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Executive Summary

Largely in response to Hidden Harm and changes resulting from the Every Child Matters agenda, Norfolk DAAT commissioned a study focused on the children of substance misusing parents and the parents themselves. The aims of the study were to: complete an audit and evaluation of current provision, working practices and systems relating to the target groups; investigate and collate existing data relating to the target groups, and to estimate the level of required services needed; make recommendations on the most appropriate services, commissioning responsibilities and planning structures for future development.

A mixed methodological approach was taken to obtain both quantitative and qualitative data from a range of professionals and services across Norfolk in one, or a combination, of the following ways: participating in a focus group, participating in an interview, completing a brief screening questionnaire, and if appropriate a more detailed questionnaire about data collection, participating in a ‘snapshot’ exercise, submitting a case study. Quantitative data collection was problematic but data for the study were collected from 28 screening questionnaires, 4 more detailed questionnaires and 6 responses to the snapshot survey. Qualitative data were collected from more than 60 people.

It was hard to draw firm conclusions from the quantitative data, though the small amount of data collected indicates that large numbers of children are likely to be affected by parental substance misuse across the County. The data further suggest that parental alcohol misuse is a serious problem. Data monitoring of the population groups is at best inconsistent and at worst absent, making future strategic planning in this area challenging. Continued introduction of the Common Assessment Framework across Norfolk has real potential for improving identification of the population groups, meaning that clearer estimates of the numbers of affected children can be made and hence resources better targeted to need.

A number of further pertinent themes emerged from the qualitative data. There is only one small service for the whole County that specifically meets the needs of the population groups. However, it was clear that many other services do go some way to addressing parental substance misuse and children of substance misusers, and that generic services have a significant role to play in an evolving partnership approach to the issue. There were also some examples of effective shared working practice. However, a lack of confidence and uncertainty about role and remit meant that many children and young people, and their families, risk falling through the net and coming to the attention of services only when their circumstances have reached complex and critical levels. Needs of different age groups varied, with service provision good for pre- and neo-nates and for adolescents, but with a gap identified for the 5-12 age group. The size of the County and the extent of and distance between rural areas brought further challenges in service delivery. It was also noted that impact upon parenting is not sufficiently addressed when working with substance misusers who are parents and their families.

There is only so much that can be done in the absence of clear and streamlined national policy. The Norfolk Hidden Harm Forum is a clear demonstration of the commitment to recognising the needs of the children of substance misusers and substance misusers who are parents at a strategic and County-wide level. In a climate wishing to actively promote integrated services, planning, commissioning and governance, repairing the fragmentation that exists is vital and could present a real opportunity to bring together multiple agendas and develop a multi-faceted and multi-disciplinary solution that everyone can support. Thus, at the heart of the findings of this study is the need for strategic streamlining and inter-agency co-operation. The foundations are in place with directives such as the Norfolk Children and Young People’s Plan, and with the progress that Norfolk has made with training and implementation of the Common Assessment Framework. Thus, it is hoped that the groundwork in place now across Norfolk, and the priority that is being given to these issues, will ease the journey towards the evolving County-wide solution needed.
Background

In excess of a quarter of a million children in England are at risk because one or both parents (or adult with parenting responsibility) is a problem drug user (ACMD, 2003). Nearly five times as many children are believed to be affected by parental problem drinking (Turning Point, 2006). Much is known about the negative impact that parental substance misuse problems can have on children (Cleaver, Unell & Aldgate, 1999; Kroll & Taylor, 2003; Gorin, 2004; Scaife, 2007; Templeton et al., 2006) and young adults (Velleman & Orford, 1999). These experiences, often co-existing with the presence of other problems such as parental violence, parental mental health problems or financial hardship, cover a wide range of harms, both in the short- and the long-term, and include the development of alcohol/drug and/or mental health problems as well as increased risk of behavioural problems, difficulties at school, challenges in developing and maintaining relationships with peers and others. Of particular concern is the negative impact in terms of parenting and family life.

Until recently it has been assumed that parental substance misuse can only impact negatively on children, both in the short- and the long-term. However, evidence of a rather different pattern in the impact of these problems has started to emerge. Research has been able to identify factors and processes that can minimise the negative impact of drug or alcohol problems. It seems that some children are resilient (Velleman and Templeton, 2006, 2007) and do not develop significant problems, or do not develop problems at any different rate to children in non-substance misusing families, either when they are young or when they reach adulthood and perhaps have families of their own.

There is evidence that supporting families affected by the substance misuse of a relative can have positive outcomes for all in the family (Copello, Velleman & Templeton, 2005); yet there are few examples of services that work with children / young people or families, and real challenges exist in supporting services to develop such services and work together to better meet the needs of these population groups. National policy directives are an important and necessary driver of policy at a regional and local level. Whilst there are good foundations in place with regards to drug policy to support children and families affected by drug misuse (ACMD, 2003, 2006), and these groups are considered where appropriate in wider child and family policy (DFES, 2004; DFES, 2005b; Cabinet Office, 2007), alcohol policy is less well developed (Cabinet Office, 2007), and there is an overall lack of clear overlap between the different areas of policy responsible for considering these population groups.

Norfolk is the fifth largest English County, and the seventh most populous non-metropolitan County. With a population of around 800,000, the County is dominated by agriculture and tourism. There are no accurate data available for Norfolk on the numbers of children of substance misusers who live in the County, nor on the numbers of substance misusers who
are parents. A review of substance misuse in families of children on the Child Protection Register (Oliver et al., 2000) reported that of 303 cases, 25% (increasing to 30% of children under 10) involved drug or alcohol misusing (birth) parents, and that 57% of mothers and 65% of fathers had children under 6 years old on the Register. Further, nearly 75% of these parents had been in contact with specialist drug services, but the number of occasions when specialist services attended a case conference was low. This report also highlighted some differences between the western and eastern parts of the County. Additionally, young carers services estimate that there are 2000 young carers in Norfolk of whom 7% are carers of substance misusing parents.

Some services exist across the County but there is limited targeted support for the population groups under investigation here. A small NSPCC project is the only specific project in the County to work with the target groups. T2, primarily a service to support young people who themselves misuse drugs and alcohol, will actively work with children and young people affected by parental substance misuse. T2 is also a good example of a service that actively involves children and young people in shaping service delivery; for example, by asking children to help write content for the service website. One area where service delivery appears to be strong in the County is in provision for pregnant substance misusers, with an effective protocol for this area of work in place (NDAAT, 2006). Other sectors where some attention is paid to the needs of the target groups are young carers, primary care, youth offending, specialist midwifery and foster carers.

Largely in response to Hidden Harm (ACMD 2003, 2006), and changes resulting from the Every Child Matters agenda, Norfolk DAAT commissioned the study reported here. This report, its findings and recommendations, has been included in the forthcoming Children and Young People's Plan for Norfolk (see [http://www.everynorfolkchildmatters.org](http://www.everynorfolkchildmatters.org)).

Aims of the Study

The target groups for the study were:

- The children of parents who are substance misusers (including pre-birth, toddler, primary school, secondary school / adolescent and young parents).
- Substance misusers who are parents.

The aims of the study were:

1. To complete an audit and evaluation of current provision, working practices and systems relating to the target groups.
2. To investigate and collate existing data relating to the target groups, and to estimate the level of required services needed.
3. To make recommendations on the most appropriate services, commissioning responsibilities and planning structures for future development, ensuring these are in line with Every Child Matters and Hidden Harm.

**Method**

A mixed methodological approach was taken to obtain both quantitative and qualitative data from a range of professionals and services across Norfolk. The NDAAT supported the researchers in identifying and contacting those who were subsequently invited to participate in the study in one, or a combination, of the following ways:

- By participating in a focus group.
- By participating in an interview.
- By completing a brief screening questionnaire and, if appropriate, a more detailed questionnaire about data collection.
- By participating in a snapshot exercise.
- By submitting a case study.

**Quantitative data collection**

A screening questionnaire was administered to a range of professionals (representing the breadth of services across the County) to establish the extent to which services were offered to, and data routinely collected about, the target groups under investigation. Participants were given a month to complete and return the questionnaire. Late responses were chased.

Where participants responded that they both work with and collect data about the target groups, a second questionnaire was administered. This questionnaire was used to collect more detailed data about the services offered to, and the data collected about, the target groups. Again participants were given a month to complete and return the questionnaires. Late responses were chased on a number of occasions.

