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children, schools and families



NHS
*National Treatment Agency
for Substance Misuse*

Department for Children, Schools and Families (DCSF), Department of Health (DH) and National Treatment Agency for Substance Misuse (NTA)

Joint Guidance on Development of Local Protocols between Drug and Alcohol Treatment Services and Local Safeguarding and Family Services

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Introduction

1. The aim of this joint guidance is to support professionals working in adult drug and alcohol treatment services and children, parenting and family services such as Family Intervention Projects (FIPs). It should assist those services to develop local protocols which enable improved joint working, thereby ensuring the children of drug users are protected from harm and their welfare needs met, and improve outcomes for drug and alcohol service users who are parents.
2. Parental or carer drug or alcohol use can reduce the capacity for effective parenting. In particular the children of parents or carers who are dependent on drugs or alcohol are more likely to develop behaviour problems, experience low educational attainment, and are vulnerable to developing substance misuse problems themselves. Some children's health or development may be impaired to the extent that they are suffering or likely to suffer significant harm.
3. Furthermore, if a drug or alcohol service user is a parent the outcome of their treatment is likely to be affected (positively or negatively) by the demands being placed on them in caring for their children. Failing to recognise this and seek any necessary support from parenting and family services could put both the service user's outcomes and those of their children at risk.
4. The government's drug strategy, **Drugs: protecting families and communities** (Home Office, 2008)¹, includes a number of specific actions relating to families and substance misusing parents, including that, *'all drug-misusing parents with treatment needs to have ready access to treatment, with all problem drug user parents whose children are at risk having prompt access to treatment, with assessments taking account of family needs'*.
5. The government's Families at Risk review, **Think Family: Improving the Life Chances of Families at Risk** (Cabinet Office, 2008)² set out plans to support families experiencing the most entrenched problems – including substance misuse and poor mental health – to reduce the impact that this has on their children.
6. DCSF's Think Family programme³ has funded local authorities to provide targeted support to these families and a coordinated response from adult and children's services working together to support the whole family.
7. The government's new national carers strategy, **Carers at the heart of 21st century families and communities** (Department of Health, 2008)⁴, has also drawn attention to the vulnerability of children who are carers in families affected by substance misuse, and the importance of better prevention and whole family working across the different agencies involved.

¹ <http://drugs.homeoffice.gov.uk/publication-search/drug-strategy/drug-strategy-2008>

² http://www.cabinetoffice.gov.uk/media/cabinetoffice/social_exclusion_task_force/assets/think_families/think_family_life_chances_report.pdf

³ <http://www.dcsf.gov.uk/everychildmatters/strategy/parents/ID91askclient/thinkfamily/tf/>

⁴ www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_08534

8. By asking drug or alcohol users whether they are parents or have childcare responsibilities, treatment services can make sure that treatment supports - and is not undermined by - the demands of the family, and ensures that clients access the wider forms of support that sustain treatment outcomes. Treatment services may also identify situations that give rise to concern about children's welfare, and make referrals to local authority children's social care services.
9. By taking a whole family approach and by working closely together, drug and alcohol services, dedicated young carer services and children, parenting and family services can meet the needs of parents whose substance misuse is adversely affecting the whole family.

What is Think Family?

The 'Think Family' approach was developed to improve the support offered to vulnerable children and adults within the same family. 'Think Family' aims to secure better outcomes for children, young people and families with additional needs by co-ordinating the support they receive from children, adult and family services. This means services work together to:

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

10. Annex A offers further details of children, parenting and family services (including FIPS), and also includes details of types of treatment available for drug users.

Scope

11. When referring to parents this guidance will apply to mothers, fathers and other adults who have responsibility for the care of children and young people. This may include any adult who has a significant relationship with the primary care givers in the family as well as the primary care givers themselves.
12. When referring to substance misuse this guidance will apply to the misuse of alcohol as well as 'problem drug use', defined by the Advisory Council on the Misuse of Drugs as drug use which has:
'serious negative consequences of a physical, psychological, social and interpersonal, financial or legal nature for users and those around them'.⁵

⁵ Advisory Council on the Misuse of Drugs (2003) Hidden Harm: responding to the needs of the children of problem drug users. <http://drugs.homeoffice.gov.uk/publication-search/acmd/hidden-harm>

13. When referring to family and parenting services this guidance will apply to the range of parent and family support programmes available in the local authority as set out in its parenting strategy. This is likely to include Family Intervention Projects (FIPs), parenting support programmes such as those delivered as part of the Parenting Early Intervention Programme or by Expert Parenting Practitioners or the Youth Offending Team and other services such as young carer projects operating under the Family Pathfinders programme. Contact details and an explanation of the types of services available can be found in the Think Family Toolkit⁶, and other details are in Annex A.
14. When referring to substance misuse treatment services this guidance will apply to those services funded through local budgets and the pooled drug treatment budget, which is allocated via local drug partnerships.

