achieve "closer integration of the Children and Young People's and Adult commissioning functions of the Partnership in line with the need to

²¹ CYPP 2009–11

deliver against the recovery and re-integration agenda. It also aims to build into commissioning and delivery frameworks clear protocols for assessing, reviewing and actively engaging with the Safeguarding agenda and delivery. Most relevantly, there is an ambition to increase support and provision for families and carers and support a greater emphasis on the development of the 'Think Family' approach and links to generic parenting and family support provision”.

SET Guidance for Safeguarding

The Southend, Essex and Thurrock (SET) Safeguarding procedures for adults and children have both recently been consulted on, with revised versions due for publication in the coming months. These documents establish a consistent approach to safeguarding issues and set out expectations for those working with parents who misuse substances, have mental health problems and are exposed to domestic abuse.

Parenting Strategy

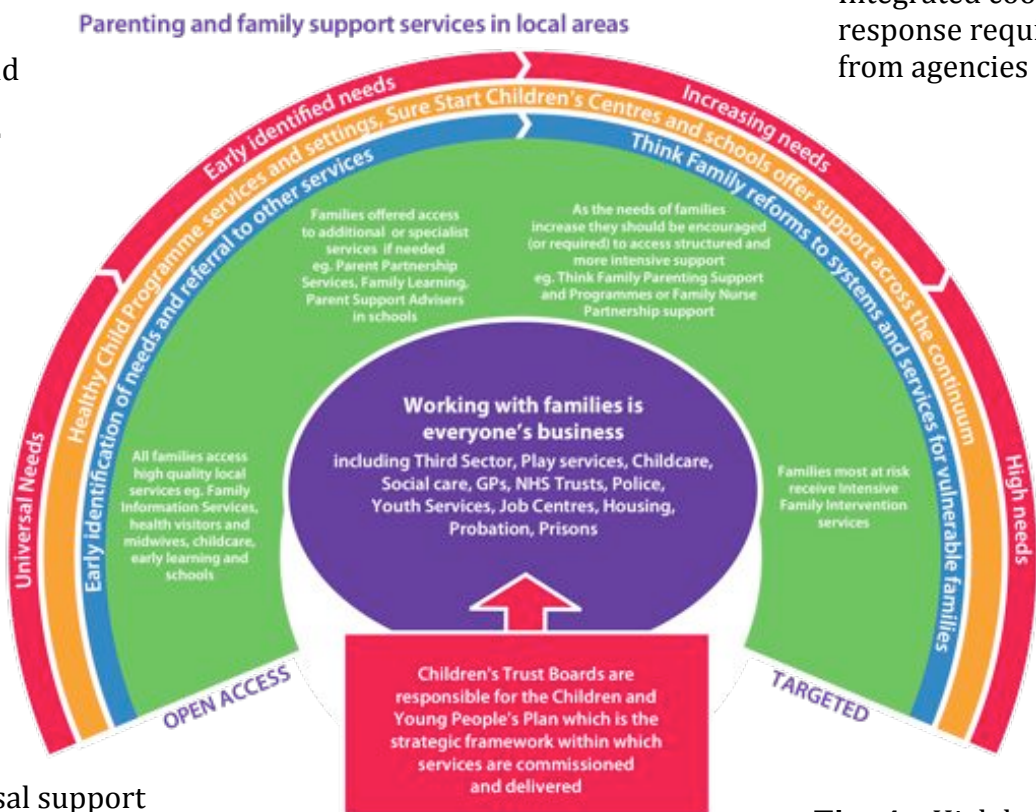
The Essex Children's Trust Parenting Strategy (2010) aims to “support all Essex parents to be positive and responsible parents so that their children are better able to fulfill their potential”. The document goes further and states that “to support parents, services provided need to be well designed, well resourced, relevant to the needs of parents and crucially, communicate with each other and work together”. In Essex, the model for parenting support has been adapted as set out in Figure 2.



Multi Agency Allocation Groups (MAAGs)

Tier 2 – Additional needs identified and accessed through CAF assessment and referral processes

Tier 3 – Complex needs requiring additional assessment. Integrated coordinated response required from agencies



Tier 1 – Universal support through provision of general information and /or advice, signposting etc.

Figure 2. Essex model for Parenting Support

Tier 4 – High level needs requiring intensive coordinated support and /or enforcement interventions

The Parenting Strategy for Essex identifies “high need holistic family support” as the 4th Tier in their model and makes the group a priority - “the needs of these families are complex and enduring but the outcomes of the child/young person are paramount.” The strategy aims to achieve this through providing intensive specialist support to the family using enforcement measures as appropriate e.g. Child Protection or Parenting Orders. The strategy suggests that “provision will be delivered by specialist practitioners qualified to provide and undertake high level robust assessments, supporting families to access agreed packages of support/care pathways or ensuring enforcement measures are in place

as required. Practitioners will need appropriate supervision to effectively undertake intensive one to one or group interventions.”

The Parenting Strategy states, “in order that the needs of these groups can be met appropriately and sensitively, consistent partnership working between all the relevant agencies is required so that families with problems are identified and offered the right support. In particular, close working with the Essex Safeguarding Children’s Board will support the identification of at risk groups needing targeted support in their role as parents.”

Domestic Abuse

The *Essex Against Domestic Violence Strategy (2008-11)* document shows that “very few definitions of domestic abuse make any reference to children. However, there is now a substantial body of evidence which shows that domestic abuse adversely affects children. This has to be recognised and addressed in programmes which seek to tackle domestic violence.”

The strategy goes on to emphasise its aim to work with local partners and agencies in their drive to tackle domestic abuse and reduce repeat victimisation.

Thresholds

The recently consulted on *Guidance for Threshold of Need and Intervention* by Essex County Council, ESCB and the Essex Children’s Trust highlights that where parents have mental health problems, substance misuse, involvement in crime, or there is domestic abuse that children are considered to be at Level 3. It goes on to say that where more than one of these are present, children are considered to be at Level 4.



3. PROBLEM ANALYSIS

SUMMARY

A number of factors for parents impact on their ability to parent well and impact negatively on their children in terms of both immediate safety and longer-term outcomes, including if a child is taken into care. Most prominent amongst these vulnerabilities for parents are drug misuse, alcohol misuse, mental health problems, domestic abuse and offending. These vulnerabilities are often linked, overlapping and mutually reinforcing. Families with multiple vulnerabilities present challenges for services, cost the local authority and health services significant amounts of money to respond to, and are difficult for staff to work with effectively across social care and partner agencies. One study estimated the costs to the taxpayer as being between £250,000 and £350,000 per family per year. Studies show that a large proportion of the child protection and looked after children cases have a substance misusing parent, and that the most common reason for this is neglect to the child. Research also indicates that children of substance misusing parents who stay with their birth families do better than those who are separated. The NTA say that “having drug users and their families and friends involved in the treatment system is crucial for effective treatment”.

“There isn’t much support for families like us in our situation. Children do better with their birth families, it’s the best place for them and with the right support, services can help this to happen”

Parent, Essex

RISK AND RESILIENCE FACTORS

Research has identified a number of child and family risk factors or characteristics that may make children and young people vulnerable and at greater risk of abuse or neglect. Risk factors are cumulative – the presence of one increases the likelihood that more will emerge – and many are inter-dependent. This includes those which are parent-related, such as substance misuse, mental health problems, being a young parent, poor parenting skills, or having experienced abuse/neglect. It also includes those which are family-related, for example, domestic abuse, family of four or more siblings, frequent home moves, lone or step parent family, and low income²².

Research also shows that the ability of children and young people to resist the effects of risk factors will be influenced by a number of other child and family ‘resilience’ or ‘protective’ factors. The most commonly

²² The Essex JSNA Children and Young People’s Chapter (2010)

cited resilience factors include having a supportive and involved grandparent, and being brought up in a birth family (with the presence of at least one supportive parent). Where the cumulative chain of adversities can be broken, most children are able to recover from even severe exposure to adversities in early life. Acute episodes of stress are less likely than an accumulation of adversity to have long-term adverse effects on children's development²³.

Poverty, unemployment, parenting alone, having a large family, poor or overcrowded housing, having a difficult child, parental illness and substance misuse, can have a negative impact on parenting. The factors are linked and mutually reinforcing²⁴.

Nearly 75% of Serious Case Reviews across England (2007 study) found that parental mental ill health, substance misuse and or domestic abuse, often in combination, were a key contributory factor.

Families with multiple problems make significant financial demands on a wide range of local services. Duplication and lack of co-ordination between services supporting the same family wastes money and reduces effectiveness. A family with severe problems could cost local services £250,000 - £350,000 in a single year²⁵. A number of studies across the country have segmented families into four broad groupings – thriving, coping, not coping and chaotic. These studies have estimated the different costs in meeting those families' needs. A “not coping family” can cost an authority ten times the cost of a “coping family”, and “a chaotic family” 75 times as much. Some families oscillate between “coping” and “not coping”: Early intervention makes good economic sense to strengthen their capability and resilience²⁶.

²³ The Essex JSNA Children and Young People's Chapter (2010)

²⁴ Ghate & Hazel (2002)

²⁵ (Sheffield Halam University 2006)

²⁶ Knowsley Council, Peterborough Council



"I always felt that my mum and dad, although they were crackheads, gave us enough love and that. They really looked after us the best they could but with the help we got things changed a lot"

Young Person,
Essex

Contact with many different services is confusing for a family, as expressed by a parent in the national Family Intervention Projects (FIP) evaluation reporting *"if you have different people... you have to go through everything you've gone through with the first one. Whereas if you've got the same one at least they get to know your family, get to know you as a person as well, and they know what help you've had, what help you haven't had, and they can just basically keep guiding you in the right direction."*

The Department of Health estimated that four million out of 11 million children in England were failing to meet their developmental goals due to stress in the family caused by mental illness, domestic abuse, the presence of drug and alcohol abuse, or by social and material conditions causing stress and chaos²⁷. Parents suffering any of these factors are typically less able to offer material support to children²⁸.

PARENTAL VULNERABILITIES

Drug Misusing Parents

Various research studies estimate that in this country:

- 2% of children live with a parent who has used a Class A drug in the last year²⁹
- 489,103 children lived with an adult who is an illicit drug user, of which:
 - 334,000 (2.8%) live with a dependent drug user
 - Around 275,069 (2.3%) children live in a household where the only adult is a drug user
 - 310,000 (2.6%) live with a drug user with concurrent mental health problems
- During periods of escalating drug use, the needs of the child(ren) can become secondary to those of the drug problem³⁰

²⁷ Desforges and Abouchaar (2003)

²⁸ End Child Poverty (NFPI, 2002)

²⁹ Health Survey for England (2004)

“Across the board, services struggle here to support families with lots of problems”

Parent, Essex

- Infants of cocaine or heroin-using mothers experience insecure or disorganised attachment³¹ and have a higher risk of experiencing neglect and unintentional injury³²
- Children of heroin-using parents are more likely to have problems with anxiety, hyperactivity, inattention, impulsivity and aggression³³, depression and worry³⁴
- The children of problem drug-using parents are more vulnerable to separation from parents than those from families without parental drug problems³⁵
- Children of drug-dependent parents have an elevated risk of problematic patterns of behaviour³⁶
- A matched control study of children (mean age 11 years) raised in families where one or both parents were dependent on heroin showed a significantly raised likelihood that these children would show depressive symptoms and be anxious, tense or worried³⁷

Research has shown that many parents who misuse drugs, particularly heroin, can often be emotionally unavailable to their children³⁸. Serious drug dependency may result in parents placing their own needs before the safety and welfare of their children. For example, young children may be left alone at home, or in the care of unsuitable or unsafe people, while the parent prioritises the acquisition of drugs.

Drug-using parents reported feeling more stressed, lacked social support and showed less adequate coping responses³⁹. This study also found that drug-using parents usually feel more stressed, lack social support and show less adequate coping responses.

³⁰ Meier (2004)

³¹ Goodman, Hans and Cox (1990); Rodning et al (1989)

³² Wasserman & Levanthal (1993)

³³ Ornoy et al (1996)

³⁴ Johnson (1991)

³⁵ Tyler et al (1997)

³⁶ Gainey et al (1997)

³⁷ Johnson et al (1991)

³⁸ *When Parents Use Drugs: Key Findings from a Study of Children in the Care of Drug-using Parents*. Dublin: The Children's Research Centre Hogan, D. and Higgins L. (2001)

³⁹ Kelley (1998)



Parental problem drug misuse affects children during middle childhood as well as early childhood. Research suggests that children's education and performance in school may suffer because parental problems dominate the child's thoughts and can adversely affect concentration⁴⁰. Parental problem drug use is associated with higher levels of aggressive, non-compliant, disruptive, destructive and antisocial behaviours in children⁴¹.

Some young people go on to learn to mirror their parents coping strategies and come to depend on drugs to deal with difficult situations and negative feelings⁴².

It is also important to acknowledge that the majority of substance misusing parents are still "good enough" parents as only a minority will have children taken into care.

Alcohol Misusing Parents

Research studies have estimated that in this country:

- Up to 1.3 million children are affected by parental alcohol problems⁴³
- Nearly 3.4 million (28%) children live with an adult binge drinker
- 2.6 million (22%) children live with a parent who is a hazardous drinker⁴⁴
- 502,000 (4.2%) live with a problem drinker with concurrent mental health problems

The impact of excessive alcohol consumption on parents' capacity to look after their children will depend on their current mental state and

⁴⁰ Cleaver, H., Unell, I. and Aldgate, A. (2010) *Children's Needs – Parenting Capacity: The impact of parental mental illness, learning disability, problem alcohol and drug use, and domestic violence on children's safety and development*

⁴¹ *Drug Addiction and Families* Barnard, M. (2007)

⁴² *Children, families and violence: Challenges for children's rights* Covell, K. and Howe, R.B. (2009)

⁴³ Prime Minister's Strategy Unit (2004)

⁴⁴ National Psychiatric Morbidity Survey (2000)

personality, their experience and tolerance of alcohol and the amount of alcohol consumed in one go and cumulatively over time.

Parental problem drinking can be associated with abuse within the family and the physical abuse of children. Determining which family member has the alcohol problem is relevant. Alcohol misuse by a father, or father figure, can be related to abuse and the physical abuse of children, while mothers with an alcohol problem are more likely to neglect their children⁴⁵. Children are most at risk of suffering significant harm when alcohol misuse is associated with abuse⁴⁶.

Parental alcohol problems continue to affect the health and development of children during middle childhood. For example, children's health may be endangered because, although alcohol consumption is not common during this period of childhood, maternal drinking increases the likelihood that children aged 10 years will start drinking⁴⁷.

Learning may also be affected. Children of parents with chronic alcohol problems are more likely to experience reading problems, poor concentration and low academic performance⁴⁸.

Research indicates that when trying to place looked after children back at home, alcohol was the most common reason for this failing⁴⁹.

⁴⁵ Cleaver, H., Unell, I. and Aldgate, A. (2010) *Children's Needs – Parenting Capacity: The impact of parental mental illness, learning disability, problem alcohol and drug use, and domestic violence on children's safety and development*. 2nd Edition. London: The Stationery Office.

⁴⁶ Cleaver, H., Unell, I. and Aldgate, A. (2010) *Children's Needs – Parenting Capacity: The impact of parental mental illness, learning disability, problem alcohol and drug use, and domestic violence on children's safety and development*. 2nd Edition. London: The Stationery Office.

⁴⁷ Macleod, J., Hickman, M., Bowen, E., Alati, R., Tilling, K. and Davey Smith, G. (2008) 'Parental drug use, early adversities, later childhood problems and children's use of tobacco and alcohol at age 10: birth cohort study.' *Addiction* 103, 1731-43.

⁴⁸ Cleaver, H., Nicholson, D., Tarr, S. and Cleaver, D. (2007) *Child Protection, Domestic Violence and Parental Substance Misuse: Family Experiences and Effective Practice*. London: Jessica Kingsley Publishers.

⁴⁹ Alcohol Concern



It is important, however, not to assume that all young people will have problems just because they grow up living with a parent who has alcohol problems. The majority will outgrow their childhood problems⁵⁰.

Substance Misusing Parents

Studies estimate that:

- In 20% - 60% of cases, children's social workers encounter parental substance/alcohol misuse⁵¹
- 40% of children caring for someone who misuses drugs or alcohol will experience educational difficulties⁵²
- Up to 70% of children taken into care have at least one parent with a substance misuse problem⁵³

Parental substance misuse features proportionately higher as the severity of cases increases⁵⁴. Parents who: (i) had a history of being in care, or known to social services as a child, (ii) had criminal convictions, or (iii) were experiencing violence, were significantly more likely to misuse substances⁵⁵.