Mid-way through the study it became clear that the low response rate for the questionnaires would make it difficult to fulfil the aims of the study. Therefore, a new strategy for data collection was employed. Front line workers were asked to participate in a ‘snapshot survey’. Workers across a range of organisations were identified by the research team in collaboration with the Steering Group and, following initial contact by members of the Steering Group in Norfolk, were asked to return some basic details about all the situations in a given time frame where they engaged (directly or indirectly, for whatever reason and for however long) with
children of substance misusers and / or substance misusers who are parents. Participants were given a spreadsheet to complete for two time periods – a week in June 2007 and a week in July 2007. Participants were also offered the opportunity of completing the survey on the telephone with a researcher, and late responses were chased.

**Qualitative data collection**

Group discussions, focus groups and interviews were held to collect data from representatives of a range of services across the County. Group discussions where held as part of two meetings of the Hidden Harm Forum in December 2006 and March 2007. Focus groups were held over the course of a three day period in December 2006. Semi-structured telephone interviews were conducted with a further group of professionals.

Case study examples of good practice, identified through the collection of qualitative and quantitative data, were invited from a number of organisations to illustrate the range of work that is undertaken across Norfolk with the target groups. Participants were provided with a template for producing the case study in order to achieve consistency.

**Data Analysis**

A cross comparative case analysis of the qualitative data from the focus group and telephone interviews was undertaken using a Thematic Analysis. Themes and sub-themes were identified and a coding framework developed. The framework was then utilised to identify and explore the similarities and differences within and between the accounts, alongside considering how the data contributed to answering the aims of the study. Validity of the analysis was checked through the use of triangulation, where three researchers separately analysed the data, then discussed and finalised theme titles and definitions. Quantitative data were entered into a database and analysed using descriptive statistics.

A draft of this report was revised following comments from the Project Steering Group. The Executive Summary and draft recommendations then formed the basis of a meeting of the Norfolk Hidden Harm Forum in November 2007 (the questions considered at this meeting are given in Appendix One), following which the discussion section and the recommendations were finalised. The involvement of the Hidden Harm Forum ensured that recommendations were realistic and locally relevant.

**Results - Quantitative data**

The screening questionnaire was administered to 125 professionals, representing a range of services across the County, including: Health, Education, Social Services, Family Support
Agencies (Voluntary and Statutory), Primary Care, Police, Youth Offending Teams, Statutory and Voluntary Substance Misuse Services, Young People’s Substance Misuse services, Young Carers projects, CAMHS, Fostering and SureStart. Twenty-eight completed and useable screening questionnaires were returned to the research team. The responses are summarised in Table 1 below, and the following points are highlighted.

- Of the four organisations that work with children only, all collect data about this work.
- Of the organisations that work with parents only, 71% (5) collect data about this work, and 43% (3) also collect data about their children.
- Of the organisations that work with children and parents, none collect data on parents only, 7% (1) collect data on children only and 86% (12) collect data on both. One respondent (7%) reported being unsure as to what data were collected.

The second questionnaire was administered to named representatives of services, based on the responses to the screening questionnaire. The aim of the second questionnaire was to collect much more detailed ‘hard’ data on the target groups under investigation. Of twenty-five questionnaires that were administered, there were 8 responses, including 4 completed questionnaires. The remaining four respondents reported that they did not collect data, or did not collect data that could be collated via such a questionnaire. Non-responders were chased, with a handful saying that they, or someone else, would consider our questionnaire and try to complete (but no more responses were received), but with some confirming that they would not be able to complete the questionnaire. The four completed questionnaires came from a Young Carers service, T2, the NSPCC specialist substance misuse service for families and TADS. The information gathered through these questionnaires is detailed below.

- **Young Carers** work with children only, and reported that they saw 29 children of substance misusers in the last 12 months (aged 7-15 years, slightly more female).
- **T2** work primarily with young people, and reported that they have seen 45 children of substance misusers since September 2006 (when data collection for their service began), almost all (42) of whom cited parental substance misuse as the primary problem (aged 13-23 years, 64% female).
- The **NSPCC** service works with parents and children, and reported that they have worked with 6 families in the last 12 months (comprising 5 adults and 6 children, aged 6 –15, more of whom were male than female).
- **TADS** work with adults only, and reported that they assessed 9 substance misusing parents in the last 12 months and have offered support to 17 parents in this time. TADS routinely asks all clients if they have children and, subsequently, about the impact of the misuse on the children and what the children’s needs might be.
Table 1 – Responses from Screening Questionnaire
Services offered to, and data collected about, the study groups (N=28)

<table>
<thead>
<tr>
<th>Service Provision</th>
<th>Description</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Services that provide support for neither substance misusing parents nor</td>
<td>3 (11%)</td>
</tr>
<tr>
<td></td>
<td>their children</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Services that only provide support for the children of parents who misuse</td>
<td>4 (14%)</td>
</tr>
<tr>
<td></td>
<td>substances</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Services that only provide support for parents who misuse substances</td>
<td>7 (25%)</td>
</tr>
<tr>
<td></td>
<td>Services that provide support for both parents who misuse substances and</td>
<td>14 (50%)</td>
</tr>
<tr>
<td></td>
<td>their children</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Total number of services that provide support for children of parents who</td>
<td>19 (64%)</td>
</tr>
<tr>
<td></td>
<td>misuse substance</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Total number of services that provide support for parents who misuse</td>
<td>21 (75%)</td>
</tr>
<tr>
<td></td>
<td>substance</td>
<td></td>
</tr>
</tbody>
</table>

| Data collection   | Services that collect information about neither substance misusing parents  | 4 (14%)|
|                   | nor their children                                                          |        |
|                   | Services that only collect information about the children of substance       | 5 (18%)|
|                   | misusers                                                                     |        |
|                   | Services that only collect information about parents who misuse substances   | 4 (14%)|
|                   | Services that collect information about both parents misuse substances and   | 16 (57%)|
|                   | their children                                                               |        |
|                   | Total number of services that collect information or data about the children | 21 (75%)|
|                   | of parents who misuse substances                                             |        |
|                   | Total number of services that collect information or data about parents who | 20 (71%)|
|                   | misuse substances                                                            |        |
|                   | Services for whom it is unknown whether they collect information about       | 1 (4%) |
|                   | parents and/ or children                                                     |        |

The snapshot survey was sent to 38 individuals; 6 were returned wholly or partially completed for one or both weeks (see Appendix Two for a table of results). Non responders were chased but this did not elicit any further responses. Some telephone and e-mail contact was needed to clarify the responses that people had given or to ask for more information.

The key messages to emerge from the snapshot survey were that, within the two-week timeframe, the target groups featured as 15-58% of the total number of clients seen by the responding workers. The 6 services identified over 117 children in the two-week timeframe aged between 5 weeks and 21 years old who were potentially being affected by parental substance misuse (primarily alcohol and heroin misuse).
Other professionals responded that they had not seen any target group cases in the two week timeframe; however, some who felt that this did not reflect their usual case profile gave us some general information about their usual contact with substance misusing parents and/or their children:

- A T2 Alcohol and Safer Sex Youth Worker estimated that 50% of the young people she sees on an individual basis have parents who are alcohol misusers (it is unclear whether these young people are seen for their own or their parents alcohol misuse).
- A YISP key worker told us that they see 3 to 4 parents a year who have drug and alcohol issues.
- A Young Carers worker told us that she would estimate substance misuse is an issue in about 5% of their cases; in the majority of cases, alcohol is the primary substance.
- A YOT worker did not see any children of substance misusers within the snapshot timeframe (out of 26 clients). However, she told us that she does occasionally have clients who are the children of substance misusers, many of whom are independent of their parents.
- A Children’s Services Social Worker estimates substance misuse is an issue in just under 20% of her department’s cases; in the majority of cases the substance is alcohol.
- A Voluntary Children and Families Project Manager told me that substance misuse features in between 10 and 12% of the cases they work with.

