Chapter 4

Surveys of specialist drug agencies, maternity units and social work services

Chapter 4 Surveys of specialist drug agencies, maternity units and social work services

4.1 In order to find out more about the level of service provision for children of problem drug users and their parents, three separate but similar two-page questionnaires were sent to all maternity units and social work services and to over 800 specialist drug agencies in the UK (Appendix 1). Mailing lists for the services were obtained from the Department of Health, the Association of Directors of Social Work and DrugScope respectively.

4.2 The maternity unit and social work service questionnaires were piloted in Glasgow and Sheffield respectively. The specialist drug agency questionnaire was piloted with agencies in the South London and Maudsley NHS Trust. Finalised questionnaires were sent out with a covering letter in February 2002. A second questionnaire was sent to non-responders in March 2002. Finally, a fortnight was spent contacting non-responders by phone, concentrating particularly on social work services where the initial response rate had been lowest. The rates received by agency type are shown in Table 4.1 below.

Table 4.1: Response rates by service type

	Drug agencies	Maternity units	Social services	Total
Sent out	803	423	196	1,422
Replied (%)	418 52%	259 61%	108 56%	785 55%

4.3 The maternity units had the highest response rate and the specialist drug agencies the lowest. The highest response rates were in Scotland, where 100% of maternity units, 63% of drug agencies and 77% of social work services replied, compared with 69% of maternity units and 49% of both drug agencies and social work services in England. None of the four social work services and only seven of 13 maternity units in Northern Ireland responded. Overall, a total of 127 services responded to the request for protocols – 62 maternity units, 40 specialist drug agencies and 25 social work services.

Specialist drug agencies

4.4 On average, the drug agencies employed 18 members of staff and saw 739 clients each year. Although there were some difficulties in interpreting the information provided on service type, they were broadly categorised as 'open access' services (21%), prescribing services (19%), residential services (14%) or counselling services (13%).

4.5 Seventy-five per cent of respondents said their agency had contact with pregnant drug users. However, 52% reported they had services for pregnant drug users, 53% reported offering services for clients who had dependent children, and only 31% provided services specifically for the children of drug-using parents. Thirty-four per cent offered training to staff for working with pregnant drug users and 33% reported that they had protocols available for this. Thirty per cent offered training for their staff in working with clients with dependent children. Residential agencies were significantly less likely than community or out-patient agencies to offer services for clients with children, services for pregnant drug users and services for the children of drug users (Table 4.2).

4.6 With regard to their level of contact with other services in managing pregnant drug users, 86% of drug agencies reported they would normally liaise with GPs, 82% with social work services and 83% with maternity units. No significant differences were reported between residential and community or out-patient agencies in their reported level of liaison with other services.

Table 4.2: Differences between residential and community-based or out-patient agencies

	Residential (n=56) (%)	Community/ out-patient (n=353) (%)	Chi (significance)
Services for clients with children	41	56	4.4 (p<0.05)
Services for pregnant clients	32	56	10.7 (p<0.01)
Services for children of drug users	12	33	9.3 (p<0.01)
Do they have data on pregnant drug users	50	40	1.8 (p=0.40, ns)
Do they have service contact with pregnant drug users	61	77	6.2 (p=0.09, ns)

4.7 Table 4.3 shows the proportion of the total sample that gathered each type of information. Up to 14% of services did not answer one or more of these questions. Although 68% of the agencies said they collected data on

the number of clients' children, only 25% had these data readily available for the previous financial year. We found that residential agencies were somewhat more likely than community or out-patient agencies to gather each type of information, but the differences were only statistically significant for the ages and gender of the children.

4.8 We compared agencies' data collection according to their geographical location, creating four regional groups – Scotland, Wales and Northern Ireland, North England and South England and a fifth group of agencies with country-wide coverage such as Phoenix House and Turning Point (Table 4.4). There was a high level of consistency across the regions. The only notable difference was the lower frequency of services for pregnant drug users and for children of drug-using parents provided by the agencies with national coverage.

Table 4.3: Frequency of information collected by specialist drug agencies

Type of information	Agencies collecting data (%)
Number of clients' dependent children	68
Age of children	61
Gender of children	53
Children's living arrangements	59
Children's needs	30
Parenting needs	34

Maternity units

4.9 The maternity units replying to the questionnaire had an average of 2,407 deliveries in the previous year (up to 31 March 2001). Ninety-two per cent of respondents reported that pregnant women were routinely assessed for both alcohol and drug use, although 'routine assessment' was open to differing interpretation. A variety of different staff were reported as carrying out the assessment, including midwife, GP, consultant or drug worker. When asked about how alcohol or drug use problems were identified, only 23 respondents provided any information. A wide range of methods were mentioned, including testing procedures and information gathered at booking-in by clinical observation, self-disclosure or from third parties.

4.10 The mean number of women with problem drug use who had delivered babies in the previous year was 24 (range 0-172). **This represents about 1% of all deliveries.** The mean number of women with problem alcohol use who delivered babies in the previous year was also 24 (range 0-738). Respondents were asked about their perceptions of changes in the level of drug use among expectant mothers in the previous five years: 2% reported a slight decrease, 15% no change, 42% a slight increase and 40% a large increase. Forty-five per cent reported they had specialist staff to deal with drug users and their children, 41% that their service employed obstetricians who had a special interest in this area and 62% that their unit employed midwives for whom this was a particular area of interest. Fifty-seven per cent of the units had specific protocols for the antenatal management of drug users; 40% could offer substitute

Table 4.4: Regional comparisons in services provided and information collected by specialist drug agencies

	Scotland (n = 97) (%)	Wales/NI (n = 19) (%)	North England (n = 154) (%)	South England (n = 111) (%)	National agencies (n = 37) (%)
Do they have a service designed for clients with dependent children?	55	53	57	55	41
Do they have a service for pregnant drug users?	52	63	59	51	25
Do they have a service for children of clients?	35	32	33	28	17
Does the agency collect information on the following:					
Number of clients with dependent children	78	82	78	76	73
Ages of the dependent children	68	82	72	67	73
Gender of the children of clients	59	77	59	65	67
Living arrangements of the children	69	65	69	68	64
Needs of the children of clients	35	44	33	35	34
Parenting needs of clients	40	44	37	40	50

prescribing to opiate-addicted pregnant women and 71% had protocols for the management of withdrawal symptoms in neonates. The reported frequency of respondents' liaison with other services is shown in Table 4.5.

Table 4.5: Frequency of joint working between maternity units and other services in relation to pregnant problem drug users

	None (%)	Occasional (%)	Often (%)
Social services addictions services	22	37	38
Social services (child and family)	2	32	64
Paediatric services	4	24	70
General practitioners	6	45	47
Other primary care	4	26	67
Non-statutory community drug services	8	27	63
Other specialist drug services	26	37	34
Police	34	57	7

Social work services

4.11 Responding agencies had an average of 1,976 new cases of children identified as in need and 143 cases on the child protection register in the year to 31 March 2001. Eighty-seven per cent of the respondents reported their agency attempted to identify alcohol and drug problems in the mother or father. Although 70% of agencies had specific staff for dealing with substance use issues (there were an average of 3.5 such staff in these agencies), only 40% of respondents said they had a protocol for decision-making for children of substance users. Around two-thirds of the agencies (65%) provided training in managing families with substance use problems.

4.12 On average, parental problem substance use was identified as a feature in 24% of cases of children on the child protection register. Where the agency was able to provide separate figures, drug use was identified as a feature in an average of 16% of cases and alcohol in 21% of cases. However, there were marked variations between services.

4.13 When asked about co-operation with other agencies, 64% of respondents reported having formal joint arrangements for working with other agencies in child protection cases involving parental drug use. However, only 43% of respondents reported providing specific services for problem drug-using parents and their dependent children. Levels of joint working with other agencies in cases of parental problem substance use are presented in Table 4.6. Liaison with general practitioners was relatively infrequent although perhaps balanced by frequent joint work with other primary care services, for example health visitors.

Table 4.6: Frequency of joint working between social work services and other agencies in cases of parental problem substance use

	None (%)	Occasional (%)	Often (%)
Maternity services	2	40	58
Paediatric services	3	44	55
GPs	10	66	24
Other primary care services	1	17	82
Drug services	1	35	64
Other specialist services	5	54	40
Police	2	33	65

Protocols and service descriptions

4.14 The survey invited respondents to supply copies of any protocols or related documents for working with this client group. As with the questionnaire response, maternity services were the most responsive and supplied 80 protocols for the committee to study, followed by the drug services with 45, and lastly social services with 26. Whilst the protocols were fairly standardised across maternity services and social services – the former providing guidelines on antenatal and post-labour care, the latter focusing on child protection issues – the responses from drug services were a more varied mix. Whilst some drug services simply had guidelines for working with the pregnant drug user, others provided reports and publicity materials that gave evidence of imaginative local initiatives to engage and work with children. Examples of these can be found in Appendix 2.

Discussion

4.15 These surveys provide a snapshot of the levels of response to pregnant drug users, parents with drug problems and their children by three key types of agency. They give some indication of the extent to which agencies are addressing these issues. However, they can say little about the quality of the services provided and inevitably leave many questions unanswered. As we had no means of validating the responses provided they must be taken at face value. Although the response rate was relatively high for national surveys of this type, between 39% and 46% of agencies did not respond. Response rates from Welsh maternity units (26%) and social work services in Northern Ireland (0%) were particularly disappointing. It is quite possible that the non-responding agencies have lower levels of service provision than responders, suggesting that the actual situation may be worse than that indicated by the analysis. However, in the absence of a method to compare responders and non-responders, this cannot be tested.

4.16 Although 75% of the specialist drug agencies said they had contact with pregnant drug users, and inevitably all would have at least some clients with children, only about half offered services that were specifically designed to help pregnant women or drug users with children, and less than one third offered any form of service for the children themselves. This seems far from satisfactory. Only about a third of agencies offered any training for staff about clients' pregnancy or children. This suggests that very few agencies have the know-how to understand these issues, let alone the resources to address them.

4.17 Significantly, 82% of the maternity units said there had been an increase in the number of pregnant drug users in their service in the past five years. The data provided by respondents suggested that about 1% of births were to problem drug users. If this is representative of maternity units as a whole, and given that there are around 600,000 births in the UK each year, this would indicate there are about 6,000 births to problem drug users each year. Given that around a third of problem drug users are female, 1% of births is consistent with our estimate that 2–3% of all children in England and Wales have a parent who is a problem drug user.

4.18 Overall, the vast majority of the maternity units appeared routinely to assess whether their patients had drug or alcohol problems. However, how sensitive and accurate the assessment might be could not be ascertained. Whilst an encouraging number of maternity units had clear protocols for managing drug dependence during pregnancy and treating neonatal abstinence syndrome, many did not.

4.19 The survey confirmed that substance misuse is a factor in a significant proportion of cases of children identified as in need and children on the child protection register. However, a large proportion of social work services were unable to give us data on the numbers of children involved, and most were unable to distinguish between drug and alcohol problems. Given that substance misuse inevitably forms part of the case load of cases of child protection and children in need, it is of concern that a third of services did not provide training in this area. We were also disappointed to learn that only 43% reported that they had guidelines or protocols to guide assessment and decision-making in this extremely difficult area.

4.20 Levels of joint work between the services appeared to vary widely and is just one aspect of an overall impression of inconsistency, with no clear geographic pattern of either service provision or regular inter-agency working. The lack of standard data collection also means that services are unable to offer a clear view of the number of parents or children they are dealing with. In the absence of information, it is therefore all too easy for agencies to be unaware of the issues and hence to avoid facing up to them. It is therefore clear that across all three types of service there is considerable scope for improvement: in data collection, client assessment, staff training, service provision and joint working. We strongly support the policy adopted by the National Treatment Agency that drug and alcohol services should collect a minimum data set that includes questions about the number of each client's children under 18 and where they are living. We also think it is essential that the Department of Health and the devolved executives should ensure that consistent data on problem drug or alcohol use are collected by maternity units from pregnant women and by social services from the parents of children 'in need' or 'at risk'. This could be done with the assistance of the Maternity External Working Groups of the Children's National Service Frameworks in both England and Wales and the newly created NHS Quality Improvement in Scotland. If these data are not collected, we will continue to remain unclear about the true extent of the problem and unable to say how successful we are at managing it.

Recommendations

8. The Department of Health and the devolved executives should ensure that all maternity units and social service children and family teams routinely record problem drug or alcohol use by a pregnant mother or a child's parents in a way that respects privacy and confidentiality but both enables accurate assessment of the individual or family and permits consistent evaluation of and comparisons between services.

9. The National Treatment Agency and the devolved executives should ensure that all specialist drug and alcohol services ask about and record the number, age and whereabouts of all their clients' children in a consistent manner.

   Recommendations about service provision, joint working and staff training are given in Chapter 7.