A study into outcomes for neglected children who returned to their parents found that there were significant gaps in the services for parents with drugs misuse and particularly alcohol misuse problems. Children whose well-being at follow-up was poor and those subjected to the most severe neglect were especially likely to have been living with parents with alcohol misuse problems. Practice in cases where parents misuse alcohol or drugs needs to include clear expectations that parents will be required to address their substance misuse before children are returned to them and that their use of substances will be closely monitored and reviewed before and during return. The study also concluded that "more

⁵⁰ Velleman, R. and Orford, J. (2001) *Risk and Resilience: Adults who were the children of problem drinkers*

⁵¹ Cleaver et al (1999); Forrester (2001)

⁵² Dearden & Becker (2004)

⁵³ Ryan et al (2006)

⁵⁴ Forrester and Harwin (2006)

⁵⁵ Forrester and Harwin (2006)

access to treatment for parental substance misuse problems is required alongside more training for practitioners on working with substance misusing parents".⁵⁶

Research also indicates that:

- Parental substance misuse can cause developmental, genetic, psychosocial, physical, social, environmental, and psychological harms to the child⁵⁷
- Children of substance misusing parents are more vulnerable to separation from their parents⁵⁸
- Child protection cases are closely correlated with parental substance misuse, especially heroin and alcohol⁵⁹
- Substance misusing parents are more likely to neglect their child's physical health⁶⁰. Neglect is more common than abuse in children of substance misusing parents⁶¹
- The strongest predictor of substance misuse among young people is use by parents/friends⁶², one study found a strong correlation between specific substances used by parents and those used by their children in adolescence⁶³
- Parental substance misuse is associated with increased risk of violence in the family home⁶⁴

However:

- Substance misuse in parents does not necessarily lead to mistreatment of children⁶⁵
- Substance misusing parents whose children live at home use drugs less frequently and live in better conditions than substance misusing parents whose children live elsewhere⁶⁶

⁵⁶ *Case management and outcomes for neglected children returned to their parents: a five year follow-up study* (DCSF, 2010)

⁵⁷ Manning et al (2009)

⁵⁸ Tyler et al (1997)

⁵⁹ Forrester (2000)

⁶⁰ Sloan (1998)

⁶¹ Barnard and McKeganey (2003)

⁶² Di Micheli and Formigoni (2002)

⁶³ Glynn (1981)

⁶⁴ Brookoff et al (1997); Bays (1990)

⁶⁵ Harbin and Murphy (2000)



“I went to a treatment service to get help and when I told them was pregnant they referred me to Social Services straight away, this was really scary. I was hoping they would look at my nice home and all that and understand I was okay, but that wasn’t the case. They would fire questions at me, I tried to work with them (the social workers) but they did nothing but judge me from the beginning”

Substance Misusing Parent, Essex

Safeguarding Children of Parents with Substance Misuse Problems and Other Vulnerabilities

- Treatment outcomes improve when families are involved and clients are supported in their role as parents⁶⁷

Substance Misuse in Pregnancy

Alcohol

Heavy drinking during pregnancy can cause Fetal Alcohol Syndrome (FAS). Features of FAS include growth deficiency for height and weight, a distinct pattern of facial features and physical characteristics and central nervous system dysfunction.

A syndrome that does not show the full characteristic features of FAS, Fetal Alcohol Spectrum Disorder, has been reported, and may develop at lower levels of drinking than is reported for FAS. The Chief Medical Officer and the National Institute of Health and Clinical Excellence (NICE) both advise pregnant women or women trying to conceive to avoid drinking alcohol, but if women choose to drink, to minimise the risk to the baby, they should not drink more than one to two units of alcohol once or twice a week and should not get drunk. The NICE guidelines emphasise the importance of avoiding alcohol especially during the first three months of pregnancy, as this is the key time for organ and nervous system development⁶⁸. Only approximately 4% of pregnant women who drink heavily give birth to a baby with Fetal Alcohol Spectrum Disorder⁶⁹.

Drugs

For pregnant drug users in general, irrespective of the type of drug used, especially where there are poor social conditions, there is an increased risk of low birth weight, premature delivery, perinatal mortality and cot death. While there is general agreement that problem drug use while pregnant can increase the risk of impairment to the unborn child’s

⁶⁶ (Meier et al)

⁶⁷ (NTA)

⁶⁸ National Institute for Health and Clinical Excellence (2008) Updated NICE guideline published on care and support that women should receive during pregnancy.

⁶⁹ Abel, E.L. (1998) ‘Fetal Alcohol Syndrome: The American Paradox.’ Alcohol and Alcoholism 33, 3, 195- 201.

development, it is also probable that most women who misuse drugs will give birth to healthy children who suffer from no long term effects⁷⁰.

There is also a risk of heroin withdrawal among babies born to heroin dependent mothers.

Drug-using parents reported feeling more stressed, lacked social support and showed less adequate coping responses⁷¹. This study also found that drug-using parents usually feel more stressed, lack social support and show less adequate coping responses.

NICE have issued "Pregnancy and complex social factors guidance"⁷² stating that previous estimates of the prevalence of deliveries to women with drug or alcohol misuse problems varied from 1% to 12%. They have assumed a more realistic figure to be around 4.5%, based on local audit figures.

Table 1: Breakdown of births in England by exemplar group

Group	Percentage (estimate)	Number of births
Women who misuse substances (alcohol and/or drugs)	4.5%	30,200
Women who are recent migrants, asylum seekers or refugees, or who have difficulty reading or speaking English	10.2%	68,400
Young women aged under 20	6.1%	40,900
Women who experience domestic abuse	7.0%	47,000

It should be recognised that vulnerable women may experience a number of complex social factors at the same time.

Figure 3. NICE "Pregnancy and complex social factors guidance" – Breakdown of births in England by exemplar group

⁷⁰ *Working Together to Safeguard Children* (HM Government, 2010)

⁷¹ Kelley (1998)

⁷² NICE (September 2010)



Domestic Abuse

One longitudinal study⁷³ found that 3% of women experience domestic abuse during pregnancy. A more recent report suggests this figure may be as high as 6.4% - 11%, depending on the type of study and the stage of pregnancy at which women are asked about domestic abuse. One study reported that 5.1% of women experienced some form of abuse at 18 weeks of gestation, with 11% experiencing domestic abuse 33 months after the birth. Assuming a midpoint of the lower and upper estimates (3% and 11% respectively) gives a figure of 7%, equivalent to around 47,000 births nationally⁷⁴.

Parents involved in Offending

The offending behaviour of parents impacts on their children's outcomes, with evidence showing that:

- 63% of boys with convicted fathers go on to be convicted themselves
- Children of prisoners have 3 times the risk for mental health problems
- Parents involved in crime can perpetuate a cycle of antisocial behaviour where the children are more likely to be both perpetrators and victims of crime themselves

Parental Domestic Abuse

The British Medical Association estimates that in 75-90% of incidents of domestic abuse, children are in the same or next room. Research has found that in initial child protection conferences there is evidence of domestic abuse in approximately half of cases. It is estimated that around 10% of children and young people under 16 years old will have lived with domestic abuse in their families in the past 12 months.

⁷³ A cross-sectional survey conducted in an inner-London teaching hospital (2001-2002)

⁷⁴ "Pregnancy and complex social factors Guidance" (NICE, Sept 2010)

“My Mum was a heroin user, a junkie, she was away from her family because of problems, we were apart from them, she couldn’t cope alone and I got taken into care”

Young Person,
Essex

Conservative estimates indicate that 30% of children living with domestic abuse are themselves physically abused by the perpetrator, and also use domestic abuse against their mothers. It is widely accepted that there are dramatic and serious effects of children witnessing domestic abuse, which often result in behavioural issues, absenteeism, ill health, bullying, anti-social behaviour, drug and alcohol misuse, self harm and psychosocial impacts⁷⁵. One study estimates that a quarter of children witnessing domestic abuse have serious social and behavioural problems.

Research indicates that children who have witnessed domestic abuse are 2.5 times more likely to develop serious social and behavioural problems than other children, and they are also more likely to be perpetrators or victims of domestic abuse as adults⁷⁶.

Parental Mental Health Problems

Most adults with mental illness experienced mental health difficulties in childhood. These problems not only persist through adulthood but can also have an impact on the next generation. There is evidence to show that effective parental support and education, starting during pregnancy, leads to improvements in children’s resilience, educational attainment and mental well-being, as well as reducing the risk of anxiety and depression in later life.

Adverse childhood experiences have a significant impact on future risky behaviour and health outcomes. A number of studies have demonstrated that a greater number of adverse childhood experiences is associated with poorer health outcomes. The main adverse childhood experiences included abuse (emotional, physical and sexual); neglect (emotional and physical); and household dysfunction (mother treated violently, household substance misuse, household mental illness, parental separation or divorce, or household member in prison).

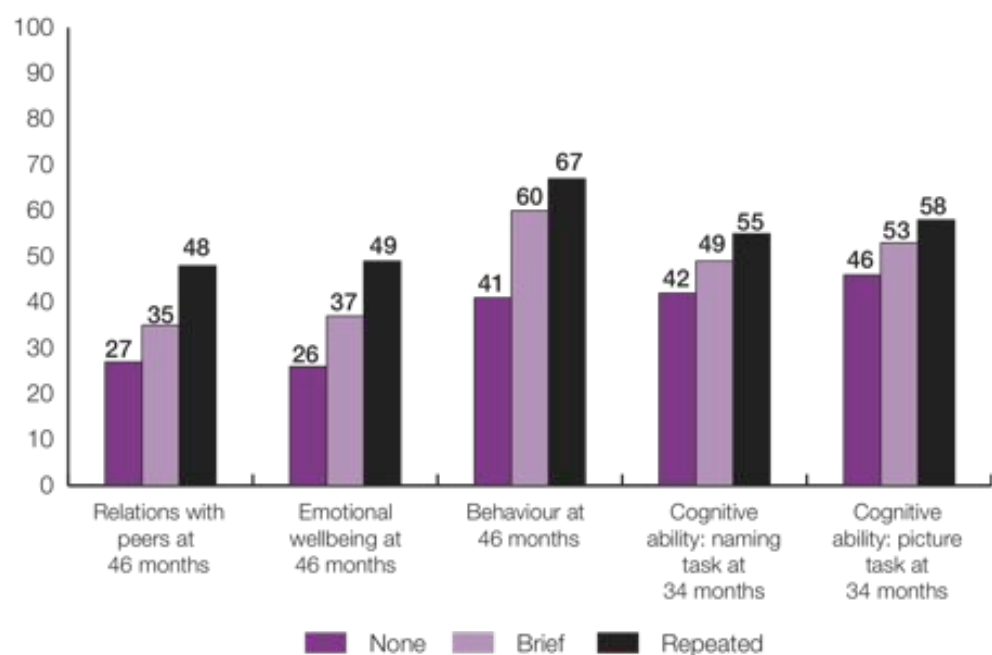
⁷⁵ British Medical Association

⁷⁶ ‘Think Family’ Research Base



One study in Scotland⁷⁷ showed how important parental health and well-being are in shaping the early experiences of young children, including their health and development. Mental health difficulties were associated with a mother's social circumstances: those who experienced poverty and those living in an area of deprivation were more likely to experience brief and repeated mental health problems. At the follow up stage, at age four, there was evidence already of clear deficits in relation to emotional, social and behavioural development of children linked to their mothers' emotional well-being. The study concluded that these deficits will undoubtedly shape their pre-school and subsequently their early school experiences.

Figure 3-F Poor child outcomes in relation to maternal mental health status (%)



Base=All mothers who participated at sweep 4, n = 3844

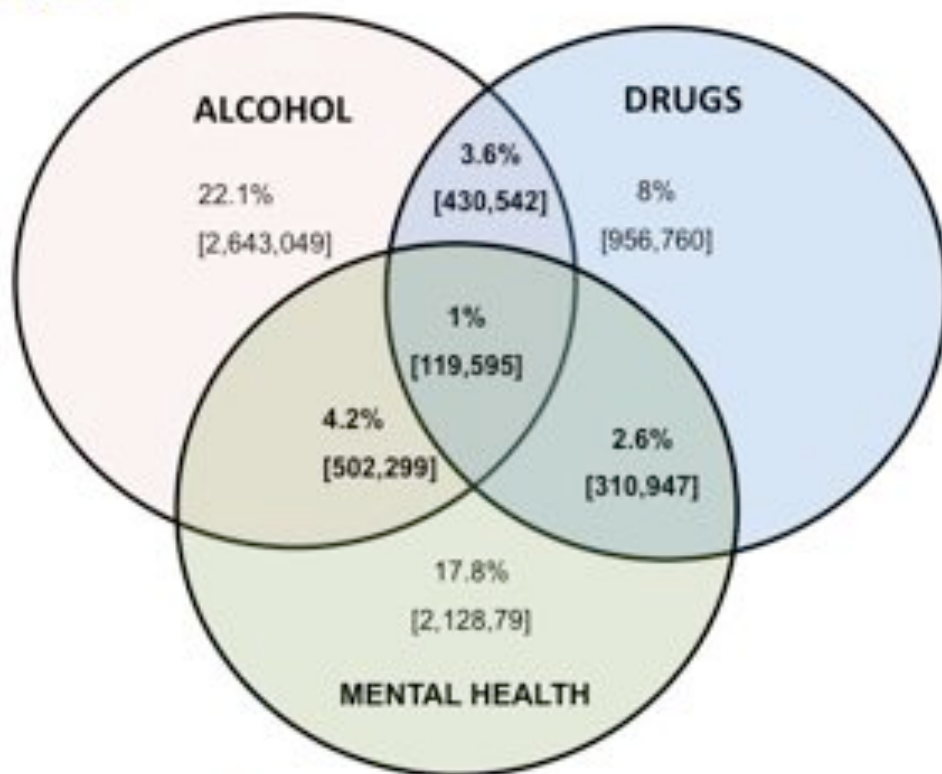
Figure 4. Poor Child Outcomes in relation to Maternal Mental Health

⁷⁷ Growing up in Scotland study [add author, date]

OVERLAPPING ISSUES: COMPLEX FAMILIES WITH MULTIPLE VULNERABILITIES

Domestic violence and abuse is more likely than not to occur within intimate partner relationships where one partner has a problem with alcohol or other drugs⁷⁸. High numbers of people presenting to alcohol, drug and domestic abuse services have children⁷⁹ and live within families whose members are doubly exposed to these potentially negative and damaging behaviours.

Figure 1.



Cumulative risk of harm from the NPMS.

Manning et al. BMC Public Health 2009 9:377 doi:10.1186/1471-2458-9-377

Figure 5. Overlapping Parental Vulnerabilities

An estimated 2% of families experience multiple problems⁸⁰, which puts children at a higher risk of adverse outcomes. There is a greater

⁷⁸ Galvani (2010)

⁷⁹ ACMD (2003) Manning et al (2009)

⁸⁰ Think Family



concentration of complex families with multiple problems in deprived areas, although even in the most deprived areas only one in twenty families experience five or more of the “basket of disadvantages”. Families living in social housing, families where the mother’s main language is not English, lone parent families and families with a young mother all face a higher than average risk of experiencing multiple problems⁸¹.

Difficulties of Working with Looked After Children from Families with Multiple Parental Vulnerabilities

At times the number and range of child and family problems makes working with these families difficult and the efforts of Children’s Social Care to deal effectively with neglect can be marginalised. One longitudinal study found that in half (51%) of cases, a clear focus on important issues in the case had not been maintained at times by children’s social care services. The study also found that in a considerable number of families key problems had not been addressed, in particular parental alcohol and drugs misuse, domestic abuse, mental health problems and lack of parenting skills⁸².

The study also found that “decisive action in cases of neglect often awaited a trigger incident of physical or sexual abuse or severe domestic abuse. Assessments were infrequent overall except in care proceedings, where specialist assessments could be helpful in making decisions as to whether or not children should be returned to their parents. In addition, many of the workers lacked knowledge about the history of the case and were sometimes unaware of key events in the past”⁸³.

The study concluded that “working with neglected children and their parents is challenging”. There were difficulties in engaging over two

⁸¹ Essex JSNA Children and Young People Chapter (2010)

⁸² Case management and outcomes for neglected children returned to their parents: a five year follow-up study (DCSF, 2010)

⁸³ Ibid

thirds of the mothers and half of the father figures, with some cases being closed as a result. The cases of 40% of the families were closed in spite of clear evidence of continuing difficulties.⁸⁴

“Four broad patterns of case management emerged. When case management was *passive throughout* (24%) children were left to suffer harm without adequate intervention, sometimes over long periods. The cases were treated as family support when they were open, and abuse, neglect and parental rejection of the children were minimised. Parental problems such as alcohol and drugs misuse or mental health difficulties received little attention. Overall there was a lack of direction in these cases and little permanence planning.”⁸⁵

This suggests that some social workers find it hard to engage and proactively work with parents who have multiple vulnerabilities. The report concludes that “intensive services are required if changes are to be made by parents, especially assistance in managing children’s behaviour, parental alcohol and drugs problems, with parenting skills and domestic abuse. In addition, the potential for foster carers to take an extended role in supporting children and parents into and during returns could usefully be developed, since this was related to children having good well-being at follow-up”.⁸⁶

Outcomes for Looked After Children

Nationally, looked after children are seven times more likely than their peers in the wider population to suffer from mental health problems. 20% have a statement of special educational need (compared with 3% of the general population). Young people who were looked after at one point are twice as likely to become teenage parents. Looked after young people are over-represented in the youth justice system while about a quarter of adults in prison were looked after as a child. Between a quarter

⁸⁴ Case management and outcomes for neglected children returned to their parents: a five year follow-up study (DCSF, 2010)

⁸⁵ Ibid

⁸⁶ Ibid



and a third of homeless rough sleepers were looked after at one point in their lives⁸⁷.

Young carers

29% of young carers look after parents with mental health problems. Extensive or inappropriate caring can be damaging, constraining young people's time and contributing to poor outcomes. 27% of all young carers of secondary school age experience some educational problems. Many miss school and fail to attain any educational qualifications. This, combined with ongoing caring responsibilities, serves to exclude some young carers from the labour market⁸⁸.

Substantial numbers of young carers report stress, anxiety, low self-esteem and depression and many report feeling isolated from their peers which has an impact on their own physical and mental health and wellbeing. They also feel that they lack the time and opportunity to socialise, and can also be reluctant to do so. Young carers also report bullying and anxiety about bullying⁸⁹.