Feedback from members of the Study Steering Group to this section of the report highlighted a sense that some of the data presented did not accurately reflect the data reported to NDTMS, nor did it always reflect the level of work felt by some members of the Steering Group to be taking place. If anything, there was a general sense that the numbers reported via the quantitative data collected methods were lower than the reality. Despite the low response to the survey, however, and the perceived differences in opinion as to the accuracy of the data reporting, a clear message does emerge about the level of contact a range of services are having with substance misusing parents and/or their children. It is difficult to extrapolate a more general estimate of numbers and need from these limited responses, particularly bearing in mind the ‘hidden population’ that are not in contact with services. However, the figures presented here give us some clues as to the extent of need. Further, it seems that children of all ages are coming to the attention of services, and that alcohol features highly in these families.
Results - Qualitative data

In addition to data collected at the Hidden Harm Forums, 30 people attended focus groups and a further 12 were interviewed by telephone. Case studies were submitted by 4 services (Appendix Four). Thus, qualitative data were gathered from in excess of 60 people from a range of services across the County. A list of agencies who participated (by at least one staff member completing a detailed questionnaire and/or taking part in a telephone interview or focus group – four of these agencies also supplied a case study) is given in Appendix Three.

Need & Provision

Getting a sense of the needs of, and current provision to, the target groups in Norfolk is a complex undertaking. Fragmentation at a number of levels encapsulates much of what is discussed here. The data collected by the research team revealed mixed messages and inconsistencies, with a range of views held about the nature of the problem, the size of the problem, how to, and who best should, respond to it. However, most professionals tend to agree that, “the need is considerable, complex, diverse and difficult to deal with”.

Mirroring Hidden Harm, a key issue to emerge from the qualitative data was that professionals do not have an accurate sense of the size of the problem they are facing, particularly in relation to children, and that this has not significantly changed since the publication of Hidden Harm. Whilst some might agree that “the needs of these children are not necessarily any different to other groups of children”, it seems clear that identifying these children can be difficult. Professionals highlighted a number of ways in which the target groups might “fall through the net”. The families of substance misusing families are often not accessing mainstream services – children often fail to attend school, and are not often seen in primary care. As one GP pointed out, “a lot of GP’s won’t ask questions to find out the circumstances of the family… if a child doesn’t come to the surgery you assume they are well”. Whilst there is no definitive answer regarding how many families are in need, there seems to be consensus that what a lot of professionals see is the ‘tip of the iceberg’ and that a much greater ‘hidden’ need is out there. Furthermore, there is more need ‘out there’ than there is capacity to meet it; “The short answer is that we have got enough to keep us busy without going out touting for business. If we went out looking for more referrals we just wouldn’t have the capacity to deal with them”.

There was acknowledgement that more recently services have been getting much better at routinely asking substance misusing parents about their children. However, there is a sense

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1 Given that qualitative data were collected from over 60 people, it is hard to be too specific about whether a comment made can be attributed to someone who attended a focus group or was interviewed by telephone. As far as possible, however, the themes identified were highlighted by more than one person or group of people, with more specific examples, statement or quotes used for the purpose of illustration.
that this is not then followed up with “adequate additional or specific service provision to these children and their families”. Generally the message seems to be that where family situations are more severe and chaotic, and therefore where there is social services involvement / child protection concerns, more gets done. There is further confusion about what services should be available to the target groups, who should deliver such services and where they should be placed (both geographically and by sector). People spoke about remit as a key factor in the provision of support to the target groups. Thinking about the needs of children of substance misusers and parents who are substance misusers in generic terms leads to a situation where something that is everyone’s responsibility becomes no one’s responsibility. Some of the more generic services spoke of concerns about trying to be everything to everyone – “Where does our job end and become someone else’s responsibility?”

Geography was a key theme to emerge from the qualitative data; respondents spoke about the rural/urban divide, poor transport links and inequitable funding. It was highlighted that whilst approximately 10% of the Norfolk population live in Norwich, it felt like the majority of the County’s services are based there. Thinking about reaching out to people in rural areas, one professional described the fact that there is a choice to be made: stay in Norwich and see 6 clients in a day, or travel one and a half hours each way to see one client. The situation is further complicated by ‘geographical fragmentation’, where the County is divided into different boundaries by all the different agencies – PCTs, Police authorities, District Councils, resulting in professionals across the County working to different definitions and thresholds, with a negative impact on communication, multi-disciplinary working and equity for clients.

There seemed to be a general consensus that professionals are not working in a strategic, systematic, aligned and coordinated way – “they are not coming together in a helpful way”. Whilst it is recognised that the needs of the target groups ‘spill over into many areas’, such as mental health and housing, there is not enough effective multi-agency work to tackle these needs holistically. Different agencies still find it difficult to communicate together, to share information and work together effectively. A respondent gave the example of the new records system for Children’s Services in Norfolk (coming on stream in Autumn 2007). This will ease communication between case workers; however this will not extend to other agencies, such as Adult Services. In summary one respondent commented, “At the moment we divide things into nice clear-cut little boxes and hand them over to the substance misuse or mental health teams. Life is not that simple”.

Changes to provision are being influenced, but also complicated, by almost continuous change at a strategic level; for example in terms of children’s services, implementation of the Hidden Harm agenda, broader changes to emerge from the national drugs and alcohol strategies, the development of integrated teams, the Common Assessment Framework and the lead professional role. The impact on service delivery and commissioning is that there is
misinformation and lack of clarity about where provision to the target group should best sit or be organised, and who should be doing the work. For example there are particular issues around adult substance misuse treatment services, and bridging Adult and Children & Young People’s services. This confusion was reflected in the data we collected.

Nonetheless, the respondents spoke of the need for creativity and flexibility in service provision. Most agreed that Norfolk is relatively resource rich, suggesting perhaps that it is not necessary to change the provision that exists, but to make sure people work in an aligned way. However again on this point there was disagreement. Some argued that services are stretched and can therefore only to the needs of their clients. One worker commented, “The expectation and pressure is to do more and more whilst there are not enough workers. Instead of doing a good job we often scrape by”.

One of the frustrations of a number of respondents was the ‘short term-ness’ of funding and projects. There is often funding available to set up services, however they tend run out of funding before they have the chance to be bedded in, to really start meeting need or properly evaluated in terms of their impact. This seems to filter through to the type of support that is available to families. Generally, respondents felt support is more about patching up than providing meaningful support which can lead to sustainable outcomes: “The nature of short-term funding and working in Norfolk means that you create short-term plugs whilst storing up potentially more complex long-term problems”. One respondent noted, “Quite often when parents have stopped using and agencies have disengaged treatments and contact, the assumption is that the children of these parents are alright, but often the repercussions for children in this situations can go on for years after substance misuse has ended and there is not much provision for this out there”. This point is of relevance particularly to children in care whose needs relating to parental substance misuse are often over-looked as it is assumed that once out of the situation, or when the substance misuse ceases, the damage disappears.

Whilst virtually no specific support is available for the target groups, it was promising to hear that many generic services do work with these groups, emphasising the complexity of the problems faced by these children and families such that they come to the attention of, or approach, a whole range of service providers, and highlighting the important role that all services have to play in the response. Further, this study was a useful vehicle in introducing people to each other who they didn’t previously know and finding out about services that they didn’t know existed. Respondents also gave some useful ideas about what more was needed for children and young people and substance misuse parents; for example, practical support (e.g. first aid, responding to overdose), respite (“they [children] need a break from their families rather than being permanently removed from the family”) and, for younger children, more guidance around staying safe and staying in education. In addition, fathers, grandparents and those living in rural areas were highlighted as groups in need.
**Provision for specific age groups**

Access to services by children of substance misusers is fraught with difficulty. First and foremost, children tend not to access support under their own steam, usually being dependent on their parents to tap them into services. Their access to even mainstream services can be patchy, for example, many of these children do not attend school and some are not registered with a health visitor.

It was noted that pre-natal and neonatal care is a strong area of service provision to the target group. A number of respondents highlighted the multi-agency pregnancy protocol as an example of good practice in this area. However, unless pregnant women are receiving drug treatment, it seems that they will fall through the net at this point. For neonatal care there is what one respondent described as a ‘concerted effort’ due to the ‘recognised risks’ – a sign perhaps that the risks for older children are still not fully recognised by some professionals.

For the under-fives, the health visiting service is a key player. Health visitors are able to identify and support families and refer on if necessary. However, once the children reach the age of five, “there are few formal safety nets within Primary Care services to help identify and support children of substance misusers”. There was little mention of other services, such as SureStart.