Chapter 5

The legal framework and child protection arrangements

The Children Acts

5.1 Local authorities, health services, housing agencies, law enforcement and other agencies in contact with families have a range of responsibilities for promoting the welfare of children and protecting them from danger. The main legislation describing these responsibilities is set out in the Children Act (1989) and the Children (Scotland) Act (1995). The key principles that underpin the legislation and apply to all families with children are derived from the United Nations Convention on the Rights of the Child. These are:

- the well-being of the child is of paramount importance in any court proceedings regarding a child's upbringing;
- all children have the right to be treated as individuals;
- all children have the right to be protected from abuse, neglect, or exploitation;
- all children able to form a view on matters that affect them have the right to express those views if they wish;
- parents should normally be responsible for the upbringing of children and should share that responsibility;
- public authorities and other agencies should promote the upbringing of children by their families so far as is consistent with safeguarding and promoting the child's well-being;
- any intervention by a public authority in the life of a child should be properly justified and supported by services from all relevant agencies working in collaboration.

5.2 The Children Acts place a duty on local authorities to provide services when:

- a child is unlikely to achieve or maintain, or have the opportunity of achieving or maintaining, a reasonable standard of health or development without the provision for him of services by a local authority;
- his health or development is likely to be significantly impaired or further impaired, without the provision for him of such services;
- he is disabled;
- he is adversely affected by the disability of any other person in his family (in Scotland only).

Children to whom these conditions apply are termed 'children in need'.

5.3 From the legal perspective, there is therefore little doubt that public services and other agencies engaging with problem drug users who have dependent children, or directly with the children themselves, have a duty to assess the needs of those children if there is evidence that their health and well-being may be at risk. A guiding principle in the legislation that should influence the approach taken is: 'parents should normally be responsible for their children'. This places the onus on public authorities not to separate the child from the parent unless it is clearly in the child's interests to do so.

Child protection arrangements

5.4 Guidance on how child welfare agencies in England and Wales should work together where there are child protection concerns is provided in Working Together to Safeguard Children, issued by the Department of Health, Home Office and DfEE in 1999. Similar guidance exists in Scotland. Each local authority is required to have an Area Child Protection Committee (ACPC) with members from social services departments, the police, probation services (in England and Wales), education, health services and non-statutory agencies. The aim of the ACPC is to promote, instigate and monitor joint policies in child protection work across all the different agencies and professional groups likely to become involved in individual cases and to facilitate co-operation and collaboration.

Children 'in need' or 'at risk'

5.5 Under the provisions of the Children Acts, social services departments are required to determine whether a child is in need of services, including services to protect them from significant harm. A child 'in need' is defined as one who is unlikely to achieve or maintain a reasonable standard of health or development, or his health and development is likely to be impaired without provision of services by a local authority. The Children Acts place local authorities under a duty to provide a range of services, as they think appropriate, to support both children in need and their families. The extent to which local authorities can provide help and support under the Acts depends upon the available resources. In England and Wales, where the local authority considers a child is 'at risk of significant harm', it may call a Child Protection Conference (Box 5.1). If the child is considered 'at risk', his or her name should be added to the Child Protection Register. Responsibility for implementing a care plan will then normally fall upon the social services department which will designate one of its staff as a key worker. If

the Conference or the local authority is unable to obtain satisfactory co-operation and compliance from the parents, they may institute court proceedings for a care or supervision order. In Scotland this latter function is carried out by the Children's Panel (Box 5.2). In an emergency, an Emergency Protection Order can be sought (Box 5.3).

5.6 The court or the Children's Panel has four main options. These are:

- no further action;
- voluntary supervision;
- a compulsory order for supervision at home or elsewhere in the community (a 'supervision order' in England and Wales; a 'looked after at home' child in Scotland);
- a compulsory order for supervision in local authority approved accommodation (a 'looked after' child in England and Wales; a 'looked after and accommodated child' in Scotland).

5.7 A basic principle of the legislation is that no court should make an order relating to a child unless it is considered that to do so would be better for the child than making no order at all. Most children who are placed on the child protection register and/or under supervision remain living with their families, during which time the family's capacity to care adequately for the child is assessed and appropriate support provided to reduce the potential for harm.

Box 5.1 The Child Protection Conference

The child protection conference brings together family members, the child (where appropriate) and professionals from the relevant agencies. Participants could include the social worker for the child and the family, a health visitor, a general practitioner or paediatrician, and other involved professionals such as teachers and nursery staff, the police and psychologists. The aims of the conference are to share and evaluate the available information, make decisions about the risk to the child, decide if the child should be placed on the child protection register and make plans for the future. These plans should have clear objectives and a review process and should identify who is responsible for doing what and when.

Box 5.2 The Children's Panel in Scotland

Arrangements in Scotland differ from those in England and Wales due to the existence of the Children's Panel. This is made up of lay members and has a statutory responsibility for considering a range of circumstances where the interests of children are involved. If, as a result of their inquiries, the local authority believes that a child may be in need of compulsory measures of care, they must pass on any information to the Reporter of the Children's Panel for consideration for the need for a Children's Hearing. Having heard the facts of the case, the Panel can recommend one of the four options outlined in paragraph 5.6. The local authority has a statutory duty to put into effect the recommendations of the Panel.

Box 5.3 The Emergency Protection Order

Any person who has reasonable grounds to believe that a child is at immediate risk of harm may apply to a magistrate (or sheriff in Scotland) for an Emergency Protection Order, authorising a child's removal to, or retention in, a place of safety. Most applications are made by local authorities and can be heard by a magistrate or sheriff at any time. Before granting an order, the magistrate or sheriff must be satisfied that there is reasonable cause to suspect the child is suffering or likely to suffer significant harm. The order may last for up to eight days. If a magistrate or sheriff is not available, a police officer or, in Scotland, a Justice of the Peace may remove a child to a place of safety for a maximum of 72 hours.

When and how to act

5.8 A clear legal framework and procedures, and a means of acquiring the necessary information about a child's circumstances, are important elements in enabling social work staff and other agencies to act in the best interests of the child. Once an assessment has been completed and the child's needs identified, the challenge is then to decide what to do. A primary consideration is whether or not the child's safety and stability can be assured if it remains with its parent or parents. When a parent consistently places the purchase and use of drugs over their child's welfare and/or fails to meet the child's physical or emotional needs, the outlook for the child's health and development is poor. A local authority or other authorised child protection agency must intervene, even against a parent's wishes, if it seems likely that a child may suffer significant harm if things are left as they are. Making a decision to remove the child from his or her family can often be extremely difficult. The possible alternative arrangements may themselves be less than ideal or in short supply. These may include: being looked after by another member of the extended family such as a grandparent; being taken into foster care; or a placement in residential care. Where removal from a parent's care is necessary, the local authority should make every effort to restore the child to his or her family whenever this is consistent with the child's welfare. This might, for example, be contingent upon the parents stabilising and reducing their illegal drug use within an agreed period of time.

5.9 Provided the child is not at risk, the local authority should not invoke child protection procedures but should offer help and support to enable parents to provide the necessary care for their child at home. Parental drug use is only one of a wide range of factors which can jeopardise the health and development of children. It should not in itself automatically lead to child protection inquiries or other forms of compulsory intervention. However, as we have already seen, *problematic* drug use by one or both parents can negatively affect the family environment and parenting capacity in so many ways that knowledge of its existence should stimulate heightened vigilance.

The current child protection system in practice

Parental problem drug and alcohol misuse in London[1, 2]

5.10 In a recent study funded by the Nuffield Foundation, a review was conducted of all 290 cases of child care concerns newly allocated for long-term social work in four London local authorities over a year. Parental substance misuse affected 100 families (34%) of the total sample. This number included 32 families involving drug misuse alone, 41 involving alcohol misuse alone and 27 involving both. The profile of the substance misuse families was very 'heavy end': 62% of all children subject to care proceedings and 40% of children on the child protection register at allocation involved substance misuse. Neglect was a common feature of cases involving both drugs and alcohol. Drug misuse alone most commonly concerned new-born babies subject to care proceedings whilst alcohol misuse was associated with violence and emotional abuse.

5.11 Despite the severity of the substance misuse cases, most of the social workers were relatively newly qualified and had had little or no training in working with drug or alcohol misuse. Notably, at allocation only 29% of families had received any input from substance misuse professionals, principally because parents said they did not need specialist help. When substance misuse professionals were involved, social workers valued their input. Only one case originated from a referral from a substance misuse professional.

5.12 A surprising finding was that 39 cases involved parental crack cocaine use – more than those involving heroin. This was thought to reflect the recent increase in crack cocaine use in London. Crack-using clients were among the most violent and threatening and a high proportion of these cases involved care proceedings or child protection procedures.

The Scottish Child Protection Audit and Review

5.13 A major review of child protection arrangements in Scotland was published in 2002[3]. A detailed audit of a representative sample of 188 children was conducted. The children were selected from a larger sample of over 5,000 cases referred because of concerns of abuse or neglect. Of the 188, 76 (40%) were 'living with parental substance misuse'. In some urban areas, the proportions were even higher. For example, in Dundee, the proportion of children subject to child protection case conferences whose parents were recorded as having problems with alcohol and/or drug misuse rose from 37% in 1998/99 to 70% in 2000. The audit did not distinguish between alcohol and other drugs of misuse. The report stated: "Where parents had serious addiction problems, children were at risk when their parents were affected by drugs. Health visitors or social workers found young children at risk from fires or other household appliances. Some parents tried to protect their children from knowledge of their drug use and from possible harm by locking them in their bedrooms for long periods of the day or night. This solution created its own abusive problems, not least children urinating and soiling in their bedrooms."

5.14 The Review concluded that: "The child protection system does not always work well for those children and adults involved in it." In particular, it found that: "Agencies are not able to always respond effectively to some problems – parental drug or alcohol misuse, domestic abuse and neglect." Among the 188 cases, 40 children were not protected or their needs were not met following the intervention of agencies, and a further 62 children were only partially protected or their needs partially met. The authors stated: "Outcomes for children were found to be highly dependent on social work doing well. Where social work performed well, outcomes were generally good and when they performed less well outcomes were generally poor. While good outcomes were assisted by the work of all agencies, they were less dependent on other agencies." The report also found that: "There was evidence of high levels of home support stabilising situations, particularly where there were problems of substance misuse…In a number of instances, particularly in relation to drugs or alcohol misuse, where strong supportive relationships had been established between social workers and misusing parents, workers were able to address the problems and parents were very positive about the support they received."

5.15 The Scottish Review made 17 recommendations. These included the need for improved sharing of information between professionals, a revised remit for Child Protection Committees, and increased resourcing of children's services. In particular, it called for 'an assessment of need of all new-born babies born to drug or alcohol misusing parents'. This assessment should be followed by an action plan that clearly states:

- the standards of childcare and developmental milestones the child is expected to experience or achieve;
- the resources to be provided for the child or to assist the parents in their parenting role;
- monitoring that will put into place along with contingency plans should the child's needs fail to be met.

The Victoria Climbié Inquiry

5.16 Published in January 2003, the report of the Inquiry by Lord Laming is a comprehensive analysis of the shortcomings of the current child protection system in England, as exemplified by the numerous professional and organisational failings that contributed to the death of Victoria Climbié[4]. The report makes 108 recommendations that, if and when implemented, would result in major changes in policies and procedures relating to child protection. They will have a major influence upon the way in which agencies and professionals – both individually and collectively – assess and deal with children about whom there are child protection concerns. Many of these will be as relevant to the children of problem drug users as to any other vulnerable children.

Recommendation

10. When revising child protection policies and procedures, full account should be taken of the particular challenges posed by parental problem drug use, with the consequent implications for staff training, assessment and case management procedures, and inter-agency liaison.

5.17 We broadly welcome all new measures that can help reduce the harm done to children. However, perhaps because substance misuse was not involved in the Victoria Climbié case, parental problem drug use *per se* was not addressed by Lord Laming. As we have shown in the present Inquiry, parental problem drug use is involved in a large proportion of cases where there is recognised child abuse or neglect, and affects a much larger number of children in less obviously acute ways. It is therefore essential in our view that this dimension of child protection is properly addressed when the Government is implementing Lord Laming's recommendations. Child protection staff will need adequate education and training to enable them to understand parental substance misuse and its impact on children; they will need to use appropriate assessment procedures to grasp what is going on; they will often need to liaise closely with drug misuse treatment services in an attempt to control the parent's substance misuse; and they may have to provide support for the children themselves that is primarily in his or her interests rather than their parents. These aspects are addressed in more detail in Chapter 7.