Outcomes

15. Key outcomes of local joint protocols would be:

- Improved safeguarding and promoting the welfare of children and young people whose health or development may be being impaired as a consequence of parental substance misuse;
- Improved outcomes for children of substance misusing parents or carers, including children who may have caring roles in the family;
- Improved joint working between adult treatment services and children's services, providing an integrated approach to ensure that their functions are discharged having regard to the need to safeguard and promote children's welfare;
- Improved treatment outcomes for parents who misuse substances beginning with access to drug treatment through to support from family services and parenting practitioners;
- Improved access to adult drug and alcohol treatment services for parents using drugs or alcohol;
- Increased retention and compliance in treatment for drug and alcohol users who are parents;
- Improved training and support to both the adult and children's workforce;
- Ensure children and young people undertaking caring roles for their parents and siblings are supported and protected from inappropriate caring.

In developing the protocols, services need to consider whether their local protocol will impact differentially on the groups and communities that are being supported and take steps to address any issues identified⁷.

⁶<http://publications.teachernet.gov.uk/default.aspx?PageFunction=productdetails&PageMode=publications&ProductId=DCSF-00685-2009>

⁷See NTA guidance 'Annual differential impact analysis of drug treatment 2006-07' http://www.nta.nhs.uk/areas/diversity/docs/differential_impact_assessment_ndtms_0607_%20240309.pdf

Development of Local Protocols

16. Local authorities' strategies for parents and families should be fully aligned with local Children and Young People's Plans (CYPP). Parenting priorities and operational linkages between different services provided for children and families should feed into the CYPP to improve co-ordination between adult and children's services and to maximise impact of delivery. At the operational level a local protocol should be developed to establish links and joint working between adult drug and alcohol treatment services and children, parenting and family services.
17. Developing a local protocol may be led by the FIP/Think Family lead and the joint commissioning manager for adult drug and alcohol treatment. It should be agreed jointly by the Director of Children's Services (DCS), the Director of Public Health, the Chair of the local drug partnership, the treatment providers and service users or the local community. Protocols should take account of other relevant local joint working arrangements, including those established between adult and children's services in relation to particular groups of vulnerable families, including those with young carers, and practitioners supporting these families through Sure Start Children's Centre services and extended services in schools.
18. The DCS has a key role to ensure that children's services are delivered effectively and co-ordinated with related policy areas. The DCS should work closely with the Director of Adult Social Services (DASS) to ensure that the needs of families are met. Both the DCSs and DASSs should identify any adults in contact with social services who are parents or carers, including those with mental health or substance misuse problems, and ensure that the needs of their children are taken into account. This should include identifying and supporting young carers. The DCS should also seek to ensure that Children's Trust partners – including health services – are involved in this joint working.
19. Many areas will have locality-based multi-agency teams supporting vulnerable children and families, a Think Family Board/Steering Group and drug or alcohol treatment commissioners. Where these bodies exist their activities should be aligned through the CYPP and reflected in the wider strategic planning for children and families, which is overseen by the Children's Trust Board. Identifying a local 'Think Family Champion' at Chief Officer level may help to champion links between children's and adult services including substance misuse and mental health services.
20. The protocol should include details of local services, referral pathways, and arrangements for the prioritisation of parents/family members. This should be in line with the NTA's Models of Care⁸, DCSF's Think Family' Toolkit⁹ and DH's Models of Care for Alcohol Misusers (MoCAM)¹⁰. Care planning should include

⁸ National Treatment Agency (2006) Models of Care: Part 2
http://www.nta.nhs.uk/areas/models_of_care/default.aspx

⁹ DCSF (2009) Think Family Toolkit: Improving Support for Families at Risk
<http://publications.teachernet.gov.uk/default.aspx?PageFunction=productdetails&PageMode=publications&ProductId=DCSF-00685-2009>

¹⁰ Department of Health (2006) Models of Care for Alcohol Misusers (MoCAM)
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_41

clear goals in relation to parenting, including positive engagement in Think Family initiatives, and there should be joint care plan reviews between treatment services and family services.

21. The protocol should include joint referral and treatment arrangements, agreed between adult treatment services, children, parenting and family services and the Local Safeguarding Children's Board. It is recommended that these arrangements are supported through joint practitioners meetings, drug and alcohol reference groups and attendance at multi-disciplinary meetings/case conferences. For example, where adult treatment services are supporting an adult from a family receiving the FIP intervention, they should be represented at FIP case review meetings to consider the progress being made by the family and any further action(s) needed by services.
22. Feedback mechanisms, accessible communications and a complaints system should be developed to encourage good practice between services and give service users the opportunity to feed back on current services.
23. Arrangements for resolving issues and differences will be important to ensure effective joint working: these should be discussed between service managers in the first instance, then escalated to the Board/Steering group if need be.