Many respondents expressed concern for 5-12 year-olds, for whom there seems to be very little in the way of support. These are school-age children, and whilst support through the school seems to be an obvious answer, respondents noted schools’ reluctance to take on a more central role in children’s lives when it comes to substance misuse and parents. There seem to be two key barriers here. The first is that schools have a very clear educational remit and feel unable to stray away from this; the second is the fear and confusion teachers feel in relation to ‘what to do about it’ when they identify a child in need of support due to the substance misuse of their parent(s). One respondent summarised the state of play for younger children: “Specialist support in Norfolk is very well provided both for adults and young people. For much younger children the provision is lacking. The Matthew project is good for supporting young people it’s a T2 service but they tend to engage with young people who are independent. The 5-12 age group are very vulnerable and can be at risk but there are no specialist agencies working in this area. Norfolk is well resourced for services but not for the lower ages”. However, one respondent from Children’s Services felt that the lack of provision to this age group matches need, feeling that there was not a large demand for services for this age group.

For young people and teenagers the picture seems to be better. As mentioned above, there are services specifically targeted at teenagers, such as the Matthew Project. However, some argue that in comparison with, for example neonatal care, provision even for this group is
lacking: “unless it comes to our attention in another way – if the police are involved, for example – there’s a lot of teenagers out there without any services, it’s often hidden”. Interestingly one of the suggestions to come to light in a focus group with a range of professionals was to have an ‘Adolescent Protection Unit’ alongside the Child Protection Unit. Again there is a sense that for this group, it is all too easy for those in need of support to fall through the net. This is particularly true of young people bridging the transition between adolescence and adulthood.

**Data and monitoring**

It is apparent that ‘hard’ data about the target groups are lacking and/or inconsistent. In many cases very practical reasons are given as to why these data are not gathered. However beyond these issues, there seems to be a general lack of motivation for collecting data in general, as one respondent pointed out, “We collect a lot of data, but a lot of it is meaningless to us”. With regard to data about substance misusing parents and their children, this is patchy and inconsistent, and is generally unable to answer key questions around the number of children and parents in need and the number receiving services. Even where this does exist, one respondent pointed out, “We know how many people are in treatment but we don’t know how many aren’t”.

Importantly, whilst a number of generic support services do engage with the target groups, their data collection does not necessarily reflect this. One voluntary support service worker explained that in their case, if substance misuse is identified subsequent to the referral and assessment process records will not be updated to that effect. Much of the work done with the target groups therefore is not classified as work with substance misusing parents and/or their children: “Often data collected doesn’t represent the complete picture as far as the sort of work that is done. Decisions made higher up, on the basis of data collected, could potentially jeopardise future funding support”.

Overall there seemed to be a real lack of awareness of the importance of collecting the most basic data on activity and effectiveness, and a reluctance to recognise the value and of recording such data; for services, individual workers and, ultimately, for children and families.

**Training needs**

This section focuses specifically on training related to working with the study target groups, so substance misusers who are parents and those (young or adult) affected by the substance misuse of someone else. It is recognised that training and workforce development are a priority across the County and that much is in place to offer high quality training on generic substance misuse related work.
There seemed to be a general lack of awareness about what training opportunities might exist or how these can be funded, resulting in a perception that training is patchy around substance misuse, particularly regarding the impact on the family. For example, there was little mention of a one day child protection and substance misuse in the family course run by the Norfolk Local Safeguarding Children Board (LSCB), whilst some people spoke of training outside of the County that they had attended. There is a sense that for a number of agencies training is a ‘one-off’, and it is unclear whether there are opportunities to refresh this knowledge to ensure that skills develop with time and experience. Whilst some participants favoured a move towards mandatory training across all agencies, others felt this would be unnecessary. A GP pointed out, “GPs should have mainstream substance misuse training as part of their training but not all doctors can be expected to be specialists or experts in the field”. There was a sense that overall, non-specialist agencies need to know more about these issues, for example what is feasible to expect from parents and what support can be offered to young children. Time was cited as a key factor for consideration here, one participant commented, ‘It is more an issue of time than inclination as social workers have a heavy case load’. However, given the high numbers of families featuring substance misuse on social worker caseloads, investing in training could bring substantial longer-term gains for the social work field and their clients. The NSPCC has recently published a resource and training pack which would be a useful tool in this area.

Feedback from the Study Steering Group highlighted differences with the views expressed by study participants. The LSCB substance misuse course runs four times a year, training about 60 people, all of whom come from services with an interest in the needs of young people. Further clarification would be needed to ensure that the needs of others (parents, other adult family members) affected by substance misuse are considered in the development of training courses. A recent audit of the young peoples’ workforce reported that workers in this area are both qualified and competent for their role, which presumably includes competency to respond to the needs of substance misusers who are parents and children and young people affected by parental substance misuse. The NDAAT has argued strongly to keep substance misuse on the local Diploma in Social work course, though it is again unclear to what extent this course specifically covers the needs of those affected by the substance misuse of someone else and the parenting needs of substance misusers who are parents.

It is clear that this is just one area where there are differences of opinion across the County and from different professional sectors. However, it is unclear how such discrepancies can be ironed out. Further, it was highlighted that the DAAT run a bursary scheme to support GPs who wish to take the RCGP part one and part two certificates in substance misuse, and that several GPs have taken up this opportunity. It is not clear, however, to what extent the RCGP certificates specifically includes families and children affected by substance misuse. Finally, a course has been developed for non substance misuse specialist front-line staff who work with
children and young people to support them in the identification and support of children and young people who may themselves who misusing drugs or alcohol. However, it is unclear to what extent this work also covers the identification and needs of children affected by the substance misuse of a parent.

Drugs versus alcohol
Again there were mixed messages across the data regarding any differences between alcohol and drugs in terms of need and provision. A number of participants felt there was nothing different to say about alcohol, whilst others felt strongly that alcohol was of more concern to them and saw it as ‘more of a problem than drug use’. One worker commented that there is a lot of ‘hidden stuff’ around alcohol, adding, “this is rarely flagged up on referrals in the same way drugs are...It is very much more hidden. Parents don’t see it as a problem, so it is difficult to work with that…. Parents who use drugs tend to keep it hidden from their children, they protect them from it – this is not the case with parents using alcohol”. Another respondent said that alcohol is “much more condoned, so therefore more hidden, both in terms of risk (physical, emotional) and the financial impact for the family”.

Others noted a difference in life styles and impact, feeling both drugs and alcohol were perhaps equally negative but in different ways. One participant noted that where alcohol misuse is present, children can suffer the consequences of domestic violence, whereas when drug misuse is present, the impact is more about children being exposed to the fear of violent and threatening people visiting their homes, sometimes demanding money, or police raids in the early hours of the day.

Summary of the Findings

It is positive to note that a wide range of professionals and organisations across Norfolk participated in this study, providing the research team with a range of views from across the County. However, it is important to highlight the difficulties encountered by the research team in terms of data collection. Local buy-in to the study was much lower than anticipated, with the quantity and quality of the quantitative data subsequently negatively affected, despite ongoing efforts, including the introduction of the snapshot survey, to increase data collection. As a result, the research team could not fully achieve the aims of the study. However, the qualitative data were excellent, and enabled some general statements and observations in response to the study’s initial aims to be made. It is important to highlight that the barriers and challenges identified are not unique to Norfolk but face all areas attempting to respond to these agendas.
1. **What have we found out about current provision in Norfolk?**

- There is only one service that specifically attempts to meet the needs of the children of substance misusers, though a handful of others do actively work with the population groups. A large proportion of the professionals (including Social Workers, YOT workers, YISP workers, Young Carers workers, adult drug & alcohol workers etc) we spoke to have had some involvement with offering some support to or referring on children of substance misusers, but this tends to happen mainly in cases where risk is identified, or where a child is identified as a Young Carer. The target groups had a significant presence on the caseloads of a range of agencies indicated by the snapshot exercise.

- We know that many of the front line professionals who come into contact with children of substance misusers most frequently (i.e. teachers, GPs) tend to perceive that they lack specialist knowledge about what to do, and who to refer on to, and so generally steer clear of getting too involved, or even asking questions.

- We know that a large number of generic family support services in the County work with these families regularly, and are aware of the impact of substance misuse on both parents and children. However, these services are not specialist services. The substance misuse is often one of a number of other issues the family is dealing with, and is often not the primary reason for referral to the service. These services offer general support and do not collect data that specifically relate to substance misuse.

- The extent to which adult substance misuse services respond to these individuals’ needs as parents is unclear. The message seems to be that this work is done on an ad hoc basis rather than systematically or strategically.

- There is inconsistency in the amount and type of services available to children of various ages. There is little support to whole families.

- We know that there is geographical disparity in service provision, with pockets of good practice. There is also some multiplicity and overlap (including between specialist and generic services), but poor communication prevents the streamlining of services.