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Chapter 6

Recent relevant developments in Government strategies, policies and programmes

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6.1 Over the past five years, there have been a number of developments in Government strategies, policies and programmes that aim to tackle drug misuse, reduce social exclusion and poverty, and improve child health. Whilst these are primarily directed at helping a wider range of people, they also offer the prospect of benefit to children of problem drug users either directly or indirectly. Indeed, in some cases, particularly in Scotland, the children of problem drug users are specifically identified. In this chapter, we have therefore attempted to summarise the main relevant initiatives of which we are aware in England, Wales and Scotland. Unfortunately, it was not possible to obtain any information about the current position in Northern Ireland. This is not a comprehensive review of all relevant initiatives but an attempt to give a broad-brush impression of recent developments. The reader should also recognise that this is the situation as it stood early in 2003. With the rapid pace of change, some of what is described may soon be superseded

6.2 We are grateful to officials in the Department of Health, the Department for Education and Skills, the Home Office, the Cabinet Office, the Scottish Executive and the Welsh Assembly Government for providing us with much of the information given here.

6.3 The actual benefit of these initiatives to the children of problem drug users is unknown at this stage for various reasons. Some have not yet begun; few are specifically targeted at the children of problem drug users; and several involve relatively small numbers of children or limited parts of the country. Where evaluation is being carried out, the results are not yet available. Nevertheless, taken as a whole, they represent welcome moves in the right direction and one which the Working Group strongly supports. Our principle concern is one of scale: where initiatives are found to be effective, can they be extended sufficiently to be of meaningful benefit to the many?

England

The Updated Drug Strategy 2002

6.4 The Updated Drug Strategy describes the wide range of measures taken by Government to tackle drug misuse at all levels. In particular there is an increased focus on limiting the availability of Class A drugs such as heroin, crack cocaine and ecstasy; a greater emphasis on helping vulnerable young people; and a substantial expansion of treatment services, headed by the National Treatment Agency. The strategy acknowledges that the children of problem drug users are at a higher risk of misusing drugs themselves. It also recognises there are often shortcomings in the support women drug users receive from treatment services in terms of childcare. An initiative in Walsall designed to improve the lives of children of problem drug users is highlighted. These references apart, however, the lack of attention to the children of problem drug users is an indication that, at a strategic level, neither the number of children involved nor the extent of their needs has yet been fully recognised.

The National Treatment Agency for Substance Misuse

6.5 This special health authority was set up in 2001 with the aim of co-ordinating the expansion of high quality, evidence-based, cost-effective treatment for people with drug or alcohol problems throughout England. In large measure, these services are organised and commissioned through the 149 local Drug Action Teams throughout England (see Chapter 7). An analysis by the NTA of the DATs' spending intentions for 2002/03 shows that relatively few DATs were investing in services likely to benefit the children of problem drug users directly[1]. Only 24% of DATs said they were investing in 'family support', 25% in 'women specific services' and 31% in 'young people's services'. This represented less than 7% of the total proposed investment. It is probable that most of this money was being directed at helping a wide range of people including the parents and siblings of problem drug users, women without children and young people who are themselves misusing drugs. It thus seems likely that a very small proportion of current drug misuse treatment budgets is being used directly to help the children of problem drug users.

6.6 The NTA has developed models of care for special groups of drug misusers who are typically poorly served by drug misuse services but for whom there may be examples of good practice[2]. These include substance misusing parents and pregnant drug users. The NTA has recognised that 'the welfare of the child is paramount' and states that: "Drug treatment services need to be aware of their responsibilities to both their clients and their clients' children." It now expects these issues to be addressed by service commissioners. The NTA has also developed Drug and Alcohol Occupational Standards (DANOS) which set out the competencies expected of staff working in drug and alcohol services. These include the importance of assessing the effect of drug use on the client's family, including children. The NTA has agreed a minimum data set of information that newly commissioned drug or alcohol treatment agencies should collect from their clients[3]. This includes recording how

many children under 18 the client has and where they are living. These are very welcome developments and indicate a foundation is being laid upon which a much more substantial structure of service provision can be built.

The Children's National Service Framework

6.7 The programme of National Service Frameworks (NSF) aims to improve standards and reduce unacceptable variations in health and social services. Each NSF sets out a programme of action and reform. They are not legally binding but implementation is expected to be a priority for both health services and their partner agencies. Work on the Children's NSF began in early 2001 and is being undertaken by a Children's Taskforce. Detailed work is being developed in six modules, each being taken forward by an External Working Group (EWG). Some of the common themes that have been identified include: tackling inequalities and problems of access; involving parents and children in choices about care; integration and partnership; and transitions between children's services and from children's to adult services.

6.8 The EWG most relevant to the children of problem drug users is Children in Special Circumstances. It quickly found that many children were in special circumstances because of the needs of their parents or carers, including children of problem drug users. Following liaison with the Prevention Working Group in summer 2002, this EWG has specifically included the needs of children of problem drug users in its remit. In order to ensure the needs of children in special circumstances can be met, the EWG has identified the following key aspirations:

- systems should be in place to identify and track children likely to achieve poorer outcomes than the general population;
- there must be high quality assessment of their developmental needs;
- those working with children should have common training, competencies, skills and values;
- adult and children's services should work effectively together;
- children should be protected from harm.

6.9 Four subgroups were created to look at the first four issues, with child protection taken as an overarching theme. The EWG is likely to make recommendations and set standards aimed at improving effective working between adult and children's services.

Children and Young People's Unit

6.10 This is a cross-departmental unit with a remit that includes developing a cross-Government strategy for all children and young people. The strategy will link in with other major policy initiatives such as the Children's National Service Framework and young people's services within the NHS. Much of the strategy will focus on outcomes to which the Government will aspire over the next 10 years and beyond. Five outcome areas have been identified: health and emotional well-being; protection and staying safe; fulfilment; social engagement; and material well-being. Outcomes for children of problem drug users are clearly at risk of being prejudiced in each of these areas, and the Unit has expressed an interest in any action or proposals to combat this problem. The strategy covers young people up to the age of 19 and will therefore also be of relevance to young people who are problem drug users, including those who are themselves parents. Some of the identified themes and service areas include: children missing school; the social and emotional well-being of children and young people; and family support services.

Green Paper on Children at Risk

6.11 At the time of finalising this report, the Government was preparing a Green Paper on Children at Risk. Its aim is to develop policies that improve the life chances of children and young people aged 0–19 at risk of a wide range of negative outcomes. These include truancy, educational underachievement, offending, victimization, teenage pregnancy, and poor mental health. A number of the key recommendations of the Laming Report are being addressed in the Green Paper. Many children of problem drug users clearly fall within the 'at risk' population with which the Review is concerned.

Extended schools

6.12 The Department for Education and Skills is encouraging schools to develop wider services for pupils, families and the community, such as health and social care, childcare and adult education ('extended schools'). Schools that have already adopted this approach have found that building better links with families and communities and offering extended services can help them in raising pupils' motivation, expectations and achievement, leading to higher standards, improved behaviour and increased involvement by parents in their children's education. Support from local community organisations can be a crucial factor in supporting families and combatting social exclusion. The range of services offered and facilities provided in 'extended schools' differ

from one school to another. In considering what they could offer, account should be taken of the needs of the pupils, families and communities in their areas, and of the school's existing expertise and facilities.

6.13 Health services offered by extended schools might include school-based clinics staffed by health professionals, not by teachers. These could offer advice and support on a range of issues of concern to young people, such as bullying, depression, drug misuse, sexual health and eating disorders. In general they would be available to both pupils and their parents and families. Other services might include parenting classes, adult and family learning, childcare, and housing and legal advice. These facilities could therefore be of potential value to both the children of problem drug users and their parents.

6.14 General guidance for schools on how to develop family and community services will be issued shortly. It will include advice and information on the range of different activities and services that schools could provide, including healthcare and social services. This will emphasise the importance of effective consultation with parents and the wider school community. The DfES will also be supporting a number of pathfinder projects to test out new approaches adopted by schools and local authorities under the new legislation.

The National Healthy School Standard

6.15 The National Healthy School Standard (NHSS) is a DfES and DH-funded initiative that aims to raise educational achievement and address health inequalities. Local Healthy Schools Programmes are required to demonstrate how they will meet the needs of all their children and young people, including those that are vulnerable.

Sure Start, Early Years and Childcare Unit

6.16 This unit, based in the DfES, develops programmes to promote the physical, intellectual and social development of young children – particularly those who are disadvantaged – so they can flourish at home, at school and during later life. It aims to help strengthen families and reduce child poverty by enabling parents to maximise their opportunities to work, learn and study, confident their children are being cared for in a safe and stimulating environment. It also contributes to building and sustaining strong local communities through high quality and innovatively delivered family services. The methods used include the development of integrated, high quality and accessible early education, childcare and specialist family services, including parental support and health advice that can engage directly with local families.

6.17 The **Sure Start** programme provides support for parents in disadvantaged areas in caring for their children. Each programme is different and designed to meet local needs, but all offer certain core services. All families are visited following the birth of a new baby to explain the services available, which helps with the early identification of individual needs. Befriending schemes offer support for families facing emotional stress or other problems. Local volunteers – often those who have faced similar difficulties themselves – are trained in counselling. Families are encouraged to access other services, initially informally and later through more formal classes and events. Support includes referral, with parents' consent, to other professional assistance. These schemes are adapted, with appropriate professional input, to provide specific support to families who have to deal with drug or alcohol misuse. Although programmes deal with whole family support, the impact on children is of primary concern. Where a local Sure Start programme comes into contact with children of problem drug users, it is expected that they will seek advice from, and work closely with, their local Drug Action Team in providing support for these families as part of their core services.

6.18 There are now over 90 **Early Excellence Centres** in England. They monitor and provide support for children's care and well-being; work with and counsel parents; offer specialist advice, respite and childcare at key stages; and mediate and co-ordinate the work of local agencies. These services are offered both by professionals working in the Centres, or EEC staff developing their own expertise. A number are already providing a range of preventative services to families where drug misuse is an issue. In the 2002 Spending Review, the Government announced plans to establish **Children's Centres** in disadvantaged areas, providing good quality childcare alongside early education, family and health services. They would build on and bring together existing programmes such as Sure Start and Early Excellence Centres.

Connexions service

6.19 Connexions is an advisory service for all young persons aged 13–19 years, aimed at helping them reach their full potential. It provides advice, information, support and practical help on a range of issues from careers to relationships and school and home problems. All young people will have access as required to a personal adviser who will carry out a full assessment of their needs and put in place support to meet those needs. The assessment framework covers 18 factors in four groups: employment and education; social and behavioural

development; personal health; and family and environment. Three factors would be particularly relevant to identifying whether parental drug use would be an issue for a young person: substance misuse; capacity of parents or carers; and family history and functioning. Confidentiality is a prime consideration in building up a relationship with young people and in gaining the trust of hard to reach and vulnerable young people.

Alternative education provision

6.20 Under the Education Act 1996, Local Education Authorities must offer suitable education at school or elsewhere for pupils of compulsory school age who are otherwise out of school or not gaining qualifications. This may be of particular relevance to children whose parents' problem drug use has led to poor attendance at school. Alternative provision is based on the needs of the child and may be provided through a number of routes, used either in isolation or in combination, including Pupil Referral Units (PRUs), Further Education Colleges through work experience, voluntary provision, Information Communication Technology (ICT) provision and home tuition. There are now more than 350 PRUs throughout England. The DfES is funding a variety of projects and providing LEAs with additional resources to help the most disaffected and at risk children and young people through the Standards Fund, such as the Social Inclusion Pupil Support grant. The largest part of that grant is the Pupil Retention Grant, which aims to support LEAs in tackling poor behaviour and providing alternative education.

Behaviour Improvement Package

6.21 The DfES Behaviour Improvement Package provides funding for the 34 local education authorities in areas of high-street crime and truancy rates. The LEAs have all submitted plans to work with clusters of primary and secondary schools to meet five key targets: improve standards of behaviour overall; reduce truancy; contain exclusions (ie keep them lower than in comparable schools); ensure there is a named key worker for every child at risk of truancy, exclusion or criminal behaviour; provide full-time supervision for pupils from day one of a temporary or permanent exclusion.

National Healthy Care Standard

6.22 The Department of Health has funded the National Children's Bureau to lead the development of a National Healthy Care Standard (NHCS). This aims to ensure that all care settings provide a healthy caring environment, high quality health assessments, health care and treatment, and promote health and well-being. Particular regard has been paid to the importance of emotional resilience to help address social and health inequalities. This will be relevant to the many children of problem drug users who are looked after under formal care arrangements.

Wales

Welsh Substance Misuse Strategy

6.23 The eight-year Welsh Substance Misuse Strategy, *Tackling substance misuse in Wales: A partnership approach*, was launched in 2000. It covers illegal drugs, alcohol, over-the-counter and prescription-only medicines and volatile substances. The four key aims of the strategy are:

- to help children, young people and adults resist substance misuse in order to achieve their full potential in society, and to promote sensible drinking in the context of a healthy lifestyle;
- to protect families and communities from anti-social and criminal behaviour and health risks related to substance misuse;
- to enable people to overcome their substance misuse problems and live healthy and fulfilling lives, and, in the case of offenders, crime free lives;
- to stifle the availability of illegal drugs and other inappropriate substances.