⁸⁷ Essex JSNA Children and Young People Chapter (2010)

⁸⁸ Ibid

⁸⁹ Ibid

4. ESSEX NEEDS ANALYSIS

SUMMARY

Using the latest methodology for generating estimates of children of substance misusing parents, Essex has an estimated:

- 73,000 (28%) children living with a binge drinking parent, of which:
 - 57,000 (22%) live with a hazardous drinker
 - 11,000 (4.2%) live with a problem drinker with concurrent mental health problems
- 7,300 (2.8%) living with a dependent drug user, of which:
 - 6,000 (2.3%) children live where the only adult uses drugs
 - 6,800 (2.6%) live with a drug user with concurrent mental health problems

In addition, other estimates that we have generated or been given show that Essex may have:

- 3,200 (2%) families with multiple vulnerabilities - including mental health problems, drug misuse, alcohol misuse, offending and domestic abuse
- There are an estimated 3,486 crack and or heroin users in Essex and it is estimated that around 1,603 (46%) of these will be parents
- 58% of current court cases for the Permanency Teams were known to have at least one substance misusing parent
- 67% of Adoption service cases involved parental substance misuse
- 50% of children attending CAMHS had at least one parent with a mental health problem who either was or had been in contact with adult mental health services, and 25% had a parent with a substance misuse problem
- Of the 1,465 children looked after in Essex, we conservatively estimate that at least 492 (33%) have a substance misusing parent, 527 (36%) have parents involved in domestic abuse, 211 (14%) have alcohol misusing parents, 421 (29%) have at least one parent with a mental health problem, and 386 (26%) have a parent involved in offending

Headlines from treatment data in Essex show that parents engage for less than half the average treatment duration for non-parents. There is an even greater difference for female parents who, on average, engage in treatment for only 37% of the average duration for non-parents. Local treatment data also shows that over 50% of non-parents will complete treatment in a planned way, compared to only 15% of non-parents.

When looking at a sample of cases of Children Looked After (CLA) in Essex, we found that the majority (83%) of cases had one or more parental vulnerabilities identified, and 40% had two or more vulnerabilities. 69% of CLA had at least one other looked-after sibling.

Our interview programme revealed that there are identified gaps in service provision for complex families, direct support for children of parents with substance misuse, mental health problems, offending and domestic abuse issues. However, this data was not habitually recorded nor brought together across the partnership for the purposes of needs analysis, identifying complex families or informing commissioning.



DEMOGRAPHICS

Essex is a large county with a wide geographical spread. It has a population of 1.3 million, of which 24% are aged under 19. While one of the 20% least deprived counties in England, it has over 46,000 children living in poverty⁹⁰.

According to the 2001 Census, 29% of households in Essex contained a dependent child, i.e. just under 160,000 households or families. Of these: 65% were married couples (approximately 2 in 3 families); 11% cohabiting couples (approximately 1 in 9 families); 18% in lone parent households (approximately 1 in 5 families); and 6% were other types of households⁹¹.

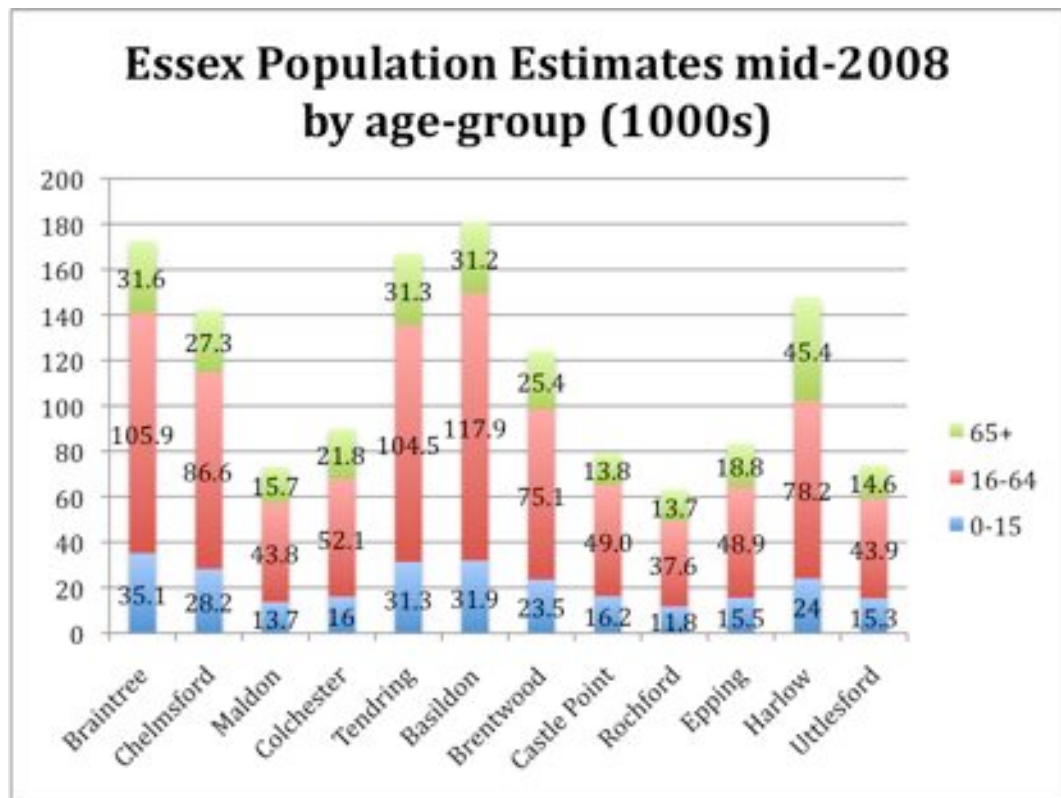


Figure 6. Essex Population Estimates

Note: Some of the following graphs pinpoint areas of Essex where need is highest. The graphs present each area's proportion of Essex's population alongside their respective proportion of domestic abuse incidents, child safeguarding referrals, and so on.

⁹⁰ Essex Children's Trust Needs Assessment March 2010 Parenting and Family Support

⁹¹ Essex Children's Trust Needs Assessment, Parenting and Family Support (March 2010)

PARENTAL VULNERABILITIES

Table 1: Summary of Prevalence Estimates for Essex

	Prevalence Estimate from National Research	Estimated No. of Children in Essex (0-15 years)	Identified No. of Children being supported by Essex services
Children of Dependent Drug Misusing Parents	2.8%	7,300	15 children supported by EYPDAS 1,603 parents in drug treatment 492 CLA
Children of Alcohol Misusing Parents	22.1%	57,902	22 children supported by EYPDAS 211 CLA
Children of Parents with Mental Health Problems	17.8%	46,636	50% of children in CAMHS have an adult with MH problems 162 with Young Carers
Children of parents with drug, alcohol AND Mental Health problems	1%	2,620	
Births to substance misusing mothers	4.5% from total of 16,264 births in Essex in 2009	732	Unsure of number identified as Foetal Alcohol Syndrome. 6 identified as in opiate withdrawal ⁹²
Children experiencing Parental Domestic Abuse	10%	26,200	646 children supported in Refuges 527 CLA in Essex 17,240 domestic abuse incidents (2009/10)
Children of Offending Parents	<i>Not available at time of publishing</i>	<i>Not available at time of publishing</i>	386 CLA
Complex Families with four or more vulnerabilities	2%	3,200	Families supported by FIPs and other family projects

⁹² Mid Essex Hospitals Trust, 2009



Substance Misusing Parents

Substance misuse treatment services are now required to report where clients. Reporting currently stands at 36% of the Essex treatment population identified as parents. It is felt that this is an under estimate so further work has been done to increase accuracy of recording, as a result estimates are likely to be nearer 46%. There are an estimated 3,486⁹³ Problem Drug Users (PDUs) using crack and or heroin in Essex and therefore it is estimated that 1,603 (46%) of these will be parents. Using the Essex DAP Treatment Bullseye⁹⁴, we can see that of the 3,486 estimated PDUs: 1,247 are engaged in treatment, 630 had been in treatment in the previous year, 441 had been in treatment in the past but not in the last two years, 814 were seen by criminal justice agencies but had not yet come into treatment, and 354 who had never come into treatment nor come to the attention of criminal justice agencies.

During 2009/10, a breakdown of court costs in child care proceedings shows that £32,000 was spent on external experts to provide adult substance misuse assessments, £10,500 on drug testing and £35,000 on external experts to provide adult psychological assessments. This totals over £77,000 for that year.

In Mid Essex in 2009, there were 6 babies identified with neonatal abstinence syndrome (meaning that they were withdrawing from opiates that their mothers had used during pregnancy) and 5 born up this year (from January to September 2010).

How well do parents do in adult substance misuse treatment services?

We looked at Essex National Drug Treatment Monitoring System (NDTMS) data taken from March 2009 to April 2010. Treatment data records the parenting status and number of children for each client, and the duration of treatment.

⁹³ Problem Drug User estimates based on Glasgow research

⁹⁴ Adult Drug Problem Profile (2010)

There is a very notable difference in the average length of treatment duration between parents and non-parents. As illustrated in figure 7, parents spend less than half the time in treatment of non-parents: 135 days compared to 350. However, the data does not provide for a direct causal explanation, so this could mean that parents may be more motivated to complete treatment earlier (parenting as a supportive factor), or their parenting circumstances may be a barrier to lengthy treatment (parenting as an inhibiting factor).

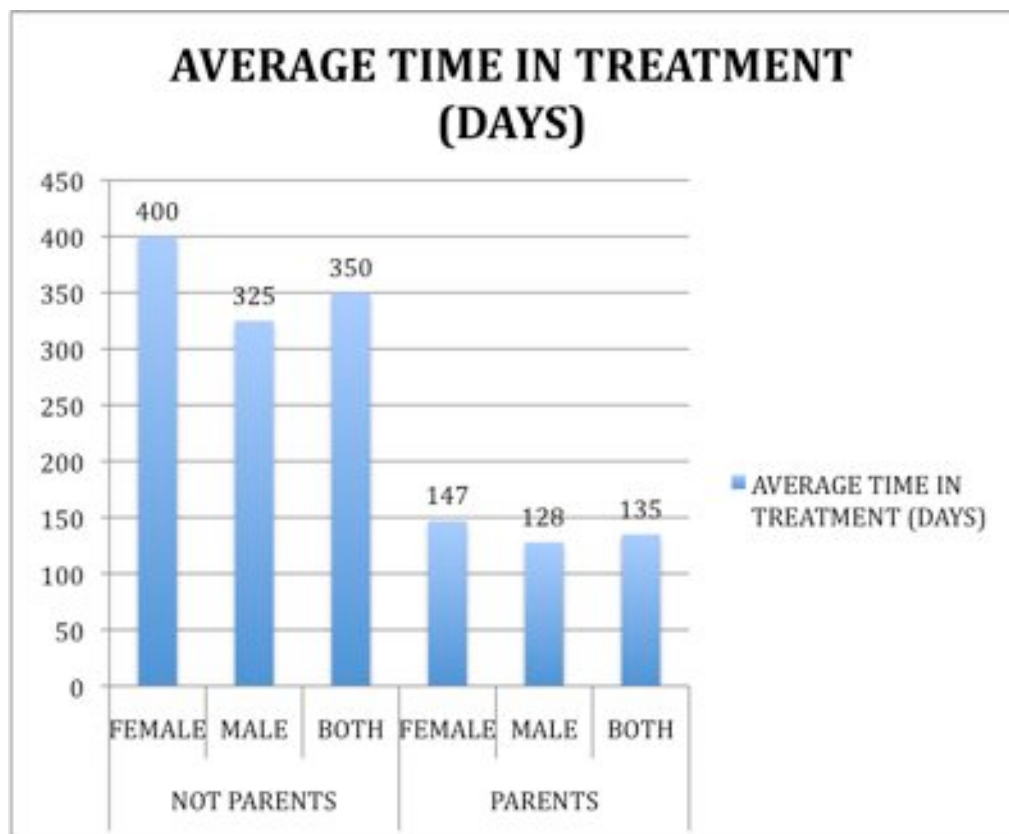


Figure 7. Average Time in Treatment for Parents and Non-Parents

We also analysed Treatment Outcomes Profile (TOPs) data for those in substance misuse treatment in Essex. We used the various drug treatment data as a proxy to describe four stages of progress through treatment:

- Stage 1. DIR: Outside of the formal treatment system
- Stage 2. First entry onto the NDTMS system: Entry to treatment
- Stage 3. TOP stage A & B: Engagement with treatment
- Stage 4. TOP stage C & D: Planned completion of treatment



Stage 1: Outside of the formal treatment system

In contrast with those starting, engaging and completing treatment, parents seen in Drug Intervention Requirement (DIR) data were more likely to be "chaotic", i.e. a greater percentage were using heroin or crack, sharing injecting equipment, and were unemployed than the non-parents. They had roughly equal level of housing problems. To test the DIR findings of those "outside of treatment", we also analysed prison drug service data (male only). We found that parents make up 49% of the total seen and were more likely than the non-parents in this cohort to be a problem drug user (PDU) with higher rates of both heroin and crack use, and more likely to have recently shared injecting equipment than the non-parents. Female parents seen at DIR were nearly twice as likely to use heroin or crack as female non-parents and more likely to be using stimulants.

Stage 2: Entry to treatment

Parents represent 20% (7% female and 13% male) of the treatment population and, according to NDTMS data, were more likely to be using cannabis, stimulants and alcohol than non-parents and less likely to be using heroin.

Parents were much more likely to have dual diagnosis issues (male 28% and female 40%) than non-parents (male and female both 10%).

In addition, parents were much less likely to be in employment and much more likely to be experiencing housing problems than non-parents. They were, however, less likely to be injecting.

Stages 3 & 4: Engagement with treatment & Planned completion

Data from Treatment Outcomes Profile (TOPs) shows that parents who complete treatment were likely to do just as well as non-parents in treatment (according to their discharge reasons). However only 15% of male parents and 12% of female parents went on to have TOPs completed at the end of treatment, compared to over half of non-parents.

“We’ve encountered some people who were very judgemental. They look at your past and feel they know how you’re going to go. This is a really negative approach. They should give families a chance, attitude is all important, if you go in the wrong way then you can alienate families. We all have potential”

Substance
Misusing Parent,
Essex

This suggests that treatment can be just as effective for parents as for non-parents, however parents are much less likely to complete their treatment journey.

Parents appeared to be more stable than non-parents at this stage (i.e. they had lower scores for chaotic/problematic behaviour and scored higher for psychological and physical health/quality of life). This either means that children are a stabilising factor or that chaotic parents are not entering treatment as they may wish to keep their parenting status secret from services.

Overall findings

By using the various drug treatment data as a proxy to describe 4 stages of progress through treatment, the various data strands appear to tell us that the profile of parents outside of the formal treatment system is more likely to be that of a problem drug user (using crack and or heroin) and more likely to be unstable/chaotic than the profile of parents within treatment and slightly more chaotic than the non-parents outside of treatment.

As you might expect, those parents who progress through treatment have a less chaotic profile, as with non-parents, however the percentage that parents make of the overall treatment population at each stage diminishes from Stage 1 (49%), Stage 2 (20%) [although recent local estimates suggest this could be at 36-46%], Stage 3 (9%) and Stage 4 (3%). This suggests that parents are much more likely to disengage from the treatment process than non-parents, and only the more stable parents will succeed in the current treatment system. This gives cause to concern that chaotic parents are not being engaged effectively by treatment services and that the potential problems that their children and families might be experiencing may remain hidden. This is set out below in Figure 8.



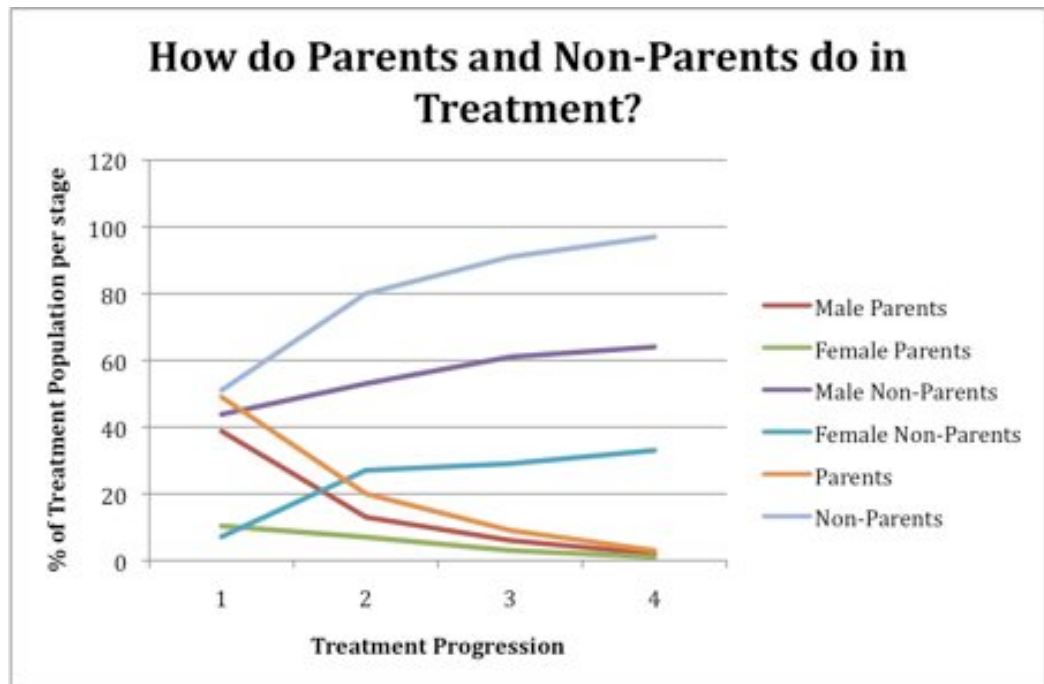


Figure 8. Parents do not engage as well in treatment as non-parents

Number of children of parents in the treatment process

Across the four main data sources, we found 2,990 children of parents known to treatment services. The table below shows a breakdown:

Table 2: Number of children identified to parents in different stages of the treatment system

Treatment Stage	No. Children Identified	% Children Identified as Looked After
Stage 1: Prison Data (Essex DAAT area only + male only)	532	5%
Stage 1: DIR Data (Essex DAAT area only)	319	9%
Stage 2: NDTMS Data	882	n/a
Stages 3 & 4: TOPS Stage A	1257	n/a
TOTAL	2,990	

Note: A full set out the analysis tables is set out in Annex 11.