2. **What have we found out about existing data held relating to the target groups?**

- Whilst limited, responses to the data questionnaires and the snapshot survey clearly illustrate that there are potentially large numbers of children across the County, of all ages, who are affected by parental substance misuse. Further, it appears that there is general consensus that alcohol misuse is a huge problem. As highlighted elsewhere, the numbers identified represent the number known to services; much of this harm remains hidden.

- We have found that the tools used for, and the level and the quality of, data collection vary greatly across organisations. It is therefore difficult to helpfully draw together what currently exists to answer questions about prevalence and therefore need.
Many of the professionals who work with the target groups do not in their work with these families focus on substance misuse per se, and they often do not collect data about these issues.

Discussion

Substance misuse is a complex issue to respond to, bringing major challenges for those responsible for developing and delivering the response; without the necessary services and support mechanisms in place there is a real danger of workers feeling out of their depth and of children and other affected family members not having their multiple needs adequately or speedily met. For Norfolk, the Hidden Harm Forum is a clear demonstration of the commitment to recognising the needs of the children of substance misusers and substance misusers who are parents at a strategic and County-wide level - "a shared consensus of moving forward". However, the low response to elements of this study might suggest that this consensus is not shared broadly or deeply enough for solutions to be effectively supported and implemented. There was feedback from some participants that the issue is simply not high enough on some people’s agendas - "The title hidden harm does suit Norfolk perfectly because that is what many people would prefer to accept". Thus, one area where future work is needed is to consider the membership of the Forum, the work that the Forum does and how broader awareness raising and dissemination is undertaken.

Fragmentation is a key issue to emerge from the data that were collected. Further, there are both tangible and conceptual barriers to provision and a comprehensive understanding of these is necessary. People spoke of practical issues around the age of children and access to specific services, scarce provision to rural areas, capacity and short term funding. More conceptual issues included a lack of confidence, priority, remit and bad communication. The impact of fragmentation and constant change is that the field is always moving, with no time to stop, take stock and consolidate. The key challenges are therefore about keeping up to speed, holding the bigger picture and seeing where and how everything needs to fit in, maintaining stability and continuity and developing future strategic direction. Norfolk, as elsewhere, is responding to the Every Child Matters and Hidden Harm agendas (Norfolk County Council and Norfolk Children and Young People’s Partnership Trust, 2006), and is also facing other changes, such as drafting new commissioning strategies, promoting the parenting agenda, and considering wider issues for adult services, addiction services and child services. This all increases the risk for further fragmentation and confusion, but in a climate wishing to actively promote integrated services, planning, commissioning and governance, repairing such fragmentation is vital and could present a real opportunity to bring together these different strands and agendas and develop a multi-faceted and multi-disciplinary solution that everyone can support. Thus, at the heart of the findings of this study is the need for strategic streamlining and inter-agency co-operation. The foundations are in
place with directives such as the Norfolk Children and Young People’s Plan, and with the progress that Norfolk has made with training and implementation of the Common Assessment Framework. The Norfolk Children and Young People’s Plan has core objectives to raise aspirations, support parents and families, and focus on prevention and early intervention. Parental substance misuse is specifically mentioned in the Plan, though it is important to highlight that it is an issue that cross-cuts with many of the other issues, priorities and partnerships agencies highlighted in the Plan, and that alcohol should also be separately and specifically considered.

Much is known from the general literature about how children, young people and families are affected by substance misuse, and consequently what is effective in responding to their needs (Copello, Templeton & Velleman, 2005; Templeton et al., 2006; Templeton, Zohhadi & Velleman, 2005; Velleman, Copello & Templeton, 2005; Velleman & Templeton 2007a,b) so these were not central areas of investigation of this study. However, work is needed to ensure the appropriate adaption and development of treatment models to young people and adults who are affected by substance misuse. There were numerous ideas for service development, which included consideration of multi-agency teams based in the same location, as well as specific consideration of the needs of male and female children and family members and also other groups of affected family member such as grandparents.

There are clear indications that many children and families are affected but as yet there is no consistent way of collecting and collating this information, nor of understanding the numbers of children and families who access services, nor of the impact that attending such services has on these children and families. Data collection was a challenge to this study, although it appears that for some this was more related to an inability to respond rather than a lack of willingness to do so. Generally data about this work is at best inconsistent, at worst absent. In many cases the target groups are part of the profile of clients of a service with a much broader remit, and data on particular issues are simply not routinely collected, making it hard for any further comparisons or conclusive statements to be made. However, the data do demonstrate that many different services across the County are in contact with the target groups and working with them directly or indirectly. Whilst it is frustrating that specific data from many generic services about the target groups are not available, and whilst training and support are needed around some of the particular issues that may arise, perhaps it is important to recognise the role that generic services play in ‘normalising’ the needs of the target groups within the extremely broad remit that many of their services have. It is unclear what impact the Common Assessment Framework, or recent guidance for Local Safeguarding Children’s Boards, or the development of Children’s Trusts might have, nor what the potential for change in other ways might be. For improvement to be seen in this area there is an

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2 The Common Assessment Framework has been piloted in some areas of Norfolk but the timing of this work meant that we were not able to explore this in depth for this study.
urgent need for workers to understand and support the need for data collection, and for it to be meaningful to the work that they do, guided by familiarity with the issues to facilitate their work. Clear direction in the form of integration with staff training, team meetings and supervision would help this process. However, straightforward adaptation of existing data monitoring systems must not be assumed as these systems are oriented towards adults and individuals.

It is clear that there are good practice service examples as well as examples of effective intra- and inter-agency working, though such information was not widely known at a County or localised level. Participating in this study allowed some people to network and find out about services that they didn’t know existed, even within their own patch.

It seems that provision to some age groups is better than others. Services are needed in certain key areas, e.g. for younger children, for other groups such as grandparents, in more rural and distant areas of the County, and to respond to alcohol specifically. The extent to which services respond to the parenting needs of clients who are parents is unclear; integrating key outcomes from this study with, among others, the forthcoming Parenting Strategy, is vital. Capacity is a problem, but it is unclear whether new services would ‘fix’ this or whether better organisation and joint-working between services could make a useful contribution to this common problem. Some examples of effective shared care practice were identified, such as the pregnancy liaison protocol (NDAAT, 2006) and the protocol for supporting parents with a disability or long-term illness (Inglis, 2006). The latter has the added benefit of a named worker (unusually employed by both adult and children’s services) to oversee the implementation and continued development of the shared working protocol.

Thus, there is a careful balancing act to be played out between better organisation and utilisation of existing services (considering for example, training, supervision, joint working protocols and capacity) and what more is needed. Linked to this is the need for a clearer understanding around whose role it is, who should be involved, how the response should be organised in practice and how services should come together in partnership to support the response. A whole range of people will knowingly or unknowingly work with, or come into contact with, the target groups. In line with a suite of documents coming out of the Every Child Matters agenda (DfES, 2004, 2005a, 2005b) the aim is to support everyone to be as well equipped as possible to deal, within parameters consistent with their role and remit, with children and families struggling with a range of problems, such that these groups can maximise their potential in life in accordance with the core outcomes of Every Child Matters. Careful recognition of, and support to, generic services who clearly have much to offer in meeting the needs of the population groups under investigation would therefore be beneficial. For example, the Schools Minister has recently announced an increase in emotional/mental health support to schools; it would be helpful if this included specific consideration of children
living in risky family environments (particularly parental drug/alcohol misuse, parental mental health problems and domestic violence and abuse). Attention to how schools could be better equipped and supported to play their part in the response, for example through implementation of the Common Assessment Framework, would be particularly beneficial given the gap in service provision that was highlighted for the 5-12 year old age group. Links were identified between Norfolk schools and some services (e.g. T2, Impact, the Matthew Project and BEST) but it was unclear how well these services were used through the schools and what more could be done to strengthen such partnerships.

Another important issue to consider is the imbalance between reactive and proactive service provision. Currently, the service response tends to focus on adult substance misusers and on goals around their addiction, and on addressing the needs of children when a crisis is reached. There are different thresholds between services for when support should be offered or referrals made. Often, attention to the family context and parenting is missing. The involvement in this study of professionals from a wide range of generic services, such as schools, primary care, youth offending and young carers, across the County emphasises the vital role that they can, and want, to play in meeting the needs of these target groups.