The strategy highlights the children of substance misusing parents as one of several particularly vulnerable groups. Their needs should be assessed in a timely and comprehensive way and services provided to safeguard their welfare when appropriate. Proposals have been put to the Welsh Assembly Government recommending a strategy which addresses the needs of children whose parents misuse drugs or alcohol. Responsibility for the formulation and implementation of local substance misuse strategies rests with the 22 Community Safety Partnerships which are based on unitary local authority boundaries. Local Substance Misuse Action Teams function under the aegis of the Community Safety Partnerships.

The Welsh Assembly Government has taken a number of initiatives that are designed to help children in general and may therefore be of value to children affected by parental substance misuse. These include:

Framework for Partnership (including Early Entitlement and Extending Entitlement)

6.24 The Framework sets out a strategic statement of how the well-being of children and young people will be improved across all areas of their lives. It is being developed by bringing together all local partners who provide services for children and young people. The Framework partnership includes the children's partnership, Early Entitlement (0–10 years) and the young people's partnership, Extending Entitlement (11–25 years), that are responsible for drawing up more detailed plans to achieve the Framework vision.

Cymorth: Children and Youth Support Fund (including Sure Start)

6.25 This Fund, which starts in April 2003, will provide extra services for children and young people in disadvantaged communities across Wales. It brings together into a single scheme a number of existing programmes: Sure Start, Children and Youth Partnership Fund, National Childcare Strategy, Youth Access Initiative and Play Grant.

Welsh National Service Framework for Children

6.26 The Welsh Children's NSF has adopted the same arrangements as in England (paragraph 6.7). It aims to improve quality and equity of service delivery by the setting of national standards for health and social care for all children from before birth, through childhood and adolescence into adulthood, and in all settings. As in England, the Children in Special Circumstances module will be considering the management of children whose parents abuse substances, whilst the Healthy Child module will consider the prevention of substance misuse in children.

Carers' Strategy (including Young Carers' Advisory Panel)

6.27 The Welsh Assembly Government has an agreed Carers' Strategy backed up by a grant scheme aimed at providing respite to carers. The objective of the Carers' Strategy in Wales: Implementation Plan is to improve in the longer term the health and well-being of carers and those for whom they care. It is being taken forward in partnership with local Government, the voluntary sector and other key agencies, to maximise opportunities to meet carers needs.

Funky Dragon (the Children and Young People's Assembly)

6.28 This is a council of representatives from local children and young people's forums and national and local peer-led groups. This new body has a direct link with the Assembly and meets regularly with the Minister for Health and Social Services, the Minister for Education and Lifelong Learning, and other officials. The meetings enable children and young people to participate in decision-making at the national level and to bring up issues such as substance misuse in the home.

Canllaw-on-line (website and helplines)

6.29 Canllaw is a comprehensive information service for young people, supported by the Assembly. Canllaw also has an information shop in Newport, and has recently produced and distributed an information handbook and the Euro under-26 discount card to all 15 and 16-year-olds in Wales.

Children's Commissioner for Wales

6.30 The Assembly has established an independent, statutory Children's Commissioner for Wales. This position has a wide-ranging remit and the Commissioner acts as an advocate for all children and young people in Wales, exercising his broad remit and powers to investigate matters affecting them. Peter Clarke, the first Children's Commissioner for Wales, took up office on 1 March 2001.

Scotland

Drug and alcohol strategic frameworks

6.31 The Executive's drugs strategy, *Tackling drugs in Scotland: Action in partnership* (1999) calls on agencies to assess the needs of the children of drug-using parents and provide services to safeguard their welfare. The *Drugs action plan: Protecting our future* (2000) identifies the children of drug-using parents as a priority group. All Drug Action Teams and Area Child Protection Committees are now required to have in place local policies on support to drug-using parents and their children in line with national guidance. The Executive's national *Plan for action on alcohol problems* (2002) and the subsequent *Alcohol problems support and treatment services framework* also cover the needs of children affected by their own and other people's alcohol problems.

6.32 The emphasis in the strategic frameworks is on partnership working and the integration of service provision involving the key statutory and voluntary sector agencies. This aspect has been strengthened recently with the publication of guidance from the Executive's Effective Interventions Unit which provides information and support to Drug Action Teams and partner agencies in the planning, design and delivery of integrated care for drug users. In addition, Drug and Alcohol Action Teams are required to co-ordinate substance misuse planning activity with other local planning arrangements, such as children's services plans, to ensure that they are compatible.

Guidelines for working with children and families affected by substance misuse

6.33 In early 2003, the Executive published *Getting our priorities right: Good practice guidance for working with children and families affected by substance misuse*[4]. The aim is to assist agencies in assessing the needs of children and families affected by substance misuse and providing services to safeguard their welfare. The guidance includes information on the extent of the problem and its impact on children, and addresses issues such as assessing risk, sharing information and confidentiality, and providing support. Key themes throughout the guidance are: that children's welfare is the most important consideration; it is everyone's responsibility to ensure that children are protected from harm; children should be helped at an early stage, rather than at a point of crisis; and everyone should work together in all aspects of the planning and delivery of care and training. An implementation plan for the guidance will be developed.

6.34 DATs and Child Protection Committees are required to have in place local policies on support to drug-using parents and their children, in line with this guidance.

Training

6.35 In 2001, the Scottish Executive established STRADA (Scottish Training – Drugs and Alcohol), a training agency for professional groups across Scotland on drug and alcohol misuse and related issues. That year, it conducted a training needs analysis in which children, young people, parenting issues, women and pregnant users were identified as major specific training needs by all respondents. Modules have been specifically devised in response to these findings. These include a two-day module on Children and Families Affected by Problem Drug and Alcohol Misuse. This is aimed at specialist workers within addiction and childcare services and also at those in more generic settings. The course relates directly to *Getting our priorities right* (see above). There is also a two-day module on Working with Women Drug and Alcohol Misusers which includes specific skill development relating to work with pregnant drug misusers.

Children's services

6.36 *For Scotland's children: Better integrated children's services*, published by the Executive in 2001, highlights the harm done to children by parental problem drug use as a matter of great concern. It emphasises that the task of helping children with drug-using parents is for everyone in universal services, such as health and education, and not just for social services. It sets out the Executive's commitment to creating a Scotland where every child, regardless of their family background, has the best possible chance in life. As indicated earlier, the focus is on better integrated services which recognise that children requiring support will often have a range of complex problems. The report provides an Action Plan containing a range of ways in which local authorities, the NHS and the voluntary sector can work together to create a single children's services system.

6.37 The **Child Protection Audit and Review**, published in December 2002 is summarised in Chapter 5.

Current or planned initiatives which will impact on the children of drug-using parents are as follows:

6.38 The **Sure Start Scotland** programme takes an integrated approach to meeting children's needs. £19 million was allocated to local authorities in 2002/03 to work in partnership with health and voluntary organisations, with an additional £31 million announced for 2003–2006. The programme targets support at families with very young children aged 0–3 years, with a particular focus on vulnerable and deprived families. The aim is to enable children to have a good start in life and to make the most of subsequent opportunities. Given that children of drug-using parents are likely to suffer greater disadvantage, it is probable that they will be amongst those families targeted in general terms. Integrated services and joint working are a key part of the programme. Provision is diverse and can include centre-based provision, nursery and childcare services, and parent support. In addition, some local authority areas have developed more specialised services and projects for the most vulnerable and marginalised groups, and this includes projects working with families affected by drug misuse.

6.39 Central to these developments has been the introduction of **community schools** where a school, or cluster of schools, provide a range of services in addition to teaching, to meet the needs of pupils and their families. Some services might be educative, for example,

the provision of parenting classes, others will be social work or health based. Some services provide much needed material and social resources, for example, breakfast clubs, after school activities and playgroups.

6.40 The **Changing Children's Services Fund**, worth some £80 million over 2002–2004, is aimed at providing funding to help local authorities, the NHS and the voluntary sector to re-orientate and improve the integration of children's services. It includes a strand aimed specifically at children and young people affected by drug misuse, their own or their parents'. The fund has enabled a broad range of new and enhanced services for children and young people to come on stream.

6.41 Starting Well is a three-year National Demonstration Project designed to explore the effect of providing intensive support to families with young children in two disadvantaged areas of Glasgow where there are high levels of problem drug use.

6.42 The Scottish Executive has allocated funding of £7 million over four years to **Social Inclusion Partnerships** (SIPs) to tackle drug misuse in their communities. In allocating drugs-related funds to SIPs, the overall theme is of partnership between all involved in resolving the drug problem in deprived areas. Whilst there is no specific focus on the children of drug-using parents, there are two areas of activity which have a direct relevance to them – providing support to families of drug users and dealing with the accommodation needs of current and former drug users. There are a number of strands to the community aspects of SIP drugs projects. Many projects involve researching the service provision available locally and building links between the different agencies dealing with drug issues, as the report recommends. In turn, these agencies are linked with groups in the community who are involved in anti-drugs work. Assistance for the families of users is also common through family support groups providing counselling, information and advice or respite care. Some projects also involve residential rehabilitation for female drug users and their children.

6.43 Healthy Living Centres, funded by the New Opportunities Fund, focus on disadvantaged areas and aim to reduce health inequalities and improve the health of the most vulnerable in the community. They tackle a range of problems, including drugs and alcohol.

6.44 The **Partnership Drugs Initiative** is a strategic funding programme to promote voluntary sector work with vulnerable children and young people affected by drug misuse, including children living in families in which parents misuse drugs. It is a partnership between the Scottish Executive, Lloyds TSB Foundation for Scotland, voluntary organisations and local Drug Action Teams.

The programme began making awards in 2001 and two funding rounds per year will continue until December 2003. Applications are prepared and submitted by local Drug Action Teams in partnership with voluntary organisations and awards are made directly to the voluntary organisation.

Recommendations

11. Reducing the harm to children as a result of parental drug use should be a main objective of the UK's drug strategies.

12. The Government should ensure that the National Children's Service Framework and equivalent strategic arrangements in Wales, Scotland and Northern Ireland, identify children of problem drug users as a large group with special needs that require specific actions by health, education and social services.

13. The National Treatment Agency, the Welsh Assembly Government and the Scottish Executive should ensure that services for adult substance misusers identify and record the existence of clients' dependent children and contribute actively to meeting their needs either directly or through referral to or liaison with other appropriate services, including those in the non-statutory sector. This should include protocols that set out arrangements between drug and alcohol services and child protection services.

14. Whenever possible, the relevant Government departments should ensure there are mechanisms in place to evaluate the extent to which the many initiatives outlined in this chapter benefit vulnerable children, including the children of problem drug users.

References

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Chapter 7

The practicalities of protecting and supporting the children of problem drug users

Chapter 7 The practicalities of protecting and supporting the children of problem drug users

7.1 In Chapter 5, we considered the legal framework and arrangements for protecting children in the UK. In Chapter 6, we looked at a range of current Government initiatives designed to help problem drug users or vulnerable children in general and thus potentially of benefit to the children of problem drug users. Here we turn our attention to services that can help the children of problem drug users directly – health, education, social services, the non-statutory sector and law enforcement. How can they act collectively in the best interests of these children? What part can each service play? Could they do more than at present and, if so, what would be required?

What services are available?

7.2 All children in the country should have right of access to services that exist to protect and foster their health and well-being. The children of problem drug users are no exception. The child's needs begin with his or her mother's pregnancy and continue through to adulthood. The current system of health, education and social care in the UK provides the following universal services:

- maternity services;
- primary health care services including general practitioners and health visitors;
- early learning services and schools.

In addition, there are services able to respond when there are particular problems. These include:

- social work services for children and families;
- services that aim to provide help for people who have drug problems;
- specialist paediatric services for children with physical or mental health problems;
- services in the voluntary sector which have a special focus on children in need or on mothers and their children.

How can services work together better in the interests of the children of problem drug users?

7.3 In recent years, there has been increasing recognition that complex health and social problems need to be addressed in an integrated way at both policy and practice level. England, Wales and Scotland all have a national drug misuse strategy which takes this approach (see Chapter 6). In England, Wales and Scotland, Drug Action Teams (DATs) or similar bodies have been established at local authority or health authority level with the explicit purpose of enabling services to work together. The DAT brings together senior staff from the main agencies working in the drugs field such as health, social work, education, the police and non-statutory organisations. Each DAT should have a strategic plan for preventing drug misuse and reducing drug-related harm in its area. In some areas the remit of the DAT has been widened to cover alcohol and tobacco. However, it appears that relatively few DATs have as yet given the children of problem drug users more than passing attention. There is also little evidence that many areas are considering how the services for adult drug users and services for children can work together in the interests of both parents with drug problems and their children. This was recognised by the Standing Conference on Drug Abuse (now DrugScope) and the Local Government Drug Forum for England and Wales who jointly published a report *Drug using parents: Policy guidelines for inter-agency working* in 1998[1]. This has been followed by a similar initiative in Scotland which led to the publication in 2003 of *Good practice guidance for working with children and families affected by substance misuse*[2].