Domestic Abuse

Home Office figures for Essex districts show that there were 11,446 domestic abuse incidents recorded in 2007/08 – this rose to 17,240 recorded incidents in 2009/10, an increase of 51% in just 2 years. The percentage of reported cases of domestic abuse reviewed by ECC social care managers within five days of receiving a report increased to 34.2%, but was below the target of 40% in 2007/08⁹⁵.

In figure 9, we see that two towns report a similar three-month average for incidents of domestic abuse between April and June 2010: Chelmsford (132) and Harlow (139). With only this data, it might be expected that the scale of domestic abuse in both towns would be broadly even.

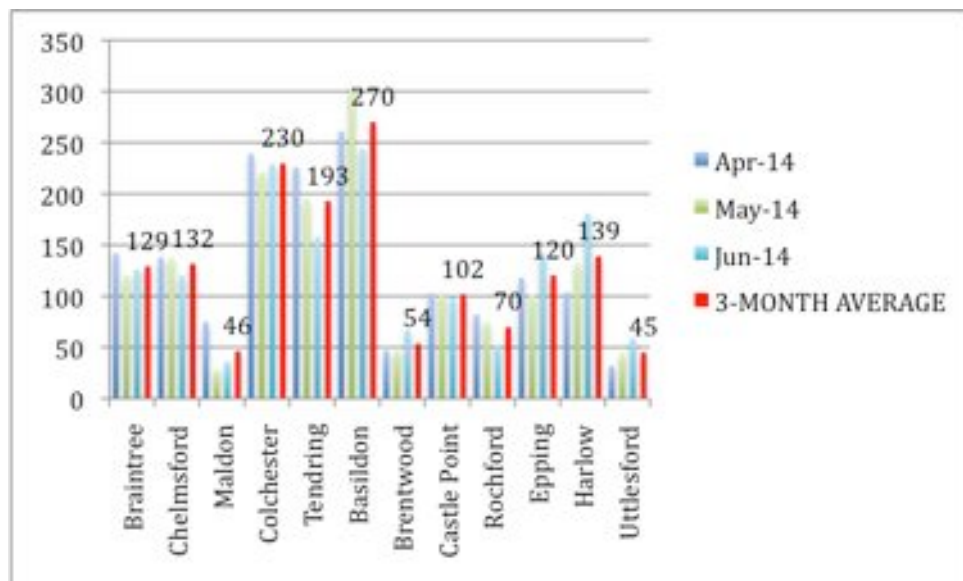


Figure 9: Numbers of Domestic Abuse Incident Notifications by District

However, figure 10 presents the proportion of domestic abuse incidents (area DV incidents/total DV incidents) alongside the area's proportion of Essex's total population (area population/total Essex population).

⁹⁵ Essex JSNA Children and Young People Chapter (2010)



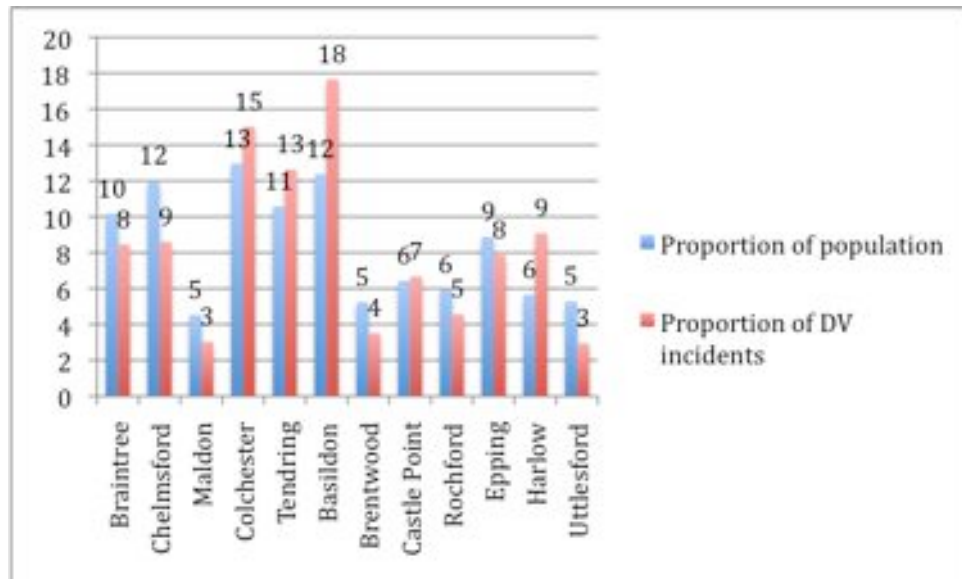


Figure 10: The proportion of DV incidents set alongside population figures

A comparison of the proportions of domestic abuse incidents in Harlow and Chelmsford shows that Chelmsford has 12% of Essex's population, yet only 9% of its domestic abuse incidents (as measured over the three month period). Harlow, however, has just 6% of Essex's population and also has 9% of its incidents of domestic abuse. Using this data, we can identify Harlow as a town with a relatively greater problem with domestic abuse than Chelmsford. This approach allows us to identify areas where there are proportionately more incidents of domestic abuse: Harlow has the highest rate, with 1.75 incidents per 1,000 people; followed by Basildon (1.56), Tendring (1.3) and Colchester (1.26).

Essex referral to domestic abuse support services statistics for 2007/8 show that only 10% of referrals to refuge came from the police. A survey of current clients in the two largest providers indicates that less than 1 in 5 clients reported the incident that led them to seek help to the police⁹⁶. There is therefore a wide discrepancy between the level of domestic abuse present in our communities and that reported to the police, as a result, many domestic abuse incidents remain hidden.

⁹⁶ Basildon and Harlow Domestic Abuse services client surveys (2008)

Of women seeking support in refuges in Essex, many had additional needs, which included 33% with mental health problems and 16% with a substance misuse problem. A total of 646 children have been supported in refuges in the last year. Both the women and children in refuges often have additional support needs and it can be difficult for them to access conventional support services⁹⁷.

Parents with Mental Health Problems

A manual audit of Child and Adolescent Mental Health Service (CAMHS) cases in Essex showed that 50% of those attending CAMHS had at least one parent who had had contact with adult mental health services (either previously or currently) and 25% had a substance misusing parent. The 'Think Family' objective within Essex CAMHS Action Plan concerning young people with a parent with mental health problems presents an opportunity to link to this project.

COMPLEX FAMILIES

Access to affordable childcare is a key need expressed by parents, also in order to enable them to work and increase income for the family. The NHS Trusts in Essex provide formal childcare arrangements, aimed specifically at low-income families. However, during 2007/2008 take-up of this option by this group by families was 1 in 7 below the target of 1 in 5 families.

An initial study mapping services across Essex identified 268 services delivering parenting support at universal, specialist and targeted levels⁹⁸. This found there were at least 34 different types of programmes being used across Essex, some of which were recognised as having a good evidence base, but some of which needed support to ensure they are based on recognised theories and can evidence outcomes⁹⁹.

⁹⁷ Women's Aid / Safer Places

⁹⁸ ECC Commissioning Analysis Team – service mapping (2009)

⁹⁹ Anglia Ruskin University (May 2009)



Young Carers

The 2001 census estimated that there could be around 5,000 young carers in ECC districts in total, however, fewer than 900 young carers have been assessed or supported by the young carers' teams across Essex, Southend and Thurrock.

Adoption

A paper by the Essex Adoption Service demonstrates that 67% of parents whose children were referred to the Adoption Service in 2009-10 with adoption as a permanence plan have issues which include drug and alcohol. A number of these parents have already lost children to adoption or to the care system and this can range from one or two children to up to 10 children or more over a number of years. The statistics also evidence that the majority of parents/mothers are in still in their twenties or early thirties leading us to an assumption that any subsequent children will be subject to similar experiences of care¹⁰⁰.

Between January and March 2010, 12 children's cases were considered by the South Adoption Panel (based in Basildon). Four out of the 12 cases did not involve drugs or alcohol. In the other eight cases (9 children) the children varied in age from 5 months to 5 years. In most of those eight cases, other children of these parents were either adopted or with a plan for adoption, in foster care, or being cared for by other family members¹⁰¹.

At-Risk Children and Poverty

There is a greater concentration of families with multiple problems in deprived areas, probably effecting the strong correlation between Child Wellbeing and poverty.

¹⁰⁰ Project proposal to reduce the number of children placed for adoption as a result of parental alcohol and drug misuse. (Tony Sharp, May 2010)

¹⁰¹ Project proposal to reduce the number of children placed for adoption as a result of parental alcohol and drug misuse. (Tony Sharp, May 2010)

The chart below sets out the latest Income Deprivation Affecting Children Index (IDACI) scores across Essex. It is significant that four of the five districts of highest deprivation in Essex (Tendring, Harlow, Basildon and Colchester) are also among the five districts with the highest number of open child safeguarding cases.

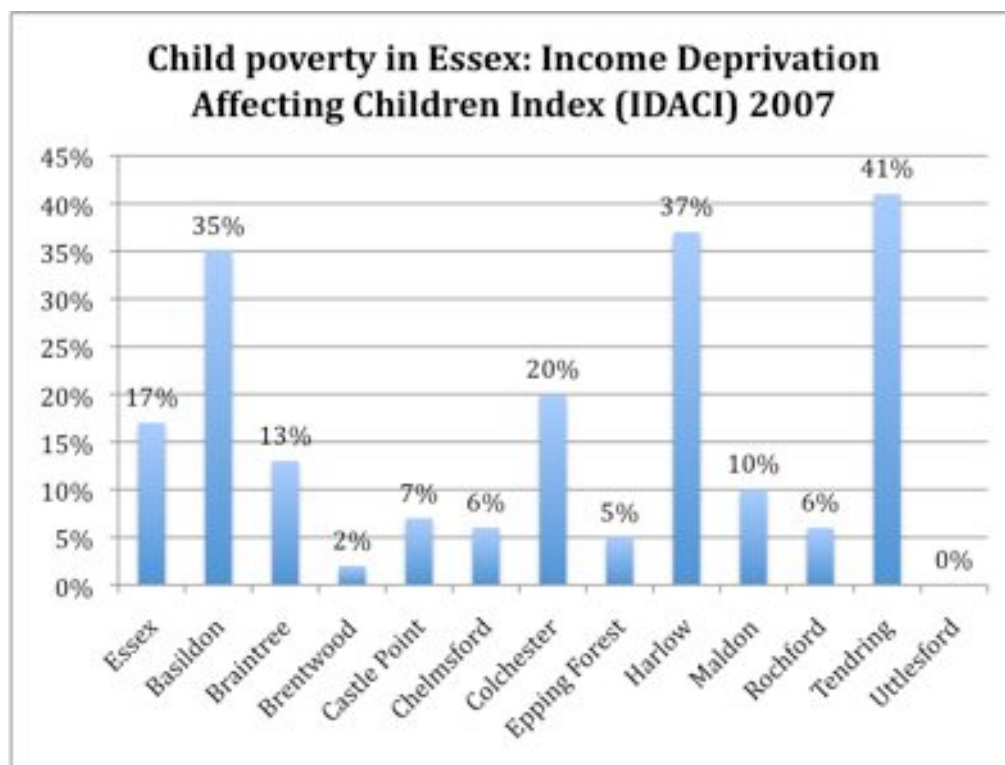


Figure 11. Child Poverty in Essex

CHILDREN LOOKED AFTER (CLA)

Summary

We analysed a variety of data supplied to us about Children Looked After (CLA) in Essex. The key points from these findings were:

Demand is growing whilst services are understaffed

There are around 1,475 CLA in Essex (excluding those accommodated under a series of short-term breaks). This number has been trending upward since December 2007 (when there were 1,203 looked after children). CLA placements have grown at 9% per year since December 2007. Local data also shows that 29% of vacant social worker and



senior practitioner posts are not filled by permanent staff, with nearly 28% of vacant posts being filled by agency staff.

Children Looked After have poor outcomes

The average Strength and Difficulties Questionnaire (SDQ) score for a looked after child in Essex is more than double the average national score for all children, meaning that children looked after experience a greater degree of problems than their non-looked after peers. In ECC districts, just 9.6% of looked after children achieved 5+ A*-C grades at GCSE in 2007, compared to 60.7% of all pupils.

Parental vulnerability is a major contributory factor to why children go into care

In a case study of 42 CLA case files, domestic abuse and substance misuse were the two most frequently cited parental vulnerabilities. We also found that 69% of CLA had at least one other looked-after sibling.

A significant number of child protection cases are long-term interventions and many children will have numerous periods in care

Essex data shows that 28% of child protection cases last 11 months or more, with 9% of these being for more than 18 months and 7% lasting over 2 years. The data also shows that 15% of children who go into care will have a second period of care, 4% will have a third, and 3% will go on to have 4 or more.

Referral data suggests that it is possible that adult drug and mental health services and CAMHS do not make many referrals to child protection

The data from the Essex Safeguarding Children Board between April and June 2010 provides a useful depiction of the sources of child safeguarding referrals. 48% of all referrals came from the police (35%) or schools (13%), indicating that the role of these services, especially the police, in safeguarding children is crucial. Community Mental Health Teams (which is likely to include adult mental health and drug services

“Everyone is 9-5. Our problems aren’t just in office hours”

Young Person,
Essex

Safeguarding
Children of
Parents with
Substance
Misuse
Problems and
Other
Vulnerabilities

and CAMHS) accounted for less than 1% of referrals. However data for these services may have been counted in other general headings for referral source.

Caseload analysis of a sample of Children Looked After

To strengthen our understanding of the factors involved in cases of looked after children, we took an anonymised sample of 42 CLA cases. For each case, we recorded any mention of the following parental vulnerabilities in the case notes: mental health problems; substance misuse; alcohol misuse; domestic abuse; and offending behaviour. In addition, we also record the number of siblings in care (whilst ensuring that any sibling was not also included in the sample, which would lead to double counting).

In the sample, we found that domestic abuse and substance misuse were the two most significant variables. These were mentioned in 36% and 33% of cases respectively. Involvement in offending (26%) and mental health problems (29%) were also significant factors across the sample. With approximately 1,475 children looked after in Essex, the findings of this survey indicate that substance misuse would feature in an estimated 492 CLA cases; an estimated 527 cases would feature domestic abuse in the family home; and an estimated 421 would feature parental mental health problems (Table 3 and Figure 12).