Safeguarding

All Services

24. Protecting a child from harm has to be the paramount concern of all agencies, including those working with adults. Section 11 of the Children Act 2004 places a statutory duty on a range of organisations, including both children's and adult services which come into contact with children, their parents and family members, to make arrangements to ensure that their functions are discharged having regard to the need to safeguard and promote the welfare of children.
25. All services working with families, including those working with adult family members, need to ensure that Local Safeguarding Children Board's safeguarding procedures are followed at all times. Staff must be trained in the use of these procedures and clear, written protocols should exist which make explicit to staff that referrals should be made to children's social care services when a child is suspected of suffering or being likely to suffer significant harm. Verbal referrals should be confirmed in writing within 48 hours.
26. Support offered by a FIP or substance misuse service where a child is the subject of a child protection plan does not affect the children's social care services social worker's role as lead professional for a child within the family and in particular:
 - The children's social care services social worker needs to form a judgement about the contribution FIPs can make in contributing to the implementation of a child protection plan for an individual child;
 - FIPs should only provide support to vulnerable families where children's social care services are satisfied that this is in the interests of the children within these families.

Family Services

27. FIPs and other family services can assist children's social care services by identifying vulnerable children and families and can contribute to the delivery of a Child Protection Plan by:

- Providing critical information about family functioning and risks or concerns about harm to children obtained during whole-family assessments and frequent (sometimes daily) visits to the family home;
- Helping secure improvements in the quality of parenting and family functioning which can in turn improve outcomes and reduce the likelihood of harm being suffered by individual children.

Drug and Alcohol Treatment Services

28. Drug and alcohol treatment services can assist children's social care services by identifying vulnerable children and families and contributing to the delivery of a Child Protection Plan by:

- Providing critical information about risks of harm to or support needs of children or young people obtained during client assessments;
- Attending child protection conferences and providing specialist advice on how addictive patterns of parental behaviour may affect the health and development of a child; and, if identified as a member of the core group by the chair of the child protection conference, to attend core group reviews as required;
- Helping secure improvements in the health and social functioning of parents, which can in turn improve parenting capacity and support improved outcomes for individual children.

Care Planning and Identification/Assessment

All Services

29. The criteria for contacting and considering referral between services or a request for a drug or alcohol user/parent to be supported should be agreed between the two services in line with local and national service definitions and descriptions.

Family Intervention Projects

30. Family Intervention Projects use a range of tools to conduct an assessment of the needs of a child/children and their parents or caregivers and deciding how they should be met, including:

- the "Framework for the Assessment of Children in Need and their Families"¹¹;

¹¹Department of Health et al (2000) Framework for the Assessment of Children in Need and their Families

- the Common Assessment Framework for children and young people (CAF)¹²;
- National eCAF, still being developed by DCSF, will be a secure IT system for storing and accessing information captured through a CAF¹³;
- ContactPoint - a quick way to find out who else is working with the same child or young person¹⁴.

31. In addition in some cases, where children have additional needs, a further whole family assessment is needed to target the root causes of the problems affecting individual family members. Assessment reports are used to draw up a whole family support plan, which is agreed with families. Progress against objectives in the support plan are reviewed at 6-8 weekly review meetings attended by relevant services and the family.

32. Such whole family assessments will include an assessment of the actual or potential impact of the drug or alcohol use on children in the family, including any who may regularly have to care for the person or take on responsibility for running the home which the adult would normally undertake.

33. For guidance on delivering Think Family systems, including detail on assessment and identifying the needs of family members, please see the Think Family Toolkit¹⁵. See Appendix B for FIP case study.

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4003256

¹² <http://www.dcsf.gov.uk/everychildmatters/strategy/deliveringservices1/caf/cafframework/>

¹³ www.dcsf.gov.uk/ecm/ecaf

¹⁴ www.dcsf.gov.uk/ecm/contactpoint

¹⁵ <http://publications.teachernet.gov.uk/default.aspx?PageFunction=productdetails&PageMode=publications&ProductId=DCSF-00685-2009>

Drug and Alcohol Treatment Services

34. Adult treatment services should be routinely screening clients for childcare responsibilities at the triage/comprehensive assessment stage and as an ongoing process throughout their treatment journey and monitored by service managers via supervision.
35. Where a drug user is responsible for the care of children, a pre-CAF assessment should be undertaken by a drug treatment worker in line with NTA guidance¹⁶ to commissioners on safeguarding children of substance misusers. The level of risk/harm may not meet the threshold for referral to children's social care services but might nevertheless require intervention from children's services. This would best be progressed by way of a CAF – possibly co-ordinated by the drug/alcohol worker. The CAF and its purpose need to be something that adult service practitioners are familiar with and can utilise. Even if a referral to children's services is not appropriate, a CAF is an appropriate way to gather the information that will then form the basis of a referral.