7.4 Both these reports provide a useful blueprint for how services should work together. The challenge is how to put their recommendations into effect. We heard that only a minority of areas in England appeared to have acted upon the SCODA report since it was published in 1998. We think an important step would be to ensure that the membership of each DAT includes representation of each of the relevant teams responsible for planning services for children in its area, and vice versa. Developing a coherent joint approach for responding to the needs of the children of problem drug users should form part of the plans of each group that are then translated into planning decisions by their constituent agencies. This has already been done in several parts of the country, eg Glasgow[3] and Sheffield. At an operational level, there should be an emphasis on collaboration between drug misuse services, maternity services and children's health and social care services; joint use of a common assessment tool; agreements on inter-agency information sharing; and joint action plans for individual cases. There is also a strong case for joint training for front-line staff. Services working with parents and their children should:

- see the health and well-being of the child as being of paramount importance;

- be accessible, welcoming and non-stigmatising to problem drug users who have children;
- be able to share information with other agencies and professionals on a 'need to know' basis when it is in the interests of the child to do so.

In this rest of this chapter, we consider the role of the various services and how each might best function if they are to address the needs of the children of problem drug users.

Recommendations

15. All Drug Action Teams or equivalent bodies should ensure that safeguarding and promoting the interests of the children of problem drug users is an essential part of their area strategy for reducing drug-related harm and that this is translated into effective, integrated, multi-agency service provision.

16. All Drug Action Teams or equivalent bodies should have cross-representation with the relevant children's services planning teams in their area.

17. Drug misuse services, maternity services and children's health and social care services in each area should forge links that will enable them to respond in a co-ordinated way to the needs of the children of problem drug users.

Maternity services

Accessible and non-judgemental services

7.5 For the health and well-being of both mother and baby, it is very desirable that every mother has access to good maternity services from as early a stage of pregnancy as possible. This is particularly the case for a woman whose drug use may be affecting her own health and that of her baby, either directly or through the unfavourable socio-economic circumstances of her life. As described in Chapter 2, hazards include the effects of the drugs themselves on the baby in the womb, associated infection such as HIV if the mother injects drugs, poverty, poor nutrition, low self-esteem, anxiety and depression. There may also be a heightened risk of assault, for example if working as a prostitute.

7.6 A woman with drug problems may have serious uncertainties about her pregnancy and anxiety about how she will be treated by the maternity services because of her drug use. This may result in delayed presentation to antenatal services and therefore a heightened risk that problems will develop. It was clear to the Inquiry that where antenatal services are accessible and welcoming and known as such by female drug users, late presentation is much less likely. If the woman already has a good and trusting relationship with a GP or specialist drug agency, this can also ensure that an early diagnosis of pregnancy is made and referral to antenatal services is prompt. The more stable and controlled the woman's drug use the better the outcome is likely to be.

An integrated approach

7.7 As we have already discussed, problem drug use brings with it numerous social problems which may complicate the pregnancy. We have therefore concluded that the best arrangements are those where the maternity services are able to offer a comprehensive and integrated approach to both the health and social care issues surrounding the pregnancy and involve the woman in the decision-making process as much as possible. As Dr Hepburn put it, "Maternity care should reflect the woman's wishes but medical and/or social problems may limit the options." Close liaison between maternity service and social care staff familiar with the issues is therefore essential. In Glasgow, it has been shown that effective antenatal care for problem drug users can be provided in the community through specialist multi-disciplinary clinics held in health centres in areas of high drug misuse. Delivery takes place in a dedicated maternity ward[4]. In Manchester, a consultant midwife provides liaison between primary care, maternity, specialist drug services and child protection services to facilitate a co-ordinated approach for pregnant women with either drug or alcohol problems[5]. In Liverpool, a Pregnancy Support Group co-ordinates a multi-disciplinary service for pregnant drug users involving a drug dependency unit, the Women's Hospital and the Social Services Drug and Alcohol Team[6].

Staff training and protocols

7.8 The medical, midwifery, social work and other staff involved in the woman's care require accurate knowledge about and appropriate attitudes to drug use and its consequences for the pregnancy and the future child. They also need sufficient training and experience to do the right things well. If women feel stigmatised or discriminated against by staff because they are drug users, a productive and co-operative relationship is unlikely and the baby may suffer. It is increasingly common for maternity services to have protocols which set out the procedures to be followed, for example in

testing for blood-borne viruses or treating opiate dependence during the pregnancy, and we would strongly support this. It is also essential that the maternity services work closely with a neonatal paediatric service which is able to offer appropriate management of the neonatal abstinence syndrome, to continue effective liaison with social care services and establish links with health visitors and community paediatric services. The service arrangements in Aberdeen provide this type of co-ordinated approach, enabling both mother and baby to receive continuity of care well beyond the birth[7].

Acting in the child's best interest

7.9 Whilst the first intention should be to enable mother and baby to stay together, objective multi-agency assessments and planning and cool judgement are required to establish what is in the best interest of the baby and to ensure that decisions are successfully implemented. Because a baby is so vulnerable in the first year of life and developmental problems at this age are difficult to recover from, delays in decision-making can be dangerous for the baby. Continued placement with the child's natural parents is much more likely to be successful if the mother in particular has access to continuing and effective treatment of both her drug and other problems, as well as effective social support once the baby is born.

Recommendations

18. Every maternity unit should ensure that it provides a service that is accessible to and non-judgemental of pregnant problem drug users and able to offer high quality care aimed at minimising the impact of the mother's drug use on the pregnancy and the baby. This should include the use of clear evidence-based protocols that describe the clinical management of drug misuse during pregnancy and neonatal withdrawals.

19. Pregnant female drug users should be routinely tested, with their informed consent, for HIV, hepatitis B and hepatitis C, and appropriate clinical management provided including hepatitis B immunisation for all babies of drug injectors.

20. Every maternity unit should have effective links with primary health care, social work children and family teams and addiction services that can enable it to contribute to safeguarding the longer-term interests of the baby.

Primary health care

7.10 Every person in the UK eligible for treatment within the NHS should be able to register with a general practitioner and have access to health care provided by a primary care team. The primary health care team includes general practitioners, practice and district nurses, health visitors and often other support staff. All children under five should have a nominated health visitor. Primary health care professionals are the first point of contact for both adults and children for most health problems and also the gateway to most specialist health services. They have the unique advantage of potentially providing continuous family health care throughout childhood and beyond. They therefore play a central role in the provision of health care for children. There are now numerous examples of primary care teams in the UK providing a high standard of care for problem drug users. What is much less certain is the extent to which even these practices are able to address the health needs of the children of problem drug users.

7.11 Children are usually registered with a GP by their parent or guardian, who is registered with the same GP. Throughout the UK, the extent to which GPs are willing and able to register and provide comprehensive health care for problem drug users varies enormously. Some practices provide an outstanding service and work closely with specialist drug agencies, whilst others refuse to register problem drug users at all. Chaotic drug users may themselves not register with a GP, for example because they have changed address or have been excluded from one GP's list and not found another. As a result, their dependent children may be unable to access primary health care. Health visitors may also lose touch with the children of problem drug users if the parent moves away from an area or the child is placed in the care of another family member.

7.12 The provision of adequate primary health care for the children of problem drug users thus depends on both being registered with a GP and having a parent who is willing and able to bring the child to the primary care team when appropriate. Effective care may also depend upon the GP or another health care professional being able to identify problems, ascertain the facts, and then, crucially, know what to do about them. The children of problem drug users may have all the health problems of other children but are also more likely to have certain conditions as a direct or indirect result of their parents' drug use. These include neonatal abstinence syndrome, infection with HIV, hepatitis B or hepatitis C, failure to thrive or meet developmental targets, and repeated accidents or other signs suggesting child abuse or neglect. Each of these issues can represent a major

challenge for primary care. Because primary care teams are invariably overstretched and necessarily concentrate on cases that are urgent and of immediate concern to patients, issues that are likely to be overlooked among children of problem drug users are chronic long-standing, low-grade social and domestic issues with a low medical content. For those practices which provide specific treatment for problem drug users such as methadone maintenance, there is also the risk that their focus may be on the individual drug user and may not extend to family work.

7.13 A recent study compared 55 children of problem drug users registered at a special practice for drug users in London with a similar number of matched children of non-drug-using parents. It found that only one-third of the study children had a GP and immunisation uptake and routine health check rates were much lower than for the control group[8]. To our knowledge, this is the only such study carried out in the UK. Whilst more such research is required, this study supports our impression that many children of problem drug users may not be benefiting from even basic primary health care.

7.14 The ideal situation is where the child is registered with a primary care team which is both committed to providing comprehensive health care for problem drug users and can recognise and meet the health needs of their children. Such a practice would liaise closely with social work children and family services, specialist drug services and the school health service, and would have access to child and adolescent mental health services when necessary. Its professional staff would have had additional training in the management of drug use. An example of a practice committed to this approach is described in Box 7.1. Particularly in areas with a high prevalence of problem drug use, providing this type of service will have resource implications for primary care services.

7.15 The Royal College of General Practitioners now runs a course for GPs on the clinical management of drug misuse. It has already been attended by over 400 GPs. In 2003, it is being opened out to other professional groups including primary care nurses, pharmacists and general psychiatrists. A number of regions are providing training for GPs from modernisation funding. The Department of Health has recommended that such courses should address parental drug use and we strongly endorse that view.

Box 7.1 A primary care clinic for problem drug users and their children

An urban general practice in an area with a high prevalence of problem drug use set up a new addictions clinic in October 2001. Its aim was to improve health care for the families of patients with drug addiction problems. For some years the practice had focused on the problem drug user. It was decided a more comprehensive service might help ensure that children of these patients would not be disadvantaged both before school and in the early years of their schooling.

The patient and her or his children must register with the practice when joining the clinic. In this way general medical services can be provided for the whole family. Oral methadone is the standard treatment for opiate addiction; benzodiazepines are rarely prescribed. The patient is seen as necessary, every week, fortnight or month, by the drug worker (seconded from the social work department), the doctor or both. The practice nurse provides well-woman care and childhood immunisations, dietary advice and general health education; the attached health visitor assists with childcare when needed; the practice secretary regularly completes a confidential questionnaire with the patient and analyses how each family is doing and coping with life. Patients are asked to bring their children to the clinic on a regular basis, as often as weekly if necessary.

As the parent's notes are completed, so too is the child's. An assessment is made of the child's appearance, general development, cleanliness, language skills, immunisation record and nursery or school attendance. If there is concern about any aspect of the child's care, the parent will be brought back more frequently until the issues are satisfactorily resolved. The clinic's measures of success for the children include full immunisation, good nursery and school attendance, and evidence that the parents are successfully coping with childrearing. In early 2003, the clinic was being attended by 52 parents with 73 children, of whom 25 were not living with the parent.

Recommendations

21. Primary Care Trusts or the equivalent health authorities in Wales, Scotland and Northern Ireland should have clear arrangements for ensuring that the children of problem drug or alcohol users in their area are able to benefit fully from appropriate services including those for the prevention, diagnosis and treatment of blood-borne virus infections.

22. Primary care teams providing services for problem drug users should ensure that the health and well-being of their children are also being met, in partnership with the school health service, children and family teams and other services as appropriate.

23. Training programmes on the management of problem drug use by primary care staff should include information about the importance of recognising and meeting the health care needs of the children of problem drug users.

Contraception and planned pregnancy

7.16 Ideally, pregnancy should be both planned and wanted by the woman herself, whatever her lifestyle and circumstances. The provision of preconceptual planning and contraceptive advice and services should thus be available to problem drug-using women. However, the Inquiry learned that most services in contact with problem drug users paid no attention to this aspect of health care provision. In giving evidence to the Inquiry, Dr Hepburn and Dr Carr from Glasgow both asserted that where a service is sympathetic and accessible to them, many female problem drug users are able to make sensible decisions about if and when to have a baby and to take effective measures to avoid pregnancy if that is their choice. Dr Carr emphasised that choice, clinical safety and compliance were the three key considerations when offering a contraceptive service. However, in her experience, neither the contraceptive pill nor the condom were suitable methods for most problem drug users because they both rely on careful and consistent forethought. Long-acting injectable contraceptives provide a practical alternative. The intrauterine progestogen coil and contraceptive implants are also effective long-term methods of contraception that can be readily reversed when required. The woman has to make a positive choice to use them, but once inserted they do not need further thought until the woman wishes to have them removed. However, they both require training to administer. Female problem drug users should also be made aware of emergency contraception now available in community pharmacies and that can prevent pregnancy if taken within 72 hours after intercourse has taken place. Termination of pregnancy should also be available if required.