Table 3: Indicated prevalence of parental vulnerabilities in CLA cases

Parental vulnerability	Mental health Problems	Substance Misuse	Alcohol Misuse	Domestic Abuse	Offending
% Of cases in sample	28.6%	33.3%	14.3%	35.7%	26.2%
Indicated prevalence (based on 1,475 CLA)	421	492	211	527	386



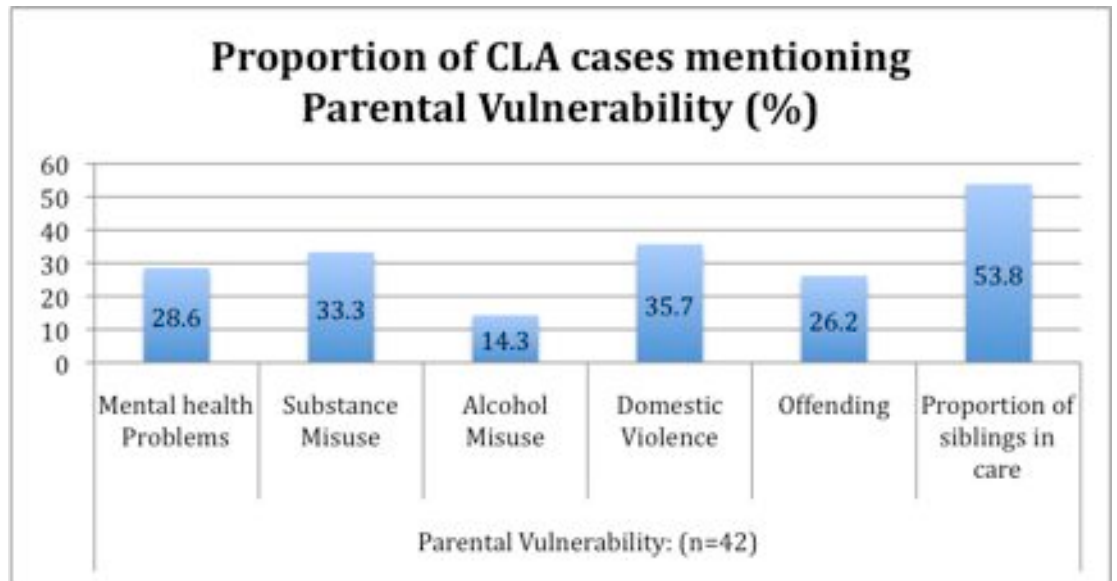


Figure 12. Proportion of CLA cases mentioning Parental Vulnerabilities

Looking at the vulnerabilities again, we found that there was significant overlap of parental vulnerabilities where children were taken into care. We found that more than half of the cases featured between 2 and 5 vulnerabilities from our list of drug misuse, alcohol misuse, mental health problems, domestic abuse and offending. Figure 13 sets out this overlap:

Overlapping Parental Vulnerabilities (PVs)

From case file audit of CLA

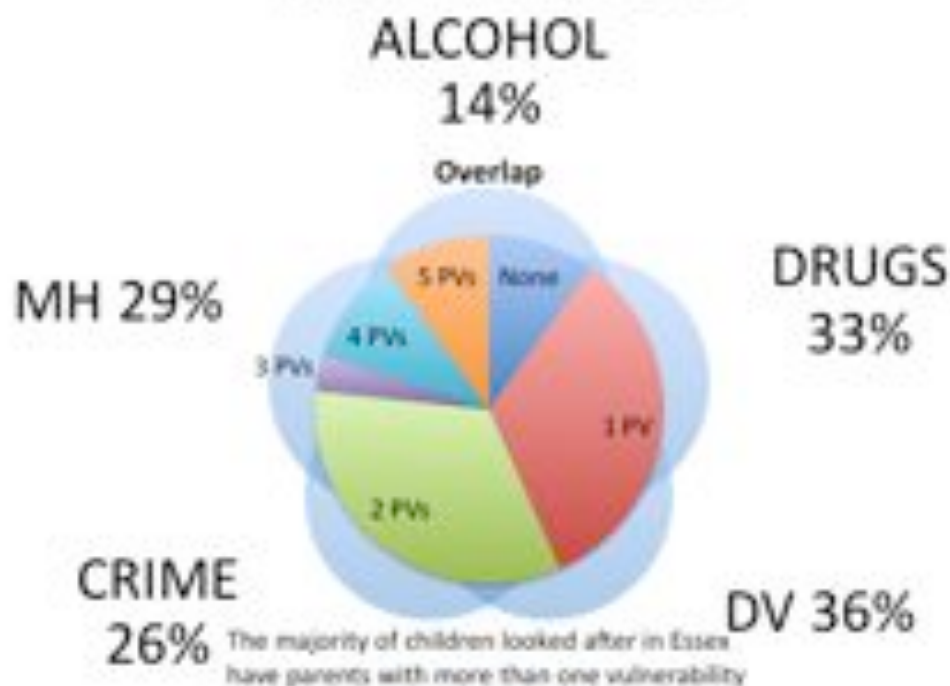


Figure 13: The Case File Audit of CLA in Essex revealed significant overlap in parental vulnerabilities

In addition, our survey found that 69% of CLA had *at least* one other looked-after sibling. In fact, out of the 91 siblings recorded, 49 (53.8%) were also looked after. We did not factor this into our estimates as the siblings logged as CLA are not necessarily currently looked after, therefore it would not be certain to make any estimates that include the extended CLA sibling group. However, it is worth noting that parental vulnerabilities are likely to have a damaging effect beyond the numbers of CLA in our estimates because we have found that the majority (69%) of those identified had a sibling who had also been looked after.

We expect these estimates to be conservative as parental vulnerabilities were not habitually recorded for all cases that we looked at, and it is therefore likely that some parental vulnerabilities existed and were either not recorded or remained hidden from social workers.



SERIOUS CASE REVIEWS

The *Review of Serious Case Reviews*¹⁰² in Essex found a series of common themes that are relevant to this project. For Children's Social Care, concerns were:

- Failure to respond to concerns
- Lack of clarity around thresholds
- Procedures not being followed
- Poor/missing assessments
- Status of professional discussions misunderstood or not clear
- Lack of planning and cases allowed to drift
- Failure to start s47 enquiries where there are clear indicators of risk of serious harm
- Failure to consider the safety of other children in the family
- Lack of focus on child/allowing parent's issues to change the focus
- Failure to address cultural identity issues where these are present
- Underestimating the effects of parental behaviour on children especially DV, poor mental health and substance use
- Failure to look beyond the child's presenting behaviour

For other agencies, the concerns were:

- Failure to pass on concerns to Children's Social Care
- Lack of knowledge about thresholds
- Failure to adequately record concerns or incidents
- Failure to follow procedures, especially with chaotic families Need to engage with fathers and male carers more
- A clearer approach to assessing levels of attachment early in the child's life and addressing issues
- Failure to share information about the child

The key learning conclusion was a "need to address parental substance use, domestic abuse and mental health issues and recognise where these present a real risk to the children's health, safety and welfare".

¹⁰² *Review of Serious Case Review Reports for the period January 2000 - December 2008* Essex County Council (2009)

"I was told by my worker at the treatment centre, 'if you slip up, we're just around the corner to help'. But you know what, even if I really needed to go I wouldn't. My worker at the centre is excellent, really good, but it's the fear of being subjected to the same process and possibly losing my child would stop me. I would be too scared. If I knew then what I know now, I wouldn't go. This experience has left me paranoid"

Substance
Misusing Parent,
Essex

QUALITATIVE FINDINGS

During our interview process and survey with frontline staff, team managers and senior managers/commissioners from across the partnership in Essex, we collected qualitative diagnostic data identifying obstacles, barriers and gaps.

Obstacles and Barriers

There are a number of obstacles that we were told impeded staff and services in Essex from intervening more effectively with complex families. The following section highlights the most commonly raised issues.

Many services are operating at, or over, capacity and there are significant staff vacancies in some key services. This results in staff being unable to work to evidence based practice as they are not allowed the time to work intensively with complex families.

Separate safeguarding boards, units, guidance and processes for adults and children present a missed opportunity to improve joint working and for children's safeguarding (rated as "inadequate") to learn more directly from adult safeguarding (rated as one of only two "excellent" authorities in the country).

Frontline staff who are keen to work in a more "Think Family" approach feel unable to make changes these themselves on an individual or a service-level basis.

Central targets, reporting, high workloads and other priority groups have meant that staff have been unable to work in a more intensive way with those with higher levels of need or to work with whole families.

Partner agencies felt that they got an inconsistent response to referrals to Children's Social Care depending on geographical area and individual worker.



It was suggested that differences in key terminology and language, such as what “safeguarding” means for different agencies, created barriers between workers.

Differences in thresholds and priorities (and targets) between services and between provision for adults and children created gaps that some vulnerable families fell into, leaving them without full access to support.

A lack of common understanding of the nature of addiction, the impact of substance misuse on parenting capacity and subsequent impact on children, and differences in their belief in the ability of substance misusing parents to change or make progress in effective treatment can result in a culture clash between services. There was also concern about differences in the perceptions of harm caused by alcohol consumption (especially in comparison drug misuse) and a lack of clear understanding of when alcohol use by parents became a problem, except when clearly linked to incidents of domestic abuse.

A perception was evident in some services that for some families, that had been known to services for a number of years (even for 3 generations as in some cases that were described to us) or had already had multiple children taken into care, change was not possible. This resulted in some families being “written off” and not being given additional support for their challenging needs.

Drug testing as part of children’s social care proceedings was often viewed by substance misuse workers and some social workers as punitive, often inaccurate and not useful in helping parents with substance misuse problems.

“The social worker was far more concerned about my use of Subutex than about my partner who is on a life licence for a double murder. This says a lot about their attitude to risk and their fears about being exposed as having little or no knowledge about drugs”

Substance
Misusing Parent,
Essex

Gaps

A number of gaps were identified that impact on effective child safeguarding responses where parents have vulnerabilities. The following section highlights the most commonly raised issues.

All agencies were aware of Southend, Essex, Thurrock (SET) procedures, including specific guidance documents on substance misusing parents. However, there was an absence of explicit joint working protocols between key agencies, including a gap around data and information sharing agreements. In the revised SET safeguarding procedures documents for adults and children, there is very little read across to each other. The children's guidance does not advocate for whole family working, and the adult guidance does not reference safeguarding children or joint working with children's services. This represents a missed opportunity to embed whole family approaches with vulnerable parents in practice across agencies and to better join up services for adults and children.

There was a gap, identified by many, in dedicated support services across Essex for the whole family – especially where those families had multiple vulnerabilities. These gaps included potential staff skills shortages in working with whole families and assessing parenting capacity. There was also a reported delay in accessing specialist parenting assessments, which slowed progress in some cases.

Gaps were identified in provision of support for parents with vulnerabilities, with some respondents talking of long waiting lists for adult mental health support and high thresholds that meant some parents could not access a service. Many also felt that there was a general lack of capacity in alcohol services, and a very low level of capacity to support non-convicted perpetrators of domestic abuse (only 30 places for the county).



Some reported that demand outweighed capacity in Family Group Conferencing, which meant that the majority of its cases were at the heavy end of child protection rather than at earlier stages (although we understand that a bid for increased capacity is currently being considered).

Many felt that there was an absence of support for families following a child being taken into care. This resulted in parents not being given additional help with their vulnerabilities or having their parenting skills improved. It also resulted in children who had gone into care not being given specific support around the potential impact of their parents vulnerabilities on their longer-term development.

Not all adult services always asked the parental status of their clients, with some workers stating that “my client is the adult, not the child”. This position was also the case for some children’s social care practitioners who saw the child as their main focus and felt that adult services needed to be the ones who supported the parents. Many adult services did not provide an additional or specific response if their clients were identified as parents. Across both children and adult services, some reported that they did not have the skills, remit or responsibility to intervene with the wider family.

Young person’s drug services, Youth Offending Service and CAMHS do not have a data system that allows them to record the parental vulnerabilities of their clients – even in relation to the specific area that they see the young person for. Children’s Social Care does have this capacity on its database however, the massive majority of these are not completed. Numbers of cases of Foetal Alcohol Syndrome and instances where babies were born experiencing heroin withdrawal were also not habitually recorded across Essex.

Adult services do habitually assess for their client’s parental status, however there seems to be a reluctance to look beyond the presenting

*“Services
should talk to
each other
more”*

Young Person,
Essex

adult to the support needs of the rest of the family (except in clear cases of child protection). It is important to remember that presenting difficulties have root causes and interventions must seek to address both.

Children’s/Vulnerable Youth Services do not habitually record client’s parental vulnerabilities. This limits their opportunities to understand their client’s needs fully, identify potential future problems, help to get parents the support they may need, or allow them to support the whole family (except in clear cases of child protection).

There was a shortage of identifiable joined-up evidence-based programmes to support vulnerable families – with the notable exception of the Family Intervention Projects (FIPs), which are locality based pilots rather than mainstreamed services consistent across the county.

Many partner agencies identified concerns that there was little or no support available for children who were below the child protection thresholds and their families. This was felt to lead to a gap in support for children in need and their families. A number of adult services unaware of the Multi-Agency Allocation Group (MAAG) process. The perception was that rather than using resources at the early identification stage, there needed to be an incident that raised the level of risk to a crisis before access to resources was possible.

All respondents were able to clearly identify what safeguarding training they had and how regularly their organisations required them to repeat the training. However, there did not seem to be a mechanism for assuring the quality of these different programmes and ensuring consistency of key messages. Development of training packages, contracts for providers and development of e-learning resources seemed to be undertaken in isolation by organisations, although all were clearly linked to SET procedures and the Essex Safeguarding Children’s Board. There was also a tendency to consider the parental vulnerabilities in isolation, i.e. separate training courses for substance misusing parents and domestic abuse etc.



5. WHAT WORKS

SUMMARY

There is a growing evidence base to support the efficacy of whole family interventions that demonstrate improved outcomes for vulnerable and complex families and provide evidence of cost savings or cost avoidance for public services. These have been shown to be effective for families with parental substance misuse, domestic abuse and mental health problems. These programmes include Westminster Family Recovery Project, Family Intervention Projects, Strengthening Families Programme, Option 2, M-PACT and Family Drug and Alcohol Courts.

“We had loads of support from family and friends when the baby arrived, they sorted us out with cots, clothes and everything. That and support from the Mulberry Tree, Drug Treatment and Social Services came together to help us turn around our lives. All these services pulled together for us and this made a very real difference”

Substance Misusing Parent, Essex

Safeguarding Children of Parents with Substance Misuse Problems and Other Vulnerabilities

PROGRAMME APPROACHES

To inform this stage of the work, we reviewed robust available evidence of programmes and approaches that have proven effectiveness with our target audience of complex families with parental vulnerabilities. From this work, we have selected the programmes with the best UK evidence base and presented a brief summary in the table below. The full evidence summary is set out in Annex 7.

Programme	Description	Outcomes
Moving Parents and Children Together programme (Essex)	The M-PACT programme is a structured ten week group programme (including a comprehensive assessment and a review session), which involves several families where at least one parent has a serious alcohol or drug problem (but is in treatment or recovery) and where there is at least one child/young person aged 8-17 years who attends the programme. Funded by the DAAT, the M-PACT Team in Essex consists of four facilitators from two services (Open Road and Essex Young People Drug and Alcohol Service).	Key benefits from attending an M-PACT programme appear to be improving communication with the family, understanding and talking about addiction, and meeting and talking to other people living in similar situations

Programme	Description	Outcomes
<p>Family Recovery Project (FRP)</p> <p>Westminster</p>	<p>Westminster has a multi agency co-located team called the Family Recovery Project (FRP) that aims to support and intervene with families who are at risk of losing their children, home and/or liberty. The FRP works in a targeted and phased way to support a family's capacity for change and to embed and sustain changes. The FRP is ground-breaking because:</p> <ul style="list-style-type: none"> • Agencies who normally only work with adults will be part of the core team around the family working alongside agencies who normally focus on children • There will be identified lead workers for each family to coordinate the range of services involved and ensure interventions are appropriately phased, reducing the volume of concurrent work with the family. • The work will be based on individual packages of intervention and support, but with clearer consequences for families who do not engage - contracts with consequences • The service will be intensive with several contacts/sessions per week when families need this <p>Each family (children and adults) will have one care plan based on one assessment and care pathway, shared with the family themselves. The professionals involved have better access to resources and, as they are now all part of the same team, less duplication of work occurs meaning better use of people's time. Having one care plan for the whole family means less duplication of work by different departments and agencies. The development of the Information Desk to collect, analyse and present data on families for use by practitioners. The information is then used to develop a number of reports which present a wide range of information in an easy to read package which identifies reasons for referral, presenting issues, intelligence gaps and recommendations. All practitioners who are members of the TAF can access these reports via SharePoint.</p> <p>The TAF devises a single care plan that takes into account the varying needs and problems of each family member. Typically, the TAF works with families for 6 to 12 months and support and services are phased to avoid overloading the family. The care plan uses intensive outreach work to create a possibility of change. In the initial phase of the care plan, several visits each week are often required before becoming less intensive as capacity is built within the family to change behaviour. The family is involved with the process throughout.</p>	<p>Costs avoided after first 60 families = £2m</p> <p>Cost saving for 60 families (after cost of running FRP) of £833k</p> <p>Average saving per family is £13,883</p> <p>Of the first 40 families who have participated in the FRP we have a number of indicators of progress:</p> <ul style="list-style-type: none"> • 83% of families have had benefits checked and corrected where necessary • 78% of parents are now engaged in parenting courses • 39% of families with a history of anti-social behaviour have reduced their anti-social behaviour (ASB) and 20% of the families have stopped ASB • 50% of children have shown an improvement in their school attendance • 47% report family functioning improving • 32% of families are now engaged with domestic abuse practitioners • 32% more of the families are now registered with GPs • 32% of the families are having their housing arrears cleared or plans in place • 21% are seeking or attending training or further education • 21% assessed for mental health and substance misuse or receiving interventions • 16% have received full immunisations



Programme	Description	Outcomes
Nurse Family Partnership (NFP)	The NFP programme is an evidence-based nurse home visiting programme developed in the USA and designed to improve the health, well-being and self-sufficiency of young first-time parents and their children. NFP is offered to first-time young mothers early in pregnancy (ideally before 17 weeks gestation) and continues until their child is 24 months old. There are three main aims, to improve maternal and child pregnancy outcomes, to improve child health and developmental outcomes, and to improve parent's economic self-sufficiency.	According to the Washington State Institute for Public Policy, the program produces \$18,000 (roughly equivalent to £11,400) in net benefits per family served. The Rand Corporation calculates that every dollar invested in providing the program to the families at greatest risk returns \$5.70, and every dollar spent on the average participating family returns \$2.88, most of this in reduced government expenditures on health care, educational and social services, and criminal justice. Clients and nurses indicated they believed good progress had been made in parenting and in other life skills.
Option 2 (Cardiff)	Option 2 works with families in which parents have drug or alcohol problems and there are children at risk of harm. A particular focus of the service is reducing the need for children to come into public care. The intervention is short (4 to 6 weeks) and intensive (workers are available 24 hours a day). Workers use a combination of Motivational Interviewing and Solution-Focused counselling styles, as well as a range of other therapeutic and practical interventions.	For Cardiff, the cost of Option2 was £2,194 per child. Option2 on average saved £3,372 per child in the cost of placements. Thus, on average each appropriate referral saved the local authority £1,178 per child. Option2 did not reduce the proportion of children who entered care Option2 significantly reduced the time children spent in care, because: Option2 children take longer to enter care; If they do enter care, they tend to stay there for a shorter time. A higher proportion of Option 2 children return home from care. As a result a quarter of Option2 children were in care at the end of the study, compared to a third of children in the comparison group.
Family Intervention Projects (FIPs)	FIPs provide intensive support for families with multiple problems often succeeds when everything else has failed, whilst delivering impressive savings in local service costs. Outcomes included: Parenting support programmes lead to an improvement in the behaviour of children Independent evaluation for the first 1,000 families to complete family intervention projects shows significant improvements at the end of an intervention for a number of factors. Families affected by a mental health problem declined from 38% to 27%; families in which domestic abuse was a concern more than halved from 22% to 9%; and families with drug & alcohol problems declined from 32% to 17%.	The average saving per family per year is £81,624 (NatCen). However, in a recent evaluation by Sheffield Hallam University and Action for Children found they can save the taxpayer over £200,000 per family per year. Independent research by NatCen shows improved outcomes across various sectors, including: <ul style="list-style-type: none"> • Reduction in housing enforcement actions from 50% to 14% • Drop in ASB by almost two-thirds • Truancy, exclusion and bad behaviour at school reduced by more than 50% • Domestic abuse incidents declined from 32% to 17% • Child Protection concerns declined from 24% to 14%