Information Sharing

36. Information sharing arrangements should be agreed between treatment services and family services to encourage joint care planning that addresses the full needs of the family and results in better outcomes for family members in treatment.
37. Through appropriate provision of guidance, training and organisational support, all practitioners should have clarity on when and how personal information can be shared legally and professionally and be confident in making decisions about sharing information. The HM Government *Information Sharing: Guidance for practitioners and managers* (2008)¹⁷ is applicable to practitioners in all sectors who have to make case-by-case decisions on information sharing, whether they are working with children, young people, adults and/or families.
38. Arrangements should be in place on confidentiality, consent, information sharing and record keeping approved by the partner agencies and the local Caldicott Guardian as outlined in *Drug Misuse and Dependence: UK Guidelines on Clinical Management* (2007)¹⁸ supported by training.
39. A monitoring system may be created: both family services and drug and alcohol treatment services should collate statistics/relevant information, including equality data, on a regular basis in order to provide management information regarding joint work/referrals in relation to substance misuse and report to the steering group. This can then feed into national evaluation when appropriate. Subject to local information sharing agreements this can draw upon:

¹⁶http://www.nta.nhs.uk/areas/treatment_planning/treatment_plans_2009_10/docs/safeguarding_the_children_of_drug_misusing_parents_1208.pdf

¹⁷ www.dcsf.gov.uk/ecm/informationsharing

¹⁸ http://www.nta.nhs.uk/publications/documents/clinical_guidelines_2007.pdf

- **National Drug Treatment Monitoring System and Treatment Outcomes Profile**, which collects data on each drug user receiving treatment, the types of treatment received and changes in the drug user's health and social functioning during their time in treatment.
- **FIP NatCen (National Centre for Social Research) Monitoring System**, which collects data on each family supported through Family Intervention Projects and changes in risk factors that occur during the time they receive support through the project.

Local Checklist

To support local protocols, treatment services and families' services should consider the following actions:

Recommended Actions for Drug and Alcohol Treatment Services
1. Effective joint working with children, parenting and family services may be best supported by establishing a single point of contact within each local treatment system to act as the main lead and contact for those services, ideally with a children and families background.
2. Treatment commissioning arrangements and process should be aligned with 'Think Family' practice as set out in the NTA's Families adult needs assessment document for 2010/11 planning round ¹⁹ .
3. All staff in treatment services should be asked to audit their caseloads to establish the numbers of patients who are parents (or have responsibility for children), including those who do not live with their children all or any of the time. As a matter of course staff should ask questions to establish if the service user has dependent children.
4. If a service user is a parent and their degree of substance misuse and personal circumstances indicate that their parenting capacity is likely to be seriously impaired or that undue caring responsibilities are likely to be falling on a child in the family, a referral should be made to children's social care services.
5. Substance misuse services should endeavour to be kept informed about the outcome of the referral to children's social care services and be aware of subsequent social work or other family support service involvement with the family. This is critical to ensure that information can be shared and links between agencies can be made as needed.

¹⁹http://www.nta.nhs.uk/areas/treatment_planning/treatment_plans_2010_11/treatment_planning_in_the_community_prisons_2010_11_templates_and_guidance.aspx

<p>6. To benefit treatment, service users should be asked to agree to their information on treatment being shared with children, parenting and family services. Consent is not needed where there is an immediate risk to the life of a child or where seeking such consent would place the child at increased risk of significant harm, in which case a referral must be made to CSC in line with local LCSB protocols.</p>
<p>7. The strategic director or joint commissioning manager from local drug partnerships along with the local commissioner responsible for alcohol services is recommended to attend Children’s Trust and Local Safeguarding Children Boards meetings. Substance misuse treatment is recommended to be a standing agenda item.</p>
<p>8. A representative from substance misuse services should attend child protection conferences if a child of a parental drug or alcohol user is the subject.</p>
<p>9. Discuss with service users the possibility of inviting the families’ service worker (FIP worker or lead professional from children’s services) to meetings. If the parent does not agree to this, discuss with them their objections and the importance of professionals working together for the benefit of themselves and their children. It may be possible to negotiate for the families’ service/children’s social worker or another relevant children’s professional (e.g. health visitor) to attend part of the meeting. Minutes of meetings must be sent to all key professionals involved.</p>
<p>10. Provide informal information and advice to families’ service staff even when the family being discussed is not allocated within the substance misuse service.</p>
<p>11. Utilise the knowledge and expertise of families’ service professionals in order to assess the potential impact of service user’s substance misuse on their children’s health and development to assist holistic work with them and to help decide if a referral for a CAF is necessary. If a CAF is necessary substance misuse services should collaborate with the action plan that follows.</p>
<p>12. When planning and providing services and support to parents, substance misuse services should consider the parent’s childcare responsibilities and provide (or help them access) suitable childcare provision to enable them to attend appointments, services and group treatments. They should also seek to provide appointments at useful times, such as within school hours.</p>

13. It is recommended that all staff in treatment services should have regular training at least every two years on safeguarding children, links to children's services, the CAF process, use of pre-CAF assessment, LSCB safeguarding children procedures, and information sharing should be implemented.
14. It is recommended that all staff in treatment services should also receive regular training on how to assess the wider needs of the family, including how equality, diversity and cultural factors might affect their access to services or outcomes.
15. Think Family and safeguarding children should be an integral part of monthly supervision sessions for all drug and alcohol treatment staff.