At the moment the good working relationships that exist tend to be forged on a very individual basis, which takes time and does not guarantee continuity of those relationships in the longer term. Further, professionals tend to fear working together, seeing confidentiality as a barrier to hide behind rather than opportunity to move work forward. Improved awareness of services, and the development of joint working and information sharing protocols (particularly between adult and children's services), would help embed such common sense working practices across the County. It is unclear how changes, such as Local Safeguarding Children Boards, Children's Trusts and the introduction of the lead professional role, could facilitate this shift. The joint-working pregnancy liaison protocol and the protocol for supporting parents with a disability or long-term illness are examples that could be adapted for this area. Having names workers to support the implementation of such joint working arrangements, as with the shared protocol for working with parents with a disability or long-term illness, is a model that could be usefully replicated.

Participants in the study seemed to have little knowledge or experience of substance misuse related training. Members of the Study Steering Group were keen to highlight were effective and quality training is on offer. However, it remains unclear to what extent training is specific to, or overtly includes, the population groups at the heart of this study, children of substance misusers or substance misusers who are parents. Consideration needs to be given to raising awareness of the training that is available and where this training is specific to these population groups.
Of key importance is continuity and strategic direction. Participants commented on the need for longer-term funding to enable continuity and consistency of service delivery that would facilitate joint-working, better links across the County and longer-term help for children and families, rather than ‘short term plugs’. It is clear that the constant struggle for funding or to collate data means time away from running and delivering services.

Hidden Harm Three Years On (ACMD, 2006) concludes with key learning points (adapted from pages 99-102). The most significant progress comes from longer-term funding that gives sufficient opportunity to embed and prove themselves. Clear leaderships and cross-sector co-ordination are vital, demonstrated by a shared strategic approach embedded within joint commissioning arrangements between adult and children’s services and supported by strong multi-agency partnerships employing clear joint protocols and procedures. Adult drug treatment services need to include consideration of parenting in their work, recognising the complex interactions that exist between substance misuse and parenting. However, given the role of generic services and the need to include a clear emphasis on alcohol, it is important to both look beyond the Hidden Harm agenda and to be creative with its interpretation and implementation. Successfully dovetailing the recommendations in Hidden Harm with the core objectives of the Every Child Matters agenda would be a real policy success.

There is only so much that can be done in the absence of clear and streamlined national policy. Revised, extended and updated guidance currently being produced by the NTA on commissioning services that adequately support family members in their own right and involve them in users’ treatment where helpful will be a real step forward. However, further work will be needed to extend such guidance to address substance misusers who are parents and the children of substance misusers. Further, alcohol policy has a way to go to catch-up with the drugs policy and Every Child Matters agendas. However, it is hoped that the groundwork in place now across Norfolk, and the priority that is being given to these issues, will ease the journey towards the evolving County-wide solution needed.

**Recommendations**

**Strategic**

1. Determine lines of communication for the ownership, dissemination and implementation of the report and its recommendations.

2. Consider how a multitude of local policy documents, and associated working parties and steering groups, can overlap to offer strategic streamlining and direction in how to best commission and meet the needs of Norfolk’s children of substance misusers and substance misusers who are parents. Close links with drugs, alcohol, mental health, domestic abuse, parenting and disability strategies are particularly encouraged.
3. Consider the future role, membership and remit of the Hidden Harm Forum. This should include agreement on how to raise awareness about the Forum and its work.

4. Consider how this issue can be integrated with other County developments, such as Local Safeguarding Children’s Boards, Children’s Trusts and the Children and Young People Partnership Board.

Service Provision

5. Produce a booklet and website summarising service provision to the population groups, with detail about geographical coverage, the level of service provided and examples of where joint working arrangements are in place.

6. Specifically consider the needs of children aged 5-12 years old.

7. Specifically consider the needs of the children of alcohol misusers and parents who are alcohol misusers.

8. Specifically consider how the issue of parenting can be addressed by services who work with substance misusers who are parents.

9. Consider the needs of specific groups of family members, such as grandparents, and how their needs could be adequately met.

10. Consider access, service provision, and the impact upon professional caseload in rural and distant areas of the County.

Supporting service development

11. Consider how a range of generic services could be supported to better play their part in responding to the needs of the population groups. The role of education and CAMHS should be particularly considered.

12. Consider continued and new funding for specialist services, and how these could be integrated with existing services and partnerships.

13. Add a specific requirement to the Common Assessment Framework to map where parental substance misuse is an issue. Associated training will be necessary to support practitioners in how to ask about such issues and record data via the CAF.

14. Ensure that training specifically considers core issues related to identification, referral, assessment and intervention with the children of substance misusers and substance misusers who are parents.

15. Consider consultation with children and young people and families about the findings of this study and how things will be progressed.

16. Ensure that managers of a range of generic and specialist services offer appropriate supervision to support staff working with complex issues such as substance misuse.

17. Consider the creation of specific roles to oversee and support implementation of inter-agency protocols, particularly between adult and childrens services, but also between substance misuse services and other services responding to issues that often overlap with substance misuse (e.g. mental health, domestic abuse, poverty and housing).
References

Experiences of Family Members in Three Contrasting Cultures. London; Taylor and Francis.


Appendix One

Questions at Hidden Harm Forum discussion meeting, November 2007

Question 1 - Where do you think the Hidden Harm agenda should sit in Norfolk?
  ➢ We are interested in your views on who you think is best placed to strategically coordinate this work.
  ➢ Who are the key players who need to be involved?
  ➢ How can we ensure that both adult and children and young people’s services jointly respond to the findings and recommendations of the research?

Question 2 - The feedback received today will help further develop the recommendations and finalise the research before it goes to the N-DAP Commissioners for approval.
  ➢ What do you think should happen to the research after this?
  ➢ How can we ensure the findings and recommendations are disseminated across the County?
  ➢ Would a facilitated next steps event be useful?

Question 3 - The research highlighted the difficulties in capturing the current picture in relation to children of problematic substance misusing parents.
  ➢ How do you think we can ensure that in the future we are able to capture this important information?

Question 4 - The research highlighted the fact that the majority of the current service provision is provided through existing services and that staff in these services need support when working with both affected children and their parents/carers.
  ➢ What do you feel are some of the areas in which staff may need further support?
  ➢ What are the important factors for ensuring that this support is given?

Question 5 - The research highlighted the need to ensure that the voices of children and young people and parents and carers are heard and help shape future developments.
  ➢ What are some of the ways this can be taken forward?
  ➢ How can we ensure that this is done in a non-tokenistic way?
  ➢ What are the important links with existing work in this area to make?
## Appendix Two - Snapshot survey results

<table>
<thead>
<tr>
<th>Type of Service</th>
<th>Worker's role</th>
<th>Total no. of clients/fortnight</th>
<th>No. of target group cases</th>
<th>Target group cases as % of caseload</th>
<th>No. of children affected</th>
<th>Age range of children / average age</th>
<th>No. of parents seen</th>
<th>Main Substance used</th>
<th>Support offered</th>
<th>Referral sources</th>
</tr>
</thead>
<tbody>
<tr>
<td>NORCAS</td>
<td>Drug &amp; Alcohol worker</td>
<td>60</td>
<td>34</td>
<td>58%</td>
<td>67</td>
<td>5 weeks – 21 years</td>
<td>34</td>
<td>Alcohol in 90% of cases</td>
<td>Counselling</td>
<td>Self referral (47%), GP (19%), Statutory Services (17%), Other (17%)</td>
</tr>
<tr>
<td>Voluntary D&amp;A Service</td>
<td>Drug &amp; Alcohol worker</td>
<td>25/ one week</td>
<td>10</td>
<td>40%</td>
<td>13</td>
<td>3 to 18+</td>
<td>10</td>
<td>Heroin in 90% of cases</td>
<td>DRR group work/ 1:1 sessions</td>
<td>Probation (80%), Self referral (20%)</td>
</tr>
<tr>
<td>YOT</td>
<td>Youth Justice Worker</td>
<td>11</td>
<td>2</td>
<td>18%</td>
<td>2</td>
<td>Missing data</td>
<td>Missing data</td>
<td>Cannabis Alcohol</td>
<td>Pre-sentence report, Home Visit</td>
<td>Norwich Youth Court</td>
</tr>
<tr>
<td>DIP team</td>
<td>Drugs worker</td>
<td>16</td>
<td>10</td>
<td>62%</td>
<td>23</td>
<td>11 months to 20 years</td>
<td>10</td>
<td>Heroin</td>
<td>Assessment/ review after resettlement</td>
<td>CARAT teams (50%), Probation, Social Worker, Drug Clinic, PPO, DIP (50%)</td>
</tr>
<tr>
<td>Young Carers project</td>
<td>Young Carers worker</td>
<td>12</td>
<td>2</td>
<td>17%</td>
<td>5</td>
<td>9 to 20</td>
<td>1</td>
<td>Alcohol</td>
<td>Support &amp; reassurance</td>
<td>School</td>
</tr>
<tr>
<td>The Matthew Project</td>
<td>Alcohol &amp; Safer Sex Youth Worker</td>
<td>34/ one week (30 in a group setting)</td>
<td>5</td>
<td>15%</td>
<td>7</td>
<td>14-15</td>
<td>1 (young father aged 19)</td>
<td>Alcohol, Cannabis</td>
<td>Education, Information, Supportive listening</td>
<td>School (80%), Social Services (20%)</td>
</tr>
</tbody>
</table>
Appendix Three - Case Studies

A: YISP Case Study

What is the service?
Youth Inclusion & Support Panels are a multi-agency planning group, which seeks to prevent offending and anti-social behaviour, and targets young people age 8-13 years, through offering voluntary support services to high-risk children and their families.