Programme	Description	Outcomes
<p>Families First (Middlesbrough)</p>	<p>Families First was established in April 2006 by Middlesbrough Council as a family focused crisis intervention service working with families where there are serious child protection concerns directly related to parental substance misuse. It is based on the Option 2 model. The service receives referrals from children's social care teams and aims to:</p> <ul style="list-style-type: none"> • Keep children with their families where it is safe and possible to do so • Help families during times of crisis • Support parents/carers to recognise their drug issues and help them to change <p>This is achieved by providing an intensive intervention and support package (for up to 8 weeks) to children and their parents/carers, delivering parenting programmes/advice and linking with other local agencies and services. To do this effectively, the team deploys both adult and children's workers flexibly to establish clear goals with the family and address 'whole-family' issues in a structured manner.</p> <p>After the initial period of intensive support, the team will continue to work with a family for a further 8-12 weeks on a less intensive basis to reinforce and consolidate new patterns of behaviour, at the end of which they will devise a long term support plan to help families maintain the progress and changes they have made. This involves transferring case-responsibility back to locality teams and mobilising mainstream services. As part of this 'maintenance' phase, Families First provides short follow-up/booster sessions at 3, 6 and 12 months to all families.</p>	<p>Families First had positive impact on care status during 12-month observation period. This is a cost effective approach to reducing the need for care. Average cost saving per child is £6,555. The mean average cost saving per family £12,642.</p> <p>Evaluation findings suggest that the Families First model prevents the need for permanent placement of children into care and reduces the time spent in temporary care placements by helping parents to provide a safe home environment or by finding an alternative kinship care placement.</p> <p>These findings are limited by a small sample size and no comparison group and therefore implementation in other areas should be accompanied by an imbedded evaluation from the project's inception, based upon the current research model</p>



Programme	Description	Outcomes
Family Pathfinders	15 local authorities developed new and innovative approaches to supporting families with multiple problems. There are a number of common practices that characterise the approach in these areas such as; having a multi-disciplinary team, often co-located, to form a Team Around the Family who coordinate tailored packages of support, with the families engagement and based on a Whole Family Assessment, so that all the needs of the family are identified and met. Each member of the multi-disciplinary team has a small case-load to reflect the high intensity support that is necessary to influence the behavioural change needed. These operational practices are underpinned by strategic buy-in from adults and children's services.	<p>No cost savings can yet be determined due to differing pathfinder approaches. However a report is expected in December 2010. To date, based upon 45 families:</p> <ul style="list-style-type: none"> • The need for Child Protection Plans has almost halved • Over 75% of the children's school attendance has improved • The majority of families have one Integrated Family Plan • Parents are being supported to access voluntary, education and training opportunities • Of families where domestic abuse was an issue, 80% have seen a reduction in domestic abuse reports to the police
Family Group Conferencing (FGC)	<p>FGC is a system of family led decision-making. It draws on the resources of the extended family and empowers those involved to negotiate their own solutions to a problem, rather than imposing external remedies.</p> <p>The approach of contingency planning involves the preparation of plans to minimise the disruption caused to families if the family situation deteriorates, for example if a parent is temporarily unable to continue with their parental responsibilities owing to a mental health problem.</p> <p>Family Group Conferencing is already being used in Essex for Child Protection and Adult Mental Health. FGC is being piloted in New Zealand for use with substance misusing parents.</p>	<p>Each conference costs approximately £475. Where the process leads to avoidance of the local authority entering into care proceedings this can add savings of £25,000 per child. Similarly the Loughborough University cost calculator has estimated that the average unit cost of a child in residential care was 4.5 times that of a child in an independent living arrangement; eight times that of a child in foster care; 9.5 times that of a placement with family or friends; and more than 12.5 times the cost of a placement with the child's own parents. This evidence points to the cost savings that could result if the FGC leads to a reduction in placements out of the family.</p> <ul style="list-style-type: none"> • Evidence clearly demonstrates a range of excellent outcomes: • Plans that are viewed as safe by families and workers in over 90% of conferences • Significantly improved communication and understanding between social services and families • A reduction in the number of children who are accommodated and increased contact with their friends and family network

Programme	Description	Outcomes
Substance Misusing Parents Project (Kent)	<p>The Substance Misusing Parents Project (SMPP) is a joint initiative between KCA drug services and Social Services Children and Families teams.</p> <p>The project works with families in which there are substance misuse issues which put the children at risk of harm, so that the risk can be reduced and the families be kept together with the benefit of reducing the number of Looked After children and the numbers of children on the child protection register</p>	<p>The cost-benefit associated with these outcomes was between £15,094 and £90,940, depending on whether children returned to their families from foster care or residential care (and assuming that these returns were directly attributable to the SMPP service).</p> <p>The benefits of SMPP involvement in cases of children in need and child protection included:</p> <ul style="list-style-type: none"> • Parental admission of the impact of the drug use on children. • Fast track referrals to methadone prescription service. • Engagement with methadone programme and abstinence from street opiates. • Consent to work alongside SMPP and to undergo random drug testing in accordance with child protection plans/and or court agreement • Decision by a mother to remove herself and children to an environment where they could be better safeguarded. • The controlled use of methadone by pregnant woman and engagement with SMPP and midwifery services by pregnant women who have had histories of previous babies becoming adopted
Family Drug and Alcohol Courts (FDAC) London	<p>FDAC attempts to improve outcomes for children subject to care proceedings by offering parents with substance misusing problems: Intensive assessment and support from the specialist court; Help from parent mentors; Quicker access to community services; and Better co-ordination between child and adult services.</p>	<p>Cost savings are still to be determined. However, interim findings there were cost savings, particularly on foster care services, because children spent less time in out-of-home care.</p> <p>The national US evaluation found that outcomes for parents and children were better when families took part in specialist drug and alcohol courts. Key findings were:</p> <ul style="list-style-type: none"> • More children were reunited with their parents • Quicker decisions were made for out of home care if reunification was not possible • There were financial savings on foster care. <p>FDAC in England is being evaluated by Brunel University.</p>



GENERAL APPROACHES

Programme	Description	Cost Effectiveness
Multi-Systemic Therapy (MST)	MST works with young people and their families to increase parenting capacity, engagement with education and training, family cohesion and promote pro-social activities for parent and child as well as to tackle underlying health or mental health problems in the young person or parent, including substance misuse and reduce young people's offending behaviour.	<p>Evidence based on a systematic review of interventions in the US has shown, amongst other things, that family-based therapy reduced re-offending by 12 per cent. Providing family therapy for young people who had offended cost an average of just over £2,000 per participant but saved tax-payers and victims of crime an estimated £52,000 per participant in the longer term ¹⁰³ .</p> <p>Positive outcomes are being reported from 10 UK trial sites: 84% of families worked with have completed the programme and 86% of young people are still living at home at the end of the programme. Unit costs work out at £8,000 for six months programme.</p>
Multi-Agency Training	A range of multi-agency training programmes can equip frontline staff to identify families at risk early and begin to engage them, and can skill up practitioners in key agencies to conduct whole family assessments and work in a multi-agency way with the family.	<p>An evaluation of training on working with substance misusing parents and their children provided in 2009 for a range of agencies in Essex found that of 244 participants, 94% felt better able to support the client group after completing the training and 98% felt the quality of instruction was of a high standard.</p> <p>The evaluation also found that there was a perceived lack of knowledge before the training by large numbers of participants, that there was a clear need for higher level training for certain professionals e.g. drug and alcohol workers and police and that training should be rolled out further. ¹⁰⁴</p>

¹⁰³ Drake K, Aos S and Miller MG (2009) Evidence-Based Public Policy Options to Reduce Crime and Criminal Justice Costs: Implications in Washington State. *Victims and Offenders* 4: 170–96 (available at www.wsipp.wa.gov/rptfiles/09-00-1201.pdf).

¹⁰⁴ Evaluation of Hidden Harm Training in Essex (Mark Bowles, TONIC, 2010)

Programme	Description
Parenting Programmes	<p>There are two broad groupings of parenting programmes:</p> <p>i) Evidenced Based Programmes that have been developed over a number of years and have undergone extensive academic evaluation and are based on sound theoretical knowledge e.g. Triple P and Webster Stratton. These can only be delivered by suitably qualified and supervised facilitator and are provided over an extended timeframe.</p> <p>ii) Knowledge Based Programmes - These are often programmes that have been developed locally by practitioners based upon their professional knowledge and experience. Initial evaluation has shown impact but this has not been tested through academic rigour over an extended period of time. Again they would need to be delivered by a suitably qualified and supervised facilitator.</p>
5-Step Intervention for family members	<p>The intervention is based on a theoretical understanding of how family members can be affected by substance misuse, a model that was developed from research with family members about what it's like to live with substance misuse.</p> <p>The stress-strain-coping- support model¹⁰⁵ states that living with a substance misuser is stressful and that this stress leads to strain that is often exhibited through physical and psychological ill health, but also by the presence of other problems and indicators, for example, relationship problems, family disharmony and disruption, financial difficulties, and problems with work or education attendance/performance.</p> <p>The model indicates that there are two ways of reducing strain; either by reducing stress and/or by altering one or both of the mediating factors of coping and support. Because the level of strain is a result of either the amount of stress, or the amount and style of coping and support, then, over time, expected change in symptoms would occur if there were changes in these other areas first</p>

¹⁰⁵ Velleman & Templeton (2003)



CHARACTERISTICS OF EFFECTIVE PROGRAMMES

(i) Flexible, Supportive and Responsive Service Design

- High quality key-workers with a focus on the right skills rather than the right qualifications
- Low caseloads (e.g. 4-6 families per worker)
- Respectful, persistent working styles
- Flexibility to use resources creatively, such as incentives/rewards and a focus on consequences will secure families' engagement
- Support that is not time-limited (interventions may last 12-18 months)
- Support is available 'out of hours'
- Effective multi-agency relationships (co-ordination, clear agreed arrangements for joint working between children's and adult services)
- Parenting support through evidence-based parenting programmes
- Services must be concerned about more than just 'their' client
- Interventions will be long term and families will dip in and out of wanting or engaging with support
- Motivation for adults to engage in treatment is not necessarily needed for treatment to be successful¹⁰⁶

(ii) No wrong door

Contact for vulnerable families with the service should open the door to a broader network of support. Public services should not seek to deflect individual issues as they arise but, instead, aim to deliver long-term solutions that might be complex and involve several services and agencies but, if ignored, mean that the family will continue to decline.

(iii) Whole family approach

Services need to work in a genuinely integrated manner to ensure interventions are coherent, aligned and take into account all the factors

"They should be less pushy and help families to move away from risky things, it's about keeping families together, obviously when it's clear the child is at risk then something should be done but if there's a chance things can be changed they should help us get there"

Substance Misusing Parent, Essex

¹⁰⁶ Quasi Compulsory Treatment: Europe study, (A. Stevens et al)

“It was great becoming a parent but really difficult, especially in our situation. They were amazing, we did different classes each week for 6 months and it really gave us confidence to move forward. It gave us skills to be parents at a time when my family wasn’t helpful. It was a difficult time but they really contributed to us keeping the baby”

Substance
Misusing Parent,
Essex

associated with the family. The fact that the poor academic record of children in the family can be directly related to inappropriate housing conditions is a matter of common sense but is not always accurately reflected in traditional service responses. Services must use methods of whole family working that are empowering.

(iv) Building on family strengths

The importance and potential strength of the family unit has often been misunderstood or underestimated by service providers. By engaging families in the care planning process and giving them a stake in their future relationship with services, they no longer become passive observers but can build their capacity to work through problems themselves. Language is important – all agencies should be adopting a “recovery” approach.

(v) Strong Strategic Leadership

This means that managers, practitioners and politicians must all take responsibility for ensuring that there is a whole family response to complex families.

(vi) It’s never too late to break the cycle

Intergenerational transmission, where many of these parental vulnerabilities mean that their children are significantly more likely to experience similar problems, typified by local case studies we were told about showing 2nd and 3rd generation drug misusers and children in care, demonstrates the need to adopt a “never too late to intervene” principle to ensure that services do not give up on families or pre-judge their ability to improve.

(vii) Fully involve families in the service

Families need to be involved fully, helped to understand the problems and feel listened to. This must be balanced with being ready to take action re child protection in a timely fashion:



“Our social worker was so good, we told him our life story and you know what, I can’t describe it very well, maybe it was his attitude but I felt comfortable and he didn’t judge me. We knew he was very busy but we never felt rushed or insignificant to him”

Substance
Misusing Parent,
Essex

- Services must fit around family rather than other way around
- Establishing trust between families and services and between agencies and each other is vital to success
- Workers must be always be non-judgemental in attitude
- Supporting the adult and the child are not mutually exclusive activities – in fact you could argue that it is impossible to do one properly without the other

(vii) Identification & Engagement – Active Advocacy

Equip front-line professionals to go beyond signposting and to be confident in identifying wider family risk issues, through whole family assessments and whole family support plans. Priority for local services must be:

- Families with multiple parental vulnerabilities should be flagged by agencies and given priority
- A proactive approach to finding and engaging complex families should be used, learning from similar models in Prolific and Priority Offenders (PPO) and the Westminster Family Recovery project
- Ensure that key identifier agencies are trained, including services for anti-social behaviour, police, schools, GPs, Sure Start, Children’s Centres, Adult mental health services, adult substance misuse services and housing services
- Strengthen family resilience, recognising parents are the most influential factor in a child’s life
- Provide ‘family friendly’ services prioritising keeping parents engaged in support services

“Attempts to reform services down single departmental, professional or issue-based lines have often given rise to unintended consequences; thinking narrowly about policy solutions can mitigate one need, but exacerbate others. We need to take a systems thinking approach.”

Systems thinking
in the Public
Sector
John Seddon
(2008)

6. DELIVERY

SUMMARY

Using the evidence of what works and the local needs analysis, we have developed a set of principles and characteristics of effective programmes that should underpin any future service development, joint working protocols and training. We have also outlined three delivery models to take this work forward:

1. A multi-agency joint working protocol
2. A programme of training, support and co-location
3. Adopting an evidence-based programme

DELIVERY MODEL OPTIONS

In this section, we set out three options of how the findings from this report could be implemented, with low, medium and higher cost options.

Option 1. Protocol Model

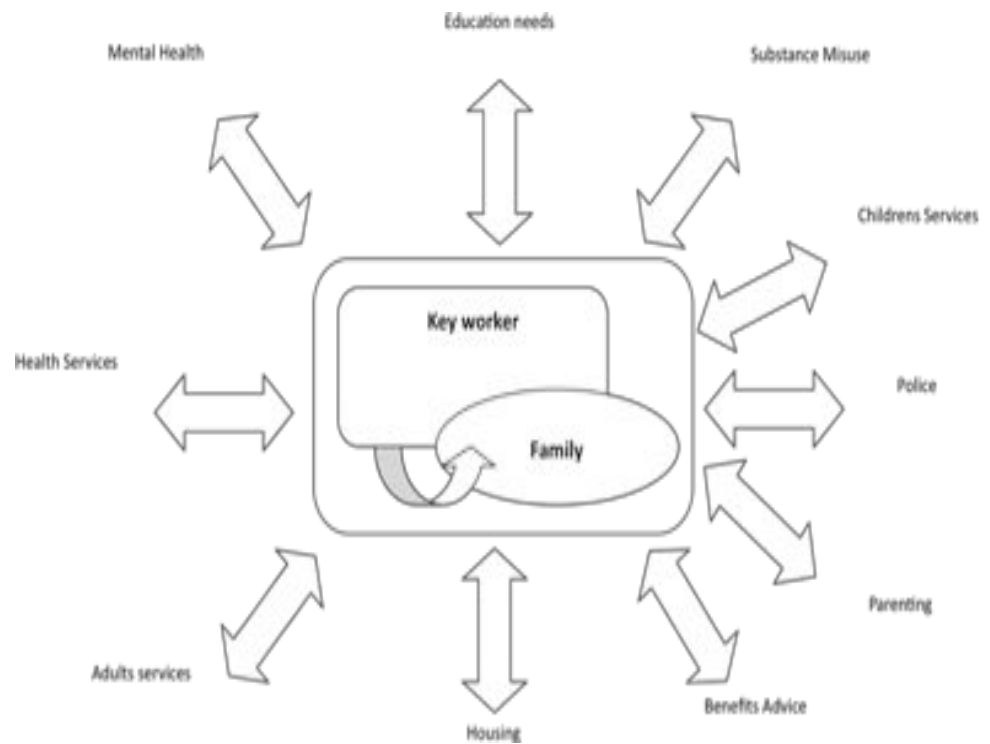
Protocols developed, and signed up to at senior level, by key agencies will be a way to achieve some of the good practice set out in this report. Protocols should be based on an agreed set of principles, examples of which are set out later in this chapter.