Recommended Actions for Children, Parenting and Family Services
1. Routinely record whether a parent has substance misuse problems on the family or child's case records and for internal data collection purposes to aid service planning.
2. Effective joint working with substance misuse services may be best supported by establishing a single point of contact with children, parenting and family services to act as the main lead and contact for drug and alcohol services, ideally with some experience of substance misuse treatment.
3. Explore with the parent the option of making a referral to an appropriate substance misuse service, informing them of the support available locally.
4. Invite involved adult substance misuse professionals to statutory meetings held in respect of children and consider inviting them to non-statutory meetings if it might be helpful. For example, Family Intervention Projects will hold regular case review meetings attended by the range of agencies involved with the family. It is important the relevant member of staff from adult treatment services is represented at these meetings. The information they will have, on how the adult family member is engaging with treatment services and progress being made, will be important in decisions about any changes needed to the FIP whole family support plan.
5. Send minutes of meetings to involved adult substance misuse professionals.
6. A families' service manager (e.g. FIP manager or the Parenting Commissioner) should attend the local drug partnership joint commissioning group meetings. 'Families' should be a standing agenda item.

<p>7. Inform adult substance misuse services of significant changes that will affect the parent or alter the needs of the child, for example if a child is returning home following a period of being accommodated by the local authority or if another family member who is substance dependent has begun living in the family home.</p>
<p>8. Whether or not adult substance misuse services are involved with a parent, utilise advice and information from those services in order to maximise your understanding of the parent's problems and the likely impact on the child's welfare.</p>
<p>9. Consider in particular whether the parents' condition or their need to attend treatment sessions may be leading to heavy caring responsibilities falling on children within the family. Ensure support offered to the family as a whole, including adult social care where appropriate, is sufficient to ensure that children are properly protected and do not have to take on levels of caring responsibility which are too much for them.</p>
<p>10. 'Think Family' commissioning arrangements and process and local parenting strategies should be aligned with treatment planning process wherever possible.</p>
<p>11. It is recommended that children, parents and family services workers undertake training on substance misuse, screening and referral protocols to build expertise. This can complement the specialist advice and input that can be provided by substance misuse services.</p>
<p>12. Training support should take account of the in-depth expertise available locally in relation to the needs of families with young carers. In particular, staff in many voluntary sector led young carers projects have built up considerable expertise in reaching out to and engaging the most vulnerable families from a range of different communities, including many affected by substance misuse problems.</p>

Department for Children, Schools and Families
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National Treatment Agency for Substance Misuse
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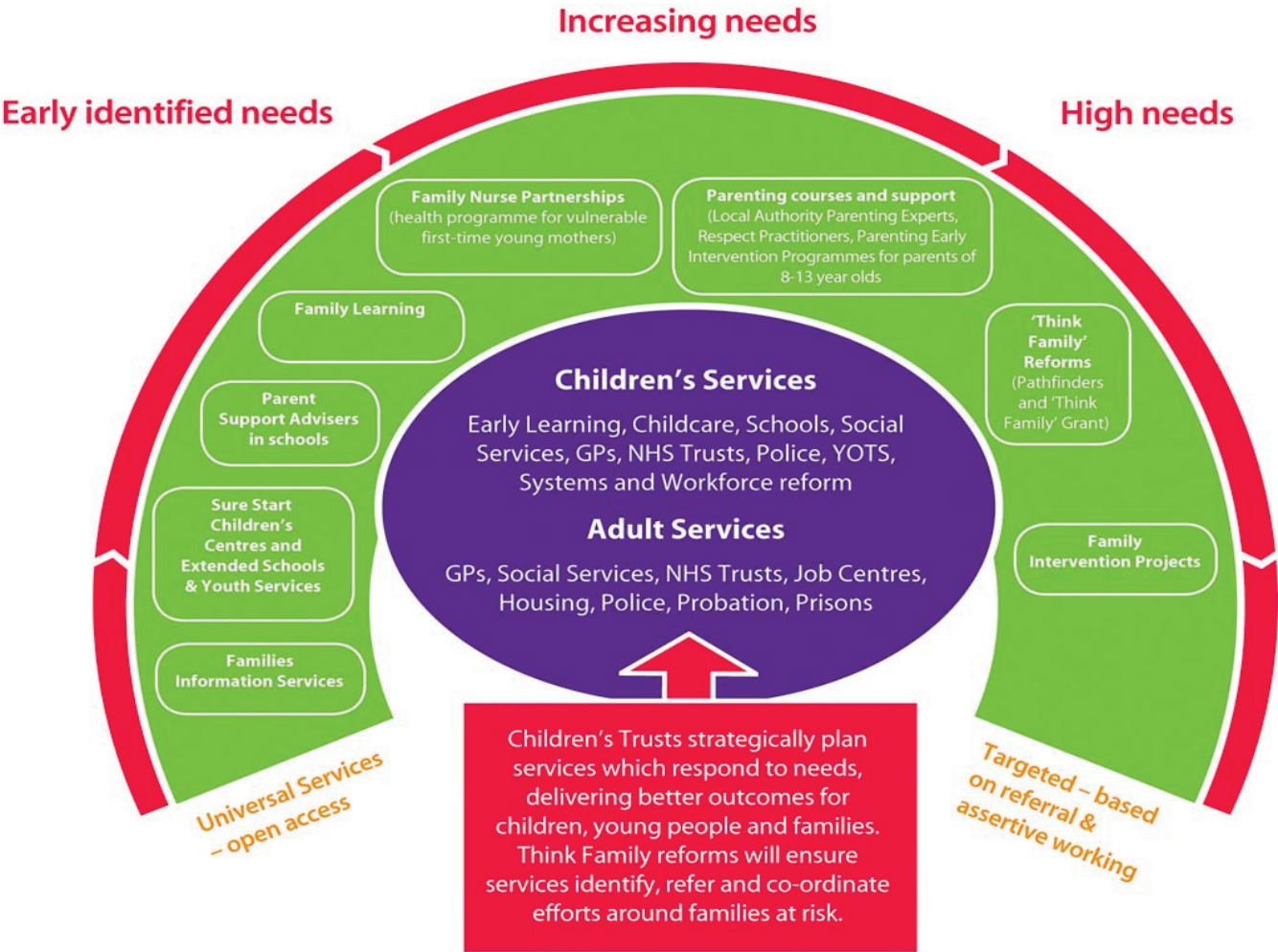
Annex A