The main emphasis of a Panel’s work is ensuring that children and their families receive at the earliest possible opportunity mainstream public services together with other complimentary interventions from voluntary and community groups.

How and why was the service developed?
In line with the 'Every Child Matters' agenda, Norfolk, as with other counties were encouraged to develop early intervention and prevention work, they were provided with a menu of options to choose from to tackle this area of work. Norfolk chose YISPs as the most workable option in the county.

Initially through 3 year ‘ring fenced’ funding from Norfolk Children’s Fund targeting anti social behaviour amongst 8 – 13 year olds, to reduce the number of children involved or at risk of being involved in offending and anti-social behaviour by ensuring that they and their families receive mainstream services and complimentary interventions from other organisations at the earliest opportunity.

Who is the service for?
Children aged 8-13 inclusive whose behaviour is of concern to two or more agencies and/or parents or carers
Child exposed to four or more risk factors
Known offending or anti-social behaviour up to Police Reprimand, or concern about potential involvement.
Children involved in committing anti-social behaviour (pre-crime)
Children who are offending but who are not being dealt with by the police or the Criminal Justice System
Children who have received a police reprimand and are considered at high risk of re-offending

How does the service work?
Norfolk Youth Offending Team won the initial tender to deliver the service through partnership working with statutory and voluntary children’s support agencies. Initially three panel areas set up across Norfolk, more recently expanded to seven key workers and seven part time admin support staff with further funding secured through local Crime & Disorder Reduction Partnerships, Local Area Agreements and ‘Second Homes’ money.

In October 2003 Practice Manager was appointed to set the service up, recruit staff and implement processes. Key worker receives a referral, carries out a validation process to verify the information, complete a comprehensive ‘ONSET assessment looking at 12 areas of the young persons life, identifying risk factors to offending. A panel meeting is called for each individual case, inviting the appropriate support agencies to the meeting who are able to offer pieces of intervention towards the Voluntary Support Plan that is compiled at the panel meeting with the family and young person’s agreement. The key worker then takes a coordination role in ensuring the work is delivered, reviewing at regular intervals with a formal review meeting every 3 months where all parties will come back together with the family and young person to review progress, amend the support plan if necessary.

Children Fund/NYOT Partnership;
Funded from Children Fund 25% crime prevention monies;
Practice Manager - October 2003;
Service Delivery staff - May 2004
Operational from 1st June 2004
LAA money for 4th panel area November 2005
Youth Justice Board monies- 5th panel and extra workers for Norwich April 2006
Second Homes money – 6th panel - January 2007

What are the experiences and outcomes of the service?
Provides information exchange on individual risk factors and problem behaviour;
Reduces demand on public service providers for acute and crisis intervention;
Reduces the number of children entering the Criminal Justice System.

We have been successful in securing a number of excellent outcomes for young people who are making better choices for their lives. We have many case studies where we can evidence that appropriately targeted interventions at an early stage can divert anti social behaviour and enable young people to make better choices for their lives.

What factors do you think are important to the success of the service?
Prevent the target group from become involved in offending and anti-social behaviour;
Reduce the risk factors and increase the protective factors within the target group
Ensure the target group are in full time education;
Ensure young people are engaged in constructive activities in spare time.
Ensure children and their families are satisfied with the YISP intervention.
Mainstreams youth crime and pools limited resources.
Provides information exchange on individual risk factors and problem behaviour;
Reduces demand on public service providers for acute and crisis intervention;
Reduces the number of children entering the Criminal Justice System.

B: TADS Case Study

What is the service?
A pregnancy liaison service for pregnant substance misusers.

How and why was the service developed?
The service was developed in 1996 after a need for closer collaboration was identified with obstetric services / substance misuse teams.

Who is the service for?
Pregnant drug and alcohol users

How does the service work?
Protocol lead care with joint care planning and monthly liaison meetings. The liaison group includes TADS staff, link midwife, link health visitor, Children's Services based at acute hospital team) link NICU staff. All service users cases discussed and issues highlighted in a proactive way. The protocol is reviewed every 2 years and is now available as an electronic version on acute trust intranet. Any changes to practice are discussed and the protocol changed.

What are the experiences and outcomes of the service?
A good example of this is that the paediatrician that would be caring for the baby on NICU sees the mum antenatally to discuss the likely care plan for the baby if the baby withdraws. This is as a result of feedback from mums on the unit that they felt poorly prepared for the baby’s care if the baby is withdrawing from opiates. Also the link NICU nurses can and do arrange for the parents to visit the NICU and meet staff, see the parents’ rooms, etc.

What factors do you think are important to the success of the service?
I think it all works because of the monthly liaison meetings, that information sharing protocols are agreed with the clients at first appointment so they are aware of the liaison service and that everyone involved is very committed to the service.
C: Crossroads Caring for Carers Case Study

Norfolk Young Carers Project (Crossroads caring for carers) has been supporting young carers in Norfolk since 1996. The project was re-launched in 2003 and currently employs two full time and two part time workers. The main remit is to offer young carers individual support. Alongside this outings are arranged and county wide events such as a Fun Day and discos at Christmas. In Norfolk there are 27 young carer support groups run by a variety of agencies including Crossroads. These exist primarily for young carers to have time off, meet young people in similar circumstances and enjoy a range of leisure activities.

Norfolk Young Carers project accepts referrals from a wide range of agencies and supports young carers up to the age of 18 and includes those caring for someone who is a substance misuser.

T is a 14 year old girl who was referred to the project following a long discussion which her mother had with her younger brother's Head Teacher as there were behaviour problems at school. It emerged the mother had a serious alcohol problem coupled with anxiety and panic attacks and other physical health problems and this had been going on for many years. There is an older brother, now 20, who left home at 15 and the household consists of mother and two children aged 14 and 12.

Following the mother's talk, the Head teacher already very familiar with the project phoned me to say the 14 year old girl had been providing lots of care to her mother and brother and was now finding life difficult. Her school was informed and Children's Services are also now involved.

The young carers project worker has been seeing this girl on an individual basis and the girl has been able to express her concerns, and also relief that matters are now out in the open. She is hoping to join a local young carers support group in September.

Despite her mother having two weeks in hospital for a detox and everyone rallying round to try and give the house a 'make over', there are still worries as the girl's mother has been drinking since.

T will be able to see a project worker for as long as she feels she needs this support. She has found the sessions very useful and has found that she can now share her worries with someone outside family and school. She has taken on huge responsibilities over many years and appears far older than her years. Hopefully our involvement will help her enjoy the rest of her teenage years.

The project is entirely voluntary and this is made clear at the beginning and the work we do with young people varies according to each individual's needs. Annual evaluations show that young carers are happy with the service they receive but often express the wish for more young carers' workers in the county.

D: NSPCC Case Study

What is the service?
The NSPCC in Norfolk provides two services; 1) Offering support and assistance to children and families of substance misusers and 2) Offers support and assistance to children living in families where domestic violence is experienced, called 'Kids without Fear'. For the purposes of this case study we have concentrated on the first area of service support.