By using a protocol model, you can ensure consistency of vision, introduce principles, establish data sharing arrangements, encourage joined approach to training, raise the profile and priority of the issue, increase early identification. The protocol can then be given further importance by ensuring that it is made explicit in commissioning arrangements for the key agencies involved and in adult and children's SET safeguarding procedures and other relevant guidance and thresholds documents.



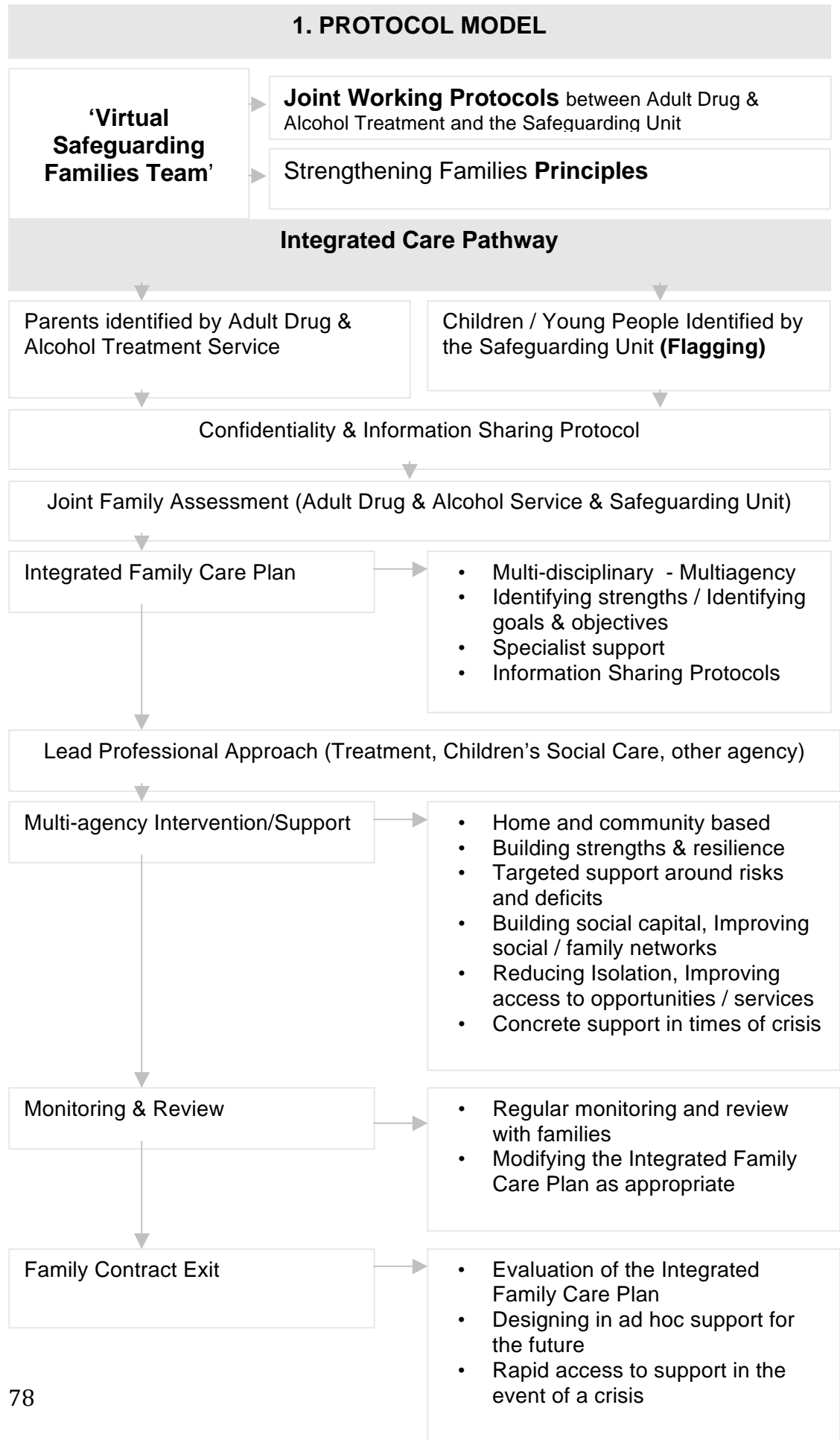
The Essex Disabled Parents Guidance states that “clearly communicated roles, responsibilities and remits are crucial to joint working practices and vital for commissioning.”

Table 4: Example of co-ordinated multi-agency approach



On the following page there is a flowchart example of what the protocol will need to consider in its development.

Figure 14: Protocol model example of co-ordinated multi-agency delivery



Option 2. Training, Support and Co-Location Model

This option is medium cost and builds on the basis of the protocols model set out in option 1, by providing training on cross cutting themes to multi-disciplinary professionals. This model provides opportunities for professionals from different backgrounds to share practice and create inter-agency relationships to improve the safeguarding of children and strengthen vulnerable families. By skilling up the key elements of the workforce, it will drive culture change and improve general practice with vulnerable families. This would help to create a range of family lead professionals across the partnership agencies. Consideration should be given to training social workers and midwives on alcohol Identification and Brief Advice (IBA).

In addition, a programme of co-location of different professionals from key agencies – for example, drugs workers being placed alongside child protection teams – should be implemented to further joint working, remove professional barriers and improve shared understanding.

Identifying champions at different levels across the partnership will help to bring leadership on whole family working within services.

The support that different agencies will need should be identified in this model. The following two pages show a diagram of the key considerations for the development of this model.

Option 2. TRAINING, SUPPORT & CO-LOCATION MODEL

Interagency training
(Drug & Alcohol
Services – Essex
Safeguarding Unit)

Based on the Strengthening
Families Principles

Developing collaborative
approaches to interagency
working and strengthening
families

Process

Interagency Training Process - Themes

1. Identification

Families experiencing:

- Substance Misuse
- Mental Health problems
- Domestic Abuse
- Or Multiple Problems

2. Engaging families

Approaches to working
with families:

- Non-judgemental
- Supportive
- Reactive in crisis
- Available
- Proactive in strengthening families

3. Family Assessment

Approaches to assessing
families:

- Home based
- Holistic
- Empowering
- Focusing on strengths, rather than risks and deficits
- Identifying goals

4. Integrated Care Planning

Approaches to integrated
care planning:

- Multi-disciplinary – specialist support (SM, MH etc)
- Lead Professional Approach
- Involving the family in decisions / forming goals
- Planning interventions that strengthen the family
- 'Family Contract'

5. Intervention/s

Approaches to providing
interventions:

- Home & Community based
- Building resilience
- Rolling with resistance
- Being persistent
- Building social capital
- Reducing isolation
- Improving family / social networks
- Improving access to opportunities / services
- Concrete support in times of crisis

6. Monitoring

Approaches to monitoring:

- Regular monitoring with families
- Modifying the plan in relation to identified goals
- Reinforcing achievements and strengthening weaknesses



Outcomes

1. Identification:

- Services are more skilled at identifying vulnerable families
- Services have developed close working relations with other agencies

2. Engaging Families:

- Services are better at engaging hard to reach families with chronic problems
- Families are motivated to tackle problems as a partner

3. Family Assessment:

- Services can assess more effectively the multiple problems that vulnerable families present with
- Families experience a 'solution focused' approach to tackling problems

4. Integrated Care Planning:

- Services plan more efficient and effective plans to strengthen vulnerable families, while reducing risks to both parents and children
- Services are working in an integrated way and planning interventions together to maximise impact and realise family potential

5. Intervention/s:

- Services create the potential for vulnerable families to achieve positive change and maintain gains over the long term, creating a legacy of families that have social capital and exhibit positive coping strategies
- Services are more persistent at maintaining relationships with families
- Families are less isolated and have better access to opportunities

6. Monitoring:

- Services are working 'with' families, rather than perceived to be working against families
- Services are reinforcing achievements and working towards strengthening weaknesses

3. Evidence Based Programme Model

Given the compelling nature of some of the emerging evidence of efficacy of certain programmes of whole family interventions with complex, high cost families, it is worth considering how Essex could adopt or adapt one of these models of practice either in specific areas (pilots) or across the board (transformation).

Co-located multi-agency team

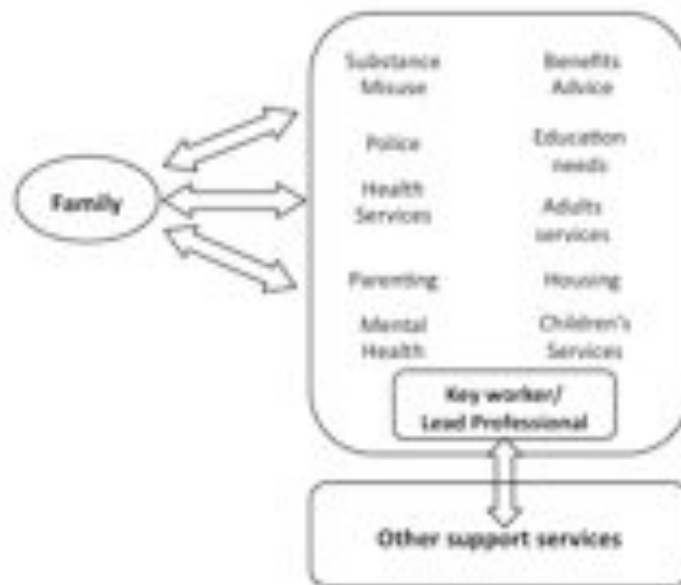


Figure 15: Possible model for co-located multi-agency teams

Over the next two pages is a diagram of a possible model that combines common elements of evidence-based programmes and should be considered in any developments for Essex.



3. EVIDENCE BASED PROGRAMME MODEL

Stage One (Prevention and early intervention) 'No wrong door'

Prioritising
Commissioning

Social Workers to 'flag'
vulnerable families

Training the universal workforce to
identify and proactively work with
families 'at risk'

Stage Two (Strengthening Families Intervention)

Delivery Options

Matrix working / Workforce development /
Virtual Teams / Pilot Champions /
Protocols / Reduce caseloads & create
specialist posts

i) Vulnerable Family

Substance Misuse / Domestic Abuse /
Mental Health / LD

ii) Identification

- 'Child in Need'
- Identification by community or
specialist services
- Self referral

iii) Engagement

- Community workers with a remit
around working with vulnerable
families (FIP)
- Specialist Workers

iv) Family Assessment

- Home based assessment by
designated worker
- I2 Family Chronology Programme

v) Integrated Family Care Plan

- Multi-disciplinary
- Identifying strengths / Identifying
goals
- Specialist support / Lead
Professional / Care Programme
Approach
- Information Sharing (SharePoint)

vi) Intervention

- Regular monitoring and review
with families
- Modifying the Integrated Family
Care Plan as appropriate

- Home and community based
- Building strengths & resilience
- Targeted support around risks and
deficits
- Building social capital
- Improving social / family networks
- Reducing Isolation
- Improving access to opportunities /
services

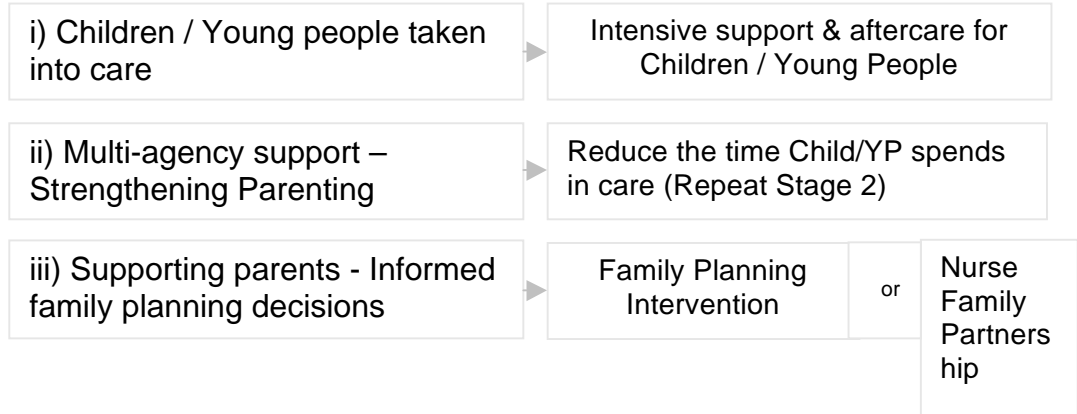
vii) Monitoring / Review

- Concrete support in times of crisis

viii) Exit or Stage Three

- Evaluation of the Integrated Family
Care Plan
- Designing in *ad hoc* support for the
future
- Rapid access to support in a crisis

Stage Three (Proactive Family Intervention – Breaking the cycle)



“People are afraid to ask for help, afraid that their families will be torn apart”

Young Person,
Essex

OPPORTUNITIES

A number of opportunities have been identified in discussions with stakeholders that could be built upon to take elements of this work forward:

Excellent status of Essex Adult Safeguarding

The adult safeguarding unit is one of only two in the country that have been inspected and assessed as Excellent by Government Inspectors. The keys to their success are based on partnership working with everyone signing up to SET procedures, which are owned by the Board; overseen by a multi agency board, Essex Safeguarding Adults Board.

Inadequate child safeguarding Ofsted rating and subsequent Improvement Notice

One of the 6 aims of the improvement plan is “effective partnerships making the difference” made up of:

- A Children’s Trust that drives better outcomes for every child
- LSCB supports high quality safeguarding across the partnership
- A shared vision by all partners and a commitment to improvement
- Joint commissioning of services that keep children safe and free from harm



*“Workers
change so
much, I can
never
remember
their names”*

Young Person,
Essex

Safeguarding
Children of
Parents with
Substance
Misuse
Problems and
Other
Vulnerabilities

Proposed Adoption Pilot

The proposal is to set up a collaborative project between adults and children's services targeting birth parents who have already had children placed for adoption and where alcohol and substance misuse was a key factor in the children's removal. The overall aim of the project is to prevent subsequent children of these parents from needing local authority accommodation and permanence outside of the family.

Other Opportunities Identified

We also identified a range of other potential opportunities already underway in Essex that this work could tie in with:

- The Schools, Children and Families Commissioning Programme
- Potential increase in Family Group Conferencing capacity
- Disabled Parents guidance that is being considered for re-writing and expanding to include parents affected by substance misuse
- The continued roll out of CAF Training
- “Protect” data sharing protocols
- The Castlepoint and Rochford pilot and data sharing exercise
- The Risk and Resilience project
- ECC interest in FDAC outcomes evaluation
- SET guidance future revisions and refresh of substance misuse and pregnancy guidelines
- Harlow Separating Parents Child Poverty pilot findings
- Essex Complexity Forum
- Integrated substance misuse commissioning group (young people and adults)
- Proposed redesign of specialist drug treatment function
- M-PACT delivery roll out to new areas
- Future Health and Well-being arrangement (NHS White Paper)
- New Executive Director for Children, Schools and Families
- Pre-proceedings Pilot (PPL)
- The CAMHS Action Plan ‘Think Family’ objective

“Social services work from a stereotype, especially about parents who are drug users. They don’t understand there is different types of drug use and different risks involved. They need to be aware of this, it’s really important to understand not all parents are bad, some just don’t have all the skills to bring up their children”

Substance
Misusing Parent,
Essex

PRINCIPLES

The following sets of principles are based on evidence and findings in this report. It represents a starter for consideration when developing the joint working protocol.

Overarching Principles

1. **The rights of the child are paramount.** The rights of parents, carers and pregnant women for support in fulfilling their parental roles and responsibilities do not override the rights of a child to be protected and be treated as an individual.
2. All practitioners who come into contact with children, parents and families in their everyday work have **a duty to safeguard** and promote the welfare of the child.
3. All services should adopt a **‘no wrong door’ ethos**, contact for vulnerable families with the service should open the door to a broader network of services
4. Families experiencing drug and alcohol related harm often have multiple vulnerabilities. It is critical all **services respond early, in an integrated way** and provide interventions that are timely, appropriate and **ultimately strengthen the family.**
5. Families experiencing drug and alcohol related harm are often resistant, difficult to engage and prone to disengage with services. It is crucial that approaches are developed to **engage families effectively** and to **maximise opportunities for positive change**, to build optimal family strength.