Interventions: description of services for children, parents and families, and drug and alcohol treatment services

Children, Parenting and Family Services

Government policy has focused on improving the quality, availability and coherence of children, parenting and family support delivered in local areas. Since 2006, all local authorities are expected to produce a parenting strategy, which sets out the range of support available locally to cover the full spectrum of family needs (outlined below). This strategy should include consideration of the types of problems experienced by vulnerable families locally and the types of services required to meet these. The needs of families with parental substance misuse problems should be considered as part of this process. Increased central funding has also been available to help local authorities commission and deliver parenting and family support programmes to help families with a range of problems and needs.

Parenting and family support services in local areas



From April 2009 all local authorities have received extra funding to provide three types of children, parent and family services:

Family Intervention Projects (FIPs)

FIPs have been operating in around a third of local authorities since 2006. They provide intensive coordinated support to families with members at risk of, or actually experiencing, very poor outcomes. FIPs usually target families facing legal action or evictions or affected by longstanding and often inter-generational worklessness and poverty which other services have found difficult to work with.

Families supported by FIPs are assigned an individual key worker who will coordinate and deliver practical support and more specialist interventions. A whole family support plan is developed which sets out the range of support that will be provided (ranging from evidence-based parenting support, help with diet, nutrition, budgeting and life skills, specialist health and behavioural interventions, support to ensure children are receiving education etc), changes expected from family members and consequences for families if changes are not made. Key workers use 'assertive and persistent' working methods to maximise the likelihood of family members engaging and benefitting.

The aim of FIP support for a family will vary depending on family member's needs but will include:

- reducing the risk of poor outcomes (amongst children, parents and other family members) or legal sanctions;
- providing or securing support which meets the full range of needs within each family;
- responding to challenging and resistant behaviours within families;
- strengthening the ability of family members to provide care and support to each other.

Parenting Early Intervention Programmes (PEIPs)

PEIPs aim to increase the availability of evidence based parenting interventions to help improve parenting skills of mothers and fathers of children (aged 8-13) who are at risk of poor outcomes.

Parenting Experts and Parenting Practitioners

These practitioners deliver and advise on the provision of parenting group-based programmes and one to one support to parents.

Other children, parent and family interventions include **Family Nurse Partnerships** – working with first time young mothers at risk of poor outcomes from early pregnancy until their child is two; targeted youth support working with young people at risk of offending and their parents; and **Multi-Systemic Therapy** pilots (MST) to help the families of young people on the edge of the criminal justice system or care.

In some areas commissioners are contracting with third sector organisations to provide high intensity services for families in significant distress and trouble.

Young carers

The potential vulnerability of children who take on caring roles in their families – particularly where substance misuse is involved – is now widely recognised. Some areas already take a “whole family” approach and have encouraged services supporting the child to work closely with substance misuse or other specialist teams who support the ill or disabled family member. Further work now being set in train under the Carers Strategy and the ‘Think Family’ programme aims to help all areas to do so. Under the Family Pathfinder programme for young carers, 18 local authority areas are being funded to test how support across adult and children’s services can be better integrated around families with young carers and deliver better protections for the children involved. Further information is available in the Think Family Toolkit (‘Improving support for young carers’)²⁰.

Family Drug and Alcohol Courts (FDAC)

FDAC attempts to improve outcomes for children subject to care proceedings by offering parents with substance misusing problems:

- Intensive assessment and support from the specialist court;
- Help from parent mentors;
- Quicker access to community services;
- Better co-ordination between child and adult services.

FDAC is based on a model widely used in the United States. The national US evaluation found that outcomes for parents and children were better when families took part in specialist drug and alcohol courts. Key findings were:

- More children were reunited with their parents;
- Quicker decisions were made for out of home care if reunification was not possible;
- There were financial savings on foster care.