This service has been operating for about five years and is funded by the NSPCC national charitable fund raising efforts. It is operated in partnership with the Trust Alcohol and Drugs Service in Norfolk with whom review meetings are held. All referrals come from TADS with whom there is a service level agreement.
Norfolk NSPCC works with family members including children, parents or carers and members of extended families where appropriate. An assessment is carried out with the whole family. If work is to go ahead an agreement will be drawn up with the family. This may be followed by individual work with the child or children, which can take place at their home, in school or at another venue. This may last for a few months or over a year, depending on need. Work may also take place with the parent/s or carer. This may involve parenting advice and support. In some cases a referral may be made to another agency. Progress of the work is reviewed regularly and the family is part of this process. Regular liaison will take place with the TADS worker and other workers involved with the family where relevant.

**How and why was the service developed?**
In the national restructuring of NSPCC teams services in the late 1990's the Norfolk team was identified as being a 'Quality parenting and family support service working in partnership with health'. As part of the then NSPCC 20/20 vision campaign i.e. to end child cruelty by 2020. There were four areas. Drugs were identified as one key area where the NSPCC felt they should be more involved because of the levels of abuse linked with substance misuse. Also, it was identified that there was a very clear need for the children of substance misusers as there was no other service available to them in Norfolk at the time.

The support available for children of substance misusers is very patchy and scarce and unless a child protection issue is identified no other service aimed specifically at this group is available.

**Who is the service for?**
The service is for children, parents and families of substance misusers. While a small proportion of the children referred to us are on the Child Protection Register the majority of children are not receiving other support. Even where children are on the CP register there may be no other services readily available which address their need for therapeutic style support.

The NSPCC service provides direct work with children based upon their needs. One of the core areas of work with the children is often to help build their self esteem and help them to understand what is happening in their families. See case study below.

**How does the service work?**
TADS staff are key workers with adults misusers. They, in consultation with the service user, will refer to the NSPCC Norfolk Family Support Service where support is needed in relation any children. This referral will be discussed between the TADS the NSPCC worker and a referral form sent together with a data protection letter, both signed by the user, together with any relevant information. This is followed by a meeting with the family, usually initially with the adult/s involved and both workers.

The referral process is an important aspect as it provides the foundation of work with the child or family and leads to better outcomes and more effective work. The NSPCC works to strict national guidelines in service delivery, mainly its Principles, Standards and Procedures and within the partnership agreement. Work is reviewed regularly and with all parties concerned. From the referral an assessment is made and on this basis a plan of work tailored to the family's needs will be made. This will usually involve individual work the children and /or work with parents. However the children are always the focus of the work. Referrals to other agencies will be made where appropriate. One of the strengths of the service is that work with an individual child can continue indefinitely and as long as necessary thereby providing the opportunity to develop strong relationship, trust and positive outcomes.

**What are the experiences and outcomes of the service?**
The NSPCC have received positive feedback from TADS staff and enjoys good communication with other agencies they work with. A new evaluation method has been recently implemented, called the 'Strengths and Difficulties Questionnaire' which is a well recognised, standardised evaluation tool. In addition service users are regularly asked for feedback and comment on the service. By enlarge the service receives a very positive response. With 3.6 practitioners dividing their time (not equally and depending on need)
between the two services the NSPCC provides in Norfolk, capacity is not large. The flow of referrals is fairly intermittent with periods when people are held on a waiting list and other times when there are few families referred. The service has dealt with between 0-8 families at any one time. Currently they have no families being supported with one due to be allocated to a worker soon. One of the key issues in providing such a service is maintaining a visible enough profile in the minds of other agency worker so that referrals are made especially bearing in mind the turn over of staff and the need to keep the NSPCC service at the forefront of people’s minds. The NSPCC produce leaflets for people referring and potential service users.

What factors do you think are important to the success of the service?

- Partnership working and trust
- The role of the TADS worker in presenting the service to the client is important. As with LA Children’s Services the NSPCC name can be off putting to some potential users who may fear that their children may be taken away.
- The service works best when service users are themselves motivated.
- The service works best when the TADS key worker has worked alongside the NSPCC and stayed on board to discuss and reassure service users of the benefits of the work.
- Both sides of the partnership need to have an investment in making the service work.
- Making the service more simple for service users to understand is important: we have a leaflet available for both referrers and users
- Streamlining the process in terms of making the work of respective agencies complementary rather than repetitive e.g. re assessments, appointments and reviews
- Reviewing the service delivery with both partners on a regular basis to ensure positive development and raise any issues
- Use of agreement as basis for work
- Ideally a greater level of NSPCC input would enable an increased presence a more sustained and higher level of awareness of the service and result in more families benefiting from the service

Composite Case sample 2006

The Norfolk NSPCC team works with an NHS unit under a partnership agreement to provide a family support service, involving individual work to drug and alcohol using parents / carers and their children.

In July 2005 a Norfolk NSPCC Children’s Services Practitioner began work with all four members of the Dunne family. The family consisted of Jill and her two boys, Adam, aged 10 and John, 7 years and new step-dad Tony.

Jill had been at the NHS Drug Unit for over a decade receiving a prescription drug to control her former heroin addiction. Jill also frequently used alcohol when she felt stressed 2005 was a very difficult year for both boys with their Mother admitted into hospital for several weeks at the start of the year due to her failing mental health. Their step-father was imprisoned mid-year for a few months and their birth-father died suddenly in the autumn. The work clearly had to be flexible and reflect such dramatic events in the boys’ lives. The importance of maintaining a consistent relationship was very important in working with this family, particularly for Adam and John.

Jill, Adam and John had lived within the same locality for many years and their involvement with many professionals over this time meant that they were often labelled and regarded themselves as a “problem family”. It was particularly important for Adam and John that they would not always be seen as ‘problem kids’ from a ‘problem family’ In the past, the children had been assessed as being in need and had been placed on the Norfolk Child Protection Register.

During 2005 the Children’s Services Practitioner assisted the family to move from their previous location which held many negative memories due to the loss of a child through cot death and extreme domestic violence from Adam and John’s father much of which they had
witnessed. This had included Jill suffering a number of broken bones in addition to the constant verbal abuse.

The Boys preferred the work to take place at School. The Boys were seen on a weekly basis and the therapeutic work included giving the Boys an opportunity to explore feelings such as anger, bereavement and loss. The work also focused on keeping safe and strategies for expressing strong emotions. The work with Adam and John had the core aim of raising their self esteem and promoting individual identity.

The concurrent work with Jill and Tony regarding their parenting skills was aimed at ensuring that Adam and John’s needs were being met and to increase their confidence and skills as parents.

Due to the years of substance misuse and domestic violence Adam and John had not had an opportunity of having any significant contact with members of their extended family due to the distance that separated them. In particular, both Adam and John had not seen their maternal grandfather for six years. The NSPCC funded a week’s holiday for the family a few miles from their grandparent’s home. This was the first holiday that the boys had.

At the end of the work with the family the Schools commented that the worker provided a sensitive approach, was efficient and reliable. The school felt the service had helped the children overcome emotional problem and shyness and provided a good link between home and school.

The work of the NSPCC was, in the words of Jill Dunne, “supportive, positive, practical and helpful”. She felt that she was reassured in knowing the NSPCC service was available and that the boys had been given an opportunity to talk about their feelings. Jill felt since accessing the service she had become more tolerant and understood better how to deal with difficult parenting situations. She felt listened to and supported by this service.

The children’s views expressed following receiving a service were that they enjoyed their time with the practitioner and felt listened to a lot. They said they found it easier to talk to people and felt better about saying how they felt. They felt safer and expressed that they were now more able to talk to their mum and enjoy family time together.
Appendix Four – List of Agencies who Participated in the Study

1. Safeguarding Children’s Board
2. NORCAS – Adult Substance Misuse Service
3. Children’s Services (including Children with Disabilities, Fostering, Safeguarding Team and BEST)
4. Impact - Substance Misuse Services, Young People
5. Behaviour Education Support Team (BEST)
6. Health Norfolk Schools
7. Youth Offending Team
8. Crossroads Young Carers Project
9. PCT
10. Statutory Service – Broadmead District Council
11. NSPCC funded voluntary service for children of substance misusers and families.
12. Education
13. TADS
14. CAMHS
15. Police – Force Intelligence Bureau
16. Voluntary agency – Orminston Children & Families Project
17. YISP
18. Statutory Service - Matrix Project (Adult Substance Misuse)
19. Matthew Project (Adult Substance Misuse Service)
20. T2 (Young People’s Drug & Alcohol Service)
21. Education
22. YOT
23. DIP Team