Strategic Principles

1. Parents should normally be responsible for the upbringing of their children and should share that responsibility. So far as is consistent with safeguarding and promoting the child’s welfare, local authorities should **promote the upbringing of children by their families**



2. Any intervention by a public authority in the life of a child must be properly justified and supported by services from all relevant agencies **working in collaboration to strengthen the family**
3. If there is a concern that a child may be 'in need' due to living in an environment where drugs/alcohol is being misused, all agencies, subject to professional codes of confidentiality, have a **duty to share information** with Children's and Family Services
4. Greatest progress is made where the needs of children of problem drug and alcohol users are identified and addressed by a **shared strategic approach**
5. **Interagency training** is not an end in itself but should be seen as a necessary and vital component of the safeguarding children process, improving communication and developing shared approaches to strengthening families
6. There appears to be an opportunity for a "**Win-Win**" situation. By developing and building capacity for whole family interventions with families with complex needs, the evidence suggests that it can be better for the outcomes of the children and the adults in that family, whilst also serving to reduce the cost burden on social and health care, and even improving staff recruitment and retention
7. Intergenerational transmission, where many of these parental vulnerabilities mean that their children are significantly more likely to experience similar problems, typified by local case studies we were told about showing 2nd and 3rd generation drug misusers and children in care, demonstrates the need to adopt a "**never too late to intervene**" principle to ensure that services do not give up on families or pre-judge their ability to improve

Service Principles

1. All agencies should adequately **assess the impact of multiple vulnerabilities** on the care and development of children, this should be considered an essential part of providing assistance

“Social Workers should be a lot more experienced. They are sending out students to very complex families, there is a real difference working with someone who is very knowledgeable, is non-judgemental and not completely reliant on asking set questions from their file. There should be specialist social workers, with experience of working with drug users. For example, a drugs worker would not be questioning me on whether I had relapsed, they are experienced enough to see that I’m well, have good colour and getting I am healthy. A young Social Worker would never know that, they see the drugs first and person second”

Substance Misusing Parent, Essex

2. While **many parents with vulnerabilities will adequately safeguard their children’s well being**, children’s life chances may be limited or threatened as a result of these factors. Agencies should explore the impact on children, be alert to their needs and welfare and respond in a integrated way to emerging problems
3. Children should be helped early **and services should not wait for crises or tragedies to occur**. This requires periodic observation, using home visits to have an opportunity to see and assess children in the environment in which they live
4. **Agencies and professionals must work together** in the planning and delivery of services, in assessment and care planning with families and in multi-disciplinary training
5. Support should be available for the extended family. Acknowledging **the value of identifying, using and building wider family strengths** when planning for children and avoiding the assumption that parents and children can cope alone

Practice Principles

1. **Children and parents should be consulted** when professionals make important decisions about things that affect them, including where, and with whom, they should live, their schooling, their relationships and lifestyle. Their rights should be respected
2. Intervention should be carried out **in partnership with the family**, and with the aim of helping them to put their child’s welfare first. In addition, services should not let go of complex families by using proactive outreach and **active advocacy**
3. Where there is parental drug and / or alcohol use it is the responsibility of practitioners to consider how to **build trusting relationships with families** and consider how attitudes and practice may act as barriers to engagement
4. Those working with families should have a detailed **understanding of child development and parenting skills**



5. Practitioners should **Identifying both strengths** (including resilience and protective factors) **and difficulties** (including vulnerabilities and risk factors) within the family and work in an integrated way to strengthen the family by reducing risks and building on strengths

7. RECOMMENDATIONS

SUMMARY

We have generated a series of recommendations for the partnership in Essex to consider. We believe that Essex should:

Identify

- Conduct an exercise to identify the top 400-600 complex families that cost Essex services the most money to deal with
- Pool training resources by bringing together budgets, expertise, venues and overlapping issues (e.g. parental drugs, alcohol, mental health, domestic abuse) into a single set of training programmes to: (i) help identifying agencies to spot signs and engage complex families; and (ii) develop whole family working practices across key agencies
- Pool communications resources to ensure that key messages about working with complex families go to all staff across agencies in a joined up way, spreading evidence of what works
- Commissioning priority should be given for parents with vulnerabilities and complex families, with commissioners actively ensuring an appropriate response from service providers

Intervene

- Improve inter-agency working through developing and implementing a specific protocol to drive improved joint working for complex families. Key agencies need to sign up, setting out expectations and commitments from each agency in line with evidence of what works
- Consider adopting an evidence based programme to deal with complex families more effectively
- Bridge the gap between adult and children's services by joining up the safeguarding functions and championing a multi-agency approach to complex families, in line with evidence based programmes
- Consider whether the current use of money for drug testing and substance misuse experts in child care proceedings could be more effectively used to fund specialist drugs worker input co-located with children's social care to joint work these cases

Prevent

- Address the current gap in support after a child goes into care when parents have vulnerabilities, by ensuring appropriate family strengthening support and parenting skills for the parents and specific support for the children who may experience long term problems
- Establish self support groups for parents (esp. mothers) going through these issues



IDENTIFY

These recommendations relate to improving the identification process of families affected by parental vulnerabilities across Essex.

Recommendation	Rationale	Lead
<p>1. Develop a shared vision that gives families affected by parental vulnerabilities as greater importance for Essex. ESCB, ESAB, the lead member for children and a senior ECC Executive should champion this issue to establish this group as a priority for adult and children's service commissioning.</p>	<p>Currently many issues of parental vulnerability that impact on children remain hidden. This action should result in improvements to systems of support commissioned to meet the needs of complex families which need strong strategic leadership.</p>	<p>Safeguarding Boards for Adults and Children and Children's Trust Board</p>
<p>2. Pool communication resources to ensure that findings from this report are widely and consistently disseminated across agencies to ensure a golden thread of key messages:</p> <ul style="list-style-type: none"> • promoting good practice, • celebrating success, • reinforcing training messages, and • bringing consistency to practice for a range of services needed to work with vulnerable families. 	<p>To bolster the protocol and training delivery model options, effective communication going out consistently and regularly to identifying and intervening agencies is essential to generate better practice at the frontline. Our interviews showed that there are significant levels of safeguarding communication, however it largely focuses on errors rather than good practice. There was a desire expressed for more information on what works.</p>	<p>ESCB, ESAB, Internal Communications departments of partner agencies, and safeguarding leads in partner agencies</p>
<p>3. Pool training resources and efforts across the partnership for both adult and children's services with regards to the issues of parental vulnerabilities. This will allow for joint commissioning (which should result in cost savings); ensure consistency of message across services, ensure consistent quality, allow for multi-agency delivery and ensure services are not competing for limited training slots and practitioner time. Two levels are needed: (i) identifying agencies targeted at health visitors, midwives, schools etc. to build confidence to identify; (ii) Key practitioners such as mental health, substance misuse, child protection, adult social care to build confidence and embed good practice.</p>	<p>This is especially important given the Serious Case Review recommendations to ensure on-going multi agency training courses at two levels for identifying agencies and key agencies working with families with substance misuse.</p> <p>The training on issues of related parental vulnerability – i.e. DV, substance misuse, offending and mental health should be brought together into one training given the overlapping nature of these vulnerabilities, with the focus being on complex families rather than single issues for parents.</p>	<p>Training leads for children's and adult's workforce across partner agencies Adult and Children's Safeguarding Teams</p> <p>EDAP and EYPDAS Trainer</p>

“Services need to help every member of the family, help them to be safe and work through their problems together”

Young Person,
Essex

Safeguarding
Children of
Parents with
Substance
Misuse
Problems and
Other
Vulnerabilities

Recommendation	Rationale	Lead
<p>4. Develop and implement tools to assist agencies in identifying families (risk assessment and screening) affected by parental vulnerabilities at the pre-CAF stage.</p>	<p>Intervening before crisis point means that workers need tools as well as training to give them the skills and confidence to take action.</p> <p>In addition to the vulnerabilities we have set out here, further consideration should also be given to parents who have been in care as a child or have previously had a child in care</p>	<p>Safeguarding Teams for Adults and Children</p>
<p>5. Encourage key services to habitually record parental status and vulnerability to help with future needs assessments and identification of cases (inc. through MAAGs, JAP and EARP).</p>	<p>Recording this data will help to flag up parents with multiple vulnerabilities and help trigger more tailored responses.</p> <p>Children's and Vulnerable Youth Services do not habitually record client's parental vulnerabilities, which limits their opportunities to understand their client's needs fully, identify potential future problems and get parents the support they may need or allow them to support the whole family (except in clear cases of child protection). Social workers should always record this on ICS.</p> <p>NICE Guidance advises to do this for pregnant women (Sept 2010).</p>	<p>SET Guidance</p>
<p>6. Conduct a data and information sharing exercise across the partnership to proactively identify the most complex/high cost 400 -600 families. It may also be beneficial to conduct further cost / benefit analysis of these families using the current cost as a baseline versus the potential benefits of using an evidence based programme. Consideration should be given to bringing together this "spend" into a virtual commissioning pot for complex families.</p>	<p>Conducting a "frequent flyer" data exercise in other areas has helped to identify high-risk families. Good examples include the Westminster FRP model. It is important to be aware that a similar exercise is being taken forward in Castlepoint and Rochford.</p> <p>Consideration should be given to the potential use of Social Impact Bonds in relation to these families and the introduction of a targeted programme.</p>	<p>Essex Partnership</p>



Recommendation	Rationale	Lead
<p>7. Ensure that the safeguarding thresholds for adults who are parents with vulnerabilities acknowledge potential impact on children and family and trigger an earlier response from adult services.</p>	<p>National guidance for adult services states: “in the course of assessing an individual’s needs, councils should recognise that adults who have parenting responsibilities for a child under 18 years may require help with these responsibilities. Undoubtedly, some people will not be eligible for support because their needs do not meet the council’s eligibility criteria. In reaching such conclusions, the council should have satisfied itself that the person’s needs would not significantly worsen or increase in the foreseeable future because of a lack of help, and thereby compromise key aspects of independence and/or well-being, including parenting responsibilities.”¹⁰⁷</p> <p>The children’s social care thresholds for Essex show that children of parents with multiple vulnerabilities are to be considered at level 3 and 4.</p> <p>Adult services do habitually assess for their client’s parental status, however there seems to be a reluctance to look beyond the presenting adult to the support needs of the rest of the family (except in clear cases of child protection). It is important to remember that presenting difficulties have root causes and interventions must seek to address both.</p>	<p>Adult Safeguarding Board</p>
<p>8. Shape the future of Children’s Centres to identify and proactively engage complex families.</p>	<p>Looking again at the role of Children’s Centres offers an opportunity to ensure that they proactively identify and engage vulnerable parents at an early stage.</p>	<p>ECC Children’s Services Commissioners</p>

¹⁰⁷ *Putting People First* (Department of Health, 2010)

INTERVENE

These recommendations aim to improve the quality and effectiveness of the intervention that vulnerable families receive in Essex.

Recommendation	Rationale	Lead
9. Develop a multi-agency, whole family working protocol for families where parents have vulnerabilities and ensure senior level support.	Improve inter-agency working through a specific protocol, which key agencies develop and sign up to. This will set out expectations and commitments for joint working from each agency in line with evidence of what works and best practice principles. Agencies should agree response time and minimum standards etc. and will involve service users in its design.	Hidden Harm Project Lead and Key Interested Partner Agencies
10. Adopt an evidence-based programme. A decision must be made either to pilot a programme in a high need area or to use the programme to drive a transformation of social and health care responses to vulnerable families more widely across Essex.	Consider how Social Impact Bonds (SIBs) could be used to support this development. Consideration should be given to the potential use of Social Impact Bonds in relation to these families and the introduction of a targeted programme.	Essex Partnership
11. Develop and adopt a whole family assessment tool and care plan across key agencies.	Good examples have been generated and used in Islington and Croydon as part of their Government funded Family Pathfinders.	Social Care for Adults and Children
12. Implement a rolling training programme to develop lead professionals for complex families from a variety of services and augment this by developing a programme of co-location opportunities between key agencies.	The training model set out in the delivery section builds on the joint working protocol and ensures evidence based improvements in practice for the key agencies that work with vulnerable families.	Safeguarding Boards for Adults and Children
13. Use Family Group Conferencing and Family Centres earlier in cases of Child Protection or Child in Need where parental vulnerabilities have been identified.	Evidence of the effectiveness of these approaches have been shown to be improved if used earlier than at crisis point.	ECC Children's Services Commissioners



Recommendation	Rationale	Lead
<p>14. Adult drug, alcohol, mental health and probation services should establish “parents” as a distinct priority group that requires a different response to the mainstream in order to best meet the needs of the individual and their family. This may also need a specific focus on mothers.</p>	<p>Commissioners need to set out explicitly in contracts their expectations regarding whole family working, identification of parents and joint working with other key agencies in line with this report. This should aim to establish family friendly services, skilled lead workers and identified champions.</p>	<p>Adult Services Commissioners and service providers</p>
<p>15. Establish better formal join up between the safeguarding Functions for adults and children in Essex.</p>	<p>Learn from what has been deemed “excellent” by inspectors of adult safeguarding to improve children's safeguarding and either create one single joint safeguarding Unit and Board or formalise links between the two. Children’s and Adult safeguarding teams do not have a formal opportunity to meet at present. This will help to stop families falling between the gaps and fragmenting families into individual adults and children rather than whole families. Many suggested this in interviews and it is backed up by the recent ‘<i>Working Together</i>’ guidance.</p>	
<p>16. Use the funding that is spent on drug testing and expert substance misuse assessments in child protection cases to fund a substance misuse worker to co-located in the child protection team to co-work cases. Alternatively, Essex will need a clear and agreed position on the usefulness and process for drug testing and the use of expert assessments as part of child protection proceedings.</p>	<p>We identified that £42.5k was spent annually on specialist substance misuse assessments and drug testing by children’s social care. The efficacy of this approach was questioned by the local drug treatment services.</p> <p>Consideration should be given to using this funding to adopt a model like the Kent SMPP model that demonstrated effectiveness.</p>	<p>EDAP and AFS</p>
<p>17. Adopt informal, positive findings from the Family Drug and Alcohol Court pilots with relevant judges, magistrates in family courts and support services.</p>	<p>Essex are already looking at the outcomes of the Family Drug and Alcohol Court Pilots in London and are waiting on the evaluation outcomes.</p>	<p>Essex Family Courts, Children’s Social Care and substance misuse services</p>

Recommendation	Rationale	Lead
<p>18. Build capacity for Domestic Abuse work with non-convicted perpetrators and complex families.</p>	<p>With only 30 places available, and over 14,000 DV incidents in Essex per year this is a considerable gap between need and availability. Given the prevalence of domestic abuse alongside other parental vulnerabilities, this is essential in a strengthening families approach.</p> <p>The Essex Domestic Abuse working group has already made this recommendation.</p>	<p>Domestic Abuse Leads</p>



PREVENT

These recommendations relate to preventing problems becoming intergenerational as well as to intervening early to prevent problems escalating.

Recommendation	Rationale	Lead
19. Establish a model of self-support groups for parents with vulnerabilities , taking an approach that partners them with functioning parent volunteers. Also, establish self support groups for vulnerable pregnant users and new parents (similar to the NCT model of support and learning) and involve the wider family in support.	<p>Croydon research shows that families with the greatest needs are often the most isolated; the most vulnerable seem to lack these social networks. On the opposite end, thriving families not only have their own strong networks, but they often use their resources to buy into services that lead to increased networks such as the National Childbirth Trust.</p> <p>Secondary research and parents themselves say that these networks are crucial to supporting their emotional health and well-being as well as access to information about services, enabling them to properly support their children.</p>	EDAP Carer/User Involvement Lead and Children's Centres
20. Ensure a greater targeting of parenting classes and resources to families with parental vulnerabilities.	Parenting classes have been shown to be effective at reducing risks and building resilience, but will often not attract or engage parents with multiple vulnerabilities. Therefore this group should be seen as a priority and be proactively targeted using a tailored approach.	Parenting Lead
21. Ensure additional midwife/health visitor resource for vulnerable pregnant women.	This is recommended in the recent NICE Guidance on pregnancy and complex social factors. This is also supported in the evidence for Nurse Family Partnerships.	Health Service Commissioners

Recommendation	Rationale	Lead
<p>22. Prioritise families for additional support once a child is taken into care. This will require: (i) tailored support for the child to deal with the longer term impact of parental vulnerabilities; (ii) tailored support for the parents to deal with the loss, a family planning intervention, and receive help for their vulnerabilities; (iii) parenting classes.</p>	<p>Option 2 evidence shows that it is possible to reduce the period of time children of substance misusing parents spend in care and that they can be effectively returned to their families. Family planning support should be given in a targeted way (as with teenage pregnancy interventions) to reduce the risk of the parent having another child quickly that may well be at risk of going into care as well.</p> <p>This recommendation should also be considered when CP and CIN cases are closed where parental vulnerabilities remain an issue.</p>	<p>Adult and Children's Social Care</p>
<p>23. The wide range of family provision in Essex should be better co-ordinated for parents with vulnerabilities and clearly identify them as a priority group, communicating this effectively to key services working with vulnerable parents.</p>	<p>There appeared to be a wealth of family provision available, but those working with the most vulnerable children and parents could not identify how to access whole family support.</p>	<p>Lead agencies on Essex Parenting Strategy and Family Services</p>
<p>24. Establish a formal system to regularly consult and involve service users (both vulnerable parents and their children) in designing service responses, developing training and evaluating performance.</p>	<p>The involvement of target families has shown to be a characteristic of the effective programmes reviewed for this report.</p>	<p>Adult and Children's Services Commissioners</p>
<p>25. Address the gap in identified support for children affected by parental vulnerabilities. In practice, a way to start to address this would be by ensuring EYPDAS, DART, Young Carers, CAMHS and YOS have this clearly included in their commissioning arrangements.</p>	<p>The evidence of intergenerational transmission to the children of parents with vulnerabilities demonstrates the need to support these children in their own right at an early stage and not waiting until they become substance misusers or offenders before offering support.</p>	<p>Children's Services Commissioners</p>



LIST OF ANNEXES

The following annexes are available as a separate document to supplement this report and give further detail on specific areas of work. They have been removed from this document in order to keep this report as brief and accessible as possible.

Annex 1	Practitioner Interview Tool
Annex 2	Bibliography
Annex 3	Glossary
Annex 4	FIP Safeguarding Protocol Exemplar
Annex 5	Evidence Based Practice Points
Annex 6	Summary of Strengthening Families Handbook
Annex 7	Evidence of What Works
Annex 8	Data Collection Tool for Pregnancy and Complex Social Factors
Annex 9	Evidence base behind suggested principles
Annex 10	Case Study
Annex 11	Data Analysis Tables
Annex 12	Local Good Practice Examples
Annex 13	Parents and Young People Interview Tool
Annex 14	Project Methodology
Annex 15	Relevant Government Policy Documents