FDAC is being evaluated by Brunel University.

Drug Treatment Services

The goal of all drug treatment will vary depending on individual needs. Some people will aim for abstinence but others will require a considerable length of time which may involve a number of attempts before a person can get control over their drugs of dependency.

The kinds of treatment that should be accessible in all areas are:

- **Harm reduction services:** including needle exchanges which operate by providing sterile injecting equipment to injecting drug users and disposing of used injecting equipment, with the aim of reducing infection. Harm reduction schemes may also offer immunisation against blood borne disease, advice or referral to other treatment services or sexual health services.

²⁰ <http://publications.everychildmatters.gov.uk/eOrderingDownload/Think-Family09.pdf>

- **Community prescribing – specialist:** offer a medically supervised substitute. This maintains the individual's tolerance to the drug of misuse and provides a basis for providing medical and psychosocial counselling and support. Most prescribing in the UK is for opiate dependence.
- **Community prescribing – GPs:** provide medically supervised substitutes through a shared care approach between primary (GPs) and secondary care (specialist drug treatment) in the management of drug misusers.
- **Key working programmes:** Often based in community drug teams or other community based services. These offer psychosocial approaches often delivered alongside pharmacological interventions, but are often the mainstay of treatment for the misuse of cocaine and other stimulants, and for cannabis and hallucinogens.
- **Formal psychosocial programmes:** These are discrete packages of psychosocial treatment offered in a range of settings, to treat drug misuse problems or co-occurring common mental disorders. These discrete packages will frequently be delivered alongside key working and pharmacological interventions if appropriate.
- **Structured day programmes:** offer intensive community-based support, treatment and rehabilitation. Programmes of defined activities for a fixed period of time will be on offer and will require a specific level of attendance, usually four to five days a week.
- **Aftercare:** provision of structured support for clients on exit from another programme. The development of an appropriate package of aftercare and support should take place in the final phase of the treatment episode of service users aiming to achieve abstinence.
- **Inpatient detoxification:** specialised units for drug users, which provide medically supervised withdrawal with 24-hour medical cover (and usually relapse prevention) and aftercare referral services.
- **Residential rehabilitation:** intensive and structured programmes in controlled residential or hospital inpatient environments. Rehabilitation services vary in approach, programme structure, intensity and duration. The majority of residential rehabilitation services require users to be drug-free on entry, although some may have on-site detoxification facilities.

Alcohol Treatment Services

Many people who drink at harmful levels, including some dependent drinkers, are able to reduce the amount they drink without professional support. They can do this through their own motivation and often with support from family and friends. One in eight people drinking at higher-risk levels will reduce their consumption to within government guidelines as a result of simple advice from their GP or a nurse.

People who find it very difficult to cut down how much they drink, and those who are drinking at higher-risk levels, often find it much easier to succeed with expert help. The NHS has alcohol support services which are often provided by the same teams that provide drug treatment services and are often structured in a similar way as described above.

Some areas provide 'walk-in' services. These services may be attended following self-referral or referral by a doctor or other practitioner. They may be provided locally by voluntary sector support or counselling services, by NHS clinical alcohol services, or by both. The services commonly use one-to-one 'talking therapies' or group work to help people reassess the effect alcohol is having on their lives and to help them develop strategies for drinking more sensibly.

In a minority of cases, the level of dependence on alcohol is so great that it can be dangerous simply to stop drinking alcohol without medical support. In such cases, local alcohol services can provide medically assisted withdrawal or 'detoxification', usually in the community. But some people need in-patient admission for this.

Residential support (rehab) is also available for a small number of dependent drinkers who have been drinking heavily for a long time and have now managed to stop drinking. It is offered to those severely dependent drinkers for whom community services are not suitable for aiding initial recovery and helping them re-establish their lives. The availability of these kinds of support services varies widely across the country.

Alcoholics Anonymous forms mutual help groups to assist people in giving up alcohol altogether.

Annex B

FIP Case Study

Changing lives

It takes a lot to turn your life around but when you have been addicted to hard drugs and alcohol for over two decades it is almost impossible. Yet one woman is beginning to build a new life for herself and her family with the help of an innovative Tower Hamlets initiative. We find out how the Family Intervention Project has not only helped transform her life but just as importantly given her the belief that she can have a future. This is Jenny's story.

Jenny may have dropped out of school when she was only 14 but she has grown into a sassy, articulate woman. At 28 she has plans to go college to complete the education she never had so she can eventually find a job to support her two children. Yet less than a year ago Jenny's life was falling apart. Up to ten times a day she and her former boyfriend would inject themselves with crack cocaine and heroin; every night Jenny prostituted herself on the backstreets of London to pay for them. She sold herself cheap – sex for just £20. It was a brutal existence.

“We lived a chaotic lifestyle and it was truly awful. Believe me it was not a career choice to go on the streets. You don't think ‘today I'm going to be a prostitute’. You just find yourself there and then you are really far into it and it's a real mess and impossible to get out of. I look back now and realise it was complete madness.”