7.17 Primary care services providing health care for problem drug users are well placed to offer family planning and contraceptive advice. Other specialist services for problem drug users, including methadone clinics and needle exchanges, are the main point of contact with many problem drug users and should consider carefully how they can address this issue, perhaps in liaison with family planning or sexual health services. Box 7.2 describes a service for female street sex workers in Glasgow that is jointly provided by social services and the Primary Care Trust.

Box 7.2 An evening health and social care service for female street sex workers[9]

The centre was opened in 1988, primarily to prevent HIV transmission between female street sex workers, most of whom are injecting drug users, and their clients. It now offers a wide range of health and social care services, including sexual health advice and contraception. It is located in the city's red light district and is open six days a week from 7.30 pm to midnight. Staffed by social workers, doctors and nurses, it typically has 20 to 50 clients nightly. A comprehensive primary care and sexual health service is offered, with injectable or implanted contraceptives and intrauterine coils being available as appropriate. Free condoms, needles and syringes are available, and referral can be made to other specialist services including a drug misuse treatment programme and a maternity unit.

Recommendations

24. All general practitioners who have problem drug users as patients should take steps to ensure they have access to appropriate contraceptive and family planning advice and management. This should include information about and access to emergency contraception and termination of pregnancy services.

25. Contraceptive services should be provided through specialist drug agencies including methadone clinics and needle exchanges. Preferably these should be linked to specialist family planning services able to advise on and administer long-acting injectable contraceptives and contraceptive coils and implants.

Early years education and schools

7.18 Parents are their children's first educators. If parents are unable to fulfil that role, education services will be faced with additional challenges in helping children achieve their potential. Early learning services and schools have a key role to play in the personal and social development of children and young people as well as their intellectual and academic progress. Children with actual or potential social problems will each present a set of unique circumstances, some of which can be tackled within the school setting. Positive school experiences have been shown to help children develop resilience in the face of adverse life circumstances[10]. Schools and their staff can do much to help vulnerable children but they cannot be expected to provide all the answers. They need to be supported by and liaise with other agencies and initiatives that have complementary resources and expertise.

7.19 With respect to parental problem drug use, teachers may find themselves in one of several situations, each of which has its own difficulties and consequences. They may be unaware that the child's parent or parents have drug problems. If they are aware, they may not realise the particular implications for the child. If they realise the implications, they may well not be aware of possible solutions or their role in these.

7.20 The needs of the children of problem drug users vary enormously. For some, their parents' drug use will not pose particular problems; for others, it will affect their entire upbringing. In particular, children who come to school hungry, stressed and tired may under-achieve and display a lack of motivation and general disengagement from school. They may truant, consistently be late, and fail to do their homework. They may end up in special education classes. On a social level, they may be bullied – possibly because they are often poorly presented in appearance. They may find it difficult to make friends and, for example, may not invite their classmates home. Their parents may not be involved in their education or in the life of the school, which may be particularly important and apparent at the primary school level. As such, the children of drug-using parents will not be unique among vulnerable young people at school.

7.21 As highlighted in Chapter 2, the issues confronting schools will also vary according to the age of the child. In early primary school, the child's problems may be manifest as hyperactivity or insecurity. In secondary school, truancy, offending or early drug, alcohol or solvent misuse may be the indicators. If the parental problems are persistent, the child may have difficulties throughout their time in the schools system.

7.22 The number of children in a school whose parents have drug problems will vary considerably, depending upon the extent of serious drug problems in its catchment area. However, no school should assume that none of its children's parents have serious drug problems. They also need to be aware of the unpredictability of the lives of many problem drug users which may veer from stability to chaos with startling speed, with consequent effects on their children. They should understand that a parent trying to come off drugs may not necessarily be capable of adequate parenting during that period, but one who is steadily maintained on a methadone programme might well be. It is important that teachers do not pathologise all children who have this kind of family. However, neither should they close their eyes to the realities, when to do so may mean that a crucial opportunity to help a child may be missed.

7.23 School may represent a safe haven for these children, the only place where there is a pattern and a structure in their lives. They may develop a trusting relationship with a teacher and, as a consequence, talk about the drug use in their family. This kind of disclosure will need to be handled carefully by the school. A clear procedure for doing so should be included in the school's drug policy and other relevant policies such as the school's confidentiality policy. Another way in which parental drug use may come to light is when an intoxicated parent arrives to pick up a pupil at the end of the school day, which is clearly a child protection issue. Responses need to strike a balance between maintaining a safe and caring environment for all pupils and providing for the welfare of the children of drug-using parents.

Children as carers

7.24 A particular issue for schools is that of pupils acting as carers for their drug-using parents. Here the roles of child and parent become confused. This can account for a range of behaviours such as persistent lateness, truancy, tiredness and consequent under-achievement. Such children may feel they are responsible for their parents' behaviour and changes in mood. As a result, they may develop intense feelings of guilt. They may be afraid of what happens at home becoming public knowledge, which may lead to their becoming isolated from other children or mixing with older children who are themselves problem drug users.

Drugs education in schools

7.25 Drugs education in schools should aim to provide children and young people with opportunities to increase their knowledge and understanding, develop their personal social skills, explore their attitudes in relations to drugs and drug use, and enable them to make informed choices. It will normally be covered within the wider context of Personal, Social and Health Education. It is important that teachers provide drugs education, with the support of other professionals and agencies as appropriate, which starts where pupils 'are at' and is sensitive to their backgrounds, experience and needs. They should know where they can get additional help and support if they want it. Teachers should ensure that the classroom is a safe learning environment and that children do not have their anxieties raised. In particular, drugs education may cause discomfort or distress to the children of problem drug users by drawing attention to their own family circumstances or heightening anxieties that their parents may come to harm. Preparation for such teaching, whether delivered by a teacher, police officer or others, should therefore address this possibility.

School policy and procedures

7.26 Many teachers may be unaware of the procedures to adopt if they discover a pupil is living with drug-using parents. They may assume that this in itself constitutes significant harm and overreact. On the other hand, some teachers may be reluctant to 'act as social workers', and may see efforts to meet the needs of children of drug-using parents as an additional and unnecessary burden.

7.27 Teachers should thus have the support of a school drug policy that provides clear guidance on how to handle drug-related incidents or how to support pupils who have drug-using parents or carers. This guidance should cover:

- procedures on dealing with disclosure and confidentiality;
- a definition of significant harm in terms of child protection and guidance on when to invoke child protection procedures;
- the boundaries of the school's responsibility;
- a protocol for the assessment of pupils' needs in terms of welfare and support;
- how to access sources of support for the child and family including links with other statutory and community services;
- when and how to involve other agencies;
- a protocol for dealing with drug-related incidents.

7.28 These policies should be developed in consultation with governors, teachers, other school staff, pupils and parents or guardians. The local education authority has a role to play in encouraging and guiding schools in the formulation of their drug policies.

7.29 All schools are required to have a designated teacher for child protection who should play a pivotal role in supporting the teaching staff. School nurses may also play an important role. Dealing with the problems that might arise with children of drug-using parents should thus be covered in the training of such key staff, so that they can be a source of advice and information in a school. They would be the first point of contact for the teacher or teaching assistant allotted to the pupil.

7.30 Possible practical steps the school could take include:

- inviting the parents to talk to the head teacher or the teacher nominated for child protection issues on a confidential one-to-one basis;
- ensuring constant vigilance of known vulnerable children;
- providing pupils with additional educational and pastoral support;
- encouraging participation in supervised extra-curricular activities;
- providing pupils with information on where they can get additional confidential support if they do not want to talk to a teacher.

7.31 The children of problem drug users should be able to benefit from initiatives which are designed to support vulnerable children, some of which may be accessed through school services, such as breakfast clubs, whilst

others may have strong links to schools, such as Connexions, the new multi-agency service in England designed to provide advice, guidance, support and personal development for all 13–19-year-olds (see 6.19).

Recommendations

26. All early years education services and schools should have critical incident plans and clear arrangements for liaison with their local social services team and area child protection committee when concerns arise about the impact on a child of parental problem drug or alcohol use.

27. All schools should identify at least one trained designated person able to deal with the problems that might arise with the children of problem drug users.

28. Gaining a broad understanding of the impact of parental problem drug or alcohol misuse on children should be an objective of general teacher training and continuous professional development.

Social services: Children and family services

7.32 Throughout the UK, every local authority area social services department has a children and families service with responsibility for child protection and childcare. For every child referred to the service, a systematic assessment is an essential first step to establish whether a child is in need or at risk and if so how. In 2000, the Department of Health introduced throughout England and Wales a new Framework for the Assessment of Children in Need and their Families. Whilst primarily designed for use by social services, the conceptual framework of assessing the child's needs against parental capacity in the context of their wider family and environment (Box 7.3) can be of use to a wider range of practitioners in health and education services. This includes inquiring about parental drug or alcohol misuse. Work on a similar approach is underway in Scotland.

7.33 The aim is to provide a common recording mechanism to improve communication, achieve consistency, avoid duplication and provide a sound basis for action. The assessment is designed to identify potential strengths within the family situation as well as difficulties. The assessment should not be a single event but a continuing process that keeps pace with the child's changing circumstances and seeks to identify strengths that can be built upon as well as weaknesses.

Box 7.3 Main headings in the Department of Health framework for assessment

Child's developmental needs
Health
Education
Emotional and behavioural development
Identity
Family and social relationships
Social presentation
Self-care skills

Family and environmental factors
Family history and functioning
Wider family
Housing
Employment
Income
Family's social integration
Community resources

Parenting capacity
Basic care
Ensuring safety
Emotional warmth
Stimulation
Guidance and boundaries
Stability

A supplementary framework for assessing problem drug use and its impact on parenting in more detail has been developed within the SCODA guidelines[1] and more recently adapted and expanded by the Scottish Executive[2]. The areas covered by the supplementary frameworks are summarised in Box 7.4.

7.34 Since April 2001, social services in England have been required to use the framework in all assessments of children in need and their families. A variety of different assessment tools are used in other parts of the UK. The supplementary framework for assessing problem drug use is used by social services in England and Wales and in a modified form in Scotland on a voluntary basis. The Inquiry considers that these assessment frameworks provide a good basis for acquiring the information needed to understand the child's circumstances and needs. It would be preferable, however, if the supplementary questions on problem drug use were included within the main assessment framework. The child's own perception of the situation should also be sought and recorded whenever possible.

Box 7.4 Supplementary framework for assessing problem drug use and its impact on parenting[1]

Parental drug use
Accommodation and the home environment
Provision of basic needs
Procurement of drugs
Health risks
Family and social supports
Parents' perception of the situation

7.35 Should the assessment lead to a decision that the child can remain at home, plans will be required to mobilise support for the family in an attempt to safeguard the child's welfare. Ideally, an holistic and integrated package of family support should be offered. Whether and how this can be done will depend upon the exact nature of the child's needs and family situation and the service resources. It could include:

- support for parents and the extended family, eg treatment of the parents' drug misuse; advice and support on parenting skills; help in improving accommodation or accessing benefits;
- support for children, eg providing occasions for the safe and contained expression of their own ideas and feelings; enabling them to have fun; arranging attendance at nursery; providing special educational support; providing access to health care and other services; arranging assessment and treatment of emotional and behavioural problems.

7.36 The support available will clearly vary considerably across the country, and what is possible may only address some of the problems and then only partially. Furthermore, given the often fluctuating nature of problem drug use and the potential for crises, frequent review of the circumstances is essential.

7.37 The Inquiry recognises that there are numerous obstacles that have to be overcome if the best of intentions are to be translated into effective action. These include:

- social work and other child welfare agencies being unaware of the child's needs;
- lack of co-operation by the parents, eg not keeping appointments, not responding to letters or calls, not enabling the worker to properly assess the child;
- issues of confidentiality, eg GPs unwilling to share information about parents' or other relatives' health;
- losing touch if the family moves away;
- difficulty in responding to the often rapid changes in the child's circumstances;
- difficulty in deciding when it is in the best interests of the child to remove it from the parents;
- in many cases, no plan can address all the needs of the child;
- lack of staff and resources to carry out the plan;
- staff insufficiently trained to tackle issues around drug misuse;
- poor liaison with other agencies, especially those whose main focus is the parent rather than the child and where the interests of the adult and the child might be in conflict, eg adult focused addiction services.