Jenny was spending nearly £1000 a week on drugs and alcohol financed by working the streets. “At around nine in the evening I would get dressed up, slap on my face and have a hit and a drink so I had the bottle to go out. It was really dangerous on the streets. I've been locked up in a room and had a knife pulled on me. Another time a man just turned on me and scrubbed my face up and down a brick wall.”

She adds, “When I would get home the next morning I would straight away inject myself and have another drink and then shut myself away in my room. Things were so bad I didn't have it in me to face what was happening.”

Jenny started on drugs when she was only 14. Her mother, who was alcoholic, had remarried and relocated the family to London from Glasgow. The relationship quickly deteriorated and Jenny was caught in the middle with devastating consequences.

“My step father started to sexually abuse me. It was terrifying and I didn't know what to do. I tried to talk to my mum about it and she pretended it wasn't happening because of her own pain. When she was my age she had been repeatedly raped by her uncle and for a lot of my life she had a love affair with vodka. But I also couldn't cope so I would get off my face as well,” she says.

Desperate to escape, Jenny spent less and less time at home and school. “Even if I had wanted to go to school I couldn't. There was a dirty pile of washing and I would have search through it to find my uniform. I didn't want to go school wearing filthy clothes so I didn't bother. I massively resented my mother and just went off the rails.”

Jenny started hanging out with much older men and at 16 she had her first experience of crack cocaine. Four years later she became pregnant. "I met this guy and he was the first person that ever really loved me and I would have done anything for him. I was desperate to be loved: I wanted to be wanted. We got married and I tried to be the perfect wife and mum."

But there were difficulties from the start. After Jenny's daughter was born she suffered from post-natal depression. "I was seeing and hearing things but was too scared to tell anyone in case they took the baby away. It was then I started taking heroin as an escape."

Jenny recovered from her depression but only to face it again after the birth of a second child; her fragile state of mind was compounded by her husband leaving her. "I really fell apart – he was my life and I entirely depended on him. I started drinking more and taking more drugs. It was such a difficult time. My cousin moved in to help with the children as I just wasn't coping."

She adds, "Also at this time I faced losing my house as I was behind on the rent. It was all so difficult I didn't know where to turn to and then thank goodness FIP came into my life."

Tower Hamlets Family Intervention Project or 'FIP' was started in 2007 and is part of a network of teams across the country funded by the Department for Children, Schools and Families. Its remit is to work intensively with vulnerable families who have a range of complex problems.

Gail McNelly is Jenny's support worker. "Jenny was living a chaotic lifestyle when we first met her," she says. "She was about to lose her home because of months of rent arrears and her health was very poor. She desperately needed someone to help her on a practical level but also someone she could rely on and trust."

Gail helped Jenny sort out her finances to avoid eviction and over a number of months gained her trust to the point where she committed to a detox programme. "Gail has helped me get into a special addictions unit which not only deals with the drugs and alcohol but also with my liver damage. Gail always comes with me to the hospital and has given me the motivation and support I need to get through this. So far I have not missed a single appointment since I have been working with FIP," says Jenny.

She adds, "FIP always make me feel they are there for me. I have been on heroin for the last decade and I took it every day as an escape. It's only been FIP in my life that has given me the strength to try and stop. So much of this place is brilliant and not just for me but also for my girls – they get counselling thanks to FIP."

Jenny's daughters are now being looked after by a foster carer. Jenny is happy with the arrangement but ultimately wants them back home but knows she has to work towards this. "I had my girls for all the wrong reasons because I was besotted with their dad, but ultimately it was the right thing to do because I love them so much - I would take bullets for them."

The girls' school has also seen a big transformation in their self esteem and behaviour. Fiona is the deputy head teacher at the school. "When Jenny was really ill the girls used to loathe coming to school. They never had clean school uniforms and were covered in headlice. Life is very different now," she says and adds, "The girls see school as a nice place to be for the first time ever. They are clean and well dressed and are making friends at the school. They see their mum regularly and like their foster home; they are most definitely blossoming," says Fiona.

Jenny is now on a methadone programme and has dramatically cut down her drug use; she often now goes for days without taking anything. "FIP has been invaluable as it has given me back my life, I don't know where I would have been without them. It's a really homely environment when you go there. It is very nurturing – it's like having an older sibling looking after you. Before I didn't know what normal was and now I can start to look at my life and try and understand what has happened and how I can change it. FIP has been so good for me and my girls who are really flourishing," Jenny says.

Nikki Bradley is FIP's project manager. She would be the first to admit that the project cannot wave a magic wand and transform lives over night but, given the right support, change can take place slowly, bit by bit.

"Jenny has been on a long journey and we are really proud to have supported her so she can start to reclaim her life. The same is true for the girls; they no longer go to bed worried about whether their mum will be alive or dead in the morning," she says.

For Jenny, FIP has most definitely been a lifeline. "Everything good that has happened to me in recent years has happened because of FIP. I was in a right state and now life suddenly looks a lot brighter for me and my family."

Some names and details have been changed to protect identities.