Unfilled posts

7.38 A particular problem affecting children's services across the country is the difficulty in recruiting and retaining staff. If there are many vacancies or rapid turnover of teams, this clearly makes it more difficult for social work services to fulfil their responsibilities for protecting and caring for children. In 2001, in both England and Scotland, 11% of all children's services social worker posts were vacant, representing a total of 2,774 posts[11]. In Wales, the overall vacancy rate was about 13%, with considerable variation between authorities. The Scottish Child Protection Audit and Review attributed these vacancies to "the unattractive nature of working with children and families in a hostile public and press climate and the migration of children's social workers to the voluntary sector or new projects such as new community schools."[11]

Training

7.39 Social care staff can only be expected to act effectively in the interests of the children of problem drug users if they are properly trained. Over the past two years Social Care Councils have been established in England, Wales, Scotland and Northern Ireland with the task of registering social care workers and regulating their conduct and training. It is to these Councils that we look to ensure that all future social care workers who are working with children and families are suitably trained regarding the impact of problem drug use on children, how such children and their families can be assessed and what practical steps can be taken to help them.

7.40 The Inquiry recognises that achieving all these elements is currently unattainable in most if not all parts of the country. However, the aim should be to move in that direction as far and as quickly as is practically possible.

Recommendations

29. All social services departments should aim to achieve the following in their work with the children of problem drug users:

- An integrated approach, based on a common assessment framework, by professionals on the ground including social workers, health visitors and GPs, nursery staff and teachers, child and adolescent mental health services.
- Adequate staffing of children and family services in relation to assessed need.
- Appropriate training of children and family service staff in relation to problem drug and alcohol use.
- A co-ordinated range of resources capable of providing real support to families with drug problems, directed both at assisting parents and protecting and helping children.
- Sufficient provision of foster care and respite care suitable for children of problem drug users when their remaining at home is unsafe.
- Efficient arrangements for adoption when this is considered the best option.
- Residential care facilities that provide a genuinely caring environment for those children for whom this is the only realistic option.

30. The Government should continue to explore all practical avenues for attracting and retaining staff in the field of child protection.

31. The new Social Care Councils for England, Wales, Scotland and Northern Ireland should ensure that all social care workers receive pre-qualification and in-service training that addresses the potential harm to children of parental substance misuse and what practical steps can be taken to reduce it. Consideration should be given to the inclusion of such training as a prerequisite for registration by the appropriate professional bodies.

Fostering, residential care and adoption

7.41 In the great majority of cases where there is concern about the well-being of the child, effective support should enable the child to remain with his or her mother and/or father. However, if it is judged this is not in the child's best interests, fostering, residential care or adoption may have to be considered. The outcomes for children placed in residential care are particularly poor, with the likelihood of future unemployment, offending and homelessness being much higher than for the general population. There is also a high level of drug misuse and pregnancy among teenagers in care. It should therefore be considered the option of last resort. There is good evidence that adopted children do better than children who grow up in the care system[12].

7.42 Table 7.1 shows the number of children in these categories in England, Wales and Scotland in 2001. No information is available about the proportions of these cases where parental problem drug or alcohol use played a significant role. However, as can be seen from Table 7.1, adoption is the outcome for only about 5% of all cases of looked after children. In practice, therefore, the number of children of problem drug users who are currently being adopted is very small. The majority of children who receive foster or residential care will return home.

7.43 The procedures required to complete an adoption can be lengthy. They may be particularly protracted when the natural parent may be given the opportunity to undergo drug rehabilitation in the hope that she or he may subsequently be able to resume parenting. The British Association for Adoption and Fostering told the Inquiry that, in their experience, where parents had a significant drug problem the assessment of their capacity for recovery was sometimes unrealistically optimistic. After a period of rehabilitation, there was often a relapse. The child's circumstances were thus no better and significant developmental damage and delay could have occurred, particularly for the very young child. The need for a comprehensive and careful assessment of the child's needs and of the home and parental circumstances cannot be underestimated. Where appropriate, this should include expert advice about the realistic prospects for treatment of the parental drug problem. Both the Department of Health and the Scottish Executive have recently been reviewing adoption with a view to enabling a greater number of adoptions to occur. However, even if the numbers were to increase by 50% or more, the actual number of children of problem drug users this would benefit would be small.

Table 7.1: Numbers of looked after children in England, Scotland and Wales on 31 March 2001

	England	Scotland	Wales	Total (%)
Foster care	38,400	3,084	2,690	44,174 (60)
With own parents	6,900	4,842	408	12,150 (17)
Other community placements	1,200	980	52	2,180 (3)
Secure units, homes and hostels	6,800	1,451	235	8,486 (11)
Placed for adoption	3,100	196	176	3,472 (5)
Other	2,500	344	83	2,979 (4)
Total	58,900	10,897	3,644	73,441 (100)

7.44 Of the three main options, fostering is most often the most appropriate and may be particularly suitable for short-term placements where it is likely that the child can return to its own parents in due course. There is a shortage of foster carers in many parts of the UK. Few will have the training to deal with issues arising from parental drug use or particular risks such as blood-borne virus infections. We were encouraged to learn that the Government is undertaking a major review of the child placement system with a particular emphasis on fostering. We consider that fostering offers the greatest potential for development. However, there is a need to increase both the flexibility of arrangements and the intensity of the support that can be offered foster parents. Much depends upon being able to recruit and retain dedicated and able foster parents. How they are trained, financially resourced and supported by health, education and social services is clearly important, especially if they are being expected to provide a caring family environment for children with significant developmental or behavioural problems.

7.45 A particular focus of the Government's new Choice Protects programme in England is on enabling more relatives to obtain formal status as foster parents for children who cannot live with their natural parents. Provided rigorous vetting and supervisory procedures are in place, this may provide a satisfactory solution for some children.

Recommendations

32. Residential care for the children of problem drug users should be considered as the option of last resort.

33. The range of options for supporting the children of problem drug or alcohol users should be broadened to include: day fostering; the provision of appropriate education, training and support for foster parents; and robust arrangements to enable suitable willing relatives to obtain formal status as foster parents.

34. Where fostering or adoption of a child of problem drug users is being seriously considered, the responsible authorities should recognise the need for rapid evidence-based decision-making, particularly in the case of very young children whose development may be irreparably compromised over a short period of time.

Specialist drug and alcohol services

7.46 Throughout the UK, there are well over 800 agencies which offer advice, treatment or support to people with drug problems. The vast majority cater for both men and women with serious drug problems. As we have seen, nearly half of all clients at drug agencies have children, a large proportion of whom continue to live with at least one parent with drug problems. However, the survey of drug agencies carried out for the Inquiry revealed that **only a minority of agencies make any provision for the children of their clients, and we identified only a handful which made deliberate attempts to assess and meet their needs.**

7.47 Because drug agencies are often the main ongoing agency in contact with problem drug-using parents, we believe they should play an important role in the overall effort to support parents and their children. Thus, we have concluded that in the medium to longer term, drug agencies should aim to contribute to assessing and meeting the needs of their clients' children. This should be seen as an integral part of reducing drug-related harm. We recognise it will not be easy and cannot be done overnight. It will have major resource, staffing and training implications. In this section, we consider what the basic elements of such provision might be and offer examples of agencies which appear to be doing this successfully.

Information

7.48 An agency cannot even begin to consider the needs of the children of its clients until its staff know they exist. An essential prerequisite is therefore to include both in the client's primary and ongoing assessment questions about whether the client has children and who is looking after them. For services in a position to explore the needs of clients' children, a detailed framework for assessing the impact of problem drug use on parenting and the child is now available (see 7.32). Consideration is currently being given to the use of the Assessment Framework by adult services where service users are parents of dependent children.

Key tasks for drug agencies

7.49 In their efforts to help the children of clients, we believe that drug agencies should concentrate upon doing the basics well and liaising closely with other agencies rather than attempting too much themselves. Key tasks should include:

- aiming to reduce or stabilise the parent's drug use as far as possible. For example, if abstinence is a realistic objective, arranging detoxification and providing effective support thereafter. If methadone maintenance is appropriate, ensuring the methadone is given in an adequate dose with supervised consumption until unsupervised consumption at home can be safely assured.
- discussing with the client safety at home including storage of drugs and needles;
- if the woman is pregnant, ensuring or enabling her to attend antenatal services;
- liaising with the family's health visitor in the child's early years;
- ensuring the child is registered with a GP and has received basic health checks and immunisation;
- assisting the parents in ensuring the child receives nursery, pre-school and school education;
- liaising with the local child protection team if there is concern that the child or children are coming to significant harm;
- involving mental health services where the client has significant mental health problems.

Woman and child-centred services

7.50 As we have seen from the analysis of the regional drug misuse databases, it is much more likely that drug-using mothers will continue to have direct responsibility for their child or children than drug-using fathers. Providing support for pregnant female drug users is also an important task. If drug agencies are to meet the needs of their clients' children, it therefore seems essential to offer services that meet the needs of women who are pregnant or have dependent children. A recent Home Office study of drug service provision for women identified 64 organisations across the UK that provided specific services for women problem drug users. In-depth case studies of 18 were then carried out[13]. The authors described a number of barriers which could reduce the attractiveness or effectiveness of services for women. These included:

- stigmatisation and child protection issues;
- weakness in maternity services;
- lack of childcare and transport facilities.

Addressing obstacles

7.51 A number of the services examined in depth had done much to address and overcome these obstacles. Approaches which they had taken to address women's overall needs included:

- building trust and confronting confidentiality issues;
- dealing with women's immediate and continuing needs;
- dealing with their mental health problems.

7.52 Ways in which they had sought to meet the needs of women with children in particular included:

- providing childcare and/or child places to enable children to remain with their mothers while they attend the service;
- home visiting targeted at pregnant women and women looking after children;
- developing close liaison with maternity services through, for example, involvement with a dedicated midwife.

Meeting childen's needs

7.53 Very few of the services appeared directly to address the needs of the children themselves. Examples included:

- setting up a specialist service for meeting the needs of the children and involvement with the formal aspects of child welfare services. Two services had

a distinct children's manager whose remit was to assess and meet the needs of children. Several services provided information to social services such as assessments and reports, and participated in multi-disciplinary meetings and child protection conferences.

- taking a holistic family approach, focusing on the child and mother together. Staff at four services worked to improve women's parenting skills, showing them how their drug use impacted on their children and working out strategies to reduce this. These drug services recognised that they had to work with women and their children in order to tackle the women's drug use effectively.

7.54 Few of the community-based organisations featured in the report had childcare facilities and across the UK there are very few residential places for mothers with children. Some of these are featured in Appendix 2. These gaps in provision are at least in part due to the expense of providing good quality facilities and additional staff and a lack of suitable space within existing services to meet crèche registration requirements. In residential care, a child place is almost as expensive as a single adult place. It is therefore clear that some aspects of improved service provision are dependent upon additional resources being made available to allow facilities to be expanded and staffed appropriately.

7.55 It was very evident to the Inquiry that the UK is at a very early stage in what we see as the necessary process of enabling drug agencies to play a significant part in meeting the needs of the children of problem drug users. Much more work will be required involving Drug Action Teams in concert with social work services, primary care trusts, maternity services and the voluntary sector to build upon the examples of good practice that already exist and gradually to increase capacity, largely within existing drug agencies. There is a need to evaluate carefully existing services, learn what works best and make the findings available to service planners throughout the country. Building capacity will require additional resources and staff. Neither is likely to be available in the quantity required in the short term. A shortage of trained staff is a key issue which can only be addressed by creating attractive and adequately paid posts and ensuring that staff obtain the specialist skills they will require.

Recommendations

35. Drug and alcohol agencies have a responsibility towards the dependent children of their clients and should aim to provide accessible and effective support for parents and their children, either directly or through good links with other relevant services.

36. The training of staff in drug and alcohol agencies should include a specific focus on learning how to assess and meet the needs of clients as parents and their children.

Specialist paediatric and child and adolescent mental health services

7.56 If a child develops either a physical or mental health problem, failure to recognise that it may have its origins in parental behaviour or home circumstances could have serious consequences for the child's future safety and well-being. Parental substance misuse may be obvious and acknowledged but it can also be concealed. If staff at an accident and emergency department or paediatric clinic or ward suspect child abuse or neglect or accidental drug overdose, an appropriate doctor or nurse should inquire if anyone at home has a drug or alcohol problem and if necessary make further inquiries, for example, with social work or the family general practitioner.

7.57 As we discussed in Chapter 2, children of problem drug users are more likely to develop behaviour disorders and other mental health problems than other children. However, the Inquiry received evidence that child and adolescent mental health services do not routinely ask about parental drug or alcohol misuse. In a review of 108 child and adolescent mental health (CAMS) cases, only 28 records showed evidence of inquiry about the child's drug use and only 20 of inquiry about parental drug or alcohol use[14]. As a result, an important contributory factor could have been missed. We therefore think that parental drug or alcohol misuse should always be considered when assessing the child in these circumstances. Consequently, professionals working in child and adolescent mental health services should receive the training needed to be able to assess parental substance misuse adequately.

Recommendations

37. The possible role of parental drug or alcohol misuse should be explored in all cases of suspected child neglect, sexual abuse, non-accidental injury or accidental drug overdose.

38. Child and adolescent mental health services should routinely explore the possibility of parental drug or alcohol misuse.

39. Acquiring the ability to explore parental substance misuse should be a routine part of training for professionals working in child and adolescent mental health services.

Specialist children's charities and other non-statutory organisations

7.58 A number of charitable organisations have the health and well-being of children as their main focus. Some of these are large and well known and provide services across the UK. Many others work at a regional or community level. We sought information from the leading charities in the field regarding their current involvement with the children of problem drug users. Some had already developed initiatives specifically aimed at helping the children of problem drug users, but these were typically on a small scale at a local community level. Most had not, although without exception they expressed a willingness to explore the possibility of future involvement. Through our survey of specialist addictions services we also learned about other organisations that have developed services designed to help children of problem drug users (Chapter 4). Our findings are summarised in Appendix 2. On the basis of the information we obtained, we concluded that there is considerable undeveloped potential within the non-statutory sector specifically to help the children of problem drug users. Partnership with the statutory agencies, with each agency contributing its particular expertise, is likely to be the best way forward.

7.59 There would be considerable merit in the formation of a national association of agencies dedicated to helping the children of problem drug or alcohol users. This would give a much needed focus for sharing ideas, experience and best practice, and catalysing the development of new services across the country.

Recommendations

40. Given the size and seriousness of the problem, all non-statutory organisations dedicated to helping children should make strategic provision for responding to the needs of children of problem drug or alcohol users.

41. Drug Action Teams should explore the potential of involving non-statutory organisations, in conjunction with health and social services, in joint work aimed at collectively meeting the needs of the children of problem drug or alcohol users in their area.

42. Agencies committed to helping the children of problem drug or alcohol users should form a national association to help catalyse the development of this important area of work.

Police

7.60 Many problem drug users have frequent contact with police because of possession of or dealing in illegal drugs, theft or other property crime, or behaviour giving rise to concern for their own or others' safety. Regarding the protection and supporting of children of problem drug users, police action will depend on whether protection is required immediately or otherwise.

7.61 Urgent protection is effected under section 46 of the Children Acts and is termed 'police protection'. There are minor differences in the legislation in Scotland (see Chapter 5). A police officer may take a child under police protection if he or she reasonably believes that the child is currently experiencing or is likely to suffer 'significant harm'. The police protection ceases as soon as the need to give protection ceases but lapses in all circumstances after 72 hours. As far as possible, children are not taken to police stations but to appropriate premises, such as the home of a responsible relative, social services accommodation or a hospital. Under section 49 of the same act, it is an offence for a parent or carer to remove a child under police protection from such premises. Section 47 requires social services to investigate the circumstances under which any child is subject of police protection. Consequently, in each and every case police are required to notify social services.

7.62 If the need is not urgent but police still have concerns for the welfare of children, the issues should be reported to social services. Every force in the country now has officers trained as specialists in child protection. All reports of concerns regarding the welfare of children

are also sent to these officers, and, in most cases, it is they who refer the matter to social services.

7.63 As part of a drive to develop a multi-agency pan-London child abuse prevention strategy, the recently formed London Child Protection Committee published in 2002 a booklet, *Capital initiatives: Safeguarding children and young people in London*. One of the 18 initiatives listed refers to drug and alcohol misuse and children at risk. Some of the borough Area Child Protection Committees in London, including Islington and Camden, have introduced protocols to provide guidance to many service providers concerned with children's welfare. A multi-agency steering group oversees the development of the strategy and the Metropolitan Police has set up a small strategy unit to spread the initiatives throughout the 32 Area Child Protection Committees in London. This is an important step, because at present the police are most likely not to communicate concerns over the welfare of problem drug users' children unless immediate action is required.

7.64 Police officers engaged on operational duties can be under immense pressure to deal with many differing and competing demands, some of a serious or potentially serious nature, as expeditiously as possible, whilst trying to maintain high visibility policing on patrol. The dangerous temptation to assume that other agencies 'know' all about a particular parent or carer who is a problem drug user is far from unique to the police service. Nevertheless, the police as an organisation are fully committed to the principle that 'the welfare of the child is paramount'. In this context, the need to report children coming to the notice of police in non-urgent circumstances is vital, and is an obligation which needs continual reinforcement to police officers. Adoption of a multi-agency child protection strategy by every force in the country would assist this process.

Recommendation

43. Every police force in the country should seek to develop a multi-agency abuse prevention strategy which incorporates measures to safeguard the children of problem drug users.

Courts and prisons

7.65 If there is a possibility of a woman being held in custody, it is clearly important for the court service to establish whether she has dependent children and, if so, whether satisfactory arrangements for their care can be made. With the establishment of special Drug Courts and Drug Treatment and Testing Orders, greater opportunities now exist for sentencers to use court orders and community-based sentences that will enable problem drug users to remain with their children if this is considered appropriate by the court. However, among around 200 recent cases handled by the pilot Drug Court in Glasgow, only 8% were women and childcare did not often appear a significant consideration[15]. Training of sentencers may be needed to enable them to understand the importance of considering the interests of the child in this context.

7.66 A Home Office survey of English women's prisons in 1997 found that 41% of sentenced prisoners and 54% of those on remand had evidence of drug dependence. Most sentenced female drug users spend less than 12 months in prison. Fifty-five per cent of all women prisoners had at least one child under 16 and 11% had one or more children in care. The proportion of drug dependent prisoners who had one or more children was not given. However, it is clear there is a large number of female drug misusers in prison and many of these have children, most of whom are probably not in care. No information is available about how many female prisoners are pregnant or give birth each year.

7.67 There is a mother and baby unit in four English prisons with a total of 64 places. Their purpose is to allow the mother and baby relationship to develop whilst safeguarding the child's welfare. Admission to a mother and baby unit is considered by a multi-disciplinary panel within the prison including representatives of social work and probation services. Those considered suitable must sign an agreement to remain free of drugs with the exception of those prescribed by the prison medical service, including methadone. Mothers are permitted to have their child with them until up to 18 months of age. Children outside the prison are not the responsibility of the prison but prisons will generally provide visiting arrangements intended to foster family links.

7.68 In Scotland's only women's prison, a multi-disciplinary case conference can recommend to the governor that a mother be allowed to keep her baby with her. If the governor agrees, the mother and baby can share a room in the low security area of the prison, away from unsuitable prisoners.

7.69 Where a female problem drug user with a dependent child or children is in prison, it is vital that steps are taken to prepare her for release and the resumption of her parental responsibilities where appropriate. This may often require close liaison between the prison authorities and a number of other agencies, including the social service children and family team, a specialist drug agency and the woman's general practitioner. If the sentence has been for a year or more, the probation service (in England and Wales) or social service criminal justice staff (in Scotland) may also be involved. A wide range of potentially difficult issues may need to be addressed. These may include an assessment of the mother's parenting capacity in the light of all the circumstances, including a review of her current drug use and related treatment in prison and the potential for relapse in the community. Thereafter, if custody of the child or children is to be resumed, there may be a need to put in place an appropriate level of support for the family and arrange suitable ongoing treatment and support for her drug problem. Ensuring all this happens is a difficult task which may be compounded if the prison is far from where the woman lives or if release from prison is at short notice. If these measures are not taken, however, there may be significant potential for harm to the child or children. This underlines the importance of women's prisons developing effective aftercare arrangements built on strong links with the relevant outside agencies.

Recommendations

44. When custody of a female problem drug user is being considered, court services should ensure that the decision fully takes into account the safety and well-being of any dependent children she may have. This may have training implications for sentencers.

45. The potential of Drug Courts and Drug Treatment and Testing Orders to provide non-custodial sentences for problem drug users with children should be explored.

46. All women's prisons should ensure they have facilities that enable pregnant female drug users to receive antenatal care and treatment of drug dependence of the same standard that would be expected in the community.

47. All female prisoners should have access to a suitable environment for visits by their children. In addition, where it is considered to be in the infant's best interests to remain with his or her mother, consideration should be given by the prison to allowing the infant to do so in a mother and baby unit or other suitable accommodation.

48. Women's prisons should ensure they have effective aftercare arrangements to enable appropriate support to be provided after release for female problem drug users with children.

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Chapter 8
Conclusions

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8.1 We believe that our report's title, Hidden Harm, accurately describes what it is about. Whilst there has been huge concern about drug misuse in the UK for many years, the children of problem drug users have largely remained hidden from view. The harm done to them is also usually unseen: a virus in the blood, a bruise under the shirt, resentment and grief, a fragmented education.

8.2 We have for the first time provided an estimate of the number of children of problem drug users in the UK. We were ourselves surprised to discover that around 2–3% of children in England and Wales and probably more in Scotland are involved. This is a situation which has developed in the space of a generation. It is a consequence of two things: the rapid rise through the 1980s and 1990s in the number of people misusing heroin and other psychoactive drugs; and the inevitability of babies when most drug misusers are of an age when they are at their most sexually active. It is clearly not a static situation. If the number of problem drug users continues to grow, so will the number of children. Conversely, it will require a decline in the number of problem drug users before the number of their children will fall. Until such a fall occurs, the most we can do is try to limit the harm and make the best of unpromising circumstances.

8.3 The impact of parental problem drug use on children is immensely complex. Because of their numerous effects on the users' physiology and behaviour, drugs and drug taking have the potential to disturb every aspect of their child's development from conception onward. The extent of the damage and disadvantage varies enormously. However, the more evidence we gathered, the more we became convinced that the consequences for children are often severe and long lasting. It was shocking to learn that almost a third of the mothers and two-thirds of the fathers in our analysis in Chapter 2 no longer lived with their children. There was clear evidence that the more severe the parents' drug problems, the more likely they are to be separated from their children. If about 2–3% of all children in England and Wales are affected but parental problem drug use is a major contributory factor in 20% or more of the cases on the child protection register, that in itself is an indication of the potential for serious harm.

8.4 There is no doubt that many problem drug users have as strong feelings of love for their children as any parent and strive to do the best they can for them. Some manage to sustain family lives that are outwardly remarkably normal. However, the testimony from some children in relatively stable families shows that the drug-related behaviour of even the best intentioned parents often generates deep feelings of rejection, shame and anger. The children often simply said that their parents were not 'there for them'.

8.5 We have not directly addressed the issue of parental alcohol use. However, it is clear from much of the evidence we have gathered that there are probably even more children affected by parental problem alcohol use and there are many families where alcohol and other drugs are both used harmfully. Physical violence is more likely where alcohol or crack cocaine is involved. The use of crack cocaine has been growing steadily in the UK in recent years and it is therefore a matter of deep concern that some of the most serious cases of child abuse in Inner London identified in the study by Harwin and Forrester involved crack cocaine[1].

8.6 If we now better understand the scale and nature of the problem, what can we do about it? We have highlighted the importance of the child protection system. Recent reviews have identified its shortcomings and we strongly support the efforts now being made to improve its effectiveness. Enabling the professionals involved to identify and respond appropriately to parental drug or alcohol misuse will be an important part of that task. Problem drug use prospers especially in circumstances of poverty and disadvantage, from which the children of problem drug users are by no means the only ones to suffer. From our Inquiry's perspective, we are therefore fully supportive of the many current initiatives designed to improve the lives of disadvantaged children in general. Our main concern is that they are not yet sufficient in scope and intensity to match the daunting numbers of children and complexity of their needs.

8.7 We think that the existing service infrastructure can do much to provide practical help that will be of real benefit to children of problem drug users. But this will not happen unless changes are made. We would make four key points:

- Effective treatment of the parents' drug problems is one of the most likely ways to enhance their parenting capacity – expanding high quality treatment services across the country should benefit children as well as adults.
- Effective treatment of the parent is not enough: substance misuse services must see the child behind the client and recognise their responsibility for ensuring the child's well-being, in partnership with others. The children must be seen and listened to, their needs assessed and responded to. Substance misuse services must therefore become family-focused and child friendly.

- Health services, social services, education services and the criminal justice system can all do more to help the children of problem drug users in ways we have outlined. These require a willingness to work together and share information, and better training. Additional or redeployed resources may also be required.

- We have seen there is considerable untapped potential in the non-statutory sector for developing genuinely helpful services. Again additional resources are likely to be needed to enable the few examples we found to develop and multiply.

8.8 In conducting our Inquiry, our eyes were opened to an aspect of drug misuse of which most of us had been largely unaware. We hope this report will open the eyes and minds of many more people and stimulate a compassionate and practical response on a large scale.

Reference

1. Harwin, J and Forrester, D. *Parental substance misuse and child welfare: A study of social work with families in which parents misuse drugs or alcohol*. London: Interim Report for Nuffield Foundation, 2